



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

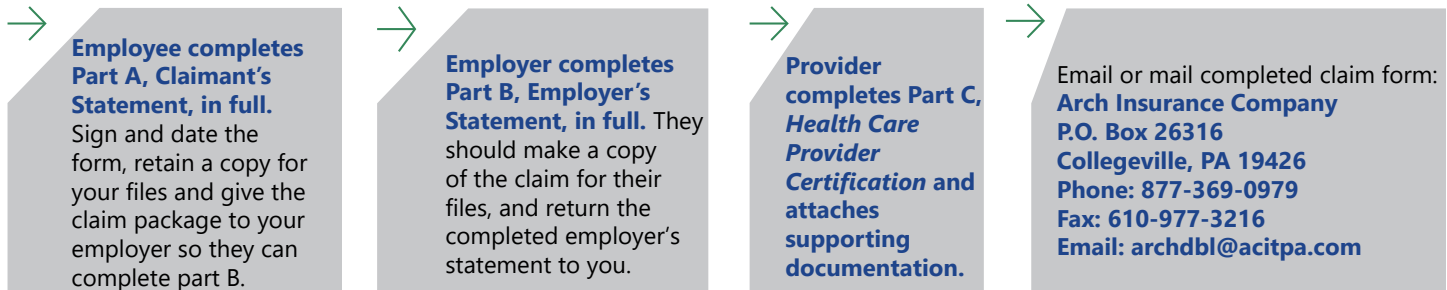


Plan your leave. Leave can be taken continuously (a/k/a block leave), intermittently, or on a reduced leave schedule, in accordance with CO FAMLI.



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



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.

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26-09-DBL04

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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 _ / | ^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 _ / | ^y _ ^y _ ^y _ ^y _ | To | ^m _ ^m _ / | ^d _ ^d _ / | ^y _ ^y _ ^y _ ^y _ |

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

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26-09-DBL04

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 _____ | ^d _____ | ^y _____ | ^y _____ |**8 Date employee was hired:**Date: | ^m _____ | ^d _____ | ^y _____ | ^y _____ |**9 Last day worked before leave:**Date: | ^m _____ | ^d _____ | ^y _____ | ^y _____ |**10 Has the employee returned to work?**☐ Yes ☐ NoReturn to work date: | ^m _____ | ^d _____ | ^y _____ | ^y _____ | ☐ Actual ☐ Estimated**11 Employee's Job Title and Description:** _____

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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 and supply the number of hours typically scheduled to work each day.

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

_____ hrs/day _____ hrs/day _____ hrs/day _____ hrs/day _____ hrs/day _____ hrs/day _____ hrs/day

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

Block Leave/Continuous Leave: _____

Intermittent Leave: _____

Reduced Leave Schedule: _____

Start date (mm/dd/yyyy) _____ **Through** (mm/dd/yyyy) _____

Dates requested: _____

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

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

Employee's Name: _____

17 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.)	☐	☐	_____	_____

18 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: | | | / | | | / | | | | |

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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

 /

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

 /

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: _____

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

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}
| _ _ / | _ _ / | _ _ _ _ |