Arch | Insurance

Minnesota Paid Leave
MINNESOTA

Family Member's Serious Health Condition

If you work in Minnesota, you can apply for the Minnesota Paid 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 MN PFML...

Check eligibility requirements for leave

Plan your leave. Leave can be taken continuously, intermittently, or on a reduced leave schdeule in accordance with MN Paid Leave.

Notify your MN 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

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.

Provider completes Part B, *Health Care Provider Certification* and attaches supporting documentation.

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

Application for Minnesota Paid Leave | Family Member's Serious Health Condition

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**

Application for Minnesota Paid Leave | Family Member's Serious Health Condition

Part A Continued

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

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

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

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

☐ Child (of any age) ☐ Spouse ☐ Domestic Partner

☐ Parent or your Spouse/Domestic Partner's Parent

☐ Sibling or your Spouse/Domestic Partner's Sibling

☐ Grandparent or your Spouse/Domestic Partner's Grandparent

☐ Grandchild or your Spouse/Domestic Partner's Grandchild

☐ Person with whom the employee has a significant bond that is or is like a family relationship

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

9 **Employer Information:**

Name _____

Street _____

Address line 2 _____

City _____

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

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

9a **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 ($) | __ |

Application for Minnesota Paid Leave | Family Member's Serious Health Condition

Part A Continued

10 **Will leave be for a continuous period of time, intermittent and/or reduced?**

☐ 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 _____

☐ Reduced — Leave Start Date: (m m / d d / y y y y) | __ __ / __ __ / __ __ __ __ |

Frequency of leave: _____

☐ Dates are estimated

11 **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: _____

12 **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	☐	☐		
b. Workers' Compensation	☐	☐		
c. Short term disability (STD)	☐	☐		
d. Other (Sick/Vacation/PTO or other employer provided leave. Please specify.)	☐	☐		

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 Minnesota Paid Leave 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) | __ __ / __ __ / __ __ __ __ |

End of Part A

Part B: Minnesota - Health Care Provider Certification

Important tips when completing this form

To request Minnesota Paid Leave benefits you will need to return this medical certification form. To start the process, complete **Sections 1 and 2**, and send it to your family member's treating healthcare provider to complete **Section 3** and return to us with your Application and any other supporting documents as part of your claim for benefits.

Section 1: Employee Information - For Completion by the Employee

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

2 **Employee's Date of Birth:** m m / d d / y y y y

3 **Employee's Phone #:** ( ) - -

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

5 **Claim Number (if available):** _____

Section 2: About the Family Member

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

- ☐ Child (of any age)
- ☐ Spouse
- ☐ Domestic Partner
- ☐ Parent or your Spouse/Domestic Partner's Parent
- ☐ Sibling or your Spouse/Domestic Partner's Sibling
- ☐ Grandparent or your Spouse/Domestic Partner's Grandparent
- ☐ Grandchild or your Spouse/Domestic Partner's Grandchild
- ☐ Person with whom the employee has a significant bond that is or is like a family relationship

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

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

3 **Family Member's Date of Birth:** m m / d d / y y y y

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

Street _____

Address line 2 _____

City _____ State _____ Zip _____

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

Part B Continued on Next Page

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Section 3: For Completion by the Family Member's Treating Health Care Provider

A family member of your patient has made a request to be absent from work to care for your patient. For us to make a decision on the employee's claim for MN PFML benefits for the care of your patient, we will need you to complete the information in Section 3. When completing this certification, we ask:

- Your answers are to be your best estimate based on your medical knowledge, experience, and examination of the patient.
- Be as specific as you can. Using terms like "as needed", "unknown" or "indeterminate" may not be enough to approve the claim.
- Limit your responses to the patient's health condition for which the employee is seeking benefits.
- Do not include 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).

1 **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 six categories is checked, (i.e., inpatient care, pregnancy) no additional information is needed. Please sign and date the form.

2 **Diagnosis Code:** _____

Diagnosis Description: _____

3 **Date health condition commenced:** | 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 |

4 **Last office visit:** | m m / d d / y y y y |

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

Provide your best estimate of how long the health condition lasted or will last: _____

Part B Continued on Next Page

5 **To qualify for benefits, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).**

_____

6 **Check the applicable box(es) and complete the information that best describes the type of time away from work that the Claimant will need to Care for their family member (your patient).**

☐ **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 ____/____/____.

☐ **Reduced Work Schedule leave:** My patient will need to work a reduced work schedule due to their family member's health condition and associated treatment and recovery period beginning ___/___/____ and ending ___/___/___ for the following:

- ☐ a reduced work day: limited to ____ hours per day;
- ☐ a reduced work week: limited to ____ day(s) per week
- ☐ Other: _____

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

Describe the estimated frequency and duration of flare-ups. (e.g., 1x per week lasting 4 hours), (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 ____ hour(s) or ____ day(s) per instance;

OR

☐ **Monthly:** ____ time(s) every ____ week(s) for a duration of ____ hour(s) or ____ day(s) per instance

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

Describe the estimated frequency and duration for treatments/appointments. (e.g., 1 x per week lasting 2 hrs), (e.g., 1 x per month lasting 4 hrs) (e.g., 3x every 2 months lasting 6 hours). **Please select and complete one:**

☐ **Weekly:** ____ time(s) every ____ week(s) for a duration of ____ hour(s) or ____ day(s) per instance;

OR

☐ **Monthly:** ____ time(s) every ____ week(s) for a duration of ____ hour(s) or ____ day(s) per instance

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: _____ **State:** _____

Telephone: (_ _ _) - | _ _ _ | - | _ _ _ _ |

Fax Number: (_ _ _) - | _ _ _ | - | _ _ _ _ |

Email Address: _____

Treating Health Care Provider 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

Application for Minnesota Paid Leave | Family Member's Serious Health Condition

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 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:

Part C Continued on Next Page

Application for Minnesota Paid Leave | Family Member's Serious Health Condition

Employee's Name:

12 **Please check the appropriate boxes:**

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

13 **Minnesota ("MN") 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 MN? ☐ Yes ☐ No (answer question 13c)

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

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

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

f. If there is no place of direction and control, no localized services and no base of operations in MN, does the employee reside in MN? ☐ 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: _____

Part C Continued on Next Page

Application for Minnesota Paid Leave | Family Member's Serious Health Condition

Employee's Name:

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 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.)	☐	☐		

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 wage replacement **during all or a portion of the leave period request-**

☐ Yes (answer question i and ii) ☐ 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

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 Minnesota Paid 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: m m / d d / y y y y

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

End of Part C