Fax or mail completed application to:
The Hartford
P.O.Box 14869
Lexington, KY 40512-4869
Fax Number: (833) 357-5153

NOTICE OREGON PAID FAMILY AND MEDICAL INSURANCE (OR PFMLI)

PART A CLAIMANT INFORMATION TO BE COMPLETED BY THE CLAIMANT - PRINT OR TYPE

1. Name: (Last, First, Middle) as shown on your Social Security card: 2. Social Security Number: 3. Birth Date:

4. Gender:
Male Female Not Designated /Other

5. Home/Cell Number:

6. Marital Status:
Single Married

7. Preferred E-Mail Address while on leave:

8. Mailing address: (Street, City or Town, State, Zip Code)

9. Employer Name:

10. Employer Telephone Number:

11. Employer Address: (Street, City, State & Zip Code)

12. Occupation:

13. Reason for Leave:

Own Serious Health Condition

Care of Family Member with a serious health condition

Bond with a Child

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

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

14. If leave is to care for a family member, the family member is the employee's:
* "Relationship" includes "biological, foster, adoptive, step, and in loco parentis relationships.

Self

Spouse

Domestic Partner

Parent

Child

Grandparent or Grandparent's Spouse/Domestic Partner

Grandchild or Grandchild's Spouse/Domestic Partner

Sibling or Sibling's Spouse/Domestic Partner

Spouse's Parent/Domestic Partner

Child's Spouse/Domestic Partner

Any individual related by blood or affinity whose close association with employee is equivalent of a family relationship

Name of family member: Date of Birth

15. Will leave be for a continuous period of time and/or intermittent (periodic) or a reduced work schedule?
Identify dates intermittent leave will likely be taken if applicable

Continuous	Start Date:	End Date:
Intermittent	Start Date:	End Date:
Reduced Schedule	Start Date:	End Date:

16. Date notice provided to Employer:

If providing less than 30 days' advance notice to the employer, please explain:

PART A (Continued)

Other Employment information - If you worked for other employers in Oregon during the past five (5) quarters besides the Employer identified in question 9 above, complete the below information. Include full-time and part-time employment. If you had more than 2 employers, list on a separate sheet and attach to this form. Please include wages received for the last five completed calendar quarters immediately prior to the start date of the leave request. A calendar quarter is January – March, April – June, July – September and October – December. Hours worked should reflect total hours worked within each calendar quarter.

17. Other Employer Name: 18. Telephone Number:

19. Period of Employment From: To: 20. Address:

	CALENDAR QUARTER	TOTAL GROSS EARNINGS	TOTAL WEEKS WORKED
1			
2			
3			
4			
5			

21. Other Employer Name: 22. Telephone Number:

19. Period of Employment From: To: 24. Address

	CALENDAR QUARTER	TOTAL GROSS EARNINGS	TOTAL WEEKS WORKED
1			
2			
3			
4			
5			

25 Certification and Signature

I was unable to work during the period for which I am claiming benefits, and I hereby certify that I have read and understand my benefits rights. I also certify that the information I completed on this form are true and accurate. I am aware that if any of the information I completed on this form are knowingly false, I may be subject to penalties which may include criminal prosecution. I am hereby authorizing you to obtain any medical, employment and wage information you need to determine my eligibility for this benefit, and to share any such information with my employer as may be necessary to process benefits and in accordance with applicable law.

If your employer has agreed to continue your regular pay while you are unable to work, do you agree to have the benefits available to you under this policy routed through your employer?

Yes No Please Sign:

Note: A "No" answer could impact you continuing to receive your regular pay from your employer in exchange for the benefits available to you from this policy.

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

Electronic Funds Transfer (EFT) is our standard method of benefit payment. When making our claim decision we may contact you to obtain your banking information.

SIGN HERE

(Claimant's Signature) (Date)

SIGN HERE

(Employer Signature) (Date)

Certification of Serious Health Condition

Oregon Paid Family and Medical Insurance (OR PFMLI)

Section I - For Completion by Employee: Complete the Employee Information section and give it to your/your family member's health care provider to complete. Have your/your family member's provider return it to you. You will need to return this form to The Hartford as soon as possible so that we can evaluate your claim.

Forms can be mailed to: The Hartford
P. O. Box 14869
Lexington, KY 40512-4869

OR Fax to: The Hartford
(833) 357-5153

Employee Information

Employee's Name: Last 4 digits of Social Security Number:

Claim Number: Date of Birth:

Employer's Name: Today's Date:

Employee's Job Title: Regular Work Schedule:

Additional Pregnancy Leave:
This option is only available if you are taking family-bonding leave or medical-pregnancy leave.
Are you currently pregnant or have you given birth in the last year, and are you asking for an additional two weeks of leave for health issues related to pregnancy, childbirth, or a related medical condition?

Yes No

If you are not currently pregnant, please provide the date that your pregnancy ended:

If you are applying to care for a family member complete the information below.

