




Certification of Child Bonding or Active Duty Deployment

If you work in Massachusetts, you can apply for Paid Family and Medical Leave (PFML). Arch Insurance will review all applications to determine your eligibility for benefits. The employee who is applying for leave, the health care provider and employer must complete a portion of this certification. This certification will be shared with Arch Insurance and your employer*.


This form **is** required for...


 **Parental leave**
to bond with a child 12 months after birth, adoption, or foster care placement.

 **Active duty leave**
to manage family affairs when a family member is in the armed forces.

 **Medical leave**
due to your own serious health condition

This form is **not** required for...

 **Family leave**
to care for a family member with a serious health condition related to military service.

 **Family leave**
to care for a family member with a serious health condition related to military service.

How to use this form

→ The employee who is applying for paid leave should complete **Sections 1 and either 2 or 3**, whichever applies.

→ The employer should complete **Section 4** and return this form to the employee.

→ The employee should submit the completed form as part of their application for paid leave. **The contents of this form will be shared with both Arch Insurance and your employer.**

***Employee**

→ Complete **Sections 1 and 2 or 3** to tell us about your reason for taking leave.

→ Print your name at the top of **Page 4 or 5 and 5**, and **Pages 7-9** before submitting **all pages** to employer.

→ Send the **entire form** and supporting documentation to Arch Insurance. Benefits will be delayed or denied with-out proper certification documentation.

***Employer**

→ Complete **Section 4** and provide information required about employee.

***Employee**

→ Email or mail completed claim form to:
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 PFML 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 DFML State 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

1 Employee Applying for Paid Leave

Instructions ▶ The person applying for paid leave from their own job is the employee. As the employee, complete this section with your own information. Arch Insurance will use **Section 1** to match this certification to the rest of your application for paid leave.

1 Your Name: First _____ Last _____

2 (If different) Your name as it appears on official documents like a driver's license or W-2:
First _____ Middle _____ Last _____

3 Phone #: (_ _ _) - | _ _ _ | - | _ _ _ _ |

3a Email Address: _____

3b Residential Address:
Street _____
Address line 2 _____
City _____ State | _ _ | Zip | _ _ _ _ _ |

4 Date of Birth: | m m / | d d / | y y y y |

5 Gender Identity: Female Male Nonbinary Gender not listed

6 Social Security Number of Individual Taxpayer ID Number (ITIN): | _ _ _ _ | - | _ _ _ | - | _ _ _ _ _ |

7 Why are you applying for leave? Child Bonding Active Duty Deployment

Will leave be for a continuous period of time and/or periodic?

Continuous Leave Start Date m m / | d d / | y y y y | Leave End Date m m / | d d / | y y y y |

Dates are estimated

Periodic Identify dates periodic leave will be taken: _____

Dates are estimated _____

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8a Employer Information:

Name _____
 Street _____
 Address line 2 _____
 City _____ State | _ _ | Zip | _ _ _ _ _ |

8b List all additional employers from the past year:

Employer #1 Name _____
 Street _____
 Address line 2 _____
 City _____ State | _ _ | Zip | _ _ _ _ _ |
 Period of Employment:
 From | ^m | ^m / | ^d | ^d / | ^y | ^y | ^y | ^y | To | ^m | ^m / | ^d | ^d / | ^y | ^y | ^y | ^y |

Employer #2 Name _____
 Street _____
 Address line 2 _____
 City _____ State | _ _ | Zip | _ _ _ _ _ |
 Period of Employment:
 From | ^m | ^m / | ^d | ^d / | ^y | ^y | ^y | ^y | To | ^m | ^m / | ^d | ^d / | ^y | ^y | ^y | ^y |

Employer #3 Name _____
 Street _____
 Address line 2 _____
 City _____ State | _ _ | Zip | _ _ _ _ _ |
 Period of Employment:
 From | ^m | ^m / | ^d | ^d / | ^y | ^y | ^y | ^y | To | ^m | ^m / | ^d | ^d / | ^y | ^y | ^y | ^y |

9 Occupation: _____

Important Tax Information

If you choose to have federal income tax withheld from your disability benefits, you should complete a W-4S. List the specific dollar amount you would like withheld weekly from your benefits. Do not give a % amount.

