THE CLAREMONT COLLEGES SERVICES

Paid Family Leave (PFL)

COMPONENT OF THE CLAREMONT COLLEGES VOLUNTARY PLAN

Enclosed you will find a packet with information to assist you in filing for Paid Family Leave (PFL) benefits through the Voluntary Disability Insurance Plan of The Claremont Colleges.

The documents must be completed by you, the qualifying family member (excluding Bonding request), and the qualifying member's treating physician. Please return the completed packet to the Disability Administration office at 101 South Mills Avenue, Claremont, CA 91711, as soon as possible so that your PFL eligibility can be verified.

PAID FAMILY LEAVE (PFL): The Paid Family Leave (PFL) benefit is a component of The Claremont Colleges Voluntary Disability Insurance (VDI) plan. PFL is designed to provide partial compensation for wages up to six (6) weeks and may be paid over a twelve (12) month period for one of the following reasons:

- To care for a seriously ill child, spouse, parent, or registered domestic partner. Effective July 1, 2014 PFL includes time off to care for a seriously ill grandparent, grandchild, sibling, or parent-in-law;
- To bond with the employee's new child or the new child of the employee's registered domestic partner;
- To bond with a child who is placed with the employee in connection with the adoption or foster care placement of the child with the employee or the employee's domestic partner.

ELIGIBILITY:

- All employees are covered by the plan on the effective date of hire unless coverage is rejected in writing. If you do not wish to participate in the voluntary disability programs, you must participate in the state disability program. Employees who are covered by The Claremont Colleges VDI plan will be covered for PFL.

EMPLOYEE RESPONSIBILITY:

1. Notify your Supervisor and your campus Human Resources Office
Notify your supervisor of your need for PFL and provide a written off-work notice from the treating physician. Contact your Human Resources Representative prior to starting your leave or within 24 hours for emergency leaves.

2. For a "Bonding" claim:

- Complete **Statement of Employee.**
- Complete **Bonding Certification.**
- Complete **Salary Continuation and Authorization to Redirect Voluntary Plan Benefits Form.** This allows Human Resources to supplement your PFL pay with accrued sick leave for use as Kin Care (in accordance with your institution's Kin Care policy), vacation, and personal holiday. This Form allows for your benefit deductions to be taken from your PFL pay if or when your supplemental pay has been exhausted.
- Submit a copy of **hospital keepsake birth certificate**.

Please note that all forms must be received **completed and signed** by the Disability Administration office before eligibility can be determined. Once eligibility is determined, you will be sent an acceptance letter with your weekly benefit amount and payments will be processed in accordance with your institution's payroll schedule. **Please note that PFL payments are subject to federal tax but not state tax.**

If you have any questions or concerns regarding PFL, please contact the Disability Administration office at (909) 607-7946.
If you have any questions regarding your institution's Kin Care or family leave policies, please contact your Human Resources Representative.

101 South Mills Avenue, Claremont, CA, 91711
(909) 607-7946 (909) 607-9688 F

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PAID FAMILY LEAVE

Statement of Employee

CARE OR BONDING PROVIDER

PLEASE COMPLETE ALL ITEMS. IF INCOMPLETE, THIS FORM WILL BE RETURNED, CAUSING A DELAY IN BENEFITS.

1. First Name | Middle Name | Last Name

2. Mailing Address | City | State | ZIP

XXX-XX-

3. Phone Number | 4. Social Security Number | 5. Date of Birth | 6. Gender ☐ Male ☐ Female

7. College | 8. Department | 9. Occupation

10. Date you last worked | 11. Date you want your PFL claim to begin

12. Did you or will you continue to work during your family leave period? ☐ Yes ☐ No | 12A. Date you returned or will return to work

12B. If you are reducing your work hours, how many hours per day will you work? Why did you or will you reduce your work hours? (describe below)

13. Legal name of person for whom you are caring or with whom you are bonding

13A. The above-named care or bonding recipient is your: ☐ Child ☐ Spouse ☐ Partner ☐ Parent ☐ Other

14. Do you have more than one employer? ☐ Yes ☐ No

15. At any time during your PFL leave were you in the custody of law enforcement authorities because you were convicted of violating a law or ordinance? ☐ Yes ☐ No

Declaration and Signature. By my signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was providing care for or bonding with the care recipient named above; (2) authorize the Disability Administration office to release my personal information as shown on this claim to the care recipient and to the care recipient's treating physician as they are respectively listed in Part C and Part D of this claim; (3) authorize my employer(s) to disclose to the Disability Administration office all facts concerning my employment that are within their knowledge; and 4) authorize release and use of information as stated in the "Information Collection and Access" portion of this form. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.

