Reset

TheStandard®

Standard Insurance Company
866.756.8116 Tel 866.751.5174 Fax
PO Box 3877 Portland OR 97208

Applying For Paid Family And Medical Leave (PFML)

To Use Paid Family And Medical Leave To:
Bond with a newborn, a newly adopted or fostered child

Complete Form PFML-1
- ☐ Complete PFML-1, Part A
- ☐ Provide PFML-1 to employer
- ☐ Employer completes PFML-1, Part B and returns to you within 3 days

Complete Form PFML-2
- ☐ Complete PFML-2 and collect supporting documentation

Send forms and documents
- ☐ Send completed forms and supporting documentation to The Standard
- ☐ The Standard accepts or denies claim within 5 days once a complete claim is received.

Please keep a copy of all pages for your records.

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Request For Delaware Paid Family And Medical Leave (Form DE PFML-1) Instructions

- To request Delaware Paid Family And Medical Leave (DE PFML), the employee requesting DE PFML must complete Part A of the *Request For Delaware Paid Family And Medical Leave* (Form DE PFML-1). All items on the form are required unless noted as optional. The employee then provides the form to the employer to complete Part B.
- The employer completes Part B of the *Request For Delaware Paid Family And Medical Leave* (Form DE PFML-1) and returns it to the employee within three days.
- Additional forms are required depending on the type of leave being requested. The employee requesting leave is responsible for the completion of these forms.
- The employee submits the completed *Request For Delaware Paid Family And Medical Leave* (Form DE PFML-1) with the required additional form to The Standard. The employee should retain a copy of each submitted form for their records.

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

The employee requesting DE PFML must complete all required information.

Delaware Paid Family And Medical Leave (DE PFML) Request (to be completed by the employee)

Question 9: Parental Leave means PFML taken by a Covered Individual to bond with or care for a Child during the first year of the Child's birth, adoption or placement with the Covered Individual.
Family Caregiving Leave means the PFML taken to care for a Family Member with a Serious Health Condition (illness or accident) or to address a Family Member's Qualifying Exigency.
Qualifying Exigency means PFML taken by a Covered Individual for qualified issues as defined in the FMLA, 29 CFR § 825.126, that arise in connection with a Deployment.
Medical Leave means PFML taken by a Covered Individual that is made necessary by the Covered Individual's own Serious Health Condition (illness or accident).

Question 10: Family Member means a Parent, Child or Spouse.

Child means an Employee's son or daughter as defined in the FMLA (29 CFR 825). Child includes an Employee's biological, adopted, or foster child, a stepchild, a legal ward, or a child of person standing In Loco Parentis who is either under 18 years of age; or 18 years of age or older and incapable of self-care because of a mental or physical disability.

Parent means an Employee's parent as defined under the FMLA. Parent includes an Employee's biological, adoptive, step, foster father or mother, or any other individual who stood In Loco Parentis to the Employee when the Employee was a son or daughter as defined by FMLA. This term does not include parents "in law".

Spouse means the Employee's husband or wife as defined or recognized in the state where the individuals were married and includes persons in common law or same-sex marriage. Spouse also includes the Employee's husband or wife in a marriage that was validly entered into outside of the United States if the marriage could have occurred here in at least one State.

Question 11: If dates are "Continuous", the employee must provide the start and end dates of the requested DE PFML. These dates should be the actual dates that the DE PFML will begin and end. If uncertain, estimate the start and end dates and indicate "Dates are estimated".

If dates are "Intermittent", enter the dates DE PFML will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate "Dates are estimated".

If the employee is working a consistent but reduced work schedule for multiple weeks, provide the days/hours of leave needed for DE PFML. If uncertain, estimate the frequency of leave and indicate "Dates are estimated".

Question 12: Date employer was notified. If the employee is submitting the DE PFML request to their employer with less than 30 days' advance notice from the start date of the DE PFML, the employee must explain why 30 days' notice could not be given. If the explanation will not fit in the space provided on the form, enter "See Attached" and add an attachment with the explanation. Be sure to include the employee's full name and their date of birth at the top of the attachment.

Employment Information (to be completed by the employee)

Question 14: Enter the date of hire to the best of the employee's recollection. If it has been more than a year since the date of hire, entering the year in which employment started is sufficient.

Question 19: List all other income you will be receiving while on DE PFML. Include the type/name of income and how much. Example PTO from employer for $500.00 a week.

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Payment for approved claims will be due 14 calendar days from the date of the claim decision.
Employee signs and dates, before giving this form to their employer to complete Part B.

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

The employer of the employee requesting DE PFML must complete all information in Part B.

Question 2: If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number.

