Certification of a Serious Health Condition

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...

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.

This form is not 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.

How to use this form

The employee who is applying for paid leave should complete **Sections 1 and 2.**

A health care provider should complete **Sections 3-6** and return this form to the employee.

The employer should complete **Section 7** 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** to tell us about your reason for taking leave.

Print your name at the top of **Page 4**, and **Pages 6-10** before giving **all pages** of the form to your health care provider who is treating you or your family member.

Give the **entire form** to the health care provider to complete **Sections 3-6** and return to you. Benefits will be delayed or denied without certification from a health care provider.

+Health care provider

Complete **Sections 3-6** to certify the patient's serious health condition.

Initial **Section 3-6** before you return the form to the employee.

If the employee is not your patient, you may need the patient's authorization to share medical information with the employee.

Return the **entire form** to the employee whose information is in **Section 1**.

***Employer**

Complete **Section 7** 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?**

☐ My own serious health condition

☐ A family member's serious health condition that is related to military service. You will need to complete ***Section 2.***

☐ A family member's serious health condition of any other kind (starts 7/1/21). You will need to complete ***Section 2.***

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 _____

8a **Employer Information:**

Name

Street

Address line 2

City

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

Questions?

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

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 |

8c **Occupation:** _____

9 **If you are applying for your own serious health condition, describe your job's physical exertion level.**

☐ 1 Sedentary ☐ 2 Light ☐ 3 Medium

☐ 4 Heavy ☐ 5 Very Heavy ☐ N/A

Check only one. Refer to the definitions below.

1 Sedentary

Sitting most of the time. Exerting up to 10 pounds of force occasionally to move objects; or a negligible amount of force frequently. ***E.g., Dispatcher, Receptionist***

2 Light

Walking or standing frequently, using physical controls while sitting or driving, or working at a production rate pace with lighter materials (e.g., clothing). Exerting up to 20 pounds of force occasionally; or up to 10 pounds of force frequently. ***E.g., Textile worker, Grocery stocker, Passenger vehicle driver***

3 Medium

Exerting 20–50 pounds of force occasionally; 10–25 pounds of force frequently; or up to 10 pounds constantly. ***E.g., Plumber, Electrician***

4 Heavy

Exerting 50 to 100 pounds of force occasionally; 25–50 pounds of force frequently; or 10–20 pounds constantly. ***E.g., Construction, Delivery driver***

5 Very Heavy

Exerting over 100 pounds of force occasionally; over 50 pounds of force frequently; or more than 20 pounds of force constantly. ***E.g., The heaviest construction jobs***

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.

Questions?

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

*Employee **Employee applying for leave:**

2 Patient Information

Instructions ▶ If you indicated that you are applying to care for a family member in **Question 7**, complete **Section 2**. Arch Insurance needs to know your relationship with the patient to certify leave eligibility. Otherwise, skip this section.

10 The family member who is experiencing a serious health condition is my:

- ☐ Child
- ☐ Sibling
- ☐ Grandchild
- ☐ Grandparent
- ☐ Spouse or domestic partner
- ☐ Spouse's or partner's parent
- ☐ Parent

11 Patient's name:

First Last

12 (If different) Patient's name as it appears on official documents like a driver's license or insurance documents:

First Middle Last

13 Patient's address

Street

Address line 2

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

14 Date of Birth: m m / d d / y y y y | __ __ / __ __ / __ __ __ __ |

15 Social Security Number of Individual Taxpayer ID Number (ITIN): | __ __ __ | - | __ __ | - | __ __ __ __ |

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.

Employee's Signature:

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

*Employee **STOP HERE.** Give this form to the patient's health care provider to complete **Sections 3-6**.

+HCP **Initial here to indicate you have completed this page:** _____

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

+Health care provider **READ THIS PAGE** Then set it aside so you can refer back to it while filling out the form.

Definition of a serious health condition

A serious health condition could include an illness, injury, impairment or physical or mental condition that involves at least one of the following two conditions:

1. At least one night of inpatient care in a hospital, hospice or residential medical facility
2. Continuing treatment by a health care provider

Inpatient care

An overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity, or any subsequent treatment in connection with such inpatient care.

