



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.

- To request Massachusetts Paid Family And Medical Leave (MA PFML), the employee requesting MA PFML must complete Part A of the *Request For Massachusetts Paid Family And Medical Leave* (Form MA 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 Massachusetts Paid Family And Medical Leave* (Form MA 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 Massachusetts Paid Family And Medical Leave* (Form MA 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 MA PFML must complete all required information.***Massachusetts Paid Family And Medical Leave (MA PFML) Request (to be completed by the employee)**

Question 10: Family member means the spouse, domestic partner, child, parent or parent of a spouse or domestic partner of the employee; a person who stood in *loco parentis* to the employee when the employee was a minor child; or a grandchild, grandparent or sibling of the employee.

Child means a biological, adopted or foster child, a stepchild or legal ward, a child to whom the employee stands in *loco parentis*.

Grandchild means a child of the employee's child.

Grandparent means a parent of the employee's parent.

Parent means the biological, adoptive, step-father or step-mother of the employee.

Spouse means a husband or wife or domestic partner of an employee.

Question 11: If dates are "Continuous", the employee must provide the start and end dates of the requested MA PFML. These dates should be the actual dates that the MA PFML will begin and end. If uncertain, estimate the start and end dates and indicate "Dates are estimated". If dates are "Periodic", enter the dates MA PFML will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate "Dates are estimated".

If dates are estimated, The Standard may require you to submit a request for payment after the MA PFML day is taken. Payment for approved claims will be due as soon as possible but in no event more than 14 days from the date of the completed request.

Question 12: Date employer was notified. If the employee is submitting the MA PFML request to their employer with less than 30 days' advance notice from the start date of the MA 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 18: List all other income you will be receiving while on MA PFML. Include the type/name of income and how much. Example PTO from employer for \$500.00 a week.

If you are pre-submitting form: Indicate if the employee is pre-submitting their MA PFML request. Pre-submitting is defined as submitting the application in advance of an upcoming qualifying event, with certain required information missing due to the information being unknown at the time of the submitting. If pre-submitting is permitted by The Standard, the missing information must be supplied as soon as it is known. Benefits cannot be determined until all of the required information is provided.

The Standard will provide the employee a notice within five days which 1) states the claim is pending; 2) identifies what information is missing; 3) instructs how to submit the missing information. **Once all information is supplied, The Standard has 14 days to pay or deny the claim.**

If The Standard does not permit pre-submitting, The Standard must return the Request for Massachusetts Paid Family And Medical Leave within five days to the employee with an explanation that the claim should be re-submitted when all information is available.

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 MA 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. You can call the state or check through the employer portal for this information.

“Wage” or “wages” means: For the purpose of payment of benefits, the remuneration paid by one or more employers to an employee for employment during the employee’s qualifying period.

Average Weekly Wage will be based on the weekly Wages in effect with the Employer on the day immediately preceding the date Family or Medical Leave under the Group Policy begins. For former Employees, the Average Weekly Wage will be based on Wages that were in effect on the last day the former Employee was in the employment of the Employer. For Covered Individuals who are paid hourly, the Average Weekly Wage is based on the hourly pay rate multiplied by the number of hours regularly scheduled to work for the Employer per week, but not more than 40 hours. If the Covered Individual does not have regular work hours, the Average Weekly Wage is based on the average number of hours worked per week for the Employer during the preceding 52 calendar weeks (or during the period of employment with the Employer if less than 52 weeks), but not more than 40 hours. If a Covered Individual has multiple Employers, the Average Weekly Wage will be calculated for each employer or Covered Business Entity separately.

