Arch Insurance

Family & Medical 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.

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.

☐ **Medical Leave due to my own serious health condition** (including pregnancy, organ or bone marrow donation)

- ☐ Complete the HIPAA Authorization form and provide it to your health care provider, allowing medical information to be shared with Arch Insurance.
- ☐ Complete the top portion of the MEDICAL CERTIFICATION - SELF CARE form
- ☐ Your health care provider completes the remainder of the MEDICAL CERTIFICATION - SELF CARE form and returns the completed form to you

☐ **Caring for your family member with a serious health condition**

- ☐ Your family member completes the HIPAA Authorization form and provides it to their health care provider, allowing medical information to be shared with you and Arch Insurance.
- ☐ Complete the top portion of the MEDICAL CERTIFICATION - FAMILY CARE form, providing information on yourself and your qualifying family member requiring care
- ☐ Your health care provider completes the remainder of the MEDICAL CERTIFICATION - FAMILY CARE form and returns the completed form to you.

☐ **Caring for a military family member injured during active duty**

- ☐ Your family member completes the HIPAA Authorization form and provides it to their health care provider, allowing medical information to be shared with you and Arch Insurance.
- ☐ Complete the top portion of the MEDICAL CERTIFICATION - MILITARY CARE form, providing information on yourself and your qualifying family member requiring care
- ☐ Your health care provider completes the remainder of the MEDICAL CERTIFICATION- MILITARY CARE form and returns the completed form to you

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 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 Medical 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?**

☐ My own serious health condition. You will need to complete the ***Self Care Form*** on page 10.

☐ A family member's serious health condition that is related to military service. You will need to complete the ***Family Care Form*** on page 14.

☐ A family member's serious health condition of any other kind (starts 7/1/21). You will need to complete the ***Military Care Form*** on page 18.

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 Medical 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 Medical 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 Medical 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 name for questions relating to Medical and PFL:

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 |

8 Last day worked before leave:

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

9 Has the employee returned to work?

☐ Yes ☐ No

Return to work date: | m m / d d / y y y y | ☐ Actual ☐ Estimated

10 Employee's Job Title and Description:

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

Request for Connecticut Paid Medical Leave

Part B Continued

10a **Please check the appropriate boxes:**

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

11 **Connecticut ("CT") Employment Verification:**

a. Are the employee's earnings reported at year end on IRS form W-2? ☐ Yes ☐ No (answer question 11b)

b. Is the employee subject to Unemployment Insurance obligations in CT? ☐ Yes ☐ No (answer question 11c)

c. Is the employee's service localized (performed entirely) within CT? ☐ Yes ☐ No (answer question 11d)

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 11e)

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 11f)

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

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

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

13 **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: _____

15 **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

16 **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 |

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

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

☐ Yes ☐ No

19 **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 |

End of Part B

HIPPA Authorization For Use And Disclosure of Information

Instructions: The individual who requires care completes this form, and provides a completed copy to their health care provider. For medical leave due to your own serious health condition, you may complete this form. For leaves to care for your qualified family member or military service member with a serious health condition, the family member who requires care ("Care Recipient") should complete the form in its entirety, sign, and date, and provide to their health care provider along with the Medical Certification form. Retain a copy of the completed form for your records.

1 Care Recipient Information

Name of Individual to Receive Care: _____
(First Name, Middle Initial, Last Name)

Mailing address of Individual Receiving Care:

Street _____

Address line 2 _____

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

Care Recipient's Contact Phone #: (__ __ __) - | __ __ __ | - | __ __ __ __ |

Care Recipient's Date of Birth: | m m / d d / y y y y |

2 Health Care Provider Information

Name of Care Recipient's Health Care Provider: _____

Mailing address of Health Care Provider: (Include full professional designation, i.e. MD, DO)

Street _____

Address line 2 _____

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

Health Care Provider's Contact Phone #: (__ __ __) - | __ __ __ | - | __ __ __ __ |

3 Authorization

I _____ **authorize** _____ **to**
(print full name of care recipient) (insert name of health care provider)

complete the Medical Certification and disclose Protected Health Information ("PHI") relating to my medical condition for which the medical certification and PFML is being requested to the paid family and medical leave ("PFML") insurance carrier listed below.