Claimant's Signature (DO NOT PRINT) | If signature is made by mark (X), place mark here

If your signature is made by mark (X), it must be attested by two witnesses with their addresses:

1. Witness Signature and Address

2. Witness Signature and Address

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PAID FAMILY LEAVE

Bonding Certification

TO BE COMPLETED BY PERSON CLAIMING PFL BENEFITS TO BOND WITH A CHILD

XXX-XX-

E1. Employee Social Security Number

E2. Employee Legal Last Name

E3. Legal Name of Child

XXX-XX-

E4. Child's Social Security Number (if available)

E5. Child's Date of Birth

E6. Child's Gender ☐ Male ☐ Female

E7. Child Named in B3 Is My:

E8. Child's Residence Address | City | State | ZIP

E9. Date of Foster Care or Adoption Placement

E10. As evidence of the relationship in E7, check one of the following and attach a copy of the document checked. (Do not send original document. It will not be returned.)

- ☐ Child's Birth Certificate
- ☐ Child's Hospital Discharge Record
- ☐ Declaration of Paternity, CS-909
- ☐ Foster Care Placement Records, SOC 815
- ☐ Certificate of Placement, AD-907
- ☐ Child's Passport showing immigration and naturalization
- ☐ Independent Adoption Placement Agreement, AD-924
- ☐ Other

E11. Declaration and Signature. By my signature on this bonding certification, I authorize the medical provider, adoption agency, adoption party (ies), or foster care placement agency to disclose to the Disability Administration office all facts concerning the birth, adoption, or foster care placement of the above-named child. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements or documents, is to the best of knowledge and belief true, correct, and complete. I agree that photocopies of his authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.

Original Signature of Bonding Claimant (rubber stamp is not acceptable)

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Salary Continuation and Redirection of Benefits Form

PAID FAMILY LEAVE

Employee Name College

Claim Effective Date

Authorization

During your leave period, you may receive Paid Family Leave (PFL) benefits. The benefit payments are not equal to your regular pay but provide approximately 60% or 70% based on your regular wages. You may authorize the use of vacation and/or personal holiday to supplement your leave benefit up to 90% of your regular salary. If you exhaust your leave accruals before the end of your leave, you will only receive the PFL benefit.

1. ☐ I authorize the use of the following paid time off. (If you select "all," write "all".)

Vacation hours Personal hours

I understand that while I receive supplemental paid time off, the normal payroll deduction(s) for my elected benefit(s) will continue (i.e., health, dental, life, etc.).

When I no longer receive supplemental paid time off, in order to continue elected benefit(s) coverage, I will be required to make cash payments to Benefits Administration or approve the redirection of benefits from my PFL pay.

Or

2. ☐ I choose not to use any paid time off.

I understand that by not authorizing the use of supplemented paid time off, I may only receive PFL payments. In order to continue my normal elected benefit(s) coverage I will be required to make cash payments to Benefits Administration or I may choose to have a portion of my PFL benefits directed to cover payments (contact the Disability Administration office for authorization form).

Section 1345 of the California Unemployment Insurance Code (CUIC) allows an individual to redirect a portion of his/her Voluntary Plan benefit payment to cover all or part of the cost of any employee-paid benefits in which the individual is currently enrolled. In order to allow the Disability Administration office to redirect a portion of the Voluntary Plan benefit payment, the individual must provide a written authorization for the redirection to begin.

If the Voluntary Plan benefit payment recipient has been declared legally incompetent, the spouse of the individual, in the absence of any other legally authorized representative, shall have the right to continue or cancel the authorization for the redirection of Voluntary Plan benefit payments. Benefit redirections are taken after taxes and deducted evenly from each benefit payment.

If you wish to stop a current benefit deduction while receiving Paid Family Leave (PFL) benefits, please provide a request in writing to Benefits Administration. Your benefit deductions will begin on the first payment cycle after your supplemental pay shas been exhausted.

☐ YES, I wish to redirect my PFL benefit payments to pay for my benefit premiums.

☐ NO, I do not wish to redirect my benefits and understand I will need to cash-pay for my premiums.

I understand that these deductions from my Voluntary Plan benefit payments will continue until I terminate them, reach my maximum PFL benefit amount or leave time, or until I return to work. I understand that I can terminate or change these deductions at any time while receiving Voluntary Plan benefit payments and that these deductions will be taken after-tax.

Employee Signature Date Signed

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