Arch | Insurance

Family and Medical Leave Insurance Program (FAMLI)
COLORADO

Neonatal Care Leave

If you work in Colorado, you can submit a claim for the Colorado Paid Family and Medical Leave Insurance (FAMLI) benefits. Arch Insurance will review all submitted claims 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*.

Before you apply for CO FAMLI...

Check eligibility requirements for leave

Plan your leave. Leave can be taken continuously (a/k/a block leave), intermittently, or on a reduced leave schedule, in accordance with CO FAMLI.

Notify your CO 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 completes 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 B.

Employer completes Part B, 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.

Provider completes Part C, *Health Care Provider Certification* and attaches supporting documentation.

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

Application for Colorado Family and Medical Leave Insurance (FAMLI) | Neonatal Care Leave

Part A: Employee Information

(to be completed by the employee requesting leave)

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 | __ __ / __ __ / __ __ __ __ |

*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 FAMLI 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 FAMLI 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**

Application for Colorado Family and Medical Leave Insurance (FAMLI) | Neonatal Care Leave

Part A Continued

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

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

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

8 **Relationship to the infant in Neonatal Intensive Care Unit (NICU):**

☐ Parent

☐ Loco Parentis

9 **Employer Information:**

Name _____

Street _____

Address line 2 _____

City _____

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

Avg # Hours Worked/Week | __ | Avg # Days Worked/Week | __ | Avg Wages ($) | __ |

9a **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 |

Avg # Hours Worked/Week | __ | Avg # Days Worked/Week | __ | Avg Wages ($) | __ |

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 |

Avg # Hours Worked/Week | __ | Avg # Days Worked/Week | __ | Avg Wages ($) | __ |

Application for Colorado Family and Medical Leave Insurance (FAMLI) | Neonatal Care Leave

Part A Continued

10 **Will leave be for a continuous period of time, intermittent and/or reduced?**

☐ 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

☐ Intermittent — Identify dates intermittent leave will be taken: _____

☐ Dates are estimated _____

☐ Reduced — Leave Start Date: (m m / d d / y y y y) | __ __ / __ __ / __ __ __ __ |

Frequency of leave: _____

☐ Dates are estimated

11 **Have you Received or Claimed any of the Following Benefits in the Preceding 52 Weeks?**

Benefit Type	Received	Claimed	From (mm/dd/yyyy)	Through (mm/dd/yyyy)
a. Unemployment benefits	☐	☐		
b. Workers' Compensation	☐	☐		
c. CO FAMLI	☐	☐		
d. Other (Sick/Vacation/PTO or other employer provided leave. Please specify.)	☐	☐		

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 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 the Colorado Family and Medical Leave Insurance program. 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

Application for Colorado Family and Medical Leave Insurance (FAMLI) | Neonatal Care Leave

Employee's Name:

Part B: Employer Information

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

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:

Part B Continued on Next Page

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

Application for Colorado Family and Medical Leave Insurance (FAMLI) | Neonatal Care Leave

Employee's Name:

12 **Please check the appropriate boxes:**

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

13 **Colorado ("CO") Employment Verification:**

a. Are the employee's earnings reported at year end on IRS form W-2? ☐ Yes ☐ No (answer question 13b)

b. Is the employee subject to Unemployment Insurance obligations in CO? ☐ Yes ☐ No (answer question 13c)

c. Is the employee's service localized (performed entirely) within CO? ☐ Yes ☐ No (answer question 13d)

d. If services are not localized, is the employee's base of operations in CO, and some of the work is performed in CO? ☐ Yes ☐ No (answer question 13e)

e. If there is no base of operations, does the employee perform some of the services within CO and receive direction and control from CO? ☐ Yes ☐ No (answer question 13f)

f. If there is no place of direction and control, no localized services and no base of operations in CO, does the employee reside in CO? ☐ Yes ☐ No

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

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

15 **Provide the employee's earnings history for the prior 5 completed calendar quarters preceding the request for leave:**

Quarter Ending (mm/yyyy)	Gross Wages ($)

16 **Provide the scheduled work hours from the last 4 weeks the employee reported to work prior to the leave:**

