



Colorado Paid **Medical** Leave (CO PML) Claim Packet

Leave Reason:

- ☐ Employee's own serious health condition, including pregnancy
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This packet contains the forms needed to process your claim for Colorado Paid Medical Leave benefits. Please keep this page for future reference and for Guardian's contact information.

Instructions for filing your Guardian Colorado Paid Medical Leave (PML) claim: File online at guardianlife.com/forms-and-claims or complete the attached Request for Paid Medical Leave form along with the Certification for Employee's Own Serious Health Condition.

Employee (Claimant) Responsibilities:

- To request Colorado PML, you must complete Section A: Employee Information on the Request for Colorado Paid Medical Leave form. All items on the form are required unless noted as optional.
- Your employer should complete and sign Section B: Employment Verification on the Request for Colorado Paid Medical Leave form and return it to Guardian **within 10 calendar days** of receipt.
- The Certification for Employee's Own Serious Health Condition is required. You're responsible for having this form completed and submitted.
- You must submit the completed **Request for Paid Medical Leave form** along with the **Certification for Employee's Own Serious Health Condition** to Guardian. You should retain a copy of each submitted form for your records.
- If you'd like to enroll in direct deposit, please complete and include the attached **Direct Pay Enrollment and Authorization for Paid Leave Claims** form (GG-016672PFL). **Note:** Direct deposit isn't available for intermittent leaves, or for situations where your employer is continuing to pay you wages.
- All required sections must be completed fully, accurately, and legibly. Missing, incomplete, or illegible information could delay payment of a claim.
- Your signature acknowledges that, to the best of your knowledge, the forms have been completed accurately.

Employer Responsibilities:

- When an employee notifies you of their intent to take leave, alert the employee that they may be eligible for Colorado Paid Medical Leave (CO PML) benefits and direct them to complete the attached forms.
- As the employer, you should fully complete and sign your portion of the Request for Colorado Paid Medical Leave form (Section B, Employment Verification) and return to Guardian **within 10 calendar days** of receipt.
- All required sections must be completed fully, accurately, and legibly. Missing, incomplete, or illegible information could delay payment of a claim.
- Track leave according to the company's internal attendance and leave policies.
- Complete Employee Benefit Eligibility Verification for PML. Employees are eligible if they have earned at least \$2,500 during the base period or alternative base period.
- To ensure accurate calculation of the CO PML benefit amount, follow the instructions and example in Section B: Employment Verification, question #10, for recording the employee's earnings under the PML program.
- Your signature acknowledges that, to the best of your knowledge, the forms have been completed accurately.



Request for Colorado Paid Medical Leave: **Employment Verification**

CO PML-1: Request for Medical Leave

Guardian Life Insurance
Paid Leave Claims Department
PO Box 14806
Lexington, KY 40512

Phone: 800-268-2525
Fax: 610-807-2684
Email: Paid_Leave_Claims@glic.com
Submit securely at guardiananytime.com/securechannel/contactus

Section A: Employee Information (completed by the employee)

First Name:	Middle Initial:	Last Name:	Guardian CO PFML Plan #:
Gender: ☐ Male ☐ Female ☐ Not Specified/Other		Date of Birth: ____/____/____	Social Security Number: - - -
Address:			
City:	State:	Zip Code:	County:
Phone Number:	Personal Email Address:		
Beginning Date for Leave:	End Date of Leave:	Occupation:	
Leave Type: ☐ Continuous ☐ Intermittent ☐ Reduced Schedule			
Leave Reason: ☐ My Own Serious Health Condition ☐ Pregnancy			

Employee Certification

Any person who knowingly and with intent to defraud any insurance company files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty. I am hereby making a request for paid medical leave benefits under the Colorado Paid Family and Medical Leave Insurance statutes and regulations. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee Signature:	Date:
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Section B: Employment Verification (completed by the employer)**Instructions:** Please complete and return to Guardian **within 10 calendar days** of receipt.

