

If you work in Delaware, you can apply for the Delaware Paid Leave Insurance. 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*.

This Application ("Claim") is completed by the individual that is requesting paid leave benefits (the "Claimant"). Applications may be filed up to 30 days prior to the start of the requested leave, and up to 30 days after the start of the leave. A fully complete application for benefits includes a Claimant statement, employer statement, certification relating to the type of leave being requested, and supporting proof documentation for the leave. Claims filed outside this window will be denied unless good cause is provided for late filing. Claim filing is the responsibility of the individual that is requesting paid leave benefits. The Claimant is responsible for providing any missing or additional requested information during the claim process and is responsible for informing all required parties of any changes to leave plans.

Before you apply for DE PFML...



Check eligibility requirements for leave



Plan your leave. Leave can be taken continuously or intermittently, in accordance with DE PFML.



Notify your DE 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 C.



Provider should complete Part B, the Health Care Provider Certification form and attach supporting documentation.



Your DE employer completes Part C, 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.



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

*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 Delaware Paid Leave 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 Delaware Paid Leave 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

25-10-DBL28

Request for Delaware Paid Family and Medical Leave (PFML) - Employee's Own Health Condition

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

Demographic Information

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: _____

Leave Information

8 Leave Pattern and Period(s) Requested:
[] Continuous: Leave Start Date (m m / d d / y y y y) Leave End Date (m m / d d / y y y y)
[] Intermittent: Leave Start Date (m m / d d / y y y y) Date(s) Requested: _____

Request for Delaware Paid Family and Medical Leave (PFML) - Employee's Own Health Condition

9 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: _____

10 Other Types of Leave:

Provide detail on other types of benefits/leave taken or requested for this leave, and whether it will extend through the current requested leave period covered by this claim.

Benefit Type	Received	Claimed	From (mm/dd/yyyy)	Through (mm/dd/yyyy)
a. Unemployment benefits	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
b. Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
c. Short term disability (STD)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
d. Other (Sick/Vacation/PTO or other employer paid leave. Please specify. _____)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

11 Will you be receiving payments from your Employer while out on DE PFML?

Yes

No

If yes, by signing below you are confirming assignment of the payment of your benefits to Your Employer.

Declaration and Signature:

WARNING: ANY PERSON WHO, KNOWINGLY OR WITH INTENT TO DEFRAUD OR TO FACILITATE A FRAUD AGAINST ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM FOR INSURANCE CONTAINING FALSE, DECEPTIVE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD.

I am hereby making a request for benefits under Delaware Paid Leave Insurance. 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
_	_	_	_	_	_	_	_

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Delaware Health Care Provider Certification - Employee's Own Health Condition

- 6 A qualifying Serious Health Condition is a physical or mental condition that fits one of the following categories
Check the box(es) for the questions below, as applicable.

- Inpatient Care:** The patient (was / is / will be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____
- Incapacity plus Treatment:** (e.g. outpatient surgery, strep throat)
- Due to the patient's health condition, the patient was (was / is / will be) incapacitated for *more than three consecutive, full calendar days*.
 - The patient was (was / is / will be) seen on the following date(s): _____
 - The health condition (had / has / will) also result(ed) in a course of continuing treatment under the supervision of a health care provider (e/g., *prescription medication (other than over the counter), therapy requiring special equipment, etc.*)
- Pregnancy:** The health condition is pregnancy. List the expected delivery date: _____
 (mm/dd/yyyy)
- Chronic Health Conditions:** (e.g., asthma, migraine headaches) Treatment visits are expected to be at least twice per year
- Permanent or Long-Term Health Conditions:** Due to the health condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).
- Health Conditions requiring Multiple Treatments:** (e.g., chemotherapy treatments, restorative surgery, etc.) Due to the health condition, it is medically necessary for the patient to receive multiple treatments.
- None of the above:** If none of the above categories is checked, (i.e., inpatient care, pregnancy) no additional information is needed. Please sign and date the form, make a copy for your files, and return the completed form to the patient.

7 **First Date of Disability:** | ^m | ^m | / | ^d | ^d | / | ^y | ^y | ^y | ^y |

Date you first examined the patient for this health condition: | ^m | ^m | / | ^d | ^d | / | ^y | ^y | ^y | ^y |

8 **Last office visit:** | ^m | ^m | / | ^d | ^d | / | ^y | ^y | ^y | ^y |

Next office visit: | ^m | ^m | / | ^d | ^d | / | ^y | ^y | ^y | ^y |

Expected return to work date: _____

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Delaware Health Care Provider Certification - Employee's Own Health Condition

9 For the health condition for which your patient is requesting time away from work, is it your belief that the health condition was caused by or otherwise related to a workplace injury or illness?

