Application for Paid Family Leave (PFL) Benefits for Bonding After Pregnancy Disability

A Component of The Claremont Colleges Voluntary Disability Plan

Plan & Benefit Information

This application packet is for filing a claim for Paid Family Leave (PFL) benefits through the Voluntary Disability Insurance (VDI) Plan of The Claremont Colleges for employees to bond with their new baby after they deliver and following a pregnancy disability leave. The PFL plan is intended as a wage loss replacement benefit for eligible employees (see below) and is not a leave entitlement. These forms must be fully completed as indicated below and returned to Human Resources or TCCS Disability Administration ***as soon as possible*** to determine your eligibility to receive paid family leave pay benefits.

Eligibility: All employees are covered by the plan on the effective date of hire unless coverage is rejected in writing. If you do not participate in the voluntary disability programs (VDI and PFL), you must participate in the state disability program. Employees who are covered by The Claremont Colleges voluntary disability plan will be covered for PFL.

Qualifying Reason: For an employee to bond with the new baby for up to 12 months after they deliver and following a pregnancy disability leave.

Maximum Benefit: Up to eight (8) weeks or the maximum benefit amount allowed for the claim, whichever comes first, and may be paid over a 12-month period. PFL benefits are paid on a 7-day calendar week per the California Employment Development Department (EDD). Note: PFL payments are subject to federal tax but not state tax.

Waiting Period Waived: Effective January 1, 2025, the 7-day waiting period no longer applies to ALL VDI and PFL claims.

Base Period: The amount of the *basic weekly benefit* depends on the total wages paid to you during a 12-month base period. As shown below, the month in which your claim begins determines which 12-month period is used.

If your claim begins in:	**The base period is the preceding:**
January, February, or March	October 1 – September 30
April, May, or June	January 1 – December 31
July, August, or September	April 1 – March 31
October, November, or December	July 1 – June 30

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Forms and Instructions

Notify Your Supervisor and Human Resources

As soon as possible, contact your supervisor and your Human Resources office to request a leave of absence to bond with your new child after delivery and following a pregnancy disability leave. Submit this request before you start your bonding leave, or within 24 hours for emergency leaves.

Paid Family Leave Benefit Application Forms

Employee Claim Form
Complete this form to provide information about your need for leave time to bond with your newborn child after you deliver and following a pregnancy disability leave, for up to 12 months from the date of birth.

Supplementation (Staff) and Coverage of Benefits Premiums
Complete this form to let us know if you want to supplement your PFL pay with your available vacation hours (for staff). On this form, you also state if you authorize your benefits deductions for your insurance plans to be taken from your PFL pay or if you will make payments directly to TCCS Benefits Administration.

Certification of Birth (Document Copy Required)
Provide a copy of the hospital keepsake birth certificate as proof of the birth of your child(ren; for multiple births) and include it with your PFL application packet.

Important: All forms must be fully completed and received by Human Resources or the TCCS Disability Office before eligibility can be determined. Incomplete or late forms will delay your benefits. Once we determine your eligibility, we will send you a letter with your weekly benefit amount and will process payments in accordance with KGI's payroll schedule.

Questions or Need Assistance? Contact Human Resources at HR@kgi.edu or (909) 607-7853 or TCCS Disability Administration at disability@claremont.edu or (909) 621-8847. If you have any questions regarding your institution's leave of absence policies, please contact Human Resources at HR@kgi.edu or (909) 607-7853.

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PAID FAMILY LEAVE

Employee Claim Form

Important: To avoid delaying PFL pay benefits, complete all the items on this form that apply to the claim.

1. First Name: _____ 2. Middle Initial(s): _____ 3. Last Name: _____
4. Home Address: _____
5. Phone: _____ 6. Email: _____
7. Workday ID #: _____ 8. Last 4 of Social Security Number: __ __ __ __ 9. Date of Birth: _____
10. TCC Institution:_____ 11. Department: _____
12. Position Title: _____
13. What date did you last work? _____ 14. What date do you want your **PFL claim to begin?** _____
15. Have you been released to return to work from your pregnancy disability? ☐ Yes ☐ No (go to #17)
16. What date were you released to return to work? _____
17. You can claim up to eight (8) weeks of PFL benefits within a 365-day period from the date of birth of your child(ren). Do you want to claim the full eight (8) weeks now? ☐ No ☐ Yes (*subject to approval of your leave by your supervisor/HR*)
18. What date did you or will you **return to work**? _____
19. Will you work intermittently during your PFL leave period? ☐ Yes ☐ No (go to #20)
20. If you are reducing your work hours, how many hours per day will you work? _____
21. What is(are) the legal name(s) of your new child(ren) with whom you are bonding?
    First Name:_____ Last Name: _____
    First Name:_____ Last Name: _____
22. What is the **date of birth** of your new child(ren)? _____ (PFL benefits are available up to 12 months from this date)
    ☐ *A copy of the hospital keepsake birth certificate is attached*. **(PFL benefits will not start without this document)**
23. At any time during your PFL leave, were you in the custody of law enforcement authorities because you were convicted of violating a law or ordinance? ☐ Yes ☐ No

Certification and Authorization

By my signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that I delivered the child(ren) named above and will/was bonding with the child(ren) named above for the period of this claim; (2) authorize the TCCS Disability Administration office to release my personal information as needed to administer this claim; and (3) authorize my employer(s) to disclose to TCCS Disability Administration all facts concerning my employment within their knowledge.