Continuing treatment by a health care provider (plus examples of conditions). Treatment for a condition that fits any of the following descriptions:

A. Any incapacity to work for more than three consecutive full calendar days that also requires medical visits. The patient's first visit must be within seven days of the start of incapacity. Telehealth appointments are also included. These medical visits must meet one of the following two patterns:
   - *Two or more visits within 30 days of a patient's incapacity to work (unless it is impossible to book two appointments in this timeframe).*
   - *One such visit—excluding a routine physical, eye or dental exam—plus a regimen of care or medication under the provider's supervision or prescription. E.g., outpatient surgery or strep throat.*

B. Any incapacity due to pregnancy or prenatal care .

C. Any incapacity due to a chronic condition , which is a condition that:
   - *Requires periodic medical visits,*
   - *Continues over an extended period of time, and*
   - *May cause episodic periods of incapacity that require leave. E.g., asthma or migraine headaches.*

D. Any incapacity due to a permanent or long-term condition that may not respond to treatment. E.g., Alzheimer's disease or terminal stages of cancer.

E. Any absence to receive multiple treatments, plus any recovery time, for either of the following:
   - *Restorative surgery after an accident or injury. E.g., joint replacements or reconstruction.*
   - *A condition that would lead to more than three consecutive days of incapacity if the patient did not receive treatment. E.g., chemotherapy treatments.*

Incapacity

An inability to perform the functions of one's job owing to the serious health condition. For unemployed applicants, it means an inability to perform the functions of their most recent position or other suitable employment.

Details on Section 4, ability to work

Section 4 establishes the start and end of the time period when the employee is incapacitated and will need time off work because of the serious health condition. This date range is the leave period. A leave period cannot be approved for longer than six months.

If the condition requires additional leave after six months or a re-evaluation, the employee can submit a new application at that time with a new certification.

Definition of a health care provider

Health Care Provider:

An individual licensed by the state, commonwealth, or territory in which the individual practices medicine, surgery, dentistry, chiropractic, podiatry, midwifery or osteopathy, and including the following:

A. Podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice in a state and within the scope of their practice as defined under the law of that state, commonwealth, or territory;

B. Nurse practitioners, nurse-midwives, clinical social workers and physician assistants who are authorized to practice under State law and who are within the scope of their practice as defined under the law of that state, commonwealth or territory;

C. Christian Science Practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts;

D. A health care provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is within the scope of practice as defined under such law.

*Employee **Employee applying for leave:**

Health Care Provider Certification of a Serious Health Condition

3 Patient's Serious Health Condition

Instructions ▶ This form should be filled out by the healthcare provider of the patient, who may or may not be the employee. For the employee to qualify for paid leave, the patient must have a serious health condition. Answer all questions fully and completely.

16 Does the patient have a serious health condition?

☐ Yes ☐ No

17 Which of the following apply to the patient's serious health condition? The condition:

☐ Requires, or did require inpatient care.

☐ Has incapacitated or will incapacitate the patient for more than three consecutive full calendar days.

☐ Requires two or more medical visits within 30 days.

☐ Requires one medical visit, plus a regimen of care.

☐ Is chronic, requires treatments at least twice a year, and may require periodic absences.

☐ Is long-term and requires ongoing medical supervision, with or without active treatment.

☐ Requires multiple treatments and would lead to a period of incapacity without treatment.

Check all that apply.

18 Provide appropriate diagnosis code and medical facts to allow an understanding of how the condition may affect the patient's ability to work.

Diagnosis Code: _____

Medical Facts: _____

Examples may include symptoms, hospitalizations, medical visits, relevant side effects to medication, and referrals for evaluation or treatment.

19 When did the condition begin?

☐ This condition began within the past 12 months.

Start date: m m d d y y y y | __ __ / __ __ / __ __ __ __ |

☐ This condition began more than one year ago.

