Arch | Insurance

Paid Leave Delaware **Bonding Leave**

If you work in Delaware, you can apply for the Delaware Paid Leave Insurance. Arch Insurance will review all applications to determine your eligibility for benefits. The employee who is applying for leave must complete this certification. This certification will be shared with Arch Insurance and your employer*.

This Application ("Claim") is completed by the individual that is requesting paid leave benefits (the "Claimant"). Applications may be filed up to 30 days prior to the start of the requested leave, and up to 30 days after the start of the leave. A fully complete application for benefits includes a Claimant statement, employer statement, certification relating to the type of leave being requested, and supporting proof documentation for the leave. Claims filed outside this window will be denied unless good cause is provided for late filing. Claim filing is the responsibility of the individual that is requesting paid leave benefits. The Claimant is responsible for providing any missing or additional requested information during the claim process and is responsible for informing all required parties of any changes to leave plans.

Before you apply for DE PFML...

Check eligibility requirements for leave

Plan your leave. Leave can be taken continuously or intermittently, in accordance with DE PFML.

Notify your DE employer at least 30 days before the start of leave (if the leave is foreseeable). Otherwise, notify your employer as soon as possible.

Complete your claim form(s) and attach required documentation

Employee complete Part A, Claimant's Statement, in full. Sign and date the form, retain a copy for your files and give the claim package to your employer so they can complete Part C.

Employee completes Part B, the *Bonding Certification,* and attach supporting documentation.

Your DE employer completes Part C, Employer's Statement, in full. They should make a copy of the claim for their files, and return the completed employer's statement to you.

Email or mail completed claim form:
Arch Insurance Company
P.O. Box 26316
Collegeville, PA 19426
Phone: 877-369-0979
Fax: 610-977-3216
Email: archdbl@acitpa.com

*Benefits described within are underwritten by Arch Insurance Company, NAIC #11150, a member company of Arch Insurance Group Inc. ("Arch"). Please refer to your policy for detailed terms and conditions. The information you provide to Arch on this form will be used to administer Delaware Paid Leave benefits. In order to process your claim application, and determine your eligibility and benefit amount, Arch may share your information with your current and/ or past employer(s), and Delaware Paid Leave Partners.
Visit **archinsurance.com/disability** or call **877-369-0979** for more information.

Questions? Contact us at **877-369-0979**
or find us online at **archinsurance.com/disability**

Request for Delaware Paid Family and Medical Leave (PFML) - Bonding Leave

Part A: Employee Information
(to be completed by the employee requesting leave)

Demographic Information

1 **Employee's Legal Name:** _____
(First Name, Middle Initial, Last Name)

2 **Employee's Mailing Address:**

Street _____

Address line 2 _____

City _____ State | __ __ | Zip | __ __ __ __ __ |

3 **Social Security Number:** __ __ __ - __ __ - __ __ __ __

4 **Employee's Date of Birth:** | m m / d d / y y y y | __ __ / __ __ / __ __ __ __ |

5 **Employee's Gender:** ☐ Male ☐ Female ☐ Non-Designated / Other

6 **Employee's Phone #:** (__ __ __) - | __ __ __ | - | __ __ __ __ |

7 **Employee's Email Address:** _____

Leave Information

8 **Leave Pattern and Period(s) Requested:**

☐ Continuous: Leave Start Date | m m / d d / y y y y | __ __ / __ __ / __ __ __ __ | Leave End Date | m m / d d / y y y y | __ __ / __ __ / __ __ __ __ |

☐ Intermittent: Leave Start Date | m m / d d / y y y y | __ __ / __ __ / __ __ __ __ | Date(s) Requested: _____ _____

9 **Was 30 days Advanced Notice Given to Your Employer for this Leave?**

☐ Yes Date notice provided to employer | m m / d d / y y y y | __ __ / __ __ / __ __ __ __ |

☐ No Reason: _____

Part A Continued on Next Page

Request for Delaware Paid Family and Medical Leave (PFML) - Bonding Leave

10 **Other Types of Leave:**
Provide detail on other types of benefits/leave taken or requested for this leave, and whether it will extend through the current requested leave period covered by this claim.

