Standard Insurance Company
860-676-1303 (Fax)
cahcgroup@uchc.edu (Email)

Request For Connecticut Paid Family And Medical Leave (Form CT PFML-1)

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

1. Employee's legal name (first name, middle initial, last name)	2. Other last names, if any, under which employee has worked

3. Employee's mailing address Street	City	State	Zip Code	Country (if not USA)

4. Employee's Social Security Number or TIN	5. Employee's date of birth (MM/DD/YYYY)	6. Employee's primary telephone number
		( )

7. Employee's preferred email address while on CT PFML (if available)	8. Employee's gender
	☐ Male ☐ Female ☐ Not designated/Other

9. Reason for CT PFML request:

☐ Bond with child ☐ Adoption/Foster child ☐ Care for family member ☐ Employee Impacted by Family Violence
☐ Military qualifying event ☐ Military Caregiver: Care of a family member injured in the line of duty
☐ Own serious health condition due to Covered Employee serving as a Bone Marrow Donor
☐ Own serious health condition due to Covered Employee serving as an Organ Donor
☐ Own serious health condition due to pregnancy ☐ Own serious health condition (other)

10. The family member is employee's: ☐ Child ☐ Spouse or registered domestic partner ☐ Family Member Equivalent
☐ Sibling ☐ Parents and legal guardians (or spouse's parent) ☐ Grandparent ☐ Grandchild

11. Will CT PFML be for a continuous period of time and/or periodic?

☐ Continuous _____ / _____ / _____ _____ / _____ / _____ ☐ Dates are estimated
CT PFML start date (MM/DD/YYYY) CT PFML end date (MM/DD/YYYY)

Identify dates periodic CT PFML will be taken:

☐ Periodic _____ ☐ Dates are estimated

12. Date employer was notified. If providing less than 30 day's advance notice to the employer, please explain:

Employment Information (to be completed by the employee)

13. Business name	14. Employee's date of hire (MM/DD/YYYY)	14a. Employee's last day of work (MM/DD/YYYY)
Capital Area Health Consortium		

15. Has your employment ended? If so, what was your termination date?
N/A

16. Employee's work location Street address
270 Farmington Avenue, Suite 352

City	State	Zip code	Country (if not U.S.A.)
Farmington	CT	06032	

17. Employer's telephone number for contact regarding this request.	18. Is employee currently receiving Workers' Compensation Benefits?
(860) 676-1110	☐ Yes ☒ No

19. List income you will be receiving while on CT PFML, source of pay and amount.
None

20. Have you taken any leave in the last 12 months?	21. If yes list dates and type of leave.
☐ Yes ☐ No	

Disclosure statement: Information regarding CT PFML benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Declaration and signature

Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, 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.

Employee's signature	Date signed (MM/DD/YYYY)

☒ I am submitting this form in advance (see instructions about pre-submitting). I understand the insurance carrier will contact me to advise how to submit the required missing information.

Standard Insurance Company
860-676-1303 (Fax)
cahcgroup@uchc.edu (Email)

Request For Connecticut Paid Family And Medical Leave (Form CT PFML-1)

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)

PART B - EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address
Capital Area Health Consortium, Inc.

Mailing address
270 Farmington Avenue, Suite 352

City	State	Zip code	Country (if not U.S.A.)
Farmington	CT	06032	

2. Employer's FEIN
51-0173264

3. Employer's EIN	4. Employer's contact name for questions related to CT PFML
51-0173264	Michelle Nielson

5. Employer's contact telephone number	6. Employer's contact email address
(860) 676-1110	nielson@uchc.edu

7. Employee's date of hire (MM/DD/YYY)	7a. Employee's last day of work (MM/DD/YYY)

8. Employee's Weekly Wages
$

9. Employee's Typical Work Week Hours
40 hours - varies per week

10a. Check Days Normally Worked ■ Monday ■ Tuesday ■ Wednesday ■ Thursday ■ Friday ☐ Saturday ☐ Sunday

10b. Is employee hourly or salaried? ☐ Hourly ■ Salaried

11. List the last date the employee will receive pay, for example the last date through which sick leave benefits, if any, will be paid.

