Arch | Insurance

Delaware Paid Leave
DELAWARE

Military Exigency Leave

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

1. **Employee completes 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.
2. **Employee completes Part B, the *Military Exigency Leave Attestation Form* and attaches supporting documentation.**
3. **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.
4. 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

Application for Delaware Family and Medical Leave Insurance | Military Exigency 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 DE 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 DE PFML Partners.
Visit **archinsurance.com/disability** or call **877-369-0979** for more information.

Part A Continued on Next Page

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

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

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

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

8 **Employer Information:**

Name _____

Street _____

Address line 2 _____

City _____

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

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

9 **Will leave be for a continuous period of time or intermittent?**

☐ 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

☐ Intermittent Identify dates intermittent leave will be taken: _____

☐ Dates are estimated _____

10 **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: _____

11 **Have you received or claimed any of the following benefits for this leave?**

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. Short term disability (STD)	☐	☐		
d. Other (Sick/Vacation/PTO or other employer provided leave. Please specify.) _____	☐	☐		

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Application for Delaware Family and Medical Leave Insurance | Military Exigency Leave

12 **Will you be recieving 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.

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 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, and I acknowledge that failure to do so may result in the accrual of interest and other penalties.
I am hereby making a request for benefits under the Delaware Paid Leave Insurance program. 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

Part B: Military Exigency Leave Attestation Form

Section 1: Employee Information - For Completion by the Employee

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

2 **Social Security Number:** __ __ __ - __ __ - __ __ __ __

Section 2: About the Military Family Member

1 **Select the family member to you. The family member is your:**

- ☐ Child (of any age)
- ☐ Parent
- ☐ Spouse

Relationships include: biological, foster, adoptive, step, and in loco parentis relationships and the same relationships to the employee's spouse, if applicable.

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

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

Street _____

Address line 2 _____

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

Section 3: About the Need for Qualified Exigency Leave

If approved, you may take leave for your Family Member's active-duty service or notice of an impending call or order to active-duty in the armed forces. **You must attach to this attestation** a copy of the Family Member's active-duty orders or other documentation issued by the military which indicates that the Family Member is on covered active duty or call to covered active-duty status such as official military correspondence from the military member's chain of command . For each reason checked, please submit supporting documentation or information to expedite processing your claim. We may require other reasonable information or documentation necessary to support your claim.

1 **I need leave for the following reason(s). Check all that apply:**

- ☐ Providing care or other needs of the military Family Member's Child or ☐ other Family Member
- ☐ Making financial or legal arrangements for the military Family Member.
- ☐ Attending counseling ☐ Attending military events or ceremonies
- ☐ Spending time with the military Family Member during a rest/recuperation leave or after returning from deployment.
- ☐ Making arrangements following the death of the military Family Member.

2 **Is written documentation supporting this request for leave available and attached?**

☐ Yes ☐ No ☐ None Available

Part B Continued on Next Page

Application for Delaware Family and Medical Leave Insurance | Military Exigency Leave

Section 4: Date, Duration and Frequency of Qualified Exigency Leave

Provide information concerning the amount of leave that is needed. Several questions in this section seek a response as to the frequency or duration of the Qualifying Exigency Leave needed. Be as specific as you can; terms such as "unknown" or "indeterminate" may not be sufficient to support paid leave coverage.

If you need differing leave dates/duration/frequency due to more than one qualifying exigency, please provide the information below as to each leave reason. You may use the space below, copies of this page, or additional pages.

1 **List the approximate date exigency started or will start:** _____ (mm/dd/yyyy)

2 **Provide your best estimate of how long the exigency will last. From:** _____ (mm/dd/yyyy) **to:** _____ (mm/dd/yyyy) .

Complete items 3 and 4 **as applicable:**

3 **Due to a qualifying exigency leave, I will need to be absent from work for a continuous period of time. Provide your best estimate of how long the exigency will last. From** _____ (mm/dd/yyyy) **to:** _____ (mm/dd/yyyy) .

4 **Due to the qualifying exigency, I will need to be absent from work on an intermittent basis (periodically). Provide your best estimate of how often (frequency) you will need to be absent and how long (duration) each appointment, meeting or leave event will last.**

From: _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy), I will be absent _____ times per ☐ day/ ☐ week/ ☐ month,

likely lasting approximately _____ ☐ days per episode.

5 **Use this space to provide the information requested in 3 and 4 as to additional exigency leave reasons, if more than one, and/or to provide any additional supporting information:**

_____

_____

Section 5: Employee Signature

I attest the information provided above is correct, the documentation I am providing is true and accurate, and I am in need of Qualified Exigency Leave as provided by Delaware Paid Leave.

Employee Signature: _____

Date: _____

End of Part B

Application for Delaware Family and Medical Leave Insurance | Military Exigency Leave

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 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:

12 Please check the appropriate boxes:

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

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

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

Part C Continued on Next Page

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or find us online at **archinsurance.com/disability**

Application for Delaware Family and Medical Leave Insurance | Military Exigency Leave

Employee's Name:

14 **Average weekly wage:**
Take the 52 weeks of gross wages prior to the submission of the claims application. $_____

15 **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 |

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

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. Short term disability (STD)	☐	☐		
d. Other (Sick/Vacation/PTO or other employer provided leave. Please specify.)	☐	☐		

17 **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. An Eligible Employee must consent to use of Accrued Paid Leave during periods of PFML.

"Accured 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. Accrued paid leave shall not include a (i) disability policy or program of the Employer; or (ii) paid Family or Medical Leave policy of the Employer.

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. 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 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. 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 |

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25-10-DBL30

End of Part C