Question 8: Wages means a Covered Individual's remuneration for Delaware based employment with the Employer as determined for purposes of old-age, survivors, and disability insurance for employees and employers under the Federal Insurance Contribution Act, 26 U.S.C. Chapter 21.
Average Weekly Wage means the employee's average gross earnings, that are earned in Delaware as determined under the Federal Insurance Contribution Act, whether salaried or hourly (prior to any payroll deductions or withholdings) as reported on the quarterly Hours and Wage report *for the 4 completed calendar quarters immediately preceding the filing of a claim application*. If 4 completed calendar quarters are unavailable, the Division will accept the weekly average of the 3 completed calendar quarter quarterly Hours & Wage reports immediately preceding the filing of a claim application.

Question 12: To qualify for reimbursement from us, the Employer must pay Wage continuation to the Covered Individual that is equal to or greater than the Weekly Benefit Amount.

Question 13: No PFML Benefits are payable for any period for which the Covered Individual is eligible for unemployment insurance benefits under 19 Del.C. Section 3311 et seq.

No PFML Benefits are payable for any period for which the Covered Individual is eligible for temporary disability benefits under Workers' Compensation Act, 19 Del.C. Section 2301 et seq. due to a workplace accident or injury.

Affirmation employee is eligible for DE PFML:
To be eligible for any family and medical leave, an employee must be in employer's employment in the state of DE for at least 12 months and been employed for at least 1,250 hours of service with the employer during the previous 12-month period. For purposes of determining whether an individual meets the service hours requirement, the legal standards established under the FMLA apply. Employee must work primarily in Delaware ("primarily" meaning 60% or more of their time each calendar quarter).

Employer signs and dates, and then returns to the employee requesting DE PFML within three business days.

Be sure to complete the appropriate additional DE PFML form(s) based on the type of DE PFML leave being requested.

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Request For
Delaware Paid Family And Medical Leave
(Form DE 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 DE PFML (if available)	8. Employee's gender ☐ Male ☐ Female ☐ Not designated/Other

9. Reason for DE PFML request:
Parental Leave (Bonding): ☐ New child ☐ Adoption/Foster child
Family Caregiving Leave: ☐ Care for Family Member with a Serious Health Condition ☐ Military exigency
Medical Leave: ☐ Own Serious Health Condition due to pregnancy ☐ Own Serious Health Condition (other)

10. The family member is employee's: ☐ Child ☐ Spouse ☐ Parent

11. Will DE PFML be used for a Continuous period of time, Intermittently and/or on a Reduced Leave Schedule?

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

☐ Intermittent (separate, non-consecutive time)
Days/hours(s) requested: _____ ☐ Dates are estimated

☐ Reduced Leave Schedule (consistent but reduced work schedule for multiple weeks)
Days/hours(s) requested: _____ ☐ Dates are estimated
(example: 2 days per week, or 4 hours per day, or every Monday)

Employment Information (to be completed by the employee)

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

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

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

16. Employee's work location Street address

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

17. Employer's telephone number for contact regarding this request.
( )

18. Are you eligible for, or receiving, Workers' Compensation (WC), Unemployment Insurance (UI) or Personal Injury Protection (PIP) benefits due to an injury from an automobile accident? ☐ Yes ☐ No If yes, indicate which benefit: ☐ (WC) ☐ (UI) ☐ (PIP)

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

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

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Request For Delaware Paid Family And Medical Leave (Form DE 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)

Declaration and signature
Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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

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

1. Business's full legal name and mailing address

Mailing address

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

2. Employer's FEIN

3. Employer's EIN	4. Employer's contact name for questions related to DE PFML

5. Employer's contact telephone number ( )	6. Employer's contact email address

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

8a. Employee's Average Weekly Wage _____

8b. Is employee subject to Social Security taxes? ☐ Yes ☐ No Medicare taxes? ☐ Yes ☐ No

8c. Has employee met the annual limit to Social Security max. contribution? ☐ Yes ☐ No ☐ N/A

9. Check Days Normally Worked ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Indicate Hours Normally Worked _____ _____ _____ _____ _____ _____ _____

10. List the dates of any period a week or longer that the employee is not scheduled or able to work due to lapses in seasonal operations, school breaks, or other suspensions or cessations of business operations while on PFML leave, including federal, state, local or Employer designated holidays: (example: December 18 - January 1 and March 25 - March 31 or N/A if not applicable)

_____

11. Will Wage continuation be paid to the Covered Individual that is equal to or greater than the Weekly Benefit Amount? ☐ Yes ☐ No

If yes, provide dates: _____

12. If employee received or will receive Wage continuation while on DE PFML, will employer be requesting reimbursement? ☐ Yes ☐ No

If yes, provide dates: _____

13. Has the employee filed for Workers' Compensation Benefits or Unemployment Benefits? ☐ Yes ☐ No

If yes, provide benefit dates: _____

14. DE PFML policy number

DE PFML insurance carrier's name and mailing address
Standard Insurance Company PO Box 3877, Portland, OR 97208 866-751-5174 Fax

Declaration and signature

☐ I affirm the employee meets the eligibility requirements for Delaware Paid Family And Medical Leave.