Carrier: Arch Insurance Company, PO Box #26316, Collegeville, PA 19426

Unless I have put a check by the information that may be disclosed, I do NOT want my Health Care Provider to disclose the following types of information:

☐ HIV/AIDS related information ☐ Mental health information ☐ Substance Abuse information ☐ Psychotherapy notes

4 ACKNOWLEDGEMENTS: I understand that:

a. This Authorization is voluntary.
b. My treatment and the payment for my treatment will not be affected by my signing or not signing this Authorization;
c. This authorization will expire one year from the date I sign below, unless otherwise revoked;
d. I may revoke this Authorization at any time by notifying the Health Care Provider in writing, but the revocation will not apply to information that has already been disclosed;
e. The information that is disclosed pursuant to this Authorization may be re-disclosed by the recipient and no longer protected; and,
f. I may request a copy of this Authorization and shall provide a copy to Arch Insurance Group.

5 Signature (Page 1 of this form must be completed before signing below)

Signature of Care Recipient or Care Recipient's Legal Representative: _____ **Date Signed:** _____ (mm/dd/yyyy)

If signed by Care Recipient's Legal Representative, complete the following:

Printed Name of Care Recipient's Legal Representative: _____

Relationship of Care Recipient to the Legal Representative: _____

Please Check which of the following provides authority to serve as a Legal representative:

☐ Parental right ☐ Power of attorney (attach copy) ☐ Health care proxy (attach copy) ☐ Court order (attach copy)

End of HIPAA Authorization

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

Medical Certification - Self Care Form

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

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

(First Name, Middle Initial, Last Name)

Medical Certification (to be completed by the employee's treating health care provider)

Instructions:

Please print information legibly, and answer all questions fully and completely. When providing information surrounding the length/duration of a condition, or the frequency of treatment, be specific. Dates are intended to be best estimates based upon the medical facts for this patient, and in alignment with general guidelines. Do not use terms such as "unknown, lifetime, indeterminate", as this will delay the patient's claim process and the answers will be deemed incomplete. After completing this form, return it to the Patient. Do not provide 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).

Definitions/Examples:

Serious Health Condition: an illness, injury, impairment or physical or mental condition that involves:
a. inpatient care in a hospital, hospice, nursing home, or residential medical facility; or
b. continuing treatment (including outpatient treatment) by a health care provider.

Inpatient care: An overnight stay in a hospital, hospice, nursing home, 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: Treatment for a condition that fits any of the following descriptions:

- Any incapacity (inability) 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 (e.g therapy) or prescription medication (e.g an antibiotic) under the provider's supervision.
        - Taking of over-the-counter medications (e.g. aspirin), or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider is not considered sufficient to be considered a regimen of continuing treatment.
- Any incapacity due to pregnancy or prenatal care
- Any incapacity due to a chronic condition, which is a condition that:
    - Requires periodic medical visits at least 2 times per year
    - Continues over an extended period of time, and
    - May cause episodic periods of incapacity that require leave. E.g., asthma, migraine headaches, diabetes, epilepsy .
- Any incapacity due to a permanent or long-term condition that may not respond to treatment. E.g., Alzheimer's disease, a severe stroke, or the terminal stages of a disease.
- 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 calendar days of incapacity if the patient did not receive treatment. E.g., cancer (chemotherapy or radiation treatments), severe arthritis (physical therapy) kidney disease (dialysis).

Incapacity: An inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom. For unemployed applicants, it means an inability to perform the functions of their most recent position or other suitable employment.

Medical Certification - Self Care Form

Continued

1 Medical Information

a. Does the Patient have a serious health condition? See above for definitions ☐ Yes ☐ No

b. What was the first date on which the patient's serious health condition commenced? _____

c. What is the probable duration of the serious health condition? (eg: 3 months, 2 weeks) _____

d. Is the serious health condition job-related? ☐ Yes ☐ No

e. Is the serious health condition pregnancy related? (If yes, complete Pregnancy section) ☐ Yes ☐ No

f. Is the serious health condition related to organ or bone marrow donation? ☐ Yes ☐ No

g. Which of the following apply to the patient's serious health condition? Check all that apply

- ☐ Requires, or did require inpatient care
- ☐ Has incapacitated or will incapacitate the patient for more than 3 consecutive full calendar days
- ☐ Requires 2 or more medical visits within 30 days
- ☐ Requires multiple treatments and would lead to a period of incapacity without treatment
- ☐ Requires 1 medical visit plus a regimen of care
- ☐ Is chronic, requires treatments at least 2x per year, and may require periodic absences
- ☐ Is long-term and requires ongoing medical supervision, with or without active treatment

2 Diagnosis/Analysis

Diagnosis code: _____

Signs & symptoms: _____

Objective findings: _____

3 Treatment & Care:

Treatment & Care: All questions must be completed. Missing or incomplete answers will delay processing of the claim. Do not list dates as "TBD", "Unknown", or "Lifetime".

