Application for Paid Family Leave (PFL) Benefits to Care for an Eligible Family Member

A Component of The Claremont Colleges Voluntary Disability Plan

Plan & Benefit Information

This application packet is for filing a claim for Paid Family Leave (PFL) benefits through the Voluntary Disability Insurance (VDI) Plan of The Claremont Colleges to care for an eligible family member. The PFL plan is intended as a wage loss replacement benefit for eligible employees (see below) and is not a leave entitlement. These forms must be fully completed as indicated below and returned to TCCS Disability Administration ***as soon as possible*** to determine your eligibility to receive paid family leave pay benefits.

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

Qualifying Reasons: (1) To care for a child, spouse, parent, registered domestic partner, grandparent, grandchild, sibling, or parent-in-law with a serious health condition; or (2) To take time off work due to a qualifying military event arising out of the overseas military deployment of the employee's family member.

Serious Health Condition Definition: An illness, injury, impairment, or physical or mental condition that involves inpatient care in a hospital, hospice, or residential medical care facility, or at home. This includes any period of incapacity (e.g., inability to work, attend school, or perform other regular daily activities) or any subsequent treatment in connection with such inpatient care, or continuing treatment by a physician or practitioner.

Qualifying Military Event: Any military even or an essential need resulting from the family member's deployment. The military event does not need to occur in California. Examples include but are not limited to: arranging child or parental care, making legal/financial arrangements, attending counseling, assisting the military family member during recover, attending a military-sponsored event/ceremony, or addressing issues due to the military family member's death.

Maximum Benefit: Up to eight (8) weeks or the maximum benefit amount allowed for the claim, whichever comes first, and may be paid over a 12-month period. PFL benefits are paid on a 7-day calendar week per the California Employment Development Department (EDD). Note: PFL payments are subject to federal tax but not state tax.

Base Period: The amount of the *basic weekly benefit* depends on the total wages paid to you during a 12-month base period. As shown below, the month in which your claim begins determines which 12-month period is used.

If your claim begins in:	The base period is the preceding:
January, February, or March	October 1 – September 30
April, May, or June	January 1 – December 31
July, August, or September	April 1 – March 31
October, November, or December	July 1 – June 30

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Forms and Instructions

Notify Your Supervisor and Human Resources
As soon as possible, contact your supervisor and your Human Resources office to request a leave of absence to care for your family member and provide a written document from your care recipient's treating doctor indicating their need for care (see "Care Recipient-Medical Certification" below). Provide notification before you start your leave, or within 24 hours for emergency leaves.

Paid Family Leave Benefit Application Forms

Employee Claim Form
Complete this form to provide information about your need for the PFL pay benefit during your leave time to care for an eligible family member.

Employee – Supplementation (Staff) and Coverage of Benefits Premiums
Complete this form to let us know if you want to supplement your PFL pay with your available vacation and/or personal hours IF you exhaust your balance of sick (kin care) hours (for staff). On this form, you also state if you authorize your benefits deductions for your insurance plans to be taken from your PFL pay or if you will make payments directly to TCCS Benefits Administration.

Care Recipient - Authorization to Furnish Medical Information
Have your care recipient complete this form to give us permission to receive their medical information from their healthcare provider on the *Medical Certification*.

Care Recipient – Medical Certification
Give this form to your care recipient's treating healthcare provider (doctor) for completion to certify their need for care.

Important: All required forms must be fully completed as indicated above and received by the TCCS Disability Office before eligibility can be determined. Incomplete or late forms will delay your benefits. We will send you a letter notifying you of the determination, which will include your weekly benefit amount if your claim is approved. We will process payments in accordance with your institution's payroll schedule.

Questions or Need Assistance? Contact TCCS Disability Administration at disability@claremont.edu or (909) 621-8847. If you have any questions regarding your institution's kin care or family leave policies, please contact your Human Resources office.

Revised 7/25/2023

PAID FAMILY LEAVE

Employee Claim Form

Important: To avoid delaying PFL pay benefits, complete all the items on this form that apply to the claim.