I understand that willfully making a false statement or concealing a material fact to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen (15) years from the date of my signature or the effective date of the claim, whichever is later.

Employee Signature: _____ **Date**: _____

If your signature is made by mark (X), it must be attested by one witness and provide their address:

Witness Signature: _____ Address: _____

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PAID FAMILY LEAVE

Supplementation (Staff) and Coverage of Benefits Premiums

First Name:_____ Last Name: _____

Date Claim Begins:_____ TCC Institution: _____

Staff: Authorization of Supplementation (not applicable to Faculty)

The Paid Family Leave (PFL) benefit payments are approximately 70% or 90% of your base wages. You may authorize the use of vacation hours to supplement your leave benefit up to 90% of your regular salary. If you exhaust your vacation accruals before the end of your leave, you will only receive the PFL benefit.

☐ **I authorize the use of my accrued time off ("accruals") as follows:**

(Indicate if you wish to allow the use of "all" or a specific number of hours.)

Vacation hours: _____

I understand that while I receive sufficient pay from my accruals, payroll deductions for my insurance benefits (i.e., medical, dental, vision, retirement, etc.) will continue. If my accruals exhaust or are not sufficient to cover my deductions, I must either allow the use of my PFL pay to cover benefit premiums (see below) OR I must make premium payments directly to TCCS Benefits Administration.

OR

☐ **I choose NOT to supplement my PFL pay with my available vacation hours ("accruals").**

I understand that by not authorizing the use of my accruals, I will only receive PFL pay, if I am eligible. To continue my coverage for my elected insurance benefits (e.g., medical, dental, vision, retirement, etc.) I must allow deductions for my benefit premiums from my PFL pay (see below) OR I must make cash payments directly to TCCS Benefits Administration.

Authorization of Coverage of Benefit Premiums

California regulations allow you to use a portion of your Paid Family Leave (PFL) payments to cover all or part of the employee portion of the premiums for the benefit insurance plans in which you are currently enrolled (e.g., medical, dental, vision, retirement, etc.). To allow the use of your PFL payments to cover your benefit premiums, you must provide a written authorization.

☐ **YES, I authorize deducting my benefit premiums from my PFL payments.**

I understand these premium deductions will continue until I terminate them, reach my maximum PFL benefit amount or leave of absence time, or until I return to work. I understand I can terminate or change these deductions at any time while receiving PFL payments (see Stopping Benefit Deductions below). I understand that benefits deductions from PFL payments can only be taken after taxes.

☐ **NO, I do NOT authorize deducting my benefit premiums from my PFL payments and understand I must make timely payments by personal check, cashier's check, or money order for my premiums to TCCS Benefits Administration.** Please contact Benefits Administration for detailed instructions: BenReps@claremont.edu or (909) 621-8151.

Stopping Benefits: If you wish to stop coverage on an after-tax benefit plan (e.g., life insurance) or would like to inquire if special approval is available to stop coverage on a current pre-tax benefit plan while on a leave of absence, submit your request in writing to TCCS Benefits Administration at BenReps@claremont.edu, or by mail, fax, or in person.

Employee Signature: _____ Date: _____

If your signature is made by mark (X), it must be attested by one witness and provide their address:

Witness Signature: _____ Address: _____

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PAID FAMILY LEAVE

Bonding Certification

Important: Read this form carefully. To avoid delaying the PFL benefits, complete all the items on this form.

Employee (Claimant) Information

First Name: _____ Last Name: _____

Date Claim Begins: _____ TCC Institution (Employer): _____

Child's Information

Full Legal Name: _____

Date of Birth: _____ Date of Adoption/Foster Care Placement: _____

Home Address: _____

This child is my (state relationship): _____

As **proof of this relationship** to the child named above, **I am attaching a copy of the following document**:

- ☐ Child's Birth Certificate
- ☐ Child's Hospital Discharge Record
- ☐ Declaration of Paternity (CS-909)
- ☐ Foster Care Placement Records (SOC 815)
- ☐ Certificate of Placement (AD-907)
- ☐ Child's Passport (showing immigration & naturalization)
- ☐ Independent Adoption Placement Agreement (AD-924)
- ☐ Other (describe): _____

Authorization and Declaration

By my signature on this bonding certification, I authorize the medical provider, adoption agency, adoption party (ies), or foster care placement agency to disclose to the TCCS Disability Administration office all facts concerning the birth, adoption, or foster care placement of the above-named child.

I understand that willfully making a false statement or concealing a material fact to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements or documents, is to the best of knowledge and belief true, correct, and complete.

I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen (15) years from the date of my signature or the effective date of the claim, whichever is later.

Employee Signature: _____ **Date**: _____

If your signature is made by mark (X), it must be attested by one witness and provide their address:

Witness Signature: _____ Address: _____