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

Certification of Health Care Provider - Employee's or Family Member's Serious Health Condition

***IMPORTANT NOTE:** The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) and the federal Genetic Information Nondiscrimination Act of 2008 (GINA) prohibit employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by 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 CalGINA and GINA, includes information about the individual's or the individual's family member's medical history, genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic information" does not include information about an individual's sex or age.

SECTION I - EMPLOYER

Company Name _____

Company Contact _____

Attach a copy of the employee's job description and the essential job functions of the employee's position to this form.

Instructions for the employee: The law permits us to require that you submit a timely, complete and sufficient medical certification to support your request for FMLA/CFRA leave to care for yourself or a covered family member with a serious health condition. If requested by your employer, your response is required to obtain the benefit of Family and Medical Leave Act (FMLA)/California Family Rights Act (CFRA) protections. Failure to provide a complete and sufficient medical certification may result in a denial of your request. You have **15 calendar days** to return this form to the company. If extenuating circumstances prevent you from returning this certification in a timely manner, please contact _____ .

_____ _____

Employee Name | Employee Contact Number

If the request is to care for a family member:

_____

Name of the family member/patient for whom you will provide care

Relationship of family member to you:

- ☐ Child (if the child is under the age of 18, or over the age of 18, if the child is incapable of self-care due to a physical or mental disability), parent or spouse. **(CFRA only, FMLA only or CFRA/FMLA depending on eligibility and leave availability)**
- ☐ Child (if the child is an adult capable of self-care), parent-in-law, grandparent, grandchild, sibling, domestic partner or someone else with a blood or family-like relationship with the employee ("designated person"). **(CFRA only)**

If the request is to care for a family member, please complete Attachment B and **provide to the health care provider**, not your employer.

I certify that the information I have provided is true and correct.

_____ _____

Employee Signature | Date

Certification of Health Care Provider - Employee's or Family Member's Serious Health Condition

SECTION II - HEALTH CARE PROVIDER

I**nstructions for the Health Care Provider:** The employee listed above has requested leave under the FMLA/CFRA to care for himself/herself or for your patient who is a family member or "designated person" listed above. Please answer fully and completely all applicable parts below. Several 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/CFRA coverage. Limit your responses solely to the condition for which the patient needs leave. Please be sure to sign the form. **PLEASE DO NOT DISCLOSE THE UNDERLYING DIAGNOSIS, INCLUDING ANY GENETIC INFORMATION*, WITHOUT THE CONSENT OF THE PATIENT.** Do not provide information about genetic tests, as defined in 29 CFR 1653.3 (f), genetic services, as defined in 29 CFR 1635.3 (e), or genetic information, as defined by CalGINA or GINA. Please be sure to sign the form.

1. Date medical condition or need for treatment commenced: _____

2. Probable duration of medical condition or need for treatment: _____

3. *Attachment A: Definitions* describes what is meant by a "serious health condition" under both the federal FMLA and California CFRA. Does the patient's condition qualify as a serious health condition?

   ☐ Yes ☐ No

4. If the certification is for the serious health condition of the employee, please answer the following:

   a. Is the employee able to perform work of any kind?

      ☐ Yes ☐ No (If "no" skip next question)

   b. Is the employee unable to perform any one or more of the essential functions of the employee's position? (Please answer after reviewing the attached job description provided by the employee that includes the essential functions of the employee's position.)

      ☐ Yes ☐ No

      If yes, to 4b, please identify the job functions the employee is unable to perform.

      _____

      _____

5. If the certification is for the care of the employee's family member or "designated person," please answer the following:

   a. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation needs or the provision of physical or psychological care?

      ☐ Yes ☐ No

   b. After review of the signed *Employee's Statement Regarding Seriously Ill Family Member* (Attachment B), does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member.)

      ☐ Yes ☐ No

6. Estimate the period of time the employee will need care or during which the employee's presence would be beneficial to participate in care for the employee's family member:

   _____

***** See the "Important Note" on page 1 of this form. CalGINA and GINA prohibit employers from obtaining genetic information. **To comply, we are asking that you not provide any genetic information when responding to this request for medical information.**

Certification of Health Care Provider - Employee's or Family Member's Serious Health Condition

7. Please answer the following questions only if the employee is asking for intermittent leave or a reduced work schedule:

Yes No

☐ ☐ Intermittent Leave: Is it medically necessary for the employee to be off work on an intermittent basis due to the serious health condition of the employee, family member or "designated person"?

If yes, please indicate the estimated frequency of the employee's need for intermittent leave due to the serious health condition and the duration of such leaves (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

☐ ☐ Reduced Schedule Leave: Is it medically necessary for the employee to work less than the employee's normal work schedule due to the serious health condition of the employee, family member or "designated person"?

If yes, please indicate the part-time or reduced work schedule the employee needs:

_____ hour(s) per day; _____ day(s) per week, from _____ through _____

☐ ☐ Time Off for Medical Appointments or Treatment: Is it medically necessary for the employee to take time off work for doctor's visits or medical treatment, either by the health care practitioner or another provider of health services?

If yes, please indicate the estimated frequency of the employee's need for leave for doctor's visits or medical treatment and the time required for each appointment, including any recovery period:

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per appointment/treatment

_____ _____
Signature of Health Care Provider Date

_____ _____
Signature of Employee Date

Physician or Practitioner Information:

_____
Physician's or Practitioner's Name

_____
Business Address

_____ ____ _____-_____
City State Zip

(____) ____-_____
Telephone

RETURN THIS FORM TO THE PATIENT. DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.

Form adapted for California use from CFRA Regulations (2 CCR sec. 11097) and CRD-E11P-ENG (1/23) and U.S. Department of Labor WH-380-E and WH-380-F Revised June 2020 (OMB Control Number 1235-0003 Expires: 06/30/2026)

Certification of Health Care Provider - Employee's or Family Member's Serious Health Condition

Attachment A: Definitions

A "serious health condition" means an illness, injury (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, domestic partner, or someone else with a blood or family-like relationship with the employee ("designated person") of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse. A serious health condition may involve one or more of the following:

HOSPITAL CARE

Inpatient care in a hospital, hospice or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care. A person is considered an "inpatient" when a health care facility formally admits the person to the facility with the expectation that the person will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or transferred to another facility and does not actually remain overnight.

ABSENCE PLUS TREATMENT

A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

1. Treatment two or more times by a health care provider (for FMLA only, the two treatments must occur within 30 days ***), by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
2. Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

For FMLA only, the employee's first treatment must occur within 7 days of first day of incapacity. ***

PREGNANCY

Any period of incapacity due to pregnancy or for prenatal care.
(Note: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA.)

CHRONIC CONDITIONS REQUIRING TREATMENT

A chronic condition, which:

1. Requires periodic visits (for FMLA ONLY, periodic means at least two times per year ***) for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
2. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
3. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

PERMANENT/LONG-TERM CONDITIONS REQUIRING SUPERVISION

A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke or the terminal stages of a disease.

MULTIPLE TREATMENTS (NON-CHRONIC CONDITIONS)

Any period of absence to receive multiple treatments (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

*** California law does not include these time limitations. If a leave is FMLA/CFRA, follow the California law without these time limitations.

Certification of Health Care Provider - Employee's or Family Member's Serious Health Condition

Attachment B: Employee's Statement Regarding Seriously Ill Family Member

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

If you are seeking leave to care for a seriously-ill family member, please provide a description of the care you will provide for your family member (include an estimate of the time period during which this care will be provided and a schedule if leave is to be taken intermittently or on a reduced work schedule):

I certify that the information I have provided is true and correct.

Signature of Employee

Date