The family member who is experiencing a serious health condition is my:

Spouse
Domestic Partner
Parent
Child
Any individual related by blood or affinity whose close association with employee is the equivalent of a family relationship
Grandchild or Grandchild's Spouse/Domestic Partner
Sibling or Sibling's Spouse/Domestic Partner
Spouse's Parent/Domestic Partner
Child's Spouse/Domestic Partner
Grandparent or Grandparent's Spouse/Domestic Partner

Family Member's Full Name: Date of Birth:

Section II - For Completion by the Health Care Provider: (See Part A and Part B attached)
INSTRUCTIONS to the HEALTH CARE PROVIDER: Please read the definition of a serious health condition below and refer to it while filling out the form. This form should be filled out by the healthcare provider of the patient, who may or many not be the employee. For the employee to qualify for paid leave, the patient must have a serious health condition. Answer all questions fully and completely.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information” as defined by GINA, includes the manifestation of disease or disorder in family members of the individual, an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services and genetic information of a fetus carried by an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Provider’s name:

Provider’s Business Address:

Type of Practice/Medical Specialty:

Telephone Number: Fax Number:

Definition of a Serious Health Condition
Serious Health Condition means an illness, injury, impairment, or physical or mental condition of a Covered Individual or their Family Member that:

1. requires inpatient care in a medical care facility such as, but not limited to, a hospital, hospice, or residential facility such as, but not limited to, a nursing home or inpatient substance abuse treatment center;

2. in the medical judgment of the treating Health Care Provider poses an imminent danger of death, or that is terminal in prognosis with a reasonable possibility of death in the near future;

3. requires constant or continuing care, including home care administered by a health care professional;

4. involves a period of incapacity. "Incapacity" is the inability to perform at least one essential job function, or to attend school or perform regular daily activities for more than three consecutive calendar days. A period of incapacity includes any subsequent required treatment or recovery period relating to the same condition. The incapacity must involve one of the following:
   a. two or more treatments by a Health Care Provider; or
   b. one treatment plus a regimen of continuing care.

5. results in a period of incapacity or treatment for a chronic Serious Health Condition that requires periodic visits for treatment by a Health Care Provider, continues over an extended period of time, and may cause episodic rather than a continuing period of incapacity, such as, but not limited to, asthma, diabetes, or epilepsy;

6. involves permanent or long-term incapacity due to a condition for which treatment may not be effective, such as, but not limited to, Alzheimer's Disease, a severe stroke, or terminal stages of a disease. The Covered Individual or Family Member must be under the continuing care of a Health Care Provider, but need not be receiving active treatment;

7. involves multiple treatments for restorative surgery or for a condition such as, but not limited to, chemotherapy for cancer, physical therapy for arthritis, or dialysis for kidney disease that if not treated would likely result in incapacity of more than three calendar days;

8. involves any period of disability due to pregnancy, childbirth, miscarriage or stillbirth, or period of absence for prenatal care;

9. involves any period of absence from work for the donation of a body part, organ, or tissue, including preoperative or diagnostic services, surgery, post-operative treatment, and recovery.

PART A - Patient's Serious Health Condition (For Completion by the Health Care Provider)

1) Does the patient have a serious health condition? Yes No

2) Which of the following apply to the patient's serious health condition (Check all that apply)

Requires or required inpatient care

Poses danger of death or is terminal in prognosis

Requires constant or continuing care, including home care administered by a health care professional

Involves a period of incapacity. "Incapacity" is the inability to perform at least one essential job function, or to attend school or perform regular daily activities for more than three consecutive calendar days. A period of incapacity includes any subsequent required treatment or recovery period relating to the same condition. The incapacity must involve one of the following: two or more treatments by a Health Care Provider; or one treatment plus a regimen of continuing care.

Results in a period of incapacity or treatment for a chronic Serious Health Condition that requires periodic visits for treatment by a Health Care Provider, continues over an extended period of time, and may cause episodic rather than a continuing period of incapacity, such as, but not limited to, asthma, diabetes, or epilepsy

Involves permanent or long-term incapacity due to a condition for which treatment may not be effective

Involves multiple treatments and if not treated would result in incapacity

Involves any period of disability due to pregnancy, childbirth, miscarriage or stillbirth, or period of absence prenatal care

Involves any period of absence from work for the donation of a body part, organ, or tissue, including preoperative or diagnostic services, surgery, post-operative treatment, and recovery

3) If the patient is a family member, will the patient require care from the employee seeking leave as the result of their serious health condition?

Yes No

4) Provide appropriate medical facts to allow an understanding of how the condition may affect the patient. Examples may include symptoms, hospitalizations, medical visits, relevant side effects to medication, and referrals for evaluation or treatment.

5) When did the condition begin? This is the start of the condition, not the start of the employee's leave from their job. If it cannot be determined, provide a start date to the best of your ability.

☐ This condition began within the past 12 months.

Start Date: ☐ This condition began more than one year ago.

6) Is the patient's serious health condition a pregnancy-related issue that results in some level of incapacity prior to giving birth?

