Arch Insurance

Paid Leave Oregon

Bonding Leave

If you work in Oregon, you can apply for the Oregon Paid Family and Medical Leave Insurance (PFMLI). 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 OR PFMLI...

Check eligibility requirements for leave

Plan your leave. Leave can be taken continuously (a/k/a block leave) or intermittently, in accordance with OR PFMLI.

Notify your OR 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 B.

Your Oregon 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.

Employee completes Part C, the *Bonding Certification* and attach supporting documentation.

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 Paid Leave Oregon 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 Paid Leave Oregon 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 Oregon Paid Family and Medical Leave (PFML) – Bonding Leave

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: _____

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Request for Oregon Paid Family and Medical Leave (PFML) – Bonding Leave

Part A Continued

Notice to Employee:
Foreseeable leave requires advance notice to your employer. Unforeseeable leave requires notive to your employer within 24 hours of the start of leave, and written notice within 3 days after the leave begins.

9 **Was 30 days 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 in the preceding 52 weeks, 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	☐	☐		
b. Workers' Compensation	☐	☐		
c. Oregon Family Leave Act (OFLA)	☐	☐		
d. OR PFML/Paid Leave Oregon	☐	☐		

Employment Information

Key Terms:

Benefit year: a period of 52 consecutive weeks beginning on the Sunday immediately preceding the day that Family Leave, Medical Leave, or Safe Leave commences for the Claimant, except that the benefit year shall be 53 weeks if a 52-week benefit year would result in an overlap of any Calendar Quarter of the Base Year of a previously filed valid Claim for PFML Benefits. A Claimant may only have one valid benefit year at a time.

Base year: the first four of the last five completed calendar quarters preceding the benefit year

Wages: has the meaning given that term in ORS 657.105, including but not limited to: commission or a guaranteed wage, compensatory pay, bonuses, vacation/PTO/sick/holiday pay, tips & gratuities, dismissal or separation allowances.

Wages does not include: expense reimbursement for meals/travel, pensions, jury pay, gifts other than tips/gratuities, benefits paid through a cafeteria plan

Example: Jada requests OR PFMLI for bonding leave with a leave start date of 9/20/2023. Her benefit year will begin on 9/17/2023, which is the Sunday prior to the start of leave on **9/20/2023**. Jada's base year for reporting wages is the **first (4)** of the **previous (5) completed quarters**. Based on her start date, the lookback quarters are **1. 4/1 – 6/30/22 2. 7/1 – 9/30/22 3. 10/1 – 12/31/22 4. 1/1 – 3/31/23 5.** 4/1 – 6/30/23. The gross wages from these first 4 quarters (4/1/2022 – 3/31/2023) will be used to determine her average weekly wage. Jada's gross wages during that time period was $39,000 making her base weekly earnings $750. This amount will be used to calculate her weekly benefit rate under OR PFMLI.

Request for Oregon Paid Family and Medical Leave (PFML) – Bonding Leave

Part A Continued

11 **Give the Name and Details of Your Recent Employers(s):**
If you had more than one employer in the base year (the first four of the last five completed calendar quarters preceding the benefit year), name all employers. Wages is your sum total of gross (pre-tax) wages in the first 4 of the last 5 quarters prior to your application for leave, for that employer. Wages should only reflect wages earned in OR employment. Average hours and days worked per week is based off your Regular Work Schedule, averaged from the 12 weeks prior to your last day worked before leave.

Employer #1 Name _____

Street _____

Address line 2 _____

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

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

Days of the Week Usually Worked:

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

Employer #2 Name _____

Street _____

Address line 2 _____

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

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

Days of the Week Usually Worked:

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

If more than 3 recent OR Employers, please include details on a separate sheet.

12 **Consent to Obtain Wages From all OR Employers:** (Only complete this question if you had more than 1 OR employer during the base year.)

If you have had more than one OR employer in the base year, do We have your consent to contact the Oregon Employment Department (OED) to obtain all wages reported in the base year, including from your other employer(s)?

☐ Yes, I consent. ☐ No, I do not consent.

