Arch Insurance

Paid Leave Oregon **Safe Leave**

OREGON

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 *Safe Leave 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) - Safe 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 **Reason for PFML Request:**

☐ Safe Leave for myself or my child due to domestic violence, harassment, sexual assault, or stalking

9 **The Family Member's Relationship to the Employee (Claimant) is:**

☐ Self ☐ Child

Request for Oregon Paid Family and Medical Leave (PFML) - Safe Leave

Part A Continued

10 **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: _____

_____

Notice to Employee:
Foreseeable leave 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.

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 **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	☐	☐	_____	_____

Request for Oregon Paid Family and Medical Leave (PFML) - Safe Leave

Part A Continued

Employment Information

Key Terms:

Benefit year: means 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 proceeding 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.

13 **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.

Request for Oregon Paid Family and Medical Leave (PFML) - Safe Leave

Part A Continued

14 **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: _____

Declaration and Signature:

WARNING: Any person who, knowingly or with intent to defraud or facilitate a fraud against any insurance company or other person, submits an application or files a claims 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)- Safe 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) - Safe 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**
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Request for Oregon Paid Family and Medical Leave (PFML) - Safe 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.

"Accrued 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 facilitate a fraud against any insurance company or other person, submits an application or files a claims 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

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

Request for Oregon Paid Family and Medical Leave (PFML)- Safe Leave

Part C: Oregon - Safe Leave Certification

(to be completed by the employee requesting leave)

Safe Leave allows an eligible individual to take reasonable leave from employment for any of the following purposes related to or resulting from domestic violence, sexual assault, harassment, or stalking:

(1) To seek legal or law enforcement assistance or remedies to ensure the health and safety of the Claimant or the Claimant's minor child or dependent, including preparing for and participating in protective order proceedings or other civil or criminal legal proceedings

(2) To seek medical treatment for or to recover from injuries caused by domestic violence or sexual assault to or harassment or stalking of the eligible Claimant or the Claimant's minor child or dependent.

(3) To obtain, or to assist a minor child or dependent in obtaining, counseling from a licensed mental health professional related to an experience of domestic violence, harassment, sexual assault or stalking.

(4) To obtain services from a victim services provider for the eligible Claimant or the Claimant's minor child or dependent.

(5) To relocate or take steps to secure an existing home to ensure the health and safety of the eligible Claimant or the Claimant's minor child or dependent.

NOTE: If more than one minor child requires care relating to Safe Leave, complete a Safe Leave Certification form for each child requiring care.

Section 1: Employee Information (to be completed by the individual requesting Safe Leave)

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

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

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

4 **Reason for Safe Leave Request:** (one or more options may be selected, continued on next page)

☐ Safe Leave to care for my Child*

Child's Age: _____ Child's First and Last Name: _____

Select type of care provided:

☐ Seek medical care for my child, (including counseling) for physical or psychological injury or disability or to aid Child in recovery from injuries caused by domestic violence, sexual assault, harassment, or stalking.

☐ Obtain services for my child from a victim services provider

☐ Relocate my child or take steps to secure an existing home

☐ Participate in and/or support my child during civil, criminal, or administrative proceedings related to or resulting from the domestic violence, sexual assault, harassment, or stalking.

*Child is an individual described in ORS 657B.010 (a) – (c) and is Under the age of 18; or Age 18 or older as an adult dependent substantially limited by a physical or mental impairment as defined in ORS 659A.104.

Oregon - Safe Leave Certification

Continued

- ☐ Safe Leave **for myself** to seek **medical care** (including counseling) for physical or psychological injury or disability **or** to **recover from injuries** caused by domestic violence, sexual assault, harassment, or stalking.
- ☐ Safe Leave **for myself** to
  - ☐ Obtain services from a victim services provider
  - ☐ Relocate or take steps to secure an existing home
  - ☐ Participate in civil, criminal, or administrative proceedings related to or resulting from the domestic violence, sexual assault, harassment, or stalking.

5 **Safe Leave Required Documentation** (Please include at least one (1) of the below documents with this application to support the request for leave:

- ☐ A copy of a police report, or a formal complaint to a school's Title IX Coordinator indicating that you or your child were a victim of domestic violence, harassment, sexual assault, or stalking
- ☐ A copy of a protective order, or other evidence that you or your child appeared in or were preparing for a civil, criminal, or administrative proceeding related to domestic violence, harassment, sexual assault, or stalking
- ☐ Written documentation from an attorney, law enforcement officer, health care provider, licensed mental health professional or counselor, member of the clergy, or victim services provider that affirms you or your child were undergoing treatment or counseling, obtaining services, or relocating as a result of domestic violence, harassment, sexual assault, or stalking.

6 **Written Description of the Purpose for This Leave** (to be completed by the claimant if no other documentation is available)

If none of the above documentation is available for good cause (e.g. due to a lack of access to services, or concerns for the safety of the claimant or claimant's child), the claimant may provide a signed written statement certifying that they are taking leave for one of the following reasons:

1. To seek medical care or psychological or other counseling for physical or psychological injury or disability,
2. To obtain services from a victim services organization,
3. To relocate due to domestic violence, harassment, sexual assault, or stalking,
4. To participate in any civil or criminal proceedings related to or resulting from domestic violence, harassment, sexual assault, or stalking.

_____

_____

_____

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

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

Oregon - Safe Leave Certification

Continued

Declaration and Signature:

I attest I am ☐ an Attorney, ☐ an Employee of the Judicial Branch's Office of the Victim Services or the Office of the Victim Advocate, or ☐ a licensed medical professional or ☐ other licensed professional. I am attesting that the above-named individual is a victim of domestic violence, harassment, sexual assault, or stalking.

Print Name: _____

Organization Name: _____

Signature: _____

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

| __ __ / | __ __ / | __ __ __ __ |