Benefit Type	Received	Claimed	From (mm/dd/yyyy)	Through (mm/dd/yyyy)
a. Unemployment benefits	☐	☐		
b. Workers' Compensation	☐	☐		
c. Short term disability (STD)	☐	☐		
d. Other (Sick/vacation/PTO or other employer paid leave. Please specify.)	☐	☐		

11 **Will you be recieving payments from your Employer while out on DE PFML?**

☐ Yes

☐ No

If yes, by signing below you are confirming assignment of the payment of your benefits to Your Employer.

Declaration and Signature:

WARNING: Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement of a material fact, may be guilty of insurance fraud. I further certify that if benefits are paid in excess of the amount to which I am entitled, I will return to the payor of such benefits, the amount that was overpaid, and I acknowledge that failure to do so may result in the accrual of interest and other penalties.

I am hereby making a request for benefits under Delaware Paid Family and Medical Leave Insurance. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee's Signature:

Date: m m / d d / y y y y

End of Part A

Request for Delaware Paid Family and Medical Leave (PFML) - Bonding Leave

Part B: Delaware Bonding Certification

(to be completed by the individual (Employee) requesting bonding leave)

Bonding Leave allows an eligible individual to take leave from employment to care for and bond with a child during the first year after the child's birth or placement. "Child" means the eligible employee's biological, adopted, or foster child. An individual may not exceed 12 weeks of paid leave in a benefit year. Applications may be filed up to 30 days prior to the start of the requested leave, and up to 30 days after the start of the leave. Claim filing is the responsibility of the individual that is requesting paid leave benefits (the "Claimant") . The claimant is responsible for providing any missing or additional requested information during the claim process and is responsible for informing all required parties of any changes to leave plans.

Please complete this form and return it to us along with your application and any other supporting documentation as part of your claim for benefits.

Section 1: Employer Information (to be completed by the individual (Employee) requesting bonding leave)

1 **Employee's Legal Name:** _____

(First Name, Middle Initial, Last Name)

2 **Social Security Number:** __ __ __ - __ __ - __ __ __ __

Section 2: Bonding Information for Child

3 **Child's ACTUAL Date of Birth:**

Date: m m / d d / y y y y

4 **Relationship of Child to Individual Requesting Leave:**

- ☐ Biological child
- ☐ Foster child
- ☐ Adopted child

4a **Placement Date for Adopted/Foster Child:**

If requesting leave to bond with an adopted or foster child, provide the DATE the child was placed with you.

Date: m m / d d / y y y y

Part B Continued on Next Page

Request for Delaware Paid Family and Medical Leave (PFML) - Bonding Leave

Section 3: Attach Bonding Leave Required Documentation

Please include at least one (1) of the below documents with this application to support the request for leave. Your claim cannot be processed without proof documentation supporting the leave.

NOTE: The proof document(s) provided must show:

- The Claimant's first and last name as parent or guardian of the child;
- The Child's first and last name; and
- The date of the Child's birth, or placement (adoption / foster care).

Birth of Child:

- ☐ Child's Birth Certificate
- ☐ Consular Report of Birth Abroad
- ☐ A document issued by Health Care Provider of the Child or pregnant Parent
- ☐ A hospital admission form associated with delivery
- ☐ any other documentation required by Delaware Paid Leave

Adoption/Foster Care:

- ☐ A copy of a court order veryfying foster care placement or adoption
- ☐ A letter signed by the attorney representing the prospective foster or adoptive parent that confirms the placement
- ☐ A document from the foster care, adoption agency, or social worker involved in the placement that confirms the placement
- ☐ A document for the child issued by the United States Citizenship and Immigration Services
- ☐ Any other documentation required by Delaware Paid Leave

Declaration and Signature:

WARNING: Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement of a material fact, may be guilty of insurance fraud. I further certify that if benefits are paid in excess of the amount to which I am entitled, I will return to the payor of such benefits, the amount that was overpaid, and I acknowledge that failure to do so may result in the accrual of interest and other penalties.