I am the person authorized to sign as the employer of the employee requesting DE PFML. My signature affirms that to the best of my knowledge and belief, the information I have provided is true and accurate.

Employer's authorized signature	Date signed (MM/DD/YYYY)

Title

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Paid Family And Medical Leave Bonding Certification (Form PFML-2) Instructions

If the employee is requesting Paid Family And Medical Leave (PFML) to bond with a newborn, an adopted child or a foster child, the employee must submit the *Bonding Certification* (Form PFML-2) with the *Request For Paid Family And Medical Leave* (Form PFML-1).

BONDING CERTIFICATION (to be completed by the employee)

The employee requesting PFML must complete all applicable requested information.
Send completed forms and supporting documentation to The Standard.

If this form is being submitted in advance (pre-submitting) and some information is unknown, the insurance carrier will contact the employee and explain how to provide the required additional information.

Question 1 & 2: If the form is submitted to the PFML insurance carrier prior to the birth of a child, this is considered presubmitting. The employee is then required to provide the required documentation of the child's birth to the PFML insurance carrier. The PFML carrier will tell the employee how to provide the required additional documentation.

There may be instances where PFML can be taken before the adoption or foster care is finalized. For example, the employee may be required to appear in court or travel to another country as part of the adoption or foster care process. The employee should include documentation to show that the PFML is necessary to further the adoption or foster care.

Question 5: If dates are "Continuous", the employee must provide the start and end dates of the requested PFML. These dates should be the actual dates that the PFML will begin and end. If uncertain, estimate the start and end dates and indicate "Dates are estimated".

If dates are "Intermittent", enter the dates PFML will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate "Dates are estimated".

If the employee is working a consistent but reduced work schedule for multiple weeks, provide the days/hours of leave needed for PFML. If uncertain, estimate the frequency of leave and indicate "Dates are estimated".

Question 6: See chart below for documentation details. Unless specified, do not send the original documents.

Bonding Form/Certification	Description
Health Care Provider certification of pregnancy	An **original** letter obtained from the birth mother's Health Care Provider that certifies pregnancy. It should include the mother's name and the expected due date.
Health Care Provider certification of birth	An **original** letter obtained from the birth mother's Health Care Provider that includes the mother's name and child's date of birth.
Birth Certificate	A **copy** of the certificate issued by the city or county office in which the child is born.
Voluntary Acknowledgment of Paternity	A **copy** of the form that establishes legal fatherhood when the parents are unmarried. Completed by both mother and father.
Court Order of Paternity	**Documentation** of the order from the family court that names the father of a child. Establishes legal fatherhood when the parents are unmarried. Completed by both mother and father.
Marriage Certificate	A **copy** of the official statement issued by the town or city clerk from which the marriage certificate was issued.
Civil union/domestic partner's documentation	A **copy** of the certificate of civil union or domestic partnership.
Foster care placement letter	A **copy** of the letter of foster care placement issued by the county or city department of social services or authorized voluntary foster care agency.
Court documents of adoption	A **copy** of the court document finalizing adoption or documentation in furtherance or court order finalizing adoption.
Other documentation	Other documentation of parental relationship may be accepted if none of the others listed apply.

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Paid Family And Medical Leave Bonding Certification (Form PFML-2)

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first name, middle initial, last name)			Employee's date of birth (MM/DD/YYYY)
Other last names, if any, under which employee has worked			Employee's Social Security Number or TIN
Employee's mailing address Street			
City	State	Zip Code	Country (if not U.S.A.)

BONDING CERTIFICATION (to be completed by the employee)

1. Child's date of birth (MM/DD/YYYY)	2. Child's gender ☐ Male ☐ Female ☐ Not designated/Other	3. Does child live with the employee requesting PFML? ☐ Yes ☐ No

4. Child is employee's:

☐ Biological child ☐ Stepchild ☐ Foster child ☐ Adopted child ☐ Legal ward

☐ *in loco parentis* child ☐ Spouse/Domestic partner's child

5. Will PFML be used for a Continuous period of time, Intermittently and/or on a Reduced Leave Schedule?

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

☐ Intermittent (separate, non-consecutive time)

Days/hours(s) requested: _____ ☐ Dates are estimated

☐ Reduced Leave Schedule (consistent but reduced work schedule for multiple weeks)

Days/hours(s) requested: _____ ☐ Dates are estimated
(example: 2 days per week, or 4 hours per day, or every Monday)

6. Select one of the following and attach the document as required as evidence of the relationship.

Parent of newborn child:

Birth mother

☐ Health Care Provider certification of pregnancy (include expected due date AND mother's name); OR

☐ Health Care Provider certification of birth (include date of birth of child AND mother's name); OR