12. Will any full days of accrued paid time* be used at the same time as PFML? ☐ Yes ☐ No
If so, please provide dates where full days of accrued paid time is being used. _____
**Accrued paid time could be sick leave, annual leave, vacation leave, personal leave, compensatory leave or paid time off.*
Use of full days of accrued paid time, in place of PFML benefits, will decrement the employee's PFML bank.

13a. What type of paid benefits will the employee receive while on CT PFML? Include the last date through which any compensation will be paid.

13b. Is the leave request a result of employee's injury on the job? ☐ Yes ■ No
If yes, has the employee applied for Worker's Compensation payments/benefits? ☐ Yes ☐ No
If yes, has the employee received Worker's Compensation payments/benefits? ☐ Yes ☐ No
Amount of Weekly Payment/Benefit: $_____ Effective date of benefits: _____

13c. If, while on CT PFML, the employee will receive wages in the form of sick leave, PTO, vacation or an extended illness leave bank that is at least equal to the benefit under the Group Policy, will the employer be requesting reimbursement ☐ Yes ■ No

14. What dates will the employer be seeking reimbursement for? N/A

15. CT PFML policy number 760970-A

CT PFML insurance carrier's name
Standard Insurance Company

Return paperwork to Capital Area Health Consortium, Inc.
email to: cahcgroup@uchc.edu or fax to: (860) 676-1303

Declaration and signature

☐ I affirm the employee meets the eligibility for Connecticut Paid Family And Medical Leave.
Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, 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 authorized signature	Date signed (MM/DD/YYYY)

Title
Director of Payroll and Benefits

Standard Insurance Company
860-676-1303 (Fax)
cahcgroup@uchc.edu (Email)

Connecticut Paid Family And Medical Leave
Release Of Personal Health Information
For Family Member
(Form CT PFML-3)

- If an employee is requesting Connecticut Paid Family And Medical Leave (CT PFML) to care for a family member with a serious health condition, the family member or an authorized representative must complete a *Release Of Personal Health Information For Family Member* (Form CT PFML-3) and submit it to their health care provider, along with a copy of the *Certification For Care Of Family Member* (Form CT PFML-4).
- The *Release Of Personal Health Information For Family Member* (Form CT PFML-3) enables the health care provider to complete *Certification For Care Of Family Member* (Form CT PFML-4) and release it to the employee seeking CT PFML benefits.
- Before completing and signing, the family member must read the *Release Of Personal Health Information For Family Member* (Form CT PFML-3) in its entirety.
- The employee requesting CT PFML submits both the *Request For Connecticut Paid Family And Medical Leave* (Form CT PFML-1) and the *Certification For Care Of Family Member* (Form CT PFML-4) to their employer's CT PFML insurance carrier, for CT PFML benefit determination.

  NOTE: This form will be retained by the health care provider. The employee should make a copy for their records before giving it to the health care provider.

Family member or authorized representative signs and dates.

This form is given to the family member's health care provider along with the *Certification For Care Of Family Member* (Form CT PFML-4).

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the family member or authorized representative and submitted to family member's health care provider with Form CT PFML-4)

Employee enters their name, and family member's name and date of birth at the top of each page.

The CT PFML insurance carrier name requested at the top of the form is the same as the CT PFML insurance carrier identified in *Request For Connecticut Paid Family And Medical Leave* (Form CT PFML-1) Part B line 13.

Family member or authorized representative must complete all applicable requested information.

If a family member is unable to fill out this form, an authorized representative must attach a copy of legal documentation, such as a health care proxy or power of attorney, permitting the representative to sign on behalf of the family member. The health care provider will require this documentation of authorization unless the authorized representative is a parent signing on behalf of a minor child.

Standard Insurance Company
860-676-1303 (Fax)
cahcgroup@uchc.edu (Email)

Connecticut Paid Family And Medical Leave
Release Of Personal Health Information
For Family Member
(Form CT PFML-3)

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first name, middle initial, last name)	
Family member's legal name	Family member's date of birth (MM/DD/YYYY))
Relationship of family member to employee	If family member is employee's son or daughter, date of birth (MM/DD/YYYY)

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the family member or authorized representative and submitted to family member's health care provider with Form CT PFML-4)

I, _____ , authorize my health care provider listed on this form to
Family member's legal name

release my personal health information to _____ and Standard Insurance Company.
Employee's legal name

Records Subject to Release: This form gives the health care provider listed permission to include information from your health care records on the attached medical certification. This form gives your health care provider permission to release only the information in your health care records that relate to your current condition, which is the subject of the employee's request for Connecticut Paid Family And Medical Leave benefits.