Employee's Name:	CO PFML Plan#:	Social Security Number: - -
Employer Name:	Employer Tax ID:	
Address:		
City:	State:	Zip Code:
Contact Name:	Title:	
Contact Phone:	Email:	
Employee's Date of Hire	Date Last Worked:	
Employee's Date of Termination (if applicable):	Employee's Job Title:	

1. **Employee Benefit Eligibility Verification:** I affirm the forementioned employee (1) works for a covered Colorado employer; and (2) has earned a minimum of \$2,500 in the base period.

☐ Employee **has** met the eligibility requirement ☐ Employee **hasn't** met the eligibility requirement

2. **Private Plan Coverage:**

a. Is the employee covered under your Guardian CO PFML Plan? ☐ Yes ☐ No

If yes, employee's coverage effective date: ____/____/____

b. Is the employee also covered by a Guardian Short Term Disability (STD) plan? ☐ Yes ☐ No

If yes, please supply the Guardian 8-digit STD plan # _____ and complete the STD supplement form

3. **Actual last day worked** before this leave began (don't use payroll week ending dates): ____/____/____

Reason for separation from work if other than leave _____

Is lack of work: temporary? Permanent? _____

Has the employee returned to work? ☐ Yes ☐ No

If yes, what date? ____/____/____

If the return to work was intermittent, list dates: _____

4. **Hours the Employee Regularly Works Each Day:**

a. ____ Sunday ____ Monday ____ Tuesday ____ Wednesday ____ Thursday ____ Friday ____ Saturday

b. If variable schedule, please describe: _____

5. **Prior leaves** taken by employee in the preceding 52 weeks:

☐ Family (PFL) ☐ Medical (PML) ☐ Both PML and PFL ☐ None

Enter the total PFL and PML time taken in the last 52 weeks:

Family (PFL) = _____ Dates: ____/____/____ - ____/____/____

Medical (PML) = _____ Dates: ____/____/____ - ____/____/____

6. **Continued Pay** (don't enter wages earned prior to leave):

a. Have you paid, or do you expect to provide wage replacement as prepayment or wages through payroll for any period after the last day of work? ☐ Yes ☐ No

Note: If yes, you are certifying that the payments are for a qualifying reason and you are entitled to reimbursement, and reimbursement is supported by law. The employee will not be paid by the PFML benefit and instead the benefit amount will be paid to you.

b. If yes, are you requesting reimbursement of the CO PFML benefits payable to your employee?

c. If yes, provide dates: ____/____/____ - ____/____/____

7. Does the employee contribute to the cost of the CO PFML coverage? ☐ Yes ☐ No (If no, skip to question 8)

a. If Yes, is the employee contributing at the current maximum State allowable employee contribution? ☐ Yes ☐ No (If Yes, skip to "c" below.)

b. If No to "a" above, at what contribution rate does the employee contribute to their CO PFML premium?
_____ %

c. Does this employee contribute to their CO PFML premiums on a:

☐ Pre-tax basis (Benefit is fully taxable)

☐ Post-tax basis (Benefit is taxable in proportion to the employer's contribution) IMPORTANT: This information is needed to accurately tax any benefits payable

Employment Verification (continued)

Employee's Name:	CO PFML Plan#:	Social Security Number: - -
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8. Workers' Compensation Liability

- a. Did the employee's medical condition happen in connection with their work or while on your premises, or was the medical condition due in any way to their occupation? ☐ Yes ☐ No
- b. If yes, has a Workers' Compensation claim been filed on behalf of this employee?
☐ Filed ☐ Intend to file ☐ Not filing. Provide reason: _____

9. How to Determine Average Weekly Wage

Benefits are calculated using an employee's Average Weekly Wage (AWW). Average weekly wage means one-thirteenth of the wages paid during the quarter of the employee's base period or alternative base period, in which the total wages were highest.

Base Period: The first four of the last five completed calendar quarters immediately preceding the first day of the employee's benefit year.

Alternative Base Period: The last four completed calendar quarters immediately preceding the benefit year.

Base Period Example:

Quarter 1 = 10/01 to 12/31

Quarter 2 = 01/01 to 03/31

Quarter 3 = 04/01 to 06/30

Quarter 4 = 07/01 to 09/30

Quarter 5 = 10/01 to 12/31

Average Weekly Wage (AWW) Calculation:

AWW = 1/13 of the wages paid during the quarter of the employee's base period in which the total wages were highest.

