



**To Use Paid Family And Medical Leave To:
Care for a family member with a serious health condition**

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-3

- ☐ Care recipient completes PFML-3 and provides to Health Care Provider
- ☐ Care recipient's Health Care Provider keeps PFML-3

Complete Form PFML-4

- ☐ Complete "Employee" information at the top of PFML-4
- ☐ Provide PFML-4 to care recipient's Health Care Provider
- ☐ Care recipient's Health Care Provider completes PFML-4 and returns to you

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 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.

**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.

Standard Insurance Company

866.756.8116 Tel 866.751.5174 Fax
PO Box 3877 Portland OR 97208

**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)
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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 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			

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

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 PFML-4)

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

The PFML insurance carrier name requested at the top of the form is the same as the PFML insurance carrier identified in *Request For Paid Family And Medical Leave* (Form 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

866.756.8116 Tel 866.751.5174 Fax
PO Box 3877 Portland OR 97208

**Paid Family And Medical Leave
Release Of Personal Health Information
For Family Member
(Form 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	

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 PFML-4)

<p>I, _____, authorize my Health Care Provider listed on this form to <div style="text-align: center;">Family member's legal name</div> release my personal health information to _____ and Standard Insurance Company. <div style="text-align: center;">Employee's legal name</div> </p> <p>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 Paid Family And Medical Leave benefits.</p> <p>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.</p> <p>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:</p> <p> ☐ HIV/AIDS related information ☐ Mental health information ☐ Alcohol/drug treatment ☐ Psychotherapy notes </p>							
<p>Health Care Provider Information (to be completed by the family member or authorized representative)</p> <p>Identify the Health Care Provider who is currently providing you with treatment for a condition that is subject to the employee's request for PFML benefits.</p> <p>1. Health Care Provider's name</p> <p>2. Health Care Provider's mailing address</p> <table border="1" style="width: 100%;"> <tr> <td>City</td> <td>State</td> <td>Zip Code</td> <td>Country (if not U.S.A.)</td> </tr> </table> <p>3. Health Care Provider's telephone number (provide area or country code) ()</p>				City	State	Zip Code	Country (if not U.S.A.)
City	State	Zip Code	Country (if not U.S.A.)				

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PO Box 3877 Portland OR 97208

**Paid Family And Medical Leave
Release Of Personal Health Information
For Family Member
(Form 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 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 PFML-4) to the employee identified on Form 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 PFML benefits as a result of my current condition.

Family member's signature	Date signed (MM/DD/YYYY)
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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)
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The employee should retain a copy for their own records.

To Be Completed by Employee

INSTRUCTION to the EMPLOYEE: The employee requesting Paid Family And Medical Leave (PFML) to care for family member with a serious health condition must submit the *Certification For Care Of Family Member (Form PFML-4)* with *Request For Paid Family and Medical Leave (Form 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 PFML-3)*. When you receive the completed *Certification For Care Of Family Member (Form PFML-4)* from the Health Care 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 Paid Family and Medical Leave (PFML). Answer each question to the best of your medical knowledge, based on your examination of the patient.

GINA Disclaimer: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information is defined to include an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

PART A: MEDICAL FACTS

1. Diagnosis _____ Primary ICD Code (optional) _____
 (Do not include the Diagnosis or Primary ICD Code for patients who are working in the following states: CT, DE, MA, MN, WA. This request is made to ensure compliance with applicable laws and guidelines.)
 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: _____

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

☐ 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.	State	State Identification Number

Declaration and signature

My signature attests that the information provided in this form is true and correct, that I have examined the patient and answered the questions accurately and to the best of my ability, and that I am a health care provider authorized to certify their condition.

Signature of Health Care Provider	Date
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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.

SI 21265-DE (6/26)



TheStandard®

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

**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.

☐ **Start** withholding 3% DE State Income Tax.

☐ **Stop** withholding 10% Federal 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