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

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

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)
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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 MA PFML (if available)				8. Employee's gender ☐ Male ☐ Female ☐ Not designated/Other		
9. Reason for MA PFML request: ☐ Bond with child ☐ Care for family member ☐ Military qualifying event ☐ Own serious health condition (Other) ☐ Care of a family member who is a service member ☐ Own serious health condition (Pregnancy)						
10. The family member is employee's: ☐ Child ☐ Spouse or registered domestic partner ☐ Sibling ☐ Parents and legal guardians (or spouse's parent) ☐ Grandparent ☐ Grandchild						
11. Will MA PFML be for a continuous period of time and/or periodic? ☐ Continuous ____ / ____ / ____ MA PFML start date (MM/DD/YYYY) MA PFML end date (MM/DD/YYYY) ☐ Dates are estimated						
Identify dates periodic MA PFML will be taken: ☐ Periodic ____ ☐ Dates are estimated						
If providing less than 30 days advanced notice to the employer, please explain: _____						

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)	
15. Employee's work location		Street address			
City		State	Zip code	Country (if not U.S.A.)	
16. Employer's telephone number for contact regarding this request. ()		17. Is employee currently receiving Workers' Compensation Benefits? ☐ Yes ☐ No			
18. List pay you will be receiving while on MA PFML, source of pay and amount.					
19. Have you taken any leave in the last 52 weeks? ☐ Yes ☐ No		20. If yes list dates and type of leave.			

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

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.

I am hereby making a request for paid family and medical leave benefits under the Massachusetts State Paid Family And Medical Leave Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

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

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)
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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 MA PFML	
5. Employer's contact telephone number ()		6. Employer's contact email address	
7. Employee's date of hire (MM/DD/YYYY)		7a. Employee's last day of work (MM/DD/YYYY)	
8. Employee's Average Weekly Wage			
9. Employee's Typical Work Week Hours			
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.			
12a. What type of paid benefits will the employee receive while on MA PFML? Include the last date through which any compensation will be paid.			
12b. If, while on fully-insured MA 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			
13. Is the employee taking federal Family Medical Leave Act (FMLA)? ☐ Yes ☐ No		14. MA PFML policy number	
MA 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 for Massachusetts Paid Family And Medical Leave. I am the person authorized to sign as the employer of the employee requesting MA 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			

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.

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 ☐ <i>in loco parentis</i> 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? <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> ☐ Continuous _____ / _____ / _____ <small style="display: block; text-align: center;">start date (MM/DD/YYYY) end date (MM/DD/YYYY)</small> </div> <div style="width: 35%;"> ☐ Dates are estimated </div> </div> ☐ 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 <small style="display: block; text-align: center;">(example: 2 days per week, or 4 hours per day, or every Monday)</small>		
6. Select one of the following and attach the document as required as evidence of the relationship. Parent of newborn child: <div style="margin-left: 20px;"> 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 </div> <div style="margin-left: 20px;"> 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: <div style="margin-left: 20px;"> ☐ Marriage certificate; OR ☐ Certificate of civil union; OR ☐ Evidence of domestic partnership </div> ☐ OR; Other documentation of parental relationship </div> <div style="margin-left: 20px;"> 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 </div> <div style="margin-left: 20px;"> Adoptive parent ☐ Court document finalizing adoption ☐ Documentation in furtherance of adoption </div>		

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)

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.

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | standard.com

* 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.



TheStandard®

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

The tax obligations for receipt of Massachusetts Paid Family and Medical Leave benefits has not yet been established by the state. However, we want to offer you the option to address any tax obligation by providing the ability to voluntarily request tax obligations withdrawn from your MA PFML benefit. You can have both Federal and Massachusetts State tax withheld from your Paid Family and Medical Leave Benefits. Taxes will be withheld after deductions (for example, child support) are taken.

- Withholding Federal and/or Massachusetts State Tax is voluntary. 10% of your benefits would be withheld for Federal taxes and 5% would be withheld for Massachusetts State taxes.
 - If you do not have Federal and/or Massachusetts State income tax withheld, you may need to make estimated quarterly tax payments.
- The Federal and Massachusetts State Tax withheld during the year will be reported on a W-2 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 5% Massachusetts 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.

☐ **Start** withholding 5% MAS Income Tax.

☐ **Stop** withholding 10% Federal Income Tax.

☐ **Stop** withholding 5% MAS Income Tax.

Signature: _____ **Date:** _____

Declaration and signature: 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.