Base Period Wages – see example above

Base Period Wages	Quarter Ending Date	Quarterly Wages (\$)	a. Total gross wages for the first 4 out of the last 5 complete quarters \$ _____ b. Total number of base weeks for the first 4 of the last 5 complete quarters _____
Quarter 1			
Quarter 2			
Quarter 3			
Quarter 4			
Quarter 5			

Employer Certification

Any person who knowingly and with intent to defraud any insurance company files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty. My signature on this affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Signature:	Date:	
Print or Type Name:	Official Title:	
Email Address:	Phone Number:	
Employer Name:	Federal Tax ID:	
Address:		
City:	State:	Zip Code:



STD Supplement

Guardian Life Insurance
Paid Leave Claims Department
PO Box 14806
Lexington, KY 40512
Fax: 610-807-2684
Email: Paid_Leave_Claims@glic.com
Submit securely at
guardiananytime.com/securechannel/contactus

Important: Completed by the employer only if the employee is covered under their Guardian Short Term Disability (STD) plan.

Employee's Name:	Plan#:	Social Security Number: - -		
If this employee is also covered under your Guardian STD plan, please supply the following: Base Earnings: \$ _____ Frequency: _____ Date of last salary change: ____/____/____ Bonus (over last 12 or 24 months): \$ _____ * Timeframe for Bonus: ____/____/____ - ____/____/____ Commissions (over last 12 or 24 months): \$ _____ * Timeframe for Commissions: ____/____/____ - ____/____/____ * Refer to your STD contract and supply the average bonus and/or commissions for the timeframe indicated (12 or 24 months) and as of your STD plan's redetermination date. If STD earnings are based on prior year W2, please attach W2, or supply the W2 earnings: \$ _____ If employed for part of the year, please supply the year-to-date earnings: \$ _____ Timeframe for the partial year earnings: ____/____/____ - ____/____/____				
Does this employee contribute to the cost of STD coverage? ☐ Yes ☐ No • If yes, what percentage of this claimant's overall STD premium does the employee pay? ____% • If yes, does this claimant contribute to their STD premiums on a: ☐ Pre-tax basis ☐ Post-tax basis • Is this a Gross Up / Bonus Back (non-taxable) arrangement? ☐ Yes ☐ No				
Employee's STD Effective Date: ____/____/____				
Job Description: Fully complete the following details about the demands of the claimant's job as performed in an 8 hour work day. Please attach a description of job duties, if available.				
	Never	Occasionally (.25 – 2.5 Hours Daily)	Frequently (2.5 – 5.5 Hours Daily)	Continuously (5.5 – 8 Hours Daily)
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐
Lift / Carry:	Indicate amount / frequency below			
0-10 lbs	☐	☐	☐	☐
10-20 lbs	☐	☐	☐	☐
20-50 lbs	☐	☐	☐	☐
50-100 lbs	☐	☐	☐	☐
Over 100 lbs	☐	☐	☐	☐
Walk	☐	☐	☐	☐
Drive	☐	☐	☐	☐
Reach Above	☐	☐	☐	☐
Bend / Stoop	☐	☐	☐	☐
Use Hands For:	Indicate amount / frequency below			
Pushing / Pulling	☐	☐	☐	☐
Fine Manipulation	☐	☐	☐	☐
Stress Level	☐ Low ☐ Moderate ☐ High ☐ Very High			
I certify the information above is correct.				
Signature:			Date:	
Print or Type Name:			Official Title:	
Email Address:			Phone Number:	
Employer Name:			Federal Tax ID:	
Address:				
City:			State:	Zip Code:



Direct Pay Enrollment and Authorization for Paid Leave Claims

Guardian Life Insurance
Paid Leave Claims Department
PO Box 14806
Lexington, KY 40512
Fax: 610-807-2684
Email: Paid_Leave_Claims@qlic.com
Submit securely at guardiananytime.com/securechannel/contactus

To enroll in direct deposit, please supply the following information.

Note: Direct deposit isn't available if you're filing a claim for intermittent leave, or in situations where we're reimbursing your employer due to their continued payment of wages. As a result, direct deposit won't be implemented in these situations.