Initial here: _____

Request for Oregon Paid Family and Medical Leave (PFML) – Bonding Leave

Part A Continued

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 Oregon Paid Family and Medical 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

End of Part A

Request for Oregon Paid Family and Medical Leave (PFML) – Bonding Leave

Employee Name:

Part B: Employer Information

(to be completed by the employer for the above named employee requesting OR 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:

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

Request for Oregon Paid Family and Medical Leave (PFML) – Bonding Leave

Employee Name: Part B Continued

12 Oregon ("OR") Employment Verification:

a. Are the employee's earnings reported at year end on IRS form W-2? ☐ Yes ☐ No (answer question 12b)

b. Is the employee subject to Unemployment Insurance obligations in OR? ☐ Yes ☐ No (answer question 12c)

c. Is the employee's service localized (performed entirely) within OR? ☐ Yes ☐ No (answer question 12d)

d. If services are not localized, is the employee's base of operations in OR, and some of the work is performed in OR? ☐ Yes ☐ No (answer question 12e)

e. If there is no base of operations, does the employee perform some of the services within OR and receive direction and control from OR? ☐ Yes ☐ No (answer question 12f)

f. If there is no place of direction and control, no localized services and no base of operations in OR, does the employee reside in OR? ☐ Yes ☐ No

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

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

14 Provide the employee's earnings history for the prior 5 completed calendar quarters preceding the request for leave:

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

15 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: _____

16 Will leave be utilized continuously or intermittently? Provide details below.

	Start date (mm/dd/yyyy)		Through (mm/dd/yyyy)
Block Leave/Continuous Leave:		—	

Dates requested:

Intermittent Leave: _____

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

Request for Oregon Paid Family and Medical Leave (PFML) – Bonding Leave

Employee Name: Part B Continued

17 **Was 30 days advance notice 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 in the preceding 52 weeks?**

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. Paid Leave Oregon	☐	☐		
d. Other (Sick/Vacation/PTO or other employer provided leave. Please specify.)	☐	☐		

19 **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 Oregon 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:

Declaration and Signature:

NOTICE: 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 the person authorized to sign as the employer of the employee requesting benefits under the Oregon Paid 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.

Employer's Signature:

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

End of Part B

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

Request for Oregon Paid Family and Medical Leave (PFML) – Bonding Leave

Part C: Oregon Bonding Certification

(to be completed by the individual (Employee) requesting bonding leave)

Bonding Leave allows an eligible individual to take leave from employment to care for and bond with a child during the first year after the child's birth or placement. "Child" means the eligible employee's biological, adopted, or foster child. An individual may not exceed 12 weeks of paid leave per child for the purpose of caring for and bonding with the child during the first year after the birth or initial placement of the child, regardless if a new benefit year starts during the first year following birth or initial placement. 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. Claim filing is the responsibility of the individual that is requesting paid leave benefits (the "Claimant") . 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.

Effective January 1, 2025, an eligible individual may take also paid family leave from employment for activities related to the legal process required for foster child placement or child adoption.

Please complete this form and return it to us along with your application and any other supporting documentation as part of your claim for benefits.

Section 1: Employee Information (to be completed by the individual (Employee) requesting bonding leave)

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

(First Name, Middle Initial, Last Name)

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

Section 2: Bonding Information for Child

3 **Child's ACTUAL Date of Birth:**

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

4 **Relationship of Child to Individual Requesting Leave:**

- ☐ Biological child
- ☐ Foster child
- ☐ Adopted child

5 **Placement Date for Adopted/Foster Child:**

If requesting leave to bond with an adopted or foster child, provide the DATE the child was placed with you.

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

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

Oregon - Bonding Certification

Continued

Section 3: Attach Bonding Leave Required Documentation

Please include at least one (1) of the below documents with this application to support the request for leave. Your claim cannot be processed without proof documentation supporting the leave.

NOTE: The proof document(s) provided must show:

- The Claimant's first and last name as parent or guardian of the child;
- The Child's first and last name; and
- The date of the Child's birth, or placement (adoption / foster care).

Birth of Child:

- ☐ Child's Birth Certificate
- ☐ Consular Report of Birth Abroad
- ☐ A document issued by Health Care Provider of the Child or pregnant Parent
- ☐ A hospital admission form associated with delivery
- ☐ any other documentation required by Paid Leave Oregon

Adoption/Foster Care:

- ☐ A copy of a court order verifying foster care placement or adoption
- ☐ A letter signed by the attorney representing the prospective foster or adoptive parent that confirms the placement
- ☐ A document from the foster care, adoption agency, or social worker involved in the placement that confirms the placement
- ☐ A document for the child issued by the United States Citizenship and Immigration Services
- ☐ Any other documentation required by Paid Leave Oregon

Declaration 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. 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 Oregon Paid Family and Medical Leave Insurance. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Signature: _____

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