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 or find us online at archinsurance.com/disability

*Employee **Employee applying for leave:**

2 Child Bonding Information

Instructions ▶ If you indicated that you are applying for child bonding in **Question 7**, complete **Section 2**.

10 Child's Date of Birth: | ^m | ^m | / | ^d | ^d | / | ^y | ^y | ^y | ^y |

11 Child's Gender: Male Female Non-Designated / Other

12 Does child live with employee requesting PFL? Yes No

13 Child is employee's:

Biological Child Adopted Child Stepchild Foster Child

Legal Ward Locus Parentis Spouse/Domestic Partner's Child

14 Select one of the following and attach the document as required as evidence of the relationship:

Parent of newborn child

Birth Mother:

- Health care provider certification of pregnancy (include expected due date AND mother's name); OR
- Health care provider certification of birth (include date of birth AND mother's name); OR
- Child's birth certificate

Foster Parent:

- Letter of foster care placement or anticipated placement issued by county or city department of Social Services or authorized voluntary foster care agency

Adoptive Parent:

- Court document finalizing adoption
- Documentation in furtherance of adoption

Other Parent:

- Copy of birth certificate naming second parent; OR
- Voluntary acknowledgement of paternity; OR
- Court order of filiation; OR
- Birth mother documents (see above) PLUS one of the following:
 - Marriage certificate; OR
 - Certificate of civil union; OR
 - Evidence of domestic partnership
- OR; Other documentation of parental relationship

15 Date of foster care or adoption placement, if applicable: | ^m | ^m | / | ^d | ^d | / | ^y | ^y | ^y | ^y |

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the state value of the claim for each such violation.

I am hereby making a request for paid family leave benefits. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

16 Employee's Signature: _____

17 Date: | ^m | ^m | / | ^d | ^d | / | ^y | ^y | ^y | ^y |

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*Employee **Employee applying for leave:**

3 Military Member Information

Instructions ► If you indicated that you are applying for Active Duty Deployment in **Question 7**, complete **Section 3**.

18 Name of military member on covered active duty or impending call to covered active duty status (international deployment):

First Middle Initial Last

19 Military member's date of birth: m m / d d / y y y y

20 Military member's mailing address

Street
 Address line 2
 City State | | Zip | | | | |

21 Military member's relationship to employee: Spouse Domestic Partner Child Parent

22 Period of military member's covered active duty:

Start date: End date:
 m m / d d / y y y y m m / d d / y y y y

23 Please select one of the following and attach the indicated document to support that the military member is on covered active duty or impending call or order to covered active duty status:

- Covered active duty orders
- Letter of impending call or order to covered duty
- Documentation of military leave signed by the approving authority for military member's Rest and Recuperation

24 What is the reason employee is requesting PFL? (One or more may be selected)

- Arranging for child care
- Arranging for parental care
- Counseling
- Making financial arrangements
- Making legal arrangements
- Acting as military member's representative before a federal, state, or local agency for purpose of obtaining, arranging, or appealing military service benefits
- Attending any event sponsored by the military or military service organizations
- Other

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*Employee

Employee applying for leave:

25 Is written documentation supporting this request for leave available and attached?

- Yes
- No
- None Available

Note: A complete and sufficient certification to support a request for PFL leave due to a qualifying event includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. If leave is requested to meet with a third party, the employee must provide the supporting documentation of the meeting that includes the name, address, appropriate contact information of the individual or entity with whom you are meeting (i.e., either telephone number, fax number, or e-mail address of the individual or entity).

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the state value of the claim for each such violation.

I am hereby making a request for paid family leave benefits. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

26 Employee's Signature:

27 Date: | ^m | ^m | / | ^d | ^d | / | ^y | ^y | ^y | ^y |

Questions?

