Application for Paid Family Leave (PFL) Benefits to Care for an Eligible Family Member

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 to care for an eligible family member. 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 Reasons: (1) To care for a child, spouse, parent, registered domestic partner, grandparent, grandchild, sibling, or parent-in-law, or designated person with a serious health condition; or (2) To take time off work due to a qualifying military event arising out of the overseas military deployment of the employee's family member.

> Serious Health Condition Definition: An illness, injury, impairment, or physical or mental condition that involves inpatient care in a hospital, hospice, or residential medical care facility, or at home. This includes any period of incapacity (e.g., inability to work, attend school, or perform other regular daily activities) or any subsequent treatment in connection with such inpatient care, or continuing treatment by a physician or practitioner.
>
> Qualifying Military Event: Any military even or an essential need resulting from the family member's deployment. The military event does not need to occur in California. Examples include but are not limited to: arranging child or parental care, making legal/financial arrangements, attending counseling, assisting the military family member during recover, attending a military-sponsored event/ceremony, or addressing issues due to the military family member's death.

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 April, May, or June	October 1 – September 30
July, August, or September October, November, or December	January 1 – December 31 April 1 – March 31 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 care for your family member and provide a written document from your care recipient's treating doctor indicating their need for care (see "Care Recipient-Medical Certification" below). Provide notification before you start your 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 the PFL pay benefit during your leave time to care for an eligible family member.

Employee – Supplementation (Staff) and Coverage of Benefits Premiums
Complete this form to let us know if you want to supplement your VDI pay with your available sick and vacation hours, provided you first exhaust all sick hours before using 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.

Care Recipient - Authorization to Furnish Medical Information
Have your care recipient complete this form to give us permission to receive their medical information from their healthcare provider on the *Medical Certification*.

Care Recipient – Medical Certification
Give this form to your care recipient's treating healthcare provider (doctor) for completion to certify their need for care.

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. Did you or will you work intermittently during your PFL leave period? ☐ Yes ☐ No (go to #19)

16. What date did you return, or will you return to work? _____

17. If you are reducing your work hours, how many hours per day will you work? _____

18. What is the legal full name of the person you are caring for? _____

19. What is the relationship to you of the person in #19?

☐ Child ☐ Spouse ☐ Partner ☐ Parent/Parent-in-Law ☐ Grandparent ☐ Grandchild ☐ Sibling

20. 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

Acknowledgement and Declaration of Caregiving

By my signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was providing care for or bonding with the care recipient named above; (2) authorize the TCCS Disability Administration office to release my personal information as shown on this claim to the care recipient and to the care recipient's treating physician as they are respectively listed in this claim; and (3) authorize my employer(s) to disclose to the TCCS Disability Administration office all facts concerning my employment that are 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

Employee - 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. Your accrued sick leave (hours) can be used to supplement your PFL pay up to 90% of your base salary. If your sick hours exhaust, you can allow the use of your available vacation hours to supplement your PFL pay during your leave.

☐ **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.)

Sick 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 sick time, and therefore, neither vacation ("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

Care Recipient - Authorization to Furnish Medical Information

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

Employee (Claimant) Completes This Section

First Name: _____ Last Name: _____

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

Care Recipient Completes This Section

This section must be ***completed and signed*** by the care recipient. It may be completed and signed by an authorized representative IF the care recipient is mentally or physically unable to do so.

First Name: _____ Last Name: _____

Date of Birth: _____ Telephone Number: _____

Home Address: _____

Health Insurance Portability and Accountability Act (HIPAA) Authorization

I, the care recipient, authorize any physician, practitioner, hospital, vocational rehabilitation counselor, or carrier to furnish and disclose to my caregiver named above and to ***The Claremont Colleges Services Disability Administration Office*** all facts concerning my disability that are within their knowledge and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability that are under their control. I understand that ***The Claremont Colleges Services Disability Administration Office*** may disclose information as authorized by the California Unemployment Insurance Code and that such re-disclosed information may no longer be protected by this rule. I agree that photocopies of this authorization shall be as valid as the original. I understand that, unless revoked by me in writing, this authorization is valid for five (5) years from the date received by ***The Claremont Colleges Services Disability Administration Office*** or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent recovery of monies to which it is legally entitled.