	Date (mm/dd/yyyy)
a. First date of treatment (list the first date the patient received treatment or was seen by you for this serious health condition)	
b. Most recent date of treatment (the most recent date the patient was seen for this serious health condition)	
c. Date patient was unable to work because of this serious health condition (date patient deemed unable to perform their job duties due to their serious health condition)	
d. Date patient will be able to return to work (estimated date the patient may return to work. This is not the FMLA end date but the date the patient is medically capable of working).	

4 Pregnancy-related serious health condition

	Date (mm/dd/yyyy)
a. Estimated delivery date:	
b. Actual delivery date:	

c. Delivery type (select one if known) ☐ Vaginal ☐ C-Section

d. Antepartum complications, if any: _____

e. Postpartum complications, if any: _____

A standard postpartum recovery period is 6 weeks for normal delivery and 8 weeks for C-Section. Unless complications are present and noted in this certification to support extension of the recovery period, the estimated return to work date will be applied based on this 6 or 8 week standard.

Medical Certification - Self Care Form

Continued

5 **Medical Leave Needed:** Indicate whether your patient will require leave from work on a continuous basis or whether the patient will require leave from work on an intermittent / reduced leave schedule basis. If intermittent or reduced work schedule, provide detail of the frequency of leave needed, and approximate duration per episode. Check all that apply

	From (mm/dd/yyyy)	Through (mm/dd/yyyy)
a. Block/Continuous leave (completely unable to work for consecutive, uninterupted days.)		
b. Reduced leave schedule (a consistent but reduced schedule for multiple weeks.)		

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

c. Intermittent Leave
(Leave in separate, non-consecutive time periods rather than a single span of time for a single qualifying reason. Episodic time off.)

From (mm/dd/yyyy)	Through (mm/dd/yyyy)

Frequency of leave required for flare-ups or treatments relating to this serious health condition (eg: 1 episode every 3 months lasting 1-2 days)

	# of times	Per Week	Per Month	Per year
Freq. of episode:				

	# Minutes	# Hours	# Full day(s)
Length of episode:			

6 **Health Care Provider Information:** Please print all requested information legibly, sign and date. Retain a copy of the form for your files and return the completed form to the patient.

First & Last Name: _____

Professional Designation: (Ex: MD, DO, PA, CNM) _____

Phone #: _____

License State: _____

Fax #: _____

License #: _____

Mailing Address: (Practice name, Street address, City, State, Zip) _____

Certification and Signature

NOTICE:

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 attest 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.

Health Care Provider Signature: _____

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

End of Medical Certification - Self Care Form

Medical Certification - Family Care Form

Employee Information (to be completed by the employee requesting leave to care for a family member with a serious health condition)

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

Family Member Information (covered family member requiring care due to their serious health condition)

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

2 **Family Member's Date of Birth:** m m d d y y y y | __ __ / __ __ / __ __ __ __ |

3 **Family Member's Mailing Address:**

Street _____

Address line 2 _____

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

4 **Family Member's Relationship to Employee requesting leave:**

- ☐ 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
- ☐ Individual related by blood or affinity whose close association the employee considers equal to that of a family relationship

5 **Provide detail on the type of care the family member will need:**

- ☐ Assistance with basic medical, hygienic, nutritional, or safety needs
- ☐ Transportation
- ☐ Physical Care
- ☐ Physical comfort
- ☐ Other: (please describe)

_____

Medical Certification (to be completed by family member's treating health care provider)

Instructions:

Please print information legibly, and answer all questions fully and completely. When providing information surrounding the length/duration of a condition, or the frequency of treatment, be specific. Dates are intended to be best estimates based upon the medical facts for this patient, and in alignment with general guidelines. Do not use terms such as "unknown, lifetime, indeterminate", as this will delay the patient's claim process and the answers will be deemed incomplete. After completing this form, return it to the Patient. Do not provide 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).

Definitions/Examples:

Serious Health Condition: an illness, injury, impairment or physical or mental condition that involves:
a. inpatient care in a hospital, hospice, nursing home, or residential medical facility; or
b. continuing treatment (including outpatient treatment) by a health care provider.

