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 "Care of an ill family member" claim:

- Complete **Statement of Employee.**
- Give **Statement of Care Recipient** to ill family member**.**
- Complete bottom portion, and have care recipient complete top portion of **Authorization for Medical Information Collection and Access.**
- Give **Doctor's Certification** to care recipient's physician for completion.
- 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.

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.

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101 South Mills Avenue, Claremont, CA, 91711
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SERVICES

PAID FAMILY LEAVE

Statement of Employee

Care Recipient

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

Statement of Care Recipient

MAY BE COMPLETED BY AUTHORIZED REPRESENTATIVE IF CARE RECIPIENT IS MENTALLY OR PHYSICALLY UNABLE TO DO SO.
MUST BE SIGNED BY CARE RECIPIENT OR CARE RECIPIENT'S AUTHORIZED REPRESENTATIVE.

B1. Recipient's Date of Birth

B2. Recipient's Telephone Number

B3. Legal Name of Care Recipient

B4. Recipient's Gender ☐ Male ☐ Female

B5. Care Recipient's Residence Address City State ZIP

B6. Health Insurance Portability and Accountability Act Authorization. I authorize any physician, practitioner, hospital, vocational rehabilitation counselor, or workers' compensation insurance carrier to furnish and disclose to my care provider, who is the claimant name and described in Part A of this claim, and to the Disability Administration office all facts concerning my condition that are within their knowledge and to allow inspection of and provide copies of any medical and billing records concerning my condition that are under their control. I understand that the Disability Administration office may disclose information as authorized by the California Unemployment Insurance Code and that such redisclosed information may no longer be protected by this rule. I agree that photocopies of this authorization shall be as valid as the original. I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by the Disability Administration office or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent the Disability Administration office recovery of monies to which it is legally entitled.

Care Recipient's Signature (DO NOT PRINT) Date Signed

B7. Personal Representative signing on behalf of care recipient must complete the following:

I represent the care of bonding recipient in this matter as authorized by: ☐ parental right power of attorney (attach copy) ☐ court order (attach copy)

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PAID FAMILY LEAVE

Authorization for Medical Information Collection and Access- Care Recipient

Care Recipient Name | Date

Caregiver Name

XXX-XX-

Social Security Number | Date of Disability

Care Recipient Date of Birth | College

TO BE COMPLETED BY THE CARE RECIPIENT AND CAREGIVER.
READ THIS FORM CAREFULLY FILL IT OUT COMPLETELY. IF INCOMPLETE, PROCESSING OF YOUR CLAIM WILL BE DELAYED.

Health Insurance Portability and Accountability Act Authorization
I authorize any physician, practitioner, hospital, vocational rehabilitation counselor, or workers' compensation insurance carrier to furnish and disclose to Disability Administration for (check employer of caregiver): all facts concerning my claim for PFL that are within their knowledge and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability that are under their control. I agree that photocopies of this authorization shall be as valid as the original. I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by Disability Administration for the above designated institution or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid

Care Recipient's Signature | Date Signed

Declaration and Signature
By my signature on this claim statement, I certify that for the period covered by this claim I was the primary caregiver for a disabled and qualified family member. 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 and that such violation is 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. By my signature on this claim statement, I authorized the Disability Administration office and my employer to furnish and disclose to State Disability Insurance all facts concerning all wages or earnings, and benefit payments during this claim that are within their knowledge. 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.

Caregiver's Signature | Date Signed

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

Doctor's Certification - Care Recipient

Doctor's certification may be completed by a licensed medical or osteopathic physician and surgeon, chiropractor, dentist, podiatrist, optometrist, designated psychologist, or an authorized medical office of a United States government facility.

DO NOT COMPLETE THIS PART IF REASON FOR PFL LEASE IS BONDING WITH CHILD.

XXX-XX-

D1. PFL Claimant's (Care Provider's) Social Security Number

D2. PFL Claimant's Name (First, Middle Initial, Last)

D3. Patient's Name (First, Middle Initial, Last)

D4. Patient's Date of Birth

D5. Does your patient require care by the Care Provider?

D6. Diagnosis or, if not yet determined, a detailed statement of symptoms. (describe below)

D7. Primary ICD Code

D8. Secondary ICD Code

D9. Date patient's condition commenced

D10. Date first care needed

D11. Date you estimate patient will no longer require care by the Care Provider

D12. Approximately how many total hours. Comments: (**Intermittent please provide Frequency and Duration**):

D13. Would disclosure of this certificate to your patient be medically or psychologically detrimental? ☐ Yes ☐ No

D14. Doctor's License Number

D15. State or Country (if not USA) in which doctor is licensed to practice

D16. Doctor's Name (First, Middle Initial, Last)

Fax Number

D17. Doctor's Address (post office box is not acceptable as the sole address)

City

State/Province

ZIP

Country (if not USA)

D18. Type of Doctor

D19. Specialty (if any)

D20. Doctor's Certification and Signature (REQUIRED): I certify under penalty of perjury that, based on my examination, this Doctor's Certificate truly describes the patient's condition and needed care and the estimated duration thereof.

Original Signature of Attending Doctor (**rubber stamp is not acceptable**)

Date Signed

Under sections 2116 and 2122 of the California Unemployment Insurance Code, it is a violation for any individual who, with intent to defraud, falsely certifies the medical condition of any person in order to obtain disability insurance benefits, whether for the maker or for any other person, and is punishable by imprisonment and/or a fine not exceeding $20,000. Sections 1143 and 3305 require additional administrative penalties.

TO CONFIRM YOUR PFL ELIGIBILITY ORIGINAL DOCUMENTS MUST BE SUBMITTED TO THE DISABILITY ADMINISTRATION OFFICE.

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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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