Yes Expected delivery ☐ No

7) Is this health condition a job-related injury? ☐ Yes ☐ No

PART B - Ability to Work: (For Completion by the Health Care Provider)

Provide your best estimate based on your medical knowledge, experience, and examination of the patient. Be as specific as you can be: terms like "unknown" or "indeterminate" may not be enough to approve a claim for paid leave benefits. This section establishes the start and end dates when the employee needs leave due to their own incapacity or the incapacity of a family member because of the serious health condition. The date range is the leave period. A leave cannot be approved for longer than 12 months. If the condition requires additional leave after 12 months or a re-evaluation, the employee can submit a new application at that time with a new certification. OR PFML must be taken in full day increments.

1) When will the employee first need to take leave? This is the first day full day of time missed from work. If any time has already been missed because of this condition, enter the earliest absence.

Start Date:

2) Do you know the last day the employee will need leave for the patient's condition? If you cannot determine this, when do you recommend re-evaluating? (Check only one)

Yes The last day the employee will need leave is:

No The patient's condition should be re-evaluated on:

3) During this leave period, which of these patterns of leave do you expect the employee to need as a result of the patient's condition?

Continuous leave (e.g., Completely unable to work for consecutive, uninterrupted days)

Reduced leave schedule (e.g., A consistent but reduced schedule for multiple weeks)

Intermittent leave (e.g., Episodic time off at irregular intervals for flare-ups or unexpected aftercare)

4) **Continuous leave needed:** When will the continuous leave period start and end?

Start Date: End Date:

Reduced leave schedule needed: When will the reduce leave schedule start and end?

Start Date: End Date:

How many days should the employee take off per week? Days per week

Intermittent leave needed: When will the intermittent leave schedule start and end?

Start Date: End Date:

Estimate the frequency and duration of intermittent leave needed, if any, over the next 12 months including any recovery period:

Frequency: times per week(s) or month(s)

Duration: day(s) per episode/treatment

Dates of scheduled treatment(s)/appointment(s):

PART B - Ability to Work: (For Completion by the Health Care Provider) - Continued

I certify 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 of Health Care Provider **Date**

Signature of Employee **Date**

Notice of Oregon Paid Family and Medical Leave Insurance

Part C: TO BE COMPLETED BY YOUR EMPLOYER

1. Employee Name:	2. Employee ID:
3. Employment Status:	If terminated, provide Active Terminated date of termination:
4. Last Date Worked:	5. First Date of Absence:

6. Did employee work a full day? Yes No If No, how many hours did they work?

7. Did this employee meet the definition of an Oregon Employee / Worker: Yes No

Note: Employees can be eligible for OR PFMLI benefits only while employed as defined by Oregon Paid Family and Medical Leave Law. You'll need to contact us immediately if there is any change in their OR employment status.

8. Please provide the number of days the employee worked per week in the 12 week prior to the leave start date:

Week Ending	Month	Day	Year	# of days worked
Week 1				
Week 2				
Week 3				
Week 4				
Week 5				
Week 6				
Week 7				
Week 8				
Week 9				
Week 10				
Week 11				
Week 12				
				Total 0.0

9. Will you be making payments to the employee from a qualifying employer sponsored policy or program (not accrued paid leave)that are equal to or greater than the OR PFMLI benefit while on leave? Yes No

If yes, will you be requesting reimbursement* for payments to the employee during their Paid Medical Leave:

Yes No If yes, what are the dates? From Through

***Note for employees with multiple Oregon employers only:* In the unlikely event that OR PFML law's method of prorating benefits between employers will entitle an employee to a greater benefit amount than you paid your employee through your employer sponsored policy or program. We don't know the exact amount you are paying your employee for this leave. So, if we reimburse you for an amount greater than the amount you paid your employee, you will be required to reconcile the difference in PFML benefits owed to your employee and the amount you paid during their Paid Medical Leave.**

Part C (Continued):

10. As of 9/3/23 or later has this employee used unpaid Oregon Family Leave Act (OFLA)?
Yes No If yes, please provide the following:

Leave Reason: _____ Time Used: _____ Date(s): _____

Leave Reason: _____ Time Used: _____ Date(s): _____

Leave Reason: _____ Time Used: _____ Date(s): _____

Leave Reason: _____ Time Used: _____ Date(s): _____

Leave Reason: _____ Time Used: _____ Date(s): _____

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11. Has the employee filed for or received:
Workers' Compensation benefits Yes No Unemployment Benefits Yes No

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12. Please provide all Wages as defined in the Oregon Paid Family and Medical Leave Law

Provide five completed calendar quarters of earnings preceding the employee's start date of leave, with the most recent quarter as outlined below. If they do not have a full five quarters, only provide the most recent four completed quarters.

PREVIOUS COMPLETED QUARTERS	CALENDAR QUARTER DATES	TOTAL EARNINGS
5 (most recent quarter)		
4		
3		
2		
1		

If the employee has fewer than four completed calendar quarters, please advise the number of completed weeks/earnings for those completed weeks.

NUMBER OF WEEKS WORKED WITH EARNINGS	TOTAL EARNINGS

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13. Will the employer be requesting reimbursement? Yes No

If Yes, please provide the dates: From: Through:

Completed By: Job Title: Phone Number:

Signature of Employer: Date: