Arch | Insurance

Family and Medical Leave Insurance Program (FAMLI)
COLORADO

Pregnancy and/or Childbirth Complications

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.

Important tips when completing this form:

To request Colorado FAMLI benefits due to complications related to pregnancy or childbirth, you will need to return this medical certification form. Complete **Section 1** and send it to your treating healthcare provider to complete **Section 2.**

If this is your first FAMLI leave of absence related to your pregnancy and childbirth, you will also need to complete and return an Application and provide any other supporting documents as part of your claim for benefits.

Section 1: For Completion by the Employee

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

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

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

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

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

*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**

Section 2: For Completion by the Treating Health Care Provider

Your patient has made a request to be absent from work because of a serious health condition related to pregnancy complications or childbirth complications. For us to make a decision on her claim for CO FAMLI benefits, we will need you to complete the information in Section 2. 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 serious health condition related to pregnancy complications or childbirth complications for which your patient is seeking leave. If your patient needs leave due to more than one health condition, please complete a separate certification for each condition.

1 **Check and complete all that apply:**

☐ My patient's baby is due/was born on _____ (date)

☐ If born, indicate: ☐ Vaginal delivery ☐ Caesarian delivery

☐ If Caesarian, has your patient experienced/is your patient experiencing any additional complications? ☐ Yes ☐ No

NOTE: Delivery by Caesarian with no additional pregnancy complications or childbirth complications will entitle your patient to 8 weeks of FAMLI leave and benefits. You do not need to complete the rest of this form. Please sign and date below.

☐ My patient is incapacitated and unable to work due to pregnancy complications or childbirth complications.

Date complication commenced: _____

Date you first examined the patient for this complication: _____

2 **Briefly describe the incapacity due to pregnancy complications or childbirth complications.**

_____

_____

3 **Provide the start and end dates for the period of leave needed for the postpartum incapacity due to pregnancy complications or childbirth complications described above. *Do not include bonding leave*, which your patient can apply for separately.**

OPTION 1 NOTE: If your patient's complications(s) occurs completely within the 6 weeks following birth (8 weeks for Caesarian delivery) please state the specific dates the complications existed or are expected to exist, as this might extend the duration of your patient's leave entitlement.

OPTION 2 NOTE: If your patient's complications(s) occurs completely within the 6 weeks following birth (8 weeks for Caesarian delivery) you do not need to complete this form. New mothers will be approved for 6 weeks of medical leave for recovery from an uncomplicated vaginal delivery or 8 weeks for Caesarian delivery and do not need any other justification for time off from work during this period.

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

(Provide your best end date estimate if not certain.)

Section 2 continued on next page

Colorado - Health Care Provider Certification | Pregnancy and/or Childbirth Complications
Continued

4 **Check the applicable box(es) and complete the information that best describes the type of time away from work that your patient will need due to her pregnancy complications or childbirth complications.**

☐ **Continuous leave:** My patient has/will be incapacitated for a **single continuous period,** including time for treatment and recovery beginning ____/____/_____ and ending ____/____/____.

☐ **Reduced Work Schedule leave:** My patient will need to work a reduced work schedule due to her incapacity and/or treatment and recovery beginning ___/___/____ and ending ___/___/___ for the following:

- ☐ a reduced work day: limited to ____ hours per day;
- ☐ a reduced work week: limited to ____ day(s) per week
- ☐ Other: _____

☐ **Intermittent leave - Incapacitation:** My patient is expected to have periodic flare-ups where intermittent absence from work will be medically necessary beginning ___/___/____ and ending ___/___/___.

Describe the estimated frequency and duration of flare-ups. (e.g., 1x per week lasting 4 hours), (e.g., 1x every 3 months lasting 1-2 days), (e.g., 3x every month lasting 1 day). **Please select and complete one:**

☐ **Weekly:** ____ time(s) every ____ week(s) for a duration of ____ hour(s) or ____ day(s) per instance;

OR

☐ **Monthly:** ____ time(s) every ____ week(s) for a duration of ____ hour(s) or ____ day(s) per instance

☐ **Intermittent leave - Treatments:** My patient is expected to attend follow-up treatment appointments due to her pregnancy complications or childbirth complications beginning ___/___/____ and ending ___/___/___.

Describe the estimated frequency and duration for treatments/appointments. (e.g., 1 x per week lasting 2 hrs), (e.g., 1 x per month lasting 4 hrs) (e.g., 3x every 2 months lasting 6 hours). **Please select and complete one:**

☐ **Weekly:** ____ time(s) every ____ week(s) for a duration of ____ hour(s) or ____ day(s) per treatment;

OR

☐ **Monthly:** ____ time(s) every ____ week(s) for a duration of ____ hour(s) or ____ day(s) per treatment

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 | _ _ / | _ _ / | _ _ _ _ |

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