Arch Insurance

Paid Leave Oregon

OREGON

Family Member's Serious Health Condition

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), 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.

Provider should complete Part C, the *Health Care Provider Certification form* 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) – Family Member's Serious 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 **The Family Member's Relationship to the Employee (Claimant) is:**

☐ Self ☐ Spouse ☐ Parent or Spouse's Parent ☐ Grandparent or Spouse's Grandparent

☐ Grandchild ☐ Child (of any age) or Child's Spouse ☐ Sibling or Spouse's Sibling ☐ Domestic Partner

☐ Anyone related by blood or affinity whose close association is the equivalent of a family relationship

9 **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) – Family Member's Serious Health Condition

Part A Continued

Notice to Employee:
Foreseeable leave (a qualifying reason such as a planned medical procedure/treatment for your qualified family member) requires advance notice to your employer. Unforeseeable leave (emergency basis or unexpected) requires notice to your employer within 24 hours of the start of leave, and written notice within 3 days after the leave begins.

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 **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) – Family Member's Serious Health Condition

Part A Continued

12 **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.

13 **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) – Family Member's Serious Health Condition

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) – Family Member's Serious Health Condition

Employee Name:

Part B: Employer Information

(to be completed by the employee and 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) – Family Member's Serious Health Condition

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.

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

Intermittent Leave: Dates requested: _____

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

Request for Oregon Paid Family and Medical Leave (PFML) – Family Member's Serious Health Condition

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**

Part C: Health Care Provider Certification

(to be completed by the employee and treating healthcare provider)

Family Leave allows an eligible individual to take leave from employment to care for their qualified family member with a serious health condition. An individual may not exceed 12 weeks of paid leave in a benefit year. 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 "Employee"). The Employee 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.

Complete the first page of this form, make a copy, and provide the entire form to your family member's health care provider for them to complete the remainder of the form. The health care provider will return the form to you, and you will submit it to us along with your application and any other supporting documentation as part of your claim for benefits. Note, your family member may also be required to complete an authorization form in order for the Provider to release health information to you.

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

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

(First Name, Middle Initial, Last Name)

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

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

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

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

Section 2: Family Member Information (covered family member requiring care due to their serious health condition)

6 **Family Member's Legal Name (First Name, Last Name):** _____

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

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

Street _____

Address line 2 _____

City _____ State Zip

Country (if not USA): _____

9 **The Family Member's Relationship to Claimant Requesting Leave:**

- ☐ Spouse
- ☐ Parent or Spouse's Parent
- ☐ Grandparent or Spouse's Grandparent
- ☐ Grandchild
- ☐ Child (of any age) or Child's Spouse
- ☐ Sibling or Spouse's Sibling
- ☐ Domestic Partner
- ☐ Any individual related by blood or affinity whose close association is the equivalent of a family relationship

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Oregon – Health Care Provider Certification – Family Member's Serious Health Condition

Continued

10 **Select the Type(s) of Care You Will Provide to the Family Member:**

- ☐ Physical Assistance (basic medical needs, activities of daily living, safety, nutrition, transportation)
- ☐ Psychological Assistance (comfort, reassurance, companionship, completing administrative tasks, changes in Family Member's care)

Section 3: Medical Certification (to be completed by the family member's treating health care provider)

The Employee ("Claimant") listed on page 1 has made a request to be absent from work to care for your patient ("Family Member") because of the patient's Serious Health Condition. For us to decide on this employee's claim for OR PFMLI benefits during that absence, we need you to complete the information in Sections 1-4. When completing this certification:

- Your answers should 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 Serious Health Condition for which your patient needs Care by the Employee. If your patient needs Care from the Employee due to more than one Serious Health Condition, please complete a separate certification for each condition.
- 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).

11 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.

☐ **Terminal Illness:** The Serious Health Condition poses an imminent danger of death, or that is terminal in prognosis with a reasonable possibility of death in the near future.

☐ **Body Part Donation:** Donation of a body part, organ, or tissue, including preoperative or diagnostic services, surgery, post-operative treatment, and recovery.

☐ **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.

Oregon – Health Care Provider Certification – Family Member's Serious Health Condition

Continued

12 **Diagnosis Code:** _____

Diagnosis Description: _____

13 **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 |

14 **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: _____

15 **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

Oregon – Health Care Provider Certification – Family Member's Serious Health Condition

Continued

16 **Check the applicable box(es) below 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 ____/____/____.

☐ **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 treatment 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: _____

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 | _ _ / _ _ / _ _ _ _ |