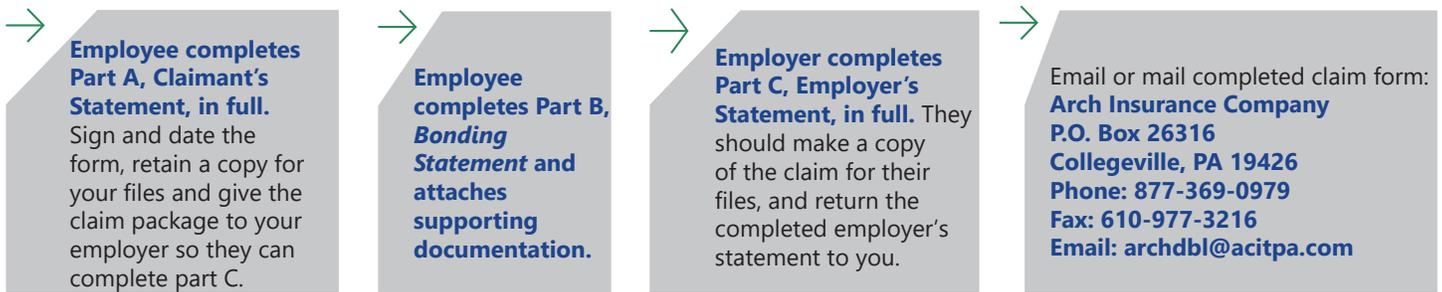


If you work in Maine, you can apply for the Maine Paid Family and Medical Leave Insurance benefits. Arch Insurance will review all submitted claims to determine your eligibility for benefits. The employee who is applying for leave must complete this certification. This certification will be shared with Arch Insurance and your employer\*.

Before you apply for ME PFML...

- Check eligibility requirements for leave
Plan your leave. Leave can be taken continuously, intermittently, or on a reduced leave schedule, in accordance with ME Paid Family and Medical Leave.
Notify your ME employer within 60 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



Application for Maine Paid Family and Medical Leave | Bonding 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 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 PFML 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 26-02-DBL10

# Application for Maine Paid Family and Medical Leave | Bonding Leave

## Part A Continued

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 (\$) | \_ |

8a List all additional employers from the past year:

Employer #1 Name \_\_\_\_\_

Street \_\_\_\_\_

Address line 2 \_\_\_\_\_

City \_\_\_\_\_ State | \_ \_ | Zip | \_ \_ \_ \_ \_ |

Period of Employment:

From | <sup>m</sup> | <sup>m</sup> / | <sup>d</sup> | <sup>d</sup> / | y | y | y | y | To | <sup>m</sup> | <sup>m</sup> / | <sup>d</sup> | <sup>d</sup> / | 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 | <sup>m</sup> | <sup>m</sup> / | <sup>d</sup> | <sup>d</sup> / | y | y | y | y | To | <sup>m</sup> | <sup>m</sup> / | <sup>d</sup> | <sup>d</sup> / | y | y | y | y |

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

**Questions?** Contact us at **877-369-0979**  
or find us online at [archinsurance.com/disability](http://archinsurance.com/disability)



## Application for Maine Paid Family and Medical Leave | Bonding Leave

# Part B: Bonding Statement

(to be completed by the employee requesting leave)

### Important directions for completing your request for benefits:

To request bonding leave benefits under Maine Paid Family and Medical Leave, you must return this completed Family Leave Bonding Statement to us with your completed Application and any other supporting documents. Incomplete or missing information may result in a delay in claim processing.

#### Section 1: Employee/Applicant Information - For Completion by the Employee

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

2 **Social Security Number:** \_ \_ - \_ - \_ \_ \_ \_

#### Section 2: Bonding Statement (Statement of the family relationship and bonding type)

1 **I am making a request for paid family leave benefits to bond with:**

Child's Gender:  Male  Female  Non-Designated / Other

Date of Birth, Adoption or Placement: | <sup>m</sup> \_ | <sup>m</sup> \_ | / | <sup>d</sup> \_ | <sup>d</sup> \_ | / | <sup>y</sup> \_ | <sup>y</sup> \_ | <sup>y</sup> \_ | <sup>y</sup> \_ |

2 **Please select one bonding type and submit a copy of the supporting documentation. Please note that additional documentation may be requested as needed:**

- Biological child - Please provide **one** of the following:
- Proof of birth (copy of birth certificate, application for a birth certificate, documentation from the health care provider who provided care during birth or recovery, or vital records showing birth of child); or
  - Statement from you establishing in loco parentis\* status
- Adopted child - Please provide proof of adoption placement (copy of adoption papers or court documents; include the child's date of birth and adoption date).
- Foster child- Please provide **one** of the following:
- Proof that you are a licensed or certified foster parent and that the child has been placed in your care; or
  - Documentation from a child placement agency, state or county department of human services, or a court indicating a kinship or emergency placement was necessary to provide for the immediate care and safety of the minor child and you will be standing in loco parentis through a power of attorney or other legal designation.

