



CO FAMLI NEONATAL CARE 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 OBTAINS THE CO FAMLI NEONATAL CARE LEAVE CERTIFICATION FORM FROM THE HEALTHCARE PROVIDER AND SUBMITS ALL FORMS 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:** P.O. Box 1596 Indianapolis, IN 46206

SECTION I | CLAIM INFORMATION (TO BE COMPLETED BY 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: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X (other or undisclosed)		
Street Address (Include Apt#/Suite):		City:	State:	ZIP Code:
Phone Number:		Email:		
Contact Preference: <input type="checkbox"/> Email <input type="checkbox"/> Phone				

SECTION I | CLAIM INFORMATION (TO BE COMPLETED BY 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):**LEAVE DETAILS**

Child's Full Name:

Relationship to the Child:

Is your name on the child's neonatal intensive care unit admittance paperwork? Yes No

Child's Date of Birth (mm/dd/yyyy):

Date Admitted to NICU (mm/dd/yyyy):

Leave Start Date (mm/dd/yyyy):

Leave End Date (mm/dd/yyyy):

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)

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 (mm/dd/yyyy):
Has employment been terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, termination date (mm/dd/yyyy) : _____	

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 Estimate
(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 (mm/dd/yyyy): : _____ Date is (check one) Actual Estimate
(If employee is taking a reduced schedule leave, please indicate the first day the employee worked full time before beginning 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 post-tax

PAY AND WAGE INFORMATION

Employee's Average Weekly Wage: _____

(If questions, please refer to the state of 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, MONTHLY, 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.

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.

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.



Underwritten by Renaissance Life & Health Insurance Company of America, Indianapolis, IN, and in New York by Renaissance Life & Health Insurance Company of New York, Binghamton, NY. Both companies may be reached at PO Box 1596, Indianapolis, IN 46206. Products may not be available in all states or jurisdictions.