This is the start of the condition, not the start of the employee's leave from their job. If it cannot be determined, provide a start date to the best of your ability.

+HCP **Initial here to indicate you have completed this page:** _____

*Employee **Employee applying for leave:**

20 **Is the patient's serious health condition a pregnancy-related issue that results in some level of incapacity prior to giving birth?**

☐ Yes. Expected delivery date:
m m d d y y y y
| __ __ / | __ __ / | __ __ __ __ |

☐ No

This excludes recovery time following birth.

If both apply, account for both in **Section 4.**

21 **Is this health condition a job-related injury?**

☐ Yes ☐ No

Check only one.

22 **If the patient is not the employee, is this health condition related to the patient's military service?**

☐ Yes ☐ No ☐ n/a, the patient is the employee

Check only one.

23 **If the patient is not the employee, will the patient require care from a family member?**

☐ Yes ☐ No ☐ n/a, the patient is the employee

Check only one.

4 Ability to Work

Instructions ▶ Provide your best estimate based on your medical knowledge, experience, and examination of the patient. Be as specific as you can be; terms like "unknown" or "indeterminate" may not be enough to approve a claim for paid leave benefits. For more information, refer to the definition of ability to work on **Page 5.**

24 **When will the employee first need to take leave?**

Start date: m m d d y y y y
| __ __ / | __ __ / | __ __ __ __ |

This is the first day of missed time from work, regardless of whether it is a partial or a full day. If any time has already been missed because of this condition, enter the earliest absence.

25 **Do you know the last day the employee will need leave for the patient's condition? If you cannot determine this, when do you recommend re-evaluating?**

☐ Yes. The last day the employee will need leave is:
m m d d y y y y
| __ __ / | __ __ / | __ __ __ __ |

☐ No. The patient's condition should be re-evaluated on:
m m d d y y y y
| __ __ / | __ __ / | __ __ __ __ |

Check only one.

+HCP **Initial here to indicate you have completed this page:** _____

*Employee **Employee applying for leave:**

26 **During this leave period, which of these patterns of leave do you expect the employee to need as a result of the patient's condition?**

☐ **Continuous leave:**
Completely unable to work for consecutive, uninterrupted days

☐ **Reduced leave schedule:**
A consistent but reduced schedule for multiple weeks.

☐ **Intermittent leave:**
Episodic time off at irregular intervals for flare-ups or unexpected aftercare

Check all that apply.

If the patient is also the employee, answer **Questions 26-28**. *Otherwise, skip to* **Section 5.**

27 **What physical exertion level did the employee select in Question 9?**

☐ 1 Sedentary ☐ 2 Light ☐ 3 Medium
☐ 4 Heavy ☐ 5 Very Heavy ☐ N/A

Check only one. Refer to definitions at the bottom of **Page 3.**

28 **Is your medical opinion that the patient must refrain from working at this level of exertion, either partly or completely, between the dates for Questions 24 and 25?**

☐ Yes ☐ No

Describe specific activities the patient should refrain from, either partly or completely, between the dates for **Questions 24 and 25**, as a result of their serious health condition.

_____

_____

_____

_____

_____

If a patient must be absent from their job for treatment, state this directly. If the patient needs to be absent for any reason other than receiving treatment, describe specific tasks, actions, or functions they cannot perform owing to their condition.

5 Estimate Leave Details

Instructions ▶ For every leave pattern you selected in **Question 26,** estimate details of that leave below. A patient who exceeds the estimated leave can submit a new application with a new certification for additional leave needs.

PART 5A - CONTINUOUS LEAVE

29 **When will the continuous leave period start and end?**

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

End / re-evaluation date: m m / d d / y y y y

+HCP **Initial here to indicate you have completed this page:** _____

*Employee **Employee applying for leave:** _____

30 **During the leave period, how many weeks of continuous full-time leave do you expect the employee will require?**

_____ Weeks of continuous leave.

☐ I do not recommend any continuous leave.