**Employee Signature:** \_\_\_\_\_

Date: | <sup>m</sup> \_ | <sup>m</sup> \_ | / | <sup>d</sup> \_ | <sup>d</sup> \_ | / | <sup>y</sup> \_ | <sup>y</sup> \_ | <sup>y</sup> \_ | <sup>y</sup> \_ |

\* In loco parentis – a relationship in which a person puts himself or herself in the situation of parent by assuming and discharging the obligations of a parent to a child.

**Questions?** Contact us at **877-369-0979**  
or find us online at [archinsurance.com/disability](http://archinsurance.com/disability)

End of Part B

26-02-DBL10

# Application for Maine Paid Family and Medical Leave | Bonding Leave

Employee's Name: \_\_\_\_\_

## Part C: 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 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: | <sup>m</sup> \_\_ <sup>m</sup> \_\_ / | <sup>d</sup> \_\_ <sup>d</sup> \_\_ / | <sup>y</sup> \_\_ <sup>y</sup> \_\_ <sup>y</sup> \_\_ |

**8 Date employee was hired:**

Date: | <sup>m</sup> \_\_ <sup>m</sup> \_\_ / | <sup>d</sup> \_\_ <sup>d</sup> \_\_ / | <sup>y</sup> \_\_ <sup>y</sup> \_\_ <sup>y</sup> \_\_ |

**9 Last day worked before leave:**

Date: | <sup>m</sup> \_\_ <sup>m</sup> \_\_ / | <sup>d</sup> \_\_ <sup>d</sup> \_\_ / | <sup>y</sup> \_\_ <sup>y</sup> \_\_ <sup>y</sup> \_\_ |

**10 Has the employee returned to work?**

Yes  No

Return to work date: | <sup>m</sup> \_\_ <sup>m</sup> \_\_ / | <sup>d</sup> \_\_ <sup>d</sup> \_\_ / | <sup>y</sup> \_\_ <sup>y</sup> \_\_ <sup>y</sup> \_\_ |  Actual  Estimated

**11 Employee's Job Title and Description:** \_\_\_\_\_

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

# Application for Maine Paid Family and Medical Leave | Bonding Leave

Employee's Name: \_\_\_\_\_

**12 Please check the appropriate boxes:**

Exempt  
  Non Exempt  
  Full Time  
  Part Time  
  Hourly  
 Hrs/Wk: \_\_\_\_\_

**13 Maine ("ME") 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 ME?  Yes  No (answer question 13c)
- c. Is the employee's service localized (performed entirely) within ME?  Yes  No (answer question 13d)
- d. If services are not localized, is the employee's base of operations in ME, and some of the work is performed in ME?  Yes  No (answer question 13e)
- e. If there is no base of operations, does the employee perform some of the services within ME and receive direction and control from ME?  Yes  No (answer question 13f)
- f. If there is no place of direction and control, no localized services and no base of operations in ME, does the employee reside in ME?  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 5 completed calendar quarters preceding the request for leave:**

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

**16 Provide the scheduled work hours from the last 4 weeks the employee reported to work prior to the leave:**

Week 1 \_\_\_\_\_  
 Week 2 \_\_\_\_\_  
 Week 3 \_\_\_\_\_  
 Week 4 \_\_\_\_\_  
 Average: \_\_\_\_\_

## Application for Maine Paid Family and Medical Leave | Bonding Leave

Employee's Name: \_\_\_\_\_

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

Yes  No

Date notice provided to employer: |       / |       / |             |

### 18 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)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
b. Workers' Compensation due to work-related injury/illness	<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 provided leave. Please specify.)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

### 19 Employer-provided Paid Leave during leave period

a. Will the employee be using any employer-provided paid leave **during the leave period requested?**

Yes (answer question b)  No

b. Will the employee be receiving wages **during all or a portion of the leave period requested?**

Yes (answer question i and ii)  No

i. provide detail on type of wages 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

**Note:** Employer reimbursement may be permitted if the employee's salary is being continued through some kinds of benefits payments made by the employer. Employer reimbursement is not permitted if the employee is using any employer-provided paid leave such as use of accrued vacation, sick, personal or parental 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 Maine Paid Family and Medical Leave 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: |       / |       / |             |

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