Renaissance®
DENTAL • VISION • LIFE • DISABILITY

Renaissance Life & Health
Insurance Company of America

PAID FAMILY AND MEDICAL LEAVE CLAIM FORM

-Please Print or Type in Dark Ink-

INSTRUCTIONS

1. **EMPLOYEE COMPLETES SECTION 1**

2. **EMPLOYER COMPLETES SECTION 2 AND RETURNS FORM TO EMPLOYEE**

3. **EMPLOYEE GATHERS REQUIRED DOCUMENTATION NOTED IN *SECTION 1 - REASON FOR LEAVE* SECTION AND SUBMITS DOCUMENTATION AND APPLICATION TO THE CARRIER**

FOR FASTEST SERVICE, PLEASE SUBMIT THE CLAIM FORM AND REQUIRED DOCUMENTATION BY EMAIL OR FAX.

- **SECURE EMAIL:** GroupClaims@RenaissanceFamily.com
- **SECURE FAX:** 607-773-2276
- **MAIL:** 225 S East Street, Suite 360; Indianapolis, IN 46202

SECTION I | CLAIM INFORMATION (TO BE COMPLETED BY THE EMPLOYEE)

EMPLOYEE INFORMATION

Your Legal First Name:	**Your Legal Last Name:**		
Social Security Number:	**Date of Birth** (mm/dd/yyyy):		
Your Employee ID:	**Your Gender:** ☐ M ☐ F ☐ X (other or undisclosed)		
Street Address (Include Apt#/Suite):	**City:**	**State:**	**ZIP Code:**
Phone Number:	**Email:**		
Contact Preference: ☐ Email ☐ Phone			

SECTION I | CLAIM INFORMATION (TO BE COMPLETED BY THE EMPLOYEE) CONTINUED

EMPLOYMENT INFORMATION

Employer Name:			
Employer Street Address (Include Apt#/Suite):	**City:**	**State:**	**ZIP Code:**
Hire Date (mm/dd/yyyy):	**Job Title:**		
Check all days you normally work: ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ Sa ☐ Su ☐ Varies week to week			
Regularly Scheduled Hours per Week:	**Average Weekly Wage:**		
Are you still employed with this employer: ☐ Yes ☐ No If no, when was employment terminated (mm/dd/yyyy):			

REASON FOR LEAVE

☐ **My own serious health condition/my own disability**

- Please attach a completed PFML Medical Certification Form from your provider

☐ **Bonding with a Newborn Child** | Child's Date of Birth (mm/dd/yyyy): _____

- Please attach a copy of one of the following:
  - Child's Birth Certificate
  - A statement from the child's health care provider stating the child's birth date
  - A statement from the health care provider of the person who gave birth stating the child's birth date
  - A statement or birth record from the hospital where the child was born with the child's birth date and signed by the birth registrar

☐ **Bonding with an Adopted/Foster Child** | Placement Date (mm/dd/yyyy): _____

- Will the absences be needed prior to the placement date for pre-adoption/foster activities such as required counseling sessions, court appearances and travel to different localities? ☐ Yes ☐ No
- Please attach a copy of documentation from the Child's health care provider or from an Adoption or Foster Care agency involved in the placement, or the Department of Children and Families (DCF), that confirms the placement and the date of placement.

☐ **A family member's serious health condition**

- Please attach the **PFML Medical Certification Form** completed by your family members' treating health care provider

☐ **To care for a family member injured during active military service**

- Please attach the **PFML Medical Certification Form** completed by the injured service member's treating health care provider

☐ **Military qualifying event**

- Please attach a copy of the family member's active-duty orders, letter from Commanding Officer or other documentation verifying the military event

☐ **Safe Leave** (including domestic/family violence and sexual assault) Note: this leave type is only available for the following Renaissance state specific PFML products: CT PFML, CO PFML. This leave type is not available under MA PFML.

