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 of Qualifying Exigency for Military Family Leave

The Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) provides that eligible employees may take leave for a qualifying exigency while the employee's spouse, child, parent, or under the CFRA only, registered domestic partner (the military member) is on covered active duty or has been notified of an impending call or order to covered active duty. The FMLA allows an employer to require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days** to provide the certification. 29 C.F.R. § 825.305(b). If the employee fails to provide complete and sufficient certification, the employee's FMLA leave request may be denied. 29 C.F.R. § 825.313. CFRA regulations incorporate FMLA-qualifying exigency certification regulations to the extent they're not inconsistent with state law. 2 CCR § 11096.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, it asks the employee for the information necessary for a complete and sufficient qualifying exigency certification, which is set out at 29 C.F.R. § 825.309. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.309.**

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

Please complete all Parts of Section II and sign the form before returning it to your employer. The FMLA allows an employer to require that you submit a timely, complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency. If requested by your employer, your response is required to obtain the benefits and protections of the FMLA and/or CFRA. 29 C.F.R. § 825.309. Failure to provide a complete and sufficient certification may result in a denial of your FMLA leave request. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member's covered active duty or call to covered active duty status. **You are responsible for making sure the certification is provided to your employer within the time frame requested, which must be at least 15 calendar days. 29 C.F.R. § 825.313.**

Provide the name of the military member on covered active duty or call to covered active duty status:

_____

Select your relationship of your military member. The military member is your:

☐ Spouse (FMLA and/or CFRA) ☐ Registered Domestic Partner (CFRA only)
☐ Parent (FMLA and/or CFRA) ☐ Child, of any age (FMLA and/or CFRA)

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. For purposes of the CFRA, a registered domestic partnership is defined as two adults that have filed a Declaration of Domestic Partnership with the California Secretary of State. 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 for a qualifying exigency related a military member who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave for a qualifying exigency related a military member for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

PART A: COVERED ACTIVE DUTY STATUS

Covered active duty or call to covered active duty in the case of a member of the Regular Armed Forces means duty during the deployment of the member with the Armed Forces to a foreign country. Covered active duty or call to covered active duty in the case of a member of the Reserve components means duty during the deployment of the member with the Armed Forces to a foreign country under a Federal call or order to active duty in support of a contingency operation pursuant to: Section 688 of Title 10 of the United States Code; Section 12301(a) of Title 10 of the United States Code; Section 12302 of Title 10 of the United States Code; Section 12304 of Title 10 of the United States Code; Section 12305 of Title 10 of the United States Code; Section 12406 of Title 10 of the United States Code; chapter 15 of Title 10 of the United States Code; or, any other provision of law during a war or during a national emergency declared by the President or Congress so long as it is in support of a contingency operation. 10 U.S.C. § 101(a)(13)(B); Cal. Gov. Code § 12945.2(b)(4)(d); Cal. Unemp. Ins. Code §§ 3302.1, 3302.2.

Certification of Qualifying Exigency for Military Family Leave

An employer may require the employee to provide a copy of the military member's active duty orders or other documentation issued by the military which indicates that the military member is on covered active duty or call to covered active duty status, and the dates of the military member's covered active duty service. **This information need only be provided to the employer once, unless additional leave is needed for a different military member or different deployment.**

Provide the dates of the military member's covered active duty service:

Please check one of the following and attach the indicated written document to support that the military member is on covered active duty or call to covered active duty status:

- ☐ A copy of the military member's covered active duty orders
- ☐ Other documentation from the military indicating that the military member is on covered active duty or has been notified of an impending call to covered active duty, such as official military correspondence from the military member's chain of command
- ☐ I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty status

PART B: QUALIFYING REASON FOR LEAVE

Under the FMLA and CFRA, leave can be taken for a number of qualifying exigencies. 29 C.F.R. § 825.126(b). Cal. Unemp. Ins. Code § 3302.2. Complete and sufficient certification to support a request for leave due to a qualifying exigency includes available written documentation which supports the need for leave such as a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming the military member's Rest and Recuperation leave, or other documentation issued by the military which indicates that the military member has been granted Rest and Recuperation leave, or a document confirming an appointment with a third party (e.g., a counselor or school official, or staff at a care facility, a copy of a bill for services for the handling of legal or financial affairs).