Care Recipient Signature: _____ **Date**: _____

A Personal Representative signing on behalf of the Care Recipient must complete the following:

I represent the care recipient in this matter as authorized by:

☐ Parental Right ☐ Power of Attorney (attach copy) ☐ Court Order (attach copy)

Personal Representative Signature: _____ Date: _____

Address: _____

TCCS Disability Administration | 101 S Mills Avenue, Claremont, CA,91711
Email disability@claremont.edu | Phone (909) 621-8847 | Fax (909) 607-9688

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Human Resources

Certification for Serious Injury or Illness of a Current Servicemember for Military Family Leave Under the Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) provides that eligible employees may take FMLA leave to care for a covered servicemember with a serious illness or injury. The FMLA allows an employer to require an employee seeking FMLA leave for this purpose to submit a medical certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, it asks the health care provider for the information necessary for a complete and sufficient medical certification. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Recertifications are not allowed for FMLA leave to care for a covered servicemember. Where medical certification is requested by an employer, an employee may not be held liable for administrative delays in the issuance of military documents, despite the employee's diligent, good-faith efforts to obtain such documents.** An employer requiring an employee to submit a certification for leave to care for a covered servicemember **must** accept as sufficient certification invitational travel orders (ITOs) or invitational travel authorizations (ITAs) issued to any family member to join an injured or ill servicemember at the servicemember's bedside. An ITO or ITA is sufficient certification for the duration of time specified in the ITO or ITA.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employee Name _____

Employer Name _____ Date _____
(List date certification requested)

This certification must be returned by: _____
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE AND/OR SERVICEMEMBER

Please complete all Parts in Section II before having the servicemember's health care provider complete Section III. The FMLA allows an employer to require that an employee submit a timely, complete and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave.

PART A: EMPLOYEE INFORMATION

Name of the current servicemember for whom employee is requesting leave: _____

Select your relationship to the current servicemember. You are the current servicemember's:

☐ Spouse ☐ Parent ☐ Child ☐ Next of Kin

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for a covered servicemember who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a covered servicemember for whom the employee has assumed the obligations of a parent. No biological or legal relationship is necessary. "Next of kin" is the servicemember's nearest blood relative, other than the spouse, parent, son or daughter, in the following order of priority: (1) a blood relative as designated in writing by the servicemember for purposes of FMLA leave, (2) blood relatives granted legal custody of the servicemember, (3) brothers and sisters, (4)grandparents, (5) aunts and uncles and (6) first cousins.

Certification for Serious Injury or Illness of a Current Servicemember for Military Family Leave Under the Family and Medical Leave Act

PART B: SERVICEMEMBER INFORMATION AND CARE TO BE PROVIDED TO THE SERVICEMEMBER

The servicemember (☐ is / ☐ is not) a current member of the Regular Armed Forces, the National Guard or Reserves. If yes, provide the servicemember's military branch, rank and unit currently assigned to:

_____

The servicemember (☐ is / ☐ is not) assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients, such as a medical hold or warrior transition unit. If yes, provide the name of the medical treatment facility or unit: _____

The servicemember (☐ is / ☐ is not) on the Temporary Disability Retired List (TDRL).

Care to be provided to the servicemember: Please complete Attachment A and provide it to the health care provider, **not your employer.**

Give your **best estimate** of the amount of leave needed to provide the care described:

_____

If a reduced work schedule is necessary to provide the care described, give your **best estimate** of the reduced work schedule you are able to work. From _____ to _____ I am able to work:

_____ _____

(Hours per day) *(Days per week)*

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all Parts of this Section fully and completely, and sign the form below. The employee listed at Section I has requested leave under the FMLA to care for a family member who is a current member of the Regular Armed Forces, the National Guard or the Reserves who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. Note: For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of the servicemember's office, grade, rank or rating. "Need for care" includes both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the servicemember is not able to care for his or her own basic medical, hygienic, or nutritional needs or safety, or needs transportation to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the servicemember who is receiving inpatient or home care. A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above.