- Please attach a copy of one of the following:
  - A police or court record related to the violence and/or sexual assault; or
  - A signed written statement from a victim services organization, an attorney, a judicial or municipal victim services office or advocate, or a licensed medical or other professional from whom you sought assistance with respect to the violence and/or sexual assault

FAMILY MEMBER INFORMATION (COMPLETE THIS SECTION IF LEAVE IS FOR A FAMILY MEMBER (INCLUDING BONDING LEAVE). IF LEAVE IS FOR YOUR OWN MEDICAL CONDITION, SKIP THIS SECTION)

Family Member Name:

Family Member Street Address (Include Apt#/Suite):	**City:**	**State:**	**ZIP Code:**

Family Member Date of Birth (mm/dd/yyyy):

Family Member's Gender:
☐ M ☐ F ☐ X (other or undisclosed)

Relationship: (Please note: covered family members may vary by state)

☐ Spouse ☐ Domestic Partner

☐ Child (Please Indicate): ☐ Biological ☐ Foster/Adopted/Legal Ward ☐ Step ☐ Grandchild

☐ Parent (Please Indicate): ☐ Biological ☐ Step ☐ In-Law

☐ Grandparent (Please Indicate): ☐ Biological ☐ Step ☐ In-Law

☐ Sibling (Please Indicate): ☐ Biological ☐ Step ☐ In-Law

☐ Other (Including an individual to whom you stood In Loco Parentis or who stood In Loco Parentis to you)
Please describe: _____

If leave is to care for a family member with a serious health condition or injured service member, describe the care you will provide (check all that apply):

☐ Assistance with daily activities or medical needs ☐ Psychological comfort

☐ Transportation ☐ Other, please describe:_____

LEAVE DATES/ABSENCE TYPE (DATES OF LEAVE ARE REQUIRED. IF ACTUAL DATES ARE NOT KNOWN, YOU MUST PROVIDE ESTIMATED DATES. IF ESTIMATED DATES ARE INDICATED, ACTUAL DATES MUST BE CONFIRMED BEFORE YOUR CLAIMCAN BE PROCESSED).

Continuous (full day absences for a consecutive period of days)

Last day you performed any work for your employer before your leave:_____ Date is (check one) ☐ Actual ☐ Estimated
First Day of Leave: _____Date is (check one) ☐ Actual ☐ Estimated
Last Day of Leave: _____Date is (check one) ☐ Actual ☐ Estimated
Return to Work Date: _____Date is (check one) ☐ Actual ☐ Estimated
☐ **Not Applicable: Continuous leave is not needed**

Reduced Schedule (partial day absences for a consecutive period of days – for example, 2 hours absent every day for a 2-week period)

Number of Hours Absent per Day_____
First Day of Reduced Schedule: _____Date is (check one) ☐ Actual ☐ Estimated
Last Day of Reduced Schedule: _____Date is (check one) ☐ Actual ☐ Estimated
Return to Full Time Work Date:: _____Date is (check one) ☐ Actual ☐ Estimated
☐ **Not Applicable: Reduced Schedule leave is not needed**

Intermittent or Periodic (absences that occur at varying times and varying numbers of hours per absence)

Expected Timeframe During Which Periodic Absences Are Needed:
Start Date: _____ End Date: _____
Estimated Frequency of Absences: _____Times ☐ Per Week ☐ Per Month
Estimated Duration of Each Absence: (check all that apply)
☐ Full Day Absences
☐ Partial Day Absences of approximately _____ hours per absence
Has the first absence already been taken? ☐ Yes ☐ No If Yes, Date and Hours_____
☐ **Not Applicable: Intermittent leave is not needed**

OTHER PAY OR BENEFITS

Are you or will you be receiving any pay from your employer for the same dates of your leave request? ☐ Yes ☐ No
If yes, please provide:

PAY TYPE(S)	START DATE	END DATE	AMOUNT	FREQUENCY (WEEKLY, MONTHY, LUMP SUM)

Are you or will you be receiving any other benefits (such as Workers' Compensation, Unemplomentt, Social Security, or other paid benefits) during your leave? ☐Yes ☐No If yes, please provide:

PAY TYPE(S)	START DATE	END DATE	AMOUNT	FREQUENCY (WEEKLY, MONTHY, LUMP SUM)

DECLARATION AND SIGNATURE:

BY SIGNING BELOW I AGREE THAT THE ABOVE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

X _____ _____

Signature of Employee *(Your signature is required for benefit consideration)* **Date Signed** *(mm/dd/yyyy)*

—State Fraud Warnings on Following Pages—

SECTION II | EMPLOYMENT VERIFICATION (TO BE COMPLETED BY THE EMPLOYER)

Note: It is recommended that the employer representative complete this information and provide it back to the employee within three (3) business days of the employee's request. State law may require employers to provide this information within a specified timeframe. If employment verification is not provided by the employer, the information provided by the employee in Part 1 may be used to adjudicate the claim.

EMPLOYER INFORMATION

Business Name:	**Contact Person's Name:**		
Business Street Address (Include Apt#/Suite):	**City:**	**State:**	**ZIP Code:**
Federal Employer Identification Number (FEIN):			
Contact Phone Number:	**Contact Email:**		

EMPLOYEE / APPLICANT INFORMATION

Employee First Name:	**Employee Last Name:**
Date of Birth *(mm/dd/yyyy)*:	**Last 4 Digits of SSN:**
Employee ID:	**Hire Date:**

Has employment been terminated? ☐ Yes ☐ No If yes, termination date: _____

JOB AND WORK SCHEDULE INFORMATION

Employee's Job Title:

Employee's Regular Work Schedule: ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ Sa ☐ Su ☐ Varies week to week

Regularly Scheduled Hours per Week:

FOR CONTINUOUS OR REDUCED SCHEDULE LEAVE
Last day employee performed any work before starting leave: _____ Date is (check one) ☐ Actual ☐ Estimated
(If employee is taking a reduced schedule leave, please indicate the last day the employee worked full time before beginning reduced schedule leave)

Return to Work Date: _____ Date is (check one) ☐ Actual ☐ Estimated
(If employee is taking a reduced schedule leave, please indicate the first day the employee returned to full time work following reduced schedule leave)

PREMIUM CONTRIBUTIONS

Percentage of premium paid by: Employee _____ % Employer_____ %

If employee pays a portion of premiums, please indicate if the employee's premiums are deducted: ☐ pre-tax or ☐ post-tax

PAY AND WAGE INFORMATION

Employee's Average Weekly Wage: _____
(If questions, please refer to the state specific guidelines on how to calculate AWW for benefit coverage.)

Will the employee be receiving any pay from the employer for the same dates of the leave request? ☐ Yes ☐ No
If yes, please provide:

PAY TYPE(S)	START DATE	END DATE	AMOUNT	FREQUENCY (WEEKLY, MONTHY, LUMP SUM)

DECLARATION AND SIGNATURE:

I DECLARE I AM AUTHORIZED TO COMPLETE AND SIGN AS A REPRESENTATIVE OF THE EMPLOYER OF THE EMPLOYEE REQUESTING PFML. BY SIGNING BELOW I AGREE THAT THE ABOVE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

X _____ _____
Printed Name of Employer's Authorized Representative **Job Title**

X _____ _____
Signature of Employer's Authorized Representative **Date Signed** (mm/dd/yyyy)

NOTE: IF THIS FORM IS NOT COMPLETED IN FULL, DETERMINATION OF BENEFITS WILL BE DELAYED UNTIL ALL REQUIRED INFORMATION HAS BEEN RECEIVED. WRITE "NA" IN NON-APPLICABLE SECTIONS.

—State Fraud Warnings on Following Pages—

LIFE AND DISABILITY STATE FRAUD WARNING STATEMENTS:

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW. PLEASE SEE BELOW FOR STATE-SPECIFIC VARIATIONS OF THIS FRAUD NOTICE.

CALIFORNIA: WARNING: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

FLORIDA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NEW YORK (EXCLUDING LIFE INSURANCE): ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

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