1. First Name: ____________________ 2. Middle Initial(s): _____ 3. Last Name: ______________________

4. Home Address: ____

5. Phone: ____________________ 6. Email: ____

7. Workday ID #: __________ 8. Last 4 of Social Security Number: __ __ __ __ 9. Date of Birth: ____________

10. TCC Institution: ______________________ 11. Department: ________________________________

12. Position Title: ____

13. What date did you last work? ____________ 14. What date do you want your PFL claim to begin? ____________

15. Did you or will you work intermittently during your PFL leave period? ☐ Yes ☐ No (go to #19)

16. What date did you return, or will you return to work? ______________

17. If you are reducing your work hours, how many hours per day will you work? ________

18. What is the legal full name of the person you are caring for? ____

19. What is the relationship to you of the person in #19?

☐ Child ☐ Spouse ☐ Partner ☐ Parent/Parent-in-Law ☐ Grandparent ☐ Grandchild ☐ Sibling

20. 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

Acknowledgement and Declaration of Caregiving

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 the care recipient named above; (2) authorize the TCCS 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 this claim; and (3) authorize my employer(s) to disclose to the TCCS Disability Administration office all facts concerning my employment that are within their knowledge.

I understand that willfully making a false statement or concealing a material fact 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 (15) years from the date of my signature or the effective date of the claim, whichever is later.

Employee Signature: ____ **Date**: ________________

If your signature is made by mark (X), it must be attested by one witness and provide their address:

Witness Signature: ______________________ Address: ________________________________

TCCS Disability Administration | 101 S Mills Avenue, Claremont, CA,91711
Email disability@claremont.edu | Phone (909) 621-8847 | Fax (909) 607-9688

PAID FAMILY LEAVE

Employee - Supplementation (Staff) and Coverage of Benefits Premiums

First Name: ________________________________ Last Name: ________________________________

Date Claim Begins:__________________ TCC Institution (Employer): ____________________________

Staff: Authorization of Supplementation (not applicable to Faculty)

The Paid Family Leave (PFL) benefit payments are approximately 60% or 70% of your base wages. You may authorize the use of vacation and/or personal hours to supplement your leave benefit up to 90% of your regular salary. If you exhaust your accruals [sick (kin care), vacation, and/or personal hours] before the end of your leave, you will only receive the PFL benefit.

☐ I authorize the use of my accrued time off ("accruals") as follows:

(Indicate if you wish to allow the use of "all" or a specific number of hours.)

Vacation hours: _______________ Personal hours: _______________ (if applicable)

I understand that while I receive sufficient pay from my accruals, payroll deductions for my insurance benefits (i.e., medical, dental, vision, retirement, etc.) will continue. If my accruals exhaust or are not sufficient to cover my deductions, I must either allow the use of my PFL pay to cover benefit premiums (see below) OR I must make premium payments directly to TCCS Benefits Administration.

OR

☐ I choose NOT to supplement my PFL pay with my available vacation and/or personal hours ("accruals").

I understand that by not authorizing the use of my accruals, I will only receive PFL pay, if I am eligible. To continue my coverage for my elected insurance benefits (e.g., medical, dental, vision, retirement, etc.) I must allow deductions for my benefit premiums from my PFL pay (see below) OR I must make cash payments directly to TCCS Benefits Administration.

Authorization of Coverage of Benefit Premiums

California regulations allow you to use a portion of your Paid Family Leave (PFL) payments to cover all or part of the employee portion of the premiums for the benefit insurance plans in which you are currently enrolled (e.g., medical, dental, vision, retirement, etc.). To allow the use of your PFL payments to cover your benefit premiums, you must provide a written authorization.

☐ YES, I authorize deducting my benefit premiums from my PFL payments.

I understand these premium deductions will continue until I terminate them, reach my maximum PFL benefit amount or leave of absence time, or until I return to work. I understand I can terminate or change these deductions at any time while receiving PFL payments (see Stopping Benefit Deductions below). I understand that benefits deductions from PFL payments can only be taken after taxes.

☐ NO, I do NOT authorize deducting my benefit premiums from my PFL payments and understand I must make timely payments by personal check, cashier's check, or money order for my premiums to TCCS Benefits Administration. Please contact Benefits Administration for detailed instructions: BenReps@claremont.edu or (909) 621-8151.

Stopping Benefits: If you wish to stop coverage on an after-tax benefit plan (e.g., life insurance) or would like to inquire if special approval is available to stop coverage on a current pre-tax benefit plan while on a leave of absence, submit your request in writing to TCCS Benefits Administration at BenReps@claremont.edu, or by mail, fax, or in person.

Employee Signature: ____ Date: ________________

If your signature is made by mark (X), it must be attested by one witness and provide their address:

Witness Signature: ______________________ Address: ________________________________

PAID FAMILY LEAVE

Statement of Care Recipient

This form may be signed by an authorized representative IF the Care Recipient is mentally or physically unable to do so. This form **must** be signed by the Care Recipient or the Care Recipient's Authorized Representative.

First Name: ______________________ Last Name: ______________________

Date of Birth: ______________ Gender: ☐ Female ☐ Male

Home Address: ____

Telephone Number: ______________________

Health Insurance Portability and Accountability Act (HIPAA) Authorization

I, the care recipient, authorize any physician, practitioner, hospital, vocational rehabilitation counselor, or carrier to furnish and disclose to my caregiver named above and to *The Claremont Colleges Services Disability Administration Office* all facts concerning my disability 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 understand that *The Claremont Colleges Services Disability Administration Office* may disclose information as authorized by the California Unemployment Insurance Code and that such re-disclosed 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 five (5) years from the date received by *The Claremont Colleges Services 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 recovery of monies to which it is legally entitled.

Care Recipient Signature: ______________________________ Date: ______________

A Personal Representative signing on behalf of the Care Recipient must complete the following:

I represent the care recipient in this matter as authorized by:

☐ Parental Right ☐ Power of Attorney (attach copy) ☐ Court Order (attach copy)

Personal Representative Signature: ______________________________ Date: __________

Address: ____

PAID FAMILY LEAVE

Care Recipient - Authorization to Furnish Medical Information

Important: Read this form carefully. To avoid delaying the PFL benefits, complete all the items on this form.

Employee (Claimant) Completes This Section

First Name: ______________________ Last Name: ______________________

Date Claim Begins:______________ TCC Institution (Employer): ______________________

Care Recipient Completes This Section

This section must be *completed and signed* by the care recipient. It may be completed and signed by an authorized representative IF the care recipient is mentally or physically unable to do so.

First Name: ______________________ Last Name: ______________________

Date of Birth: ______________ Telephone Number: ______________________

Home Address: ____

Health Insurance Portability and Accountability Act (HIPAA) Authorization

I, the care recipient, authorize any physician, practitioner, hospital, vocational rehabilitation counselor, or carrier to furnish and disclose to my caregiver named above and to *The Claremont Colleges Services Disability Administration Office* all facts concerning my disability 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 understand that *The Claremont Colleges Services Disability Administration Office* may disclose information as authorized by the California Unemployment Insurance Code and that such re-disclosed 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 five (5) years from the date received by *The Claremont Colleges Services 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 recovery of monies to which it is legally entitled.

Care Recipient Signature: ______________________________ Date: ______________

A Personal Representative signing on behalf of the Care Recipient must complete the following:

I represent the care recipient in this matter as authorized by:

☐ Parental Right ☐ Power of Attorney (attach copy) ☐ Court Order (attach copy)

Personal Representative Signature: ______________________________ Date: __________

Address: ____

THE CLAREMONT COLLEGES
SERVICES

PAID FAMILY LEAVE

Care Recipient - Medical Certification

Caregiver (Claimant) Information

First Name: ______________________ Last Name: ______________________
Date Claim Begins: ______________ TCC Institution (Employer): ______________________

Care Recipient (Patient) Information

First Name: ______________________ Last Name: ______________________
Date of Birth: ______________

Licensed Healthcare Provider of Care Recipient (Patient) Completes This Section

Certification must be by a licensed physician, surgeon, osteopath, chiropractor, dentist, podiatrist, optometrist, designated psychologist, licensed nurse, mid-wife, nurse practitioner, or an authorized medical officer of a United States Government facility.

1. Does your Patient require care by the Caregiver (Claimant) named above? ☐ Yes ☐ No
2. Date the Patient's condition began: ______________
3. Provide the **Start Date** of when the Patient needs care: ______________
4. Provide the **End Date** (last date) you estimate for the need for care: ______________
5. At what intervals, (frequency and duration) does the Patient need care? (e.g., continually, every 4 hours for 20 minutes, etc.)
   ____
6. What is the Patient's diagnosis, or if not yet determined, provide details of their symptoms requiring care:
   ____
7. Primary ICD Code: ______________
8. Secondary ICD Code: ______________
9. In your opinion, would disclosure of this Medical Certification to your patient be medically or psychologically detrimental?

   ☐ Yes ☐ No

I certify under penalty of perjury that, based on my examination, the foregoing Medical Certification truly describes the patient's disability (if any) and the estimated duration thereof.

I certify that I am a ______________________ licensed to practice in the State of ______________
(Type of Doctor)

Doctor's Name: ____
State License Number: ______________________ Medical Group (if any): ______________________

Signature of Attending Doctor: ______________________ Date: ______________
Address: ____
Phone: ______________ Email: ______________ FAX: ______________