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

Medical Certification - Family Care form continues on next page

Medical Certification - Family Care Form

Continued

Continuing treatment by a health care provider: Treatment for a condition that fits any of the following descriptions:

- Any incapacity (inability) 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 (e.g therapy) or prescription medication (e.g an antibiotic) under the provider's supervision.
        - Taking of over-the-counter medications (e.g. aspirin), or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider is not considered sufficient to be considered a regimen of continuing treatment.
- Any incapacity due to pregnancy or prenatal care
- Any incapacity due to a chronic condition, which is a condition that:
    - Requires periodic medical visits at least 2 times per year
    - Continues over an extended period of time, and
    - May cause episodic periods of incapacity that require leave. E.g., asthma, migraine headaches, diabetes, epilepsy .
- Any incapacity due to a permanent or long-term condition that may not respond to treatment. E.g., Alzheimer's disease, a severe stroke, or the terminal stages of a disease.
- 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 calendar days of incapacity if the patient did not receive treatment. E.g., cancer (chemotherapy or radiation treatments), severe arthritis (physical therapy) kidney disease (dialysis).

Incapacity: An inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom. For unemployed applicants, it means an inability to perform the functions of their most recent position or other suitable employment.

1 Medical Information

a. Does the Patient (family member) have a serious health condition? See above for definitions ☐ Yes ☐ No

b. What was the first date on which the patient's serious health condition commenced? _____

c. What is the probable duration of the serious health condition? (eg: 3 months, 2 weeks) _____

d. Which of the following apply to the patient's serious health condition? Check all that apply

- ☐ Requires, or did require inpatient care
- ☐ Has incapacitated or will incapacitate the patient for more than 3 consecutive full calendar days
- ☐ Requires 2 or more medical visits within 30 days
- ☐ Requires multiple treatments and would lead to a period of incapacity without treatment
- ☐ Requires 1 medical visit plus a regimen of care
- ☐ Is chronic, requires treatments at least 2x per year, and may require periodic absences
- ☐ Is long-term and requires ongoing medical supervision, with or without active treatment

2 Diagnosis/Analysis

Diagnosis code: _____

Signs & symptoms: _____

Objective findings: _____

Medical Certification - Family Care form continues on next page

Medical Certification - Family Care Form

Continued

3 **Leave Needed:** Indicate whether your patient (family member) will require care by the employee listed above (the patient's family member) on a continuous, reduced leave schedule or intermittent basis. If intermittent or reduced leave schedule, provide detail of the frequency of leave needed, and approximate duration per episode. Check all that apply.

	From (mm/dd/yyyy)	Through (mm/dd/yyyy)
a. Block/Continuous leave (completely unable to work for consecutive, uninterupted days.)		
b. Reduced leave schedule (a consistent but reduced schedule for multiple weeks.)		

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

c. Intermittent Leave
(Leave in separate, non-consecutive time periods rather than a single span of time for a single qualifying reason. Episodic time off.)

	From (mm/dd/yyyy)	Through (mm/dd/yyyy)

Frequency of leave required for flare-ups or treatments relating to this serious health condition (eg: 1 episode every 3 months lasting 1-2 days)

	# of times	Per Week	Per Month	Per year
Freq. of episode:				

	# Minutes	# Hours	# Full day(s)
Length of episode:			

4 **Health Care Provider Information:** Please print all requested information legibly, sign and date. Retain a copy of the form for your files and return the completed form to the patient.

First & Last Name: _____

Professional Designation: (Ex: MD, DO, PA, CNM) _____

Phone #: _____

License State: _____

Fax #: _____

License #: _____

Mailing Address: (Practice name, Street address, City, State, Zip) _____

Certification and Signature

NOTICE:

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 attest 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.

Health Care Provider Signature: _____

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

End of Medical Certification - Family Care form

Medical Certification - Military Care Form

Employee Information (to be completed by the employee requesting leave to care for a family member with a serious health condition)

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

(First Name, Middle Initial, Last Name)

Service Member Information (Military service member requiring care due to their serious health condition)

Note: Under CT PFML, a "Covered service member" means a current member of the Armed Service. Covered service member for purposes of military caregiver leave does not include veterans.

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 or Spouse's Parent ☐ Child (of any age) or Child's Spouse ☐ Next of Kin

4 **Service Member Affilliation (Active Duty)**

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

5 **Provide detail on the type of care the service member will need:**

☐ Assistance with basic medical, hygienic, nutritional, or safety needs

☐ Transportation ☐ Physical Care ☐ Physical comfort

☐ Other: (please describe) _____

Medical Certification (Completed by service member's treating health care provider)

Instructions:

Please print information legibly, and answer all questions fully and completely. When providing information surrounding the length/duration of a condition, or the frequency of treatment, be specific. Dates are intended to be best estimates based upon the medical facts for this patient, and in alignment with general guidelines. Do not use terms such as "unknown, lifetime, indeterminate", as this will delay the patient's claim process and the answers will be deemed incomplete. After completing this form, return it to the Patient. Do not provide 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).