I am hereby making a request for benefits under Delaware Paid Family and Medical Leave Insurance. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Signature: _____

Date: m m / d d / y y y y

End of Part B

Request for Delaware Paid Family and Medical Leave (PFML) - Bonding Leave

Employee Name:

Part C: Employer Information

(to be completed by the employer for the above named employee requesting DE PFML)

1 **Employer Information:**

Business's Full Legal Name:

Street

Address line 2

City State | __ __ | Zip | __ __ __ __ __ |

Country (if not USA):

2 **Policy Number:**

3 **Business's Federal Employer Identification Number (FEIN):**

4 **Employer contact person (Name & Title) for this leave request:**

5 **Contact Phone #:** (__ __ __) - | __ __ __ | - | __ __ __ __ |

6 **Contact email address:**

7 **Employee's current employment status:**

☐ Actively employed-not terminated

☐ Terminated from employment — Date termed: m m / d d / y y y y | __ __ / __ __ / __ __ __ __ |

8 **Date employee was hired:**

Date: m m / d d / y y y y | __ __ / __ __ / __ __ __ __ |

9 **Last day worked before leave:**

Date: m m / d d / y y y y | __ __ / __ __ / __ __ __ __ |

10 **Has the employee returned to work?**

☐ Yes ☐ No

Return to work date: m m / d d / y y y y | __ __ / __ __ / __ __ __ __ | ☐ Actual ☐ Estimated

11 **Employee's Job Title and Description:**

12 **Select the days of the week the employee usually works:**

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Part C Continued on Next Page

Questions? Contact us at **877-369-0979**
or find us online at **archinsurance.com/disability**

Request for Delaware Paid Family and Medical Leave (PFML) - Bonding Leave

Employee Name:

13 **Average weekly wage:**

Take the 52 weeks of gross wages prior to the submission of the claims application. $ _____

14 **Was 30 days advance given to you by the employee requesting foreseeable leave?**

☐ Yes ☐ No

Date notice provided to employer: m m / d d / y y y y

15 **Has the employee received or claimed any of the following benefits for this leave?**

Benefit Type	Received	Claimed	From (mm/dd/yyyy)	Through (mm/dd/yyyy)
a. Unemployment benefits (CESA)	☐	☐		
b. Workers' Compensation due to work-related injury/illness	☐	☐		
c. Short term disability (STD)	☐	☐		
d. Other (Sick/Vacation/PTO or other employer provided leave. Please specify.) _____	☐	☐		

16 **Employer-provided Paid Leave during leave period**

If the Employer provides Accrued Paid Leave or other Wage continuation to the Eligible Employee during a period of PFML, the Employer is accountable for paying only the amount of Accrued Paid Leave or other Wage continuation that when combined with the Weekly Benefit Amount is equal to or less than the Eligible Employee's average weekly wage such that the Eligible Employee does not receive more than 100% of their average weekly wage. An Eligible Employee must consent to use of Accrued Paid Leave during periods of PFML.

"Accured Paid Leave" means leave earned by or otherwise provided to an Eligible Employee pursuant to a benefit plan or policy offered by the Employer, including, but not limited to, Sick Pay (including Delaware Paid Sick Leave), annual leave, Vacation Pay, personal leave, compensatory leave or Paid Time Off. Accrued paid leave shall not include a (i) disability policy or program of the Employer; or (ii) paid Family or Medical Leave policy of the Employer.

a. Will the employee be using any Accrued Paid Leave **during the leave period requested?**

☐ Yes (answer question b) ☐ No

b. Will the employee be receiving wage replacement **during all or a portion of the leave period requested?**

☐ Yes (answer question i) ☐ No

i. provide detail on type of wage replacement and the date(s) it will be paid for:

_____

ii. if yes, is reimbursement requested by employer? ☐ Yes ☐ No

*Reimbursement is only available if employer continued salary during leave

Declaration and Signature:

NOTICE: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages.

I am the person authorized to sign as the employer of the employee requesting benefits under the Delaware Paid Leave Insurance program. My signature affirms that to the best of my knowledge the information I have provided is true, accurate, and complete. Any false statements or other failure to provide truthful, accurate and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Employee's Signature: _____

Date: m m / d d / y y y y

End of Part C