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*Employer Employee applying for leave:

4 Employer's Certification & Information

Instructions ► Sign and date to agree to this declaration. Complete all required information.

PART 4A - EMPLOYER INFORMATION

28 Employer Information:

Business's Full Legal Name: _____

Street _____

Address line 2 _____

City _____ State | _ _ | Zip | _ _ _ _ _ |

Country (if not USA): _____

29 Policy Number:

30 Employer's FEIN:

31 Employer's SIC Code:

Division:

32 Contact name for questions relating to Medical and PFL:

33 Contact Phone #: (_ _ _) - | _ _ _ _ | - | _ _ _ _ _ |

34 Contact email address:

PART 4B - EMPLOYEE INFORMATION

35 Employee's Occupation:

36 Please check the appropriate boxes:

Exempt Non Exempt Full Time Part Time Hourly Hrs/Wk: _____

37 Employees Basic Weekly Earnings: \$

38 Date of last change in earnings

Date: | ^m _ ^m _ / | ^d _ ^d _ / | ^y _ ^y _ ^y _

39 Date employee was hired

Date: | ^m _ ^m _ / | ^d _ ^d _ / | ^y _ ^y _ ^y _

Questions?

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*Employer

Employee applying for leave:

40 Last date worked: Date: ^{m m d d y y y y}
 |__ __ / |__ __ / |__ __ __ __ | # of Hours _____

41 Date returned to work: Date: ^{m m d d y y y y}
 |__ __ / |__ __ / |__ __ __ __ |

42 Please list all benefits that the employee is receiving or eligible to receive as a result of his/her medical and/or paid family leave (e.g. salary continuance, sick pay, state disability, worker's compensation, etc.)

| Benefit | Gross Weekly Amount | Date Began | Paid Through Date |
|---------|---------------------|------------|-------------------|
| | | | |

43 Has employee been laid off?
 Yes No
 If yes, date: ^{m m d d y y y y}
 |__ __ / |__ __ / |__ __ __ __ |

Reason:

44 Has employee been terminated?
 Yes No
 If yes, date: ^{m m d d y y y y}
 |__ __ / |__ __ / |__ __ __ __ |

Reason:

45 Employee's normal work schedule
 Mon Tues Wed Thurs Fri Sat Sun _____ Hours/Day _____ Hours/Week

46 If the employee received or will receive full wages while on leave, will employer be requesting reimbursement?
 Yes No

If yes, please indicate the dates employee is paid from:

^{m m d d y y y y} |__ __ / |__ __ / |__ __ __ __ | through ^{m m d d y y y y} |__ __ / |__ __ / |__ __ __ __ |

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*Employer

Employee applying for leave:

47 Enter the last four quarters of gross wages for the employee.

Quarter #1

Quarter ending date: | m m / | d d / | y y y y |

Gross amount paid: \$ _____

Quarter #2

Quarter ending date: | m m / | d d / | y y y y |

Gross amount paid: \$ _____

Quarter #3

Quarter ending date: | m m / | d d / | y y y y |

Gross amount paid: \$ _____

Quarter #4

Quarter ending date: | m m / | d d / | y y y y |

Gross amount paid: \$ _____

48 In the preceding 52 weeks, has the employee taken leave for:

- Medical Leave
 PFL
 Both Medical Leave and PFL
 None

49 Enter the total number of weeks and days for both Medical and PFL in the last 52 weeks.

Medical

of Weeks: _____ # of Days: _____ Specific dates for disability: _____

PFL

of Weeks: _____ # of Days: _____ Specific dates for disability: _____

50 Is the employee taking Family Medical Leave Act (FMLA) concurrently with PFL? Yes No

PART 4C - DECLARATION AND SIGNATURE

This is to certify that the facts as indicated above are true to the best of my knowledge.

51 Signature: _____ Date: | m m / | d d / | y y y y |

52 Printed name: _____

53 Title: _____

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