Yes

No

10 If the employer does not supply a statement of your patient's essential functions or a job description, answer these questions based upon the patient's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a health condition is considered to be not able to perform the essential job functions of the position during the absence for treatment(s).

Due to the health condition, my patient (was not able/ Is not able/ will not be able) to perform one or more of the essential job functions(s). Identify at least one essential job function your patient was/is/will be unable to perform:

11 Provide the relevant medical facts relating to the health condition requiring this leave (these facts may include diagnosis, symptoms, or any regimen of continuing treatment such as the use of specialized equipment):

Diagnosis Code:

Diagnosis Description:

12 Provide the relevant medical facts related to the health condition requiring this leave (these facts may include diagnosis, symptoms, or any regimen of continuing treatment such as the use of specialized equipment):

Continuous leave: My patient has/will be incapacitated for a **single continuous period** due to their own health condition, including time for treatment and recovery beginning ___/___/___ and ending ___/___/___.

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

Describe the estimated frequency and duration of flare-ups. (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 ___ day(s) per instance;
 OR **Monthly:** ___ time(s) every ___ week(s) for a duration of ___ day(s) per instance

Intermittent leave - Treatments: My patient is expected to have periodic treatment where intermittent absence from work will be medically necessary beginning ___/___/___ and ending ___/___/___.

Describe the estimated frequency and duration for treatments/appointments. (e.g., 3x every 2 months). **Please select and complete one:**

Weekly: ___ time(s) every ___ week(s) for a duration of ___ day(s) per instance;
 OR **Monthly:** ___ time(s) every ___ week(s) for a duration of ___ day(s) per instance

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Delaware Health Care Provider Certification - Employee's Own Health Condition

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 and State: _____

Telephone: _____

Fax Number: _____

Email Address: _____

Certification and Signature:

WARNING: Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement of a material fact, may be guilty of insurance fraud.

My signature attests that the information provided in this form is true and correct, 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.

Signature: _____

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

Request for Delaware Paid Family and Medical Leave (PFML) - Employee's Own Health Condition

Employee's Name: _____

Part C: Employer Information

(to be completed by the employer for the above named employee requesting DE 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 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 terminated: | ^m _ ^m _ / | ^d _ ^d _ / | ^y _ ^y _ ^y _ |

8 Date employee was hired:

Date: | ^m _ ^m _ / | ^d _ ^d _ / | ^y _ ^y _ ^y _ |

9 Last day worked before leave:

Date: | ^m _ ^m _ / | ^d _ ^d _ / | ^y _ ^y _ ^y _ |

10 Has the employee returned to work?

Yes No

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

11 Employee's Job Title and Description: _____

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

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

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13 Average weekly wage:

Take the average weekly wages for the 4 completed calendar quarters immediately preceding the submission of the claims application. \$ _____

14 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 |

15 Has the employee received or claimed any of the following benefits for this leave?

Table with 5 columns: Benefit Type, Received, Claimed, From (mm/dd/yyyy), Through (mm/dd/yyyy). Rows include Unemployment benefits (CESA), Workers' Compensation due to work-related injury/illness, Short term disability (STD), and Other (Sick/Vacation/PTO or other employer provided leave).

16 Employer-provided Paid Leave during leave period

If the Employer provides Accrued Paid Leave or other Wage continuation to the Eligible Employee during a period of PFML, the Employer is accountable for paying only the amount of Accrued Paid Leave or other Wage continuation that when combined with the Weekly Benefit Amount is equal to or less than the Eligible Employee's average weekly wage such that the Eligible Employee does not receive more than 100% of their average weekly wage.

"Accrued Paid Leave" means leave earned by or otherwise provided to an Eligible Employee pursuant to a benefit plan or policy offered by the Employer, including, but not limited to, Sick Pay (including Delaware Paid Sick Leave), annual leave, Vacation Pay, personal leave, compensatory leave or Paid Time Off.

a. Will the employee be using any Accrued 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) No

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

ii. if yes, is reimbursement requested by employer? Yes No

*Reimbursement is only available if employer continued salary during 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.

I am the person authorized to sign as the employer of the employee requesting benefits under the Delaware 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.

Signature: _____

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

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