PART A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name: _____

Health Care Provider's Business Address: _____

Type of Practice/Medical Speciality: _____

Telephone _____ Fax _____ Email _____

Please select the type of FMLA health care provider you are:

☐ DOD health care provider
☐ VA health care provider
☐ DOD TRICARE network authorized private health care provider
☐ DOD non-network TRICARE authorized private health care provider
☐ Health care provider as defined in 29 CFR 825.125

Certification for Serious Injury or Illness of a Current Servicemember for Military Family Leave Under the Family and Medical Leave Act

PART B: MEDICAL INFORMATION

Please provide appropriate medical information of the patient as requested below. Limit your responses to the servicemember's condition for which the employee is seeking leave. If you are unable to make certain military-related determinations contained below, you are permitted to rely upon determinations from an authorized DOD representative, such as a DOD Recovery Care Coordinator, or an authorized VA representative. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Do not provide the underlying diagnosis, including any genetic information, without written consent from the patient.

Patient's Name: _____

List the approximate date condition started or will start: _____

Provide your **best estimate** of how long the condition will last: _____

The servicemember's injury or illness: *(Select as appropriate)*

☐ Was incurred in the line of duty on active duty

☐ Existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty

☐ None of the above

The servicemember (☐ is / ☐ is not) undergoing medical treatment, recuperation or therapy for this condition.

The servicemember's medical condition is classified as: *(Select as appropriate)*

☐ **(VSI) Very Seriously Ill/Injured:** Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. *Please note this is an internal DOD casualty assistance designation used by DOD health care providers.*

☐ **(SI) Seriously Ill/Injured:** Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. *Please note this is an internal DOD casualty assistance designation used by DOD health care providers.*

☐ **OTHER Ill/Injured:** A serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank or rating.

☐ **NONE OF THE ABOVE.** *Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under 29 C.F.R. § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.*

PART C: AMOUNT OF LEAVE NEEDED

For the medical condition checked in Part B, complete all that apply. Some questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage.

Due to the condition, the servicemember will need care for a **continuous period of time**, including any time for treatment andrecovery. Provide your **best estimate** of the beginning date _____ and end date _____ for this period of time.

Due to the condition, it is medically necessary for the servicemember to attend **planned medical treatment** appointments (scheduled medical visits). Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery _____ *(e.g. 3 days/week)*

Due to the condition, it is medically necessary for the servicemember to receive care on an **intermittent basis** (periodically), such as the care needed because of episodic flare-ups of the condition or assisting with the servicemember's recovery. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, intermittent care is estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Signature of Health Care Provider _____

Date _____

Certification for Serious Injury or Illness of a Current Servicemember for Military Family Leave Under the Family and Medical Leave Act

RETURN THIS FORM TO THE PATIENT. DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.
Employers should retain a copy of this certification in their records for three years (29 U.S.C 2616; 29 CFR 825.500).

This form adapted for California use from U.S. Department of Labor WH-385 Revised June 2020 (OMB Control Number 1235-0003 Expires: 6/30/2026)

PLEASE DO NOT DISCLOSE THE UNDERLYING DIAGNOSIS, INCLUDING ANY GENETIC INFORMATION*, WITHOUT THE CONSENT OF THE PATIENT.

* 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 an individual or family member of the individual, except as specifically allowed by this law. To comply, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes 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.

Certification for Serious Injury or Illness of a Current Servicemember for Military Family Leave Under the Family and Medical Leave Act

Attachment A

Employee's Statement Regarding Seriously Injured or Ill Current Servicemember

To be completed and signed by the employee needing family leave to care for a seriously injured or ill current servicemember. **Employee should provide this section to the health care provider under separate cover. This information is not to be provided to the employer.**

Describe the care to be provided to the current servicemember and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule: