Arch | Insurance

Family Leave Claim Form

PFML Paid Family & Medical Leave
CONNECTICUT

If you work in Connecticut, 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 must complete this certification. This certification will be shared with Arch Insurance and your employer*.

Before you apply for CT PFML...

✓ **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 CT PFML Act.

✓ **Notify your CT 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

→ **Complete 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.

→ **Your CT 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.

→ **Complete the certification for your leave type and attach 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

Qualifying Leave Types (select one)

Note: If utilizing more than 1 type of leave, a separate claim package must be completed for each leave type; leave may not be requested for the same period of time.

☐ **Bonding Leave with a new child** (birth, adoption or foster placement)

- ☐ Complete CT - BONDING CERTIFICATION form
- ☐ Attach documentation as listed on the form, supporting your relationship with the new child

☐ **Qualifying exigencies associated with a call to active duty overseas**

- ☐ Complete the CT - MILITARY EXIGENCY form
- ☐ Attach proof documents supporting the leave (options listed on the form)

☐ **Family violence leave**

If you are experiencing family violence, you may be eligible to receive up to **12 days** of CT PFML benefits to seek medical or psychological care, to seek support from a victim services organization, to relocate, or to participate in any civil or criminal proceeding(s) relating to family violence.

- ☐ Complete the CT - FAMILY VIOLENCE Statement
- ☐ Attach proof documents supporting the leave (options listed on the form)

*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 eligibility and benefit amount, Arch may share your information with your current and/ or past employer(s), and CT PFML 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**

Request for Connecticut Paid Family 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 | __ __ / __ __ / __ __ __ __ |

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

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

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

8 **Why are you applying for leave?**

☐ Bond with my new child. You will need to complete the ***Bonding Certification Form*** on page 8.

☐ Qualifying Military Exigency. You will need to complete the ***Military Exigency Form*** on page 9.

☐ Family Violence. You will need to complete the ***Family Violence Form*** on page 11.

9 **The Family Member's Relationship to the Employee (Claimant) is:**

☐ Self ☐ Spouse ☐ Parent or Spouse's Parent ☐ Grandparent or Spouse's Grandparent

☐ Grandchild ☐ Child (of any age) or Child's Spouse ☐ Sibling or Spouse's Sibling

10 **Employer Information:**

Name _____

Street _____

Address line 2 _____

City _____

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

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

Request for Connecticut Paid Family Leave

Part A Continued

10a **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 ($) | __ |

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 |

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

11 **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 _____

12 **Was 30 days Advanced Notice Given to Your Employer for this Leave?**

☐ Yes Date notice provided to employer | m m / d d / y y y y |

☐ No Reason: _____

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

Request for Connecticut Paid Family Leave

Part A Continued

13 **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. PFML	☐	☐	_____	_____
d. Other (Sick/Vacation/PTO or other employer provided leave. Please specify.)	☐	☐	_____	_____

I am hereby making a request for benefits under the Connecticut Paid Family and Medical Leave Act. Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, 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. 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.

Employee's Signature:

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

End of Part A

Request for Connecticut Paid Family Leave

Part B: Employer Information

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

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 Contact:

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:

Questions? Contact us at **877-369-0979**
or find us online at **archinsurance.com/disability**
23-07-DBL02

Request for Connecticut Paid Family Leave

Part B Continued

12 **Please check the appropriate boxes:**

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

13 **Connecticut ("CT") 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 CT? ☐ Yes ☐ No (answer question 13c)

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

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

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

f. If there is no place of direction and control, no localized services and no base of operations in CT, does the employee reside in CT? ☐ 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 4 completed calendar quarters preceding the request for leave:**

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

14 **Provide the scheduled work hours from the last 12 weeks the employee reported to work prior to the leave:**

Week 1 _____
Week 2 _____
Week 3 _____
Week 4 _____
Week 5 _____
Week 6 _____
Week 7 _____
Week 8 _____
Week 9 _____
Week 10 _____
Week 11 _____
Week 12 _____
Average: _____

16 **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) _____

Request for Connecticut Paid Medical Leave

Part B Continued

17 **Was 30 days advance given to you by the employee requesting foreseeable leave?**

☐ Yes ☐ No **Date notice provided to employer:** m m / d d / y y y y

18 **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	☐	☐		
b. Workers' Compensation	☐	☐		
c. PFML	☐	☐		
d. Other (Sick/Vacation/PTO or other employer provided leave. Please specify.)	☐	☐		

19 **Is the employee taking CT FMLA concurrently with this leave?**

☐ Yes ☐ No

20 **Is the employee required to utilize PTO, Sick or other paid time off, prior to or while receiving paid leave benefits?**

☐ Yes ☐ No

If yes, provide details on the number of hours the employee has available, and list the date(s) this paid time off is applicable for. PFML benefits may not be received concurrently with paid time off. **As required by Conn. Gen. Stat. § 31-51ll(e), an employee is able to retain at least two weeks of paid time off if CT FMLA is running concurrently with PFML. These 2 weeks should not be included in the details**

Number of hours: _____ **Start date: (mm/dd/yyyy)** _____ **End date: (mm/dd/yyyy)** _____

Declaration and Signature:

I am the person authorized to sign as the employer of the employee requesting benefits under the Connecticut Paid Family and Medical Leave Law. Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, 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

CT- Bonding Certification Form

Employee Information (to be completed by the employee requesting Bonding leave)

1 **Employee's Legal Name:** _____

Bonding Certification (to be completed by the employee)

1 **Child's ACTUAL Date of Birth:** | m m / d d / y y y y |

2 **Relationship of child to Employee requesting leave:**

☐ Biological child ☐ Foster child ☐ Adopted child ☐ Stepchild ☐ Legal Ward ☐ Loco Parentis

2a **Placement Date for Adopted/Foster Child:**
If requesting leave to bond with an adopted or foster child or legal ward, provide the DATE the child was placed with you.
| m m / d d / y y y y |

3 **Attach Proof Documentation Supporting the Leave:**
Examples of valid proof documentation are listed below. Your claim cannot be accepted without proof documentation supporting the leave.

Birth of Child

- ☐ Child's Birth Certificate, or
- ☐ Statement from Child's health care provider confirming child's date of birth, or
- ☐ Statement from health care provider of person who gave birth, confirming child's date of birth.

Adoption/Foster Care

- ☐ Statement from adoption or foster care agency, or the Connecticut Department of Children and Families confirming the placement, and date of placement, or
- ☐ Statement from the child's health care provider confirming the placement, and date of placement

Declaration and Signature:

I am hereby making a request for benefits under the Connecticut Paid Family and Medical Leave Law. Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, 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. 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.

Signature: _____

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

Military Exigency Form

Employee Information (to be completed by the employee requesting leave due to a qualifying military exigency)

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

Service Member Details & Qualifying Exigency (to be completed by the employee)

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

2 **Service Member's Mailing Address:**

Street _____

Address line 2 _____

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

3 **Service Member's Relationship to Employee requesting leave:**

☐ Spouse ☐ Parent ☐ Child

4 **Current Service Member Affiliation**

☐ Air Force ☐ Army ☐ Coast Guard ☐ Marine Corps ☐ Navy ☐ Reserves ☐ National Guard

5 **Proof Documentation of affiliation** (proof documentation of service must be included with the claim, options are listed below)

☐ Copy of Active-Duty Orders

☐ Letter of impending activation

☐ Letter from commanding officer or approving authority for service member's Rest and Recuperation

☐ Other documentation reasonably acceptable in circumstances where the documentation specified above is unavailable.

6 **Select Reason(s) for requesting leave** (one or more reasons may be selected)

☐ Arranging for child care

☐ Making financial arrangements

☐ Arranging for parental care

☐ Counseling

☐ Making legal arrangements

☐ Making arrangements following the death of the military member

☐ Attending any event sponsored by the military or military service organization

☐ Spending time with the military member during a rest and recuperation leave or following return from deployment (leave for this reason is limited to 15 calendar days for each instance of R&R)

☐ Other: (provide detail) _____

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

Military Exigency form continues on next page.

Military Exigency Form

Continued

Service Member Details & Qualifying Exigency (to be completed by the employee)

7 **Date(s) or period of time for which leave is requested:**

	Start date (mm/dd/yyyy)	Through (mm/dd/yyyy)
Block/Continuous Leave:	_____	_____
Intermittent Leave:	Dates requested: _____	
Reduced Leave Schedule:	Frequency of leave: (eg: 2 days per week, or 4 hours per day, or every Monday) _____	

Third Party Information

If applicable, please provide information below that may be used to verify meetings or appointments with a third party related to the qualifying exigency. Examples of meetings with third parties include arranging for childcare or parental care, to attend non-medical counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the Service Member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations. This information may be used to verify that the information contained on this form is accurate.

Individual (e.g., name and title) or Entity/Organization:

Address: _____

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

Telephone: _____ Fax: _____

Email: _____

Describe purpose of meeting: _____

Declaration and Signature:

I am hereby making a request for benefits under the Connecticut Paid Family and Medical Leave Law. Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, 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. 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.

Signature: _____

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

End of Military Exigency form

CT- Family Violence Statement

Employee Information (to be completed by the employee requesting leave)

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

Family Violence Required Documentation

☐ Signed written statement from applicant certifying that the applicant is taking leave for one of the following reasons:
1. To seek medical care or psychological or other counseling for physical or psychological injury or disability,
2. To obtain services from a victim services organization,
3. To relocate due to such family violence, or
4. To participate in any civil or criminal proceedings related to or resulting from such family violence

☐ A police or court record related to the family violence; or

☐ A signed written statement that the applicant is a victim of family violence, provided such statement is from an employee or agent of a victim services organization, an attorney, an employee of the Judicial Branch's Office of the Victim Services or the Office of the Victim Advocate, or a licensed medical professional or other licensed professional from whom the applicant has sought assistance with respect to the family violence.

Written Description of the purpose for this leave (to be completed by the Applicant)

_____

_____

Declaration and Signature:

I am hereby making a request for benefits under the Connecticut Paid Family and Medical Leave Law. Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, 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. 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.

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

Third Party Signature:

I attest I am ☐ an Attorney, ☐ an employee of the Judicial Branch's Office of the Victim Services or the Office of the Victim Advocate, or ☐ a licensed medical professional or ☐ other licensed professional. I am attesting that the applicant named in this document is a victim of family violence.

Print Name: _____ **Organization Name:** _____ **Date:** _____

Signature: _____

End of CT- Family Violence Statement