Please describe the reason for requesting FMLA or CFRA leave due to a qualifying exigency, including information on the type of qualifying exigency and any available written documentation of the exigency event. Do not include medical information, including physical or psychiatric care and details relating to that care - simply check the appropriate qualifying exigency category and state, for example, 'to arrange for parental care.'

Select the appropriate **Qualifying Exigency Category** and, if needed, provide additional information related to the event:

- ☐ Short notice deployment (i.e., deployment within seven or fewer days of notice)
- ☐ Military events and related activities (e.g., official ceremonies or events, or family support and assistance programs):
- ☐ Childcare related activities for the child of the military member (e.g., arranging for alternative childcare):
- ☐ Care for the military member's parent (e.g., admitting or transferring the parent to a new care facility):
- ☐ Financial and legal arrangements related to the deployment (e.g., obtaining military identification cards)
- ☐ Counseling related to the deployment (i.e., counseling provided by someone other than a health care provider)
- ☐ Military member's short-term, temporary Rest and Recuperation leave (R&R) (leave for this reason is limited to 15 calendar days for each instance of R&R)
- ☐ Post deployment activities (e.g., arrival ceremonies, or reintegration briefings and events):
- ☐ Any other event that the employee and employer agree is a qualifying exigency:

Available written documentation supporting this request for leave is (☐ attached / ☐ not attached / ☐ not available).

Certification of Qualifying Exigency for Military Family Leave

PART C: AMOUNT OF LEAVE NEEDED

Provide information concerning the amount of leave that will be needed. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency leave needed. Be as specific as you can; terms such as "*unknown*" or "*indeterminate*" may not be sufficient to determine FMLA coverage.

List the approximate date exigency started or will start: _____

Provide your best estimate of how long the exigency lasted or will last:

From _____ to _____

Due to a qualifying exigency, I need to work a **reduced schedule**. Provide your **best estimate** of the reduced schedule you are able to work:

From _____ to _____

I am able to work _____ *(e.g. 5 hours/day, up to 25 hours per week)*

Due to a qualifying exigency, I will need to be absent from work for a **continuous period of time**. Provide your **best estimate** of the beginning and ending dates for the period of absence:

From _____ to _____

Due to a qualifying exigency, I will need to be absent from work on an **intermittent basis** (periodically).

Provide your **best estimate** of the frequency (how often) and duration (how long) of each appointment, meeting or leave event, including any travel time.

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

My leave is due to a qualifying exigency that involves **Rest and Recuperation leave** (R & R) of the military member (leave for this reason is limited to 15 calendar days for each instance of R & R leave).

List the dates of the military member's R &R leave:

From _____ to _____

PART D: THIRD PARTY INFORMATION

If applicable, please provide information below that may be used by your employer to verify meetings or appointments with a third party related to the qualifying exigency. Examples of meetings with third parties include: arranging for childcare or parental care, to attend non-medical counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations. This information may be used by your employer to verify that the information contained on this form is accurate.

Do not include medical information, including physical or psychiatric care and details relating to that care. California Employers: never call a medical provider directly unless you have written authorization to do so from the individual who is under the medical provider's care.

Individual *(e.g. name and title)* or Entity/Organization: _____

Address: _____

Telephone _____ Fax _____ Email _____

Describe Purpose of Meeting: _____

Employee Signature: _____ Date _____

RETURN THIS FORM TO YOUR EMPLOYER. 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-384 Revised June 2020 (OMB Control #1235-0003 Exp. 6/30/2026)