Definitions/Examples:

Serious Health Condition: an illness, injury, impairment or physical or mental condition that involves:
a. inpatient care in a hospital, hospice, nursing home, or residential medical facility; or
b. continuing treatment (including outpatient treatment) by a health care provider.

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

Medical Certification - Military Care form continues on next page

Medical Certification - Military Care Form

Continued

Continuing treatment by a health care provider: Treatment for a condition that fits any of the following descriptions:

- Any incapacity (inability) 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 (e.g therapy) or prescription medication (e.g an antibiotic) under the provider's supervision.
        - Taking of over-the-counter medications (e.g. aspirin), or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider is not considered sufficient to be considered a regimen of continuing treatment.
- Any incapacity due to pregnancy or prenatal care
- Any incapacity due to a chronic condition, which is a condition that:
    - Requires periodic medical visits at least 2 times per year
    - Continues over an extended period of time, and
    - May cause episodic periods of incapacity that require leave. E.g., asthma, migraine headaches, diabetes, epilepsy .
- Any incapacity due to a permanent or long-term condition that may not respond to treatment. E.g., Alzheimer's disease, a severe stroke, or the terminal stages of a disease.
- 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 calendar days of incapacity if the patient did not receive treatment. E.g., cancer (chemotherapy or radiation treatments), severe arthritis (physical therapy) kidney disease (dialysis).

Incapacity: An inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom. For unemployed applicants, it means an inability to perform the functions of their most recent position or other suitable employment.

1 Medical Information

a. Does the Patient (service member) have a serious health condition? See above for definitions ☐ Yes ☐ No

b. What was the first date on which the patient's serious health condition commenced? _____

c. What is the probable duration of the serious health condition? (eg: 3 months, 2 weeks) _____

d. Which of the following apply to the patient's serious health condition? Check all that apply

- ☐ Requires, or did require inpatient care
- ☐ Has incapacitated or will incapacitate the patient for more than 3 consecutive full calendar days
- ☐ Requires 2 or more medical visits within 30 days
- ☐ Requires multiple treatments and would lead to a period of incapacity without treatment
- ☐ Requires 1 medical visit plus a regimen of care
- ☐ Is chronic, requires treatments at least 2x per year, and may require periodic absences
- ☐ Is long-term and requires ongoing medical supervision, with or without active treatment

2 Diagnosis/Analysis

Diagnosis code: _____

Signs & symptoms: _____

Objective findings: _____

Medical Certification - Military Care form continues on next page

Medical Certification - Military Care Form

Continued

3 **The Service Member's/Patient's injury or illness:**

- ☐ Was incurred in the line of duty on active duty
- ☐ Existed before the beginning of the Service Member's active duty and was aggravated by service in the line of duty or active duty
- ☐ None of the above.

4 **Leave Needed:** Indicate whether your patient (family member) will require care by the employee listed above (the patient's family member) on a continuous, reduced leave schedule or intermittent basis. If intermittent or reduced leave schedule, provide detail of the frequency of leave needed, and approximate duration per episode. Check all that apply.

	From (mm/dd/yyyy)	Through (mm/dd/yyyy)
a. Block/Continuous leave (completely unable to work for consecutive, uninterupted days.)		
b. Reduced leave schedule (a consistent but reduced schedule for multiple weeks.)		

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

c. Intermittent Leave
(Leave in separate, non-consecutive time periods rather than a single span of time for a single qualifying reason. Episodic time off.)

	From (mm/dd/yyyy)	Through (mm/dd/yyyy)

Frequency of leave required for flare-ups or treatments relating to this serious health condition (eg: 1 episode every 3 months lasting 1-2 days)

	Freq. of episode:	# of times	Per Week	Per Month	Per year

	# Minutes	# Hours	# Full day(s)
Length of episode:			

5 **Health Care Provider Information:** Please print all requested information legibly, sign and date. Retain a copy of the form for your files and return the completed form to the patient.

First & Last Name: _____

Professional Designation: (Ex: MD, DO, PA, CNM) _____

Phone #: _____

License State: _____

Fax #: _____

License #: _____

Mailing Address: (Practice name, Street address, City, State, Zip) _____

Certification and Signature

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I attest 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.

Health Care Provider Signature: _____

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

End of Medical Certification - Military Care form