Duration of Revocable Release: This authorization ends after one year, or when you revoke the release. You can cancel this release at any time. To cancel, send a letter to the health care provider listed on this form.

This form does NOT allow your health care provider to release the following types of information, unless you specifically permit such release. Put an "X" next to any information your health provider MAY release:

☐ HIV/AIDS related information ☐ Mental health information ☐ Alcohol/drug treatment ☐ Psychotherapy notes

Health Care Provider Information (to be completed by the family member or authorized representative)

Identify the health care provider who is currently providing you with treatment for a condition that is subject to the employee's request for CT PFML benefits.

1. Health care provider's name

2. Health care provider's mailing address

City	State	Zip Code	Country (if not U.S.A.)

3. Health care provider's telephone number (provide area or country code)
( )

Standard Insurance Company
860-676-1303 (Fax)
cahcgroup@uchc.edu (Email)

Connecticut Paid Family And Medical Leave
Release Of Personal Health Information
For Family Member
(Form CT PFML-3)

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first legal name, middle initial, last name)	
Family member's legal name (first name, middle initial, last name)	Family member's date of birth (MM/DD/YYYY)

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the family member or authorized representative and submitted to family member's health care provider with Form CT PFML-4)

Family member Information (to be completed by the family member or authorized representative)

4. Family member's mailing address

City	State	Zip Code	Country (if not U.S.A.)

5. Family member's Social Security Number	6. Family member's telephone number (provide area or country code) ( )

READ AND SIGN BELOW

I have a serious health condition and thereby request that the health care provider listed give a completed *Health Care Provider Certification For Care Of Family Member With Serious Health Condition* (Form CT PFML-4) to the employee identified on Form CT PFML-4, I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and any estimation of the amount of care that I require from the employee requesting CT PFML benefits as a result of my current condition.

Family member's signature	Date signed (MM/DD/YYYY)

Authorized representative

I, _____ , represent the family member in this matter as authorized by:

Print legal name

☐ Parental right ☐ Power of attorney (attach copy) ☐ Court order (attach copy) ☐ Health care proxy (attach copy)

Authorized representative's signature	Date signed (MM/DD/YYYY)

The employee should retain a copy for their own records.

Standard Insurance Company
860-676-1303 (Fax)
cahcgroup@uchc.edu (Email)

Connecticut Paid Family And Medical Leave Certification For Care Of Family Member (Form CT PFML-4) Instructions

To Be Completed by Employee

INSTRUCTION to the EMPLOYEE: **The employee requesting Connecticut Paid Family And Medical Leave (CT PFML) to care for family member with a serious health condition must submit the *Certification For Care Of Family Member* (Form CT PFML-4) with *Request For Paid Family and Medical Leave* (Form CT PFML-1). Fill out the employee information of this form and give to the health care provider along with *Release Of Personal Health Information For Family Member* (Form CT PFML-3). When you receive the completed *Certification For Care Of Family Member* (Form CT PFML-4) from the healthcare provider, send the completed forms and supporting documentation to The Standard.**

Employee's Name				
Employee's Address	City	State	ZIP	Phone No.
Family member's Name	Relationship of family member to employee	Family member date of birth		
Family member's Address	City	State	ZIP	Phone No.

To Be Completed By Health Care Provider

INSTRUCTIONS for HEALTH CARE PROVIDERS

This form is used to certify a serious health condition in order to qualify for CT PFML. Qualifying serious health conditions and authorized healthcare providers are described below. Answer each question to the best of your medical knowledge, based on your examination of the family member.

SERIOUS HEALTH CONDITION

A "**serious health condition**" is defined as a condition that involves inpatient care or continuing treatment by a health care provider.

- "**Treatment**" includes examinations to determine if a serious health condition exists and evaluations of the condition.
- A "**regime of continuing treatment**" includes, for example, a course of prescription medication (e.g. an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition.
- It does not include taking of over-the-counter medications such as aspirin, antihistamines, or salves, or bed rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.
- A person has a "serious health condition" if he/she has one or more of the following conditions summarized below:

Inpatient Care:

- An overnight stay in a hospital, hospice, or residential medical care facility.
- Includes any period of incapacity or any subsequent treatment in connection with the overnight stay.

(*Note: If surgery is elective, and an overnight stay in the hospital is required, leave is covered.*)

Continuing Treatment by a Health Care Provider (*any one or more of the following*)

Incapacity and Treatment: A period of incapacity of more than three consecutive full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:

- Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity, unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or
- At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider.

Examples: the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

Pregnancy: Any period of incapacity due to pregnancy.

Chronic Conditions Requiring Treatments: Any period of incapacity due to or treatment for a chronic serious health condition which:

- Requires periodic visits for treatment by a health care provider at least twice a year; and
- Recurs over an extended period of time; and
- May cause episodic rather than a continuing period of incapacity.

Examples: asthma, migraine headaches, diabetes, epilepsy

Permanent/Long-Term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider.

"Serious health condition resulting in incapacitation that occurs during a pregnancy" means:

- Prenatal medical appointments
- Pregnancy-related complications
- Recovery from pregnancies that do not end in a live birth
- Childbirth and delivery, and
- The period of time after the delivery during which the biological mother is certified by her doctor to be unable to perform the requirements for her job.

Standard Insurance Company
860-676-1303 (Fax)
cahcgroup@uchc.edu (Email)

HEALTHCARE PROVIDERS

"Health Care Provider" means:

- A doctor of medicine or osteopathy authorized to practice medicine or surgery by the state in which the doctor practices,
- A podiatrist, dentist, clinical psychologist, or optometrist authorized to practice in the state and performing within the scope of his or her practice;
- A chiropractor authorized to practice in the state and performing within the scope of his or her practice;
- A nurse practitioner, nurse-midwife, clinical social worker, or physician assistant authorized to practice in the state and performing within the scope of his or her practice;
- A Christian Science practitioner listed with the First Church of Christ, Scientist, in Boston, Massachusetts; or
- Any health care provider from whom the employer or the employer's group health plan's benefits manager will accept a medical certification to substantiate a claim for benefits.

Standard Insurance Company
860-676-1303 (Fax)
cahcgroup@uchc.edu (Email)

Connecticut Paid Family And Medical Leave Certification For Care Of Family Member (Form CT PFML-4)

PART A: MEDICAL FACTS

1. Diagnosis _____ Primary ICD Code *(optional)* _____

   Approximate date condition commenced: _____ Probable duration of condition: _____

   Was the family member admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

   If so, dates of admission: _____

   _____

   Date(s) you treated the family member for condition: _____

   _____

   Will the family member need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

   Was the family member referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ Yes ☐ No

   If so, state the nature of such treatments and expected duration of treatment: _____

   _____

2. Is the medical condition pregnancy? ☐ Yes ☐ No If so, expected/actual delivery date: _____

3. Complications with the pregnancy or delivery? ☐ Yes ☐ No Please explain: _____

   _____

   _____

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the family member needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

5. Is the family member an active service member? ☐ Yes ☐ No

   If yes, is the condition a result of military service? ☐ Yes ☐ No

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your family member's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

6. Will the family member be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the family member need care? ☐ Yes ☐ No

   Explain the care needed by the family member and why such care is medically necessary: _____

   _____

   _____

7. Will the family member require follow-up treatments, including any time for recovery? ☐ Yes ☐ No

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

   _____

   _____

   Explain the care needed by the family member, and why such care is medically necessary: _____

   _____

   _____

Standard Insurance Company
860-676-1303 (Fax)
cahcgroup@uchc.edu (Email)

Connecticut Paid Family And Medical Leave Certification For Care Of Family Member (Form CT PFML-4)

8. Will the family member require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ Yes ☐ No

   Estimate the hours the family member needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the family member, and why such care is medically necessary: _____

   _____

   _____

9. Will the condition cause episodic flare-ups periodically preventing the family member from participating in normal daily activities?

   ☐ Yes ☐ No

   Based upon the family member's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the family member may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

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

   Duration: _____ hours or ____ day(s) per episode

   Does the family member need care during these flare-ups? ☐ Yes ☐ No

   Explain the care needed by the family member, and why such care is medically necessary _____

   _____

   _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Health Care Provider's Name		Date	
Address	City	State	ZIP
Phone No.	Fax No.		
Specialty/Type of Practice		License No.	

Declaration and signature

Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, 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.

Signature of Health Care Provider	Date