☐ Child's birth certificate

Other parent

☐ Copy of birth certificate naming second parent; OR

☐ Voluntary acknowledgment of paternity; OR

☐ Court order of Paternity; OR

☐ Birth mother documents (see above) PLUS one of the following:

- ☐ Marriage certificate; OR
- ☐ Certificate of civil union; OR
- ☐ Evidence of domestic partnership

☐ OR; Other documentation of parental relationship

Foster parent

☐ Letter of foster care placement or anticipated placement issued by county or city department of Social Services or authorized voluntary foster care agency

Adoptive parent

☐ Court document finalizing adoption

☐ Documentation in furtherance of adoption

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7. Date of foster care or adoption placement, if applicable (MM/DD/YYYY)	
Declaration and signature I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 4 of this form.	
Employee's signature	Date signed (MM/DD/YYYY)

Paid Family And Medical Leave
Claim Form Fraud Notices

The fraud notices shown apply to your paid family and medical leave claim submissions.

COLORADO

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

CONNECTICUT

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.

DELAWARE

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

MAINE

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MASSACHUSETTS

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW YORK

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.

OREGON

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

WASHINGTON

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

ALL OTHER STATES

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Sign Up for Digital Payments

Have you signed up for digital payments yet? If so, you can disregard this notice.

Get your claim payment faster with digital payments with Standard Insurance Company. If your claim is approved, you can choose to have benefits paid to you via Zelle or direct deposit.[1]

How do digital payments work?

1. Your digital payment eligible claim is approved.[2]
2. You'll receive an email or text notification with a link to choose your payment preference.[3]
3. Follow the link to complete digital payment setup.

To sign up for digital payments,[4] choose one of the following options:

1. **Fastest Option:** Call or text "HELLO" to 833.591.8047 and follow the prompts to choose your payment preference and to provide employee and employer information.
2. **Additional Option:** Complete and submit this form below:
   - Fax to: 888.878.3686
   - Mail to: Standard Insurance Company, P.O. Box 2800, Portland, OR 97208

Digital Payment Sign Up Form

Employee First Name _____ Employee Last Name _____

Employee DOB (MM/DD/YY) _____ Employee Zip Code _____

Employer Name _____

Check "✓" to choose your preferred payment method.

Digital payment (Zelle or direct deposit) ☐ Payment by check ☐

Your contact details

Enter the mobile number or email address where you will receive notifications. This information is required for Zelle or direct deposit.

Mobile: _____ Email: _____

Email notifications will come from notification@thepaychoice.com. Text messages will come from 26489 or 21239.

The payment method you choose can be saved for any recurring payment you may receive. **If you don't choose a notification method, we may use the method we have on file or mail a check.**

1 By electing to receive claim payments digitally, we're not guaranteeing approval of your claim.
2 Not all benefits are eligible for digital claim payments.
3 If your claim is approved and you do not respond to the text or email notification with your preferred payment option within (3) calendar days, The Standard‡ will automatically send a paper check.
4 If you elect to receive claim payments digitally, you authorize use of the information you provide to access your bank account information for the purpose of facilitating payment transactions.

‡ The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of 1100 SW Sixth Avenue, Portland, Oregon in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

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Delaware Paid Family and Medical Leave (PFML) Voluntary Tax Withholding Request

We want to offer you the option to address any tax obligation by providing the ability to voluntarily request tax obligations withdrawn from your Delaware PFML benefit. You can have both Federal and Delaware State tax withheld from your Paid Family and Medical Leave Benefits. Taxes will be withheld after deductions are taken.

- Withholding Federal and/or Delaware State Tax is voluntary. 10% of your benefits would be withheld for Federal taxes and 3% would be withheld for Delaware State taxes.
  - If you do not have Federal and/or Delaware State income tax withheld, you may need to make estimated quarterly tax payments.
- The Federal and Delaware State Tax withheld during the year will be reported on a Tax Form that is mailed after the end of the year.

You can stop the tax withholding at any time during your benefit claim.

- If you do not want to have income tax withheld from your weekly benefits, you do not have to return this form.
- Any monies you have withheld cannot be returned to you except by the Federal or State government as part of your income tax refund.

To **start or stop** withholding 10% Federal and/or 3% Delaware State Income Tax, complete the form below and return it to The Standard at PO Box 3877, Portland OR 97208.

Type or print: SSN: ___ ___ _____

First Name M.I. Last Name

Home Address (Number and Street or Rural Route)

City or Town State Zip Code

Telephone Number: ( ) ___ _____

Check All Boxes That Apply

☐ **Start** withholding 10% Federal Income Tax.
☐ **Stop** withholding 10% Federal Income Tax.
☐ **Start** withholding 3% DE State Income Tax.
☐ **Stop** withholding 3% DE State Income Tax.

Signature: _____ **Date:** _____

Declaration and signature: Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Print