Continuous leave is full-time leave taken without interruptions. In answering this question, include any continuous leave that the employee has already taken for this condition. For partial weeks, round up.

PART 5B - REDUCED LEAVE SCHEDULE

31 **Not including continuous leave covered in Part 5A, how many weeks of a reduced leave schedule will the employee need during the leave period?**

_____ Weeks of a reduced leave schedule

☐ No reduced leave schedule needed

A reduced leave schedule is a consistent schedule that is less than the employee's usual schedule. For example, taking off the same number of hours or days each week.

32 **When will the reduced leave schedule start and end?**

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

End / re-evaluation date: m m / d d / y y y y

33 **How many hours should the employee take off per week?**

_____ Hours of reduced leave schedule ☐ No reduced leave schedule needed

PART 5C - INTERMITTENT LEAVE

34 **When will the intermittent leave schedule start and end?**

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

End / re-evaluation date: m m / d d / y y y y

35 **Not including any leave covered in Part 5B, on average how often will the condition require the employee to be absent from their job?**

☐ No other absences expected
☐ Once or more per week, approximately _____ Times per week
☐ Once or more per month, approximately _____ Times per month
☐ Once or more per year, approximately _____ Times total

36 **How long will a single absence typically last?**

☐ No more than one full work day, up to _____ Hours.
☐ More than one day, up to _____ Days.
☐ N/A, no intermittent leave

+HCP **Initial here to indicate you have completed this page:** _____

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

*Employee **Employee applying for leave:**

6 Provider's Certification & Information

Instructions ▶ Sign and date to agree to this declaration. Provide the relevant licensing and contact information about your practice or business. Before returning the form to the employee, review to be sure you have initialed **Sections 3–5.**

I certify that the information provided in this form is true and correct, that I have examined the patient and answered the questions accurately and to the best of my ability, and that I am a health care provider authorized to certify their condition.

*See **Page 5** for the definition of a healthcare provider.*

37 **Signature:** Date: m m / d d / y y y y

38 **Printed name and title:**

Name:

Title:

39 **Certificate License:** State

40 **Area of practice or medical specialty:**

41 **Name of your practice or business:**

42 **Address:**

Office Email Address:

43 **Office Phone #:** ( ) - | | - | | | |

44 **Office fax #:** ( ) - | | - | | | | *(Optional)*

+Health care provider When you have completed and signed the certification, return it to the employee. The employee will submit this information for review by the Department of Family and Medical Leave and their employer.

+HCP **Initial here to indicate you have completed this page:** _____

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

*Employer **Employee applying for leave:**

7 Employer's Certification & Information

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

PART 7A - EMPLOYER INFORMATION

45 **Employer Information:**

Business's Full Legal Name:

Street

Address line 2

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

Country (if not USA):

46 **Policy Number:**

47 **Employer's FEIN:**

48 **Employer's SIC Code:** Division:

49 **Contact name for questions relating to Medical and PFL:**

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

51 **Contact email address:**

PART 7B - EMPLOYEE INFORMATION

52 **Employee's Occupation:**

53 **Please check the appropriate boxes:**

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

54 **Employees Basic Weekly Earnings:** $

55 **Date of last change in earnings**

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

56 **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:**

57 **Last date worked:** Date: | m m / d d / y y y y | # of Hours _____

58 **Date returned to work:** Date: | m m / d d / y y y y |

59 **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

60 **Has employee been laid off?**

☐ Yes ☐ No If yes, date: | m m / d d / y y y y |

Reason: _____

61 **Has employee been terminated?**

☐ Yes ☐ No If yes, date: | m m / d d / y y y y |

Reason: _____

62 **Employee's normal work schedule**

☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun _____ Hours/Day _____Hours/Week

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

☐ Yes ☐ No

64 **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 |

*Employer **Employee applying for leave:** _____

65 **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: $ _____

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

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

67 **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: _____

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

PART 7C - DECLARATION AND SIGNATURE

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

69 **Signature:** _____ Date: m m / d d / y y y y

70 **Printed name:** _____

71 **Title:** _____