Week 1 _____

Week 2 _____

Week 3 _____

Week 4 _____

Average: _____

17 **Will leave be utilized continuously or intermittently or on a reduced leave schedule? Provide details below.**

Block Leave/Continuous Leave: Start date (mm/dd/yyyy) _____ — Through (mm/dd/yyyy) _____

Intermittent Leave: Dates requested: _____

Reduced Leave Schedule: Frequency of leave: (eg: 2 days per week, or 4 hours per day, or every Monday) _____

Part B Continued on Next Page

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Application for Colorado Family and Medical Leave Insurance (FAMLI) | Neonatal Care Leave

Employee's Name:

19 **Has the employee received or claimed any of the following benefits in the preceding 52 weeks?**

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. CO FAMLI	☐	☐		
d. Other (Sick/Vacation/PTO or other employer provided leave. Please specify.)	☐	☐		

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

An employee cannot receive both wage replacement benefits under the FAMLI Act and employer-provided paid leave for the same hours absent, except that pursuant to C.R.S. 8-13.3-510(1)(c), an employer and an employee may mutually agree that the employee may use any ***accrued*** **employer-provided leave** as a **supplement** to family and medical leave insurance benefits in an amount not to exceed the difference between the individual's wage replacement benefits under the FAMLI Act and the individual's average weekly wage.

"Employer-provided paid leave" means vacation leave, paid sick leave, paid personal leave, paid parental leave, paid leave under C.R.S. 24-34-402.7, and any other employer-paid time off, except that employer-provided paid leave does not include benefits under a commercial short-term or long-term disability policy for purposes of these rules.

a. Will the employee be using any employer-provided 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 and ii) ☐ No

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

ii. are you requesting reimbursement* of FAMLI benefits? ☐ Yes ☐ No

Note: Employer reimbursement may be permitted if the employee's salary is being continued through some kinds of benefits payments made by the employer. Employer reimbursement is not permitted if the employee is using any employer-provided paid leave such as use of accrued vacation, sick, personal or parental 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 Colorado Family and Medical 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.

Signature:

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

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

End of Part B

Part C: Colorado - Neonatal Care Leave Certification

Important tips when completing this form

To request Colorado FAMLI benefits you will need to provide proof that your infant was admitted to the neonatal intensive care unit (NICU). **You can either provide the admission documentation from the neonatal intensive care unit, or complete and return this neonatal care certification form.** To start the process, complete **Sections 1 and 2**, and send it the treating healthcare provider to complete **Section 3** and return to us with your Application and any other supporting documents as part of your claim for benefits.

Section 1: Employee Information - For Completion by the Employee

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

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

3 **Employee's Phone #:** ( ) - | | - | |

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

5 **Claim Number (if available):** _____

Section 2: About the Family Member

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

2 **Infant's Date of Birth:** | m m / d d / y y y y |

Section 3: For Completion by the Child's Treating Health Care Provider

A family member of your patient has made a request to be absent from work to care for their child while under neonatal intensive care. For us to make a decision on the employee's claim for CO FAMLI benefits for the care of your patient, we will need you to complete the information in Section 3. When completing this certification, we ask:

- Your answers are to be your best estimate based on your medical knowledge, experience, and examination of the patient.
- Be as specific as you can. Using terms like "as needed", "unknown" or "indeterminate" may not be enough to approve the claim.
- Limit your responses to the patient's health condition for which the employee is seeking benefits.
- Do not include information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. §1635.3(b).

1 **Diagnosis Code:** _____

Diagnosis Description: _____

Part C Continued on Next Page

2 **Date the infant entered the NICU:** | m m / d d / y y y y |

Estimated or actual date the infant was released from the NICU: | m m / d d / y y y y |

3 **Name of hospital or facility where Neonatal Intensive Care unit is located:** _____

Health Care Provider Information and Signature

Print Treating Health Care Provider Name: _____

Specialty/Board Certification: _____

Treating Health Care Provider's Business address: _____

Certification License Number: _____ **State:** _____

Telephone: (_ _ _) - | _ _ _ | - | _ _ _ _ |

Fax Number: (_ _ _) - | _ _ _ | - | _ _ _ _ |

Email Address: _____

Treating Health Care Provider Signature: _____

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

End of Part C