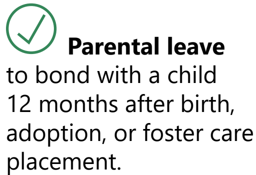
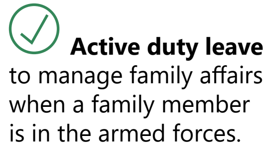
Certification of Child Bonding or Active Duty Deployment

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...

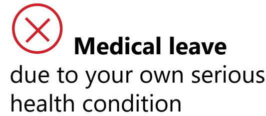


Parental leave to bond with a child 12 months after birth, adoption, or foster care placement.

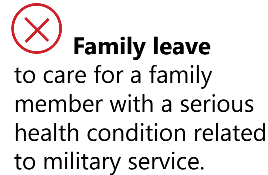


Active duty leave to manage family affairs when a family member is in the armed forces.

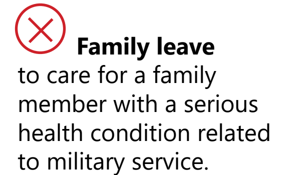
This form is not required for...



Medical leave due to your own serious health condition



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 eligibil¬ity 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

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

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.

*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 ☐ Locos 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

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

*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: m m / d d / y y y y

End date: 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

*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

*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 y |

39 Date employee was hired

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

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

*Employer **Employee applying for leave:** ______

40 **Last date worked:** Date: | __ __ / | __ __ / | __ __ __ __ | (mm/dd/yyyy) # of Hours ______

41 **Date returned to work:** Date: | __ __ / | __ __ / | __ __ __ __ | (mm/dd/yyyy)

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: | __ __ / | __ __ / | __ __ __ __ | (mm/dd/yyyy)

Reason: ______

44 **Has employee been terminated?**

☐ Yes ☐ No If yes, date: | __ __ / | __ __ / | __ __ __ __ | (mm/dd/yyyy)

Reason: ______

45 **Employee's normal work schedule**

☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun ______ Hours/Day ______Hours/Week

46 **Has employee earned at least $6,000 during the last 4 completed calendar quarters?**

☐ Yes ☐ No

47 **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:

| __ __ / | __ __ / | __ __ __ __ | (mm/dd/yyyy) through | __ __ / | __ __ / | __ __ __ __ | (mm/dd/yyyy)

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

*Employer **Employee applying for leave:** ____________________

48 **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: $ ________

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

- ☐ Medical Leave
- ☐ PFL
- ☐ Both Medical Leave and PFL
- ☐ None

50 **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: ______

51 **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.

52 **Signature:** ____________________ Date: m m / d d / y y y y

53 **Printed name:** ____________________

54 **Title:** ____________________

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or find us online at **archinsurance.com/disability**