Following Guardian's receipt of your request, please allow up to 10 business days for set up of your direct deposit. If you have any questions about completing this form, please contact us at 800-268-2525.

Claimant Name: _____ Group #: _____ Claim Number (if known): _____

Account Type: ☐ Checking Account ☐ Savings Account

Bank Name: _____

Bank Routing Number (ABA#): _____

Bank Account Number: _____

Nine-digit Routing Number	Account Number	Do not include the check sequence number
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Authorization

I authorize Guardian Life Insurance Company of America ("Company") to deposit any benefits I'm eligible to receive directly into the account and bank I've indicated above or to such other account as the bank or any successor bank designates as my account. I also authorize the Company to debit my account for any deposits made in error. I also understand that the direct deposit service will stay in effect until I notify the Company in writing of the cancellation or until I'm no longer eligible for or due payments, whichever comes first. If covered under another Guardian Disability / Paid Leave plan, this request will also apply to those coverages/claims, if applicable, and should they be approved. I understand that I can view my Explanation of Benefits (EOBs) and payment history via registration on guardianlife.com.

☐ Check this box if you **don't** want to receive paper EOBs in the mail if your direct deposit request is approved.

Claimant Signature

Date

Joint Account Holder Agreement

Are you the sole account holder? ☐ Yes ☐ No

I understand and agree that any funds deposited after the date of death of the Claimant that aren't otherwise payable under the plan are to be immediately returned to Guardian Life Insurance Company of America.

Joint Account Holder Signature

Joint Account Holder Printed Name

Date



Colorado Paid Medical Leave: **Certification for Employee's Own Serious Health Condition**

CO PML – 2: Own Serious Health Condition

Guardian Life Insurance
Paid Leave Claims Department
PO Box 14806
Lexington, KY 40512

Phone: 800-268-2525
Fax: 610-807-2684
Email: Paid_Leave_Claims@glic.com
Submit securely at guardiananytime.com/securechannel/contactus

Employee Information (completed by the employee)

First Name:	Middle Initial:	Last Name:	Guardian CO PFML Plan #:
Phone Number:	Date of Birth:		Social Security Number:
	____/____/____		- -
Employer Name:			

What's the Paid Leave for?

☐ My Own Serious Health Condition ☐ Pregnancy

Note: If pregnancy and the infant is admitted to the NICU after birth, the child's parents or a person that is standing in loco parentis may be eligible for additional leave under the neonatal care leave. Contact Guardian for the next steps.

Employee's Health Care Provider Information

Health Care Provider's Name:
Health Care Provider's Business Address:
Phone Number:

CO PML - Certification for Employee's Own Serious Health Condition

Employee First Name:

Employee Last Name:

Plan Number:

Part A: Medical Information (completed by the employee's health care provider)

Please provide your contact information, complete all relevant parts of this Section, and sign the form. The employee has requested paid leave benefits under Colorado Paid Medical Leave (CO PML).

Limit your response to the medical condition(s) for which the employee is seeking CO PML. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. After completing Part A, complete Part B to provide information about the amount of leave needed.

1. Approximate date the condition started or will start: ____/____/____

2. Best estimate of how long the condition lasted or will last:

3. Check the box(es) for the question below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care:** The patient ☐ has been / ☐ is expected to be admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following dates: _____

☐ **Incapacity plus Treatment:** (e.g., outpatient surgery, broken leg)

Due to the condition, the patient ☐ has been / ☐ is expected to be incapacitated for more than three consecutive, full calendar days from ____/____/____ to ____/____/____

The patient was/will be seen on the following date(s): _____

And, the condition, ☐ has / ☐ hasn't, resulted in a course of continuing treatment under the supervision of a health care provider.

☐ **Pregnancy:** The health condition is pregnancy.

Expected delivery date: ____/____/____ Type of Delivery: ☐ Vaginal ☐ Cesarean Section ☐ Multiple Births

Is this a pregnancy or childbirth complication? ☐ Yes ☐ No

☐ **Chronic Conditions:** (e.g., asthma, migraine headaches) It's medically necessary for the patient to receive treatment from healthcare provider for this condition at least twice per year.

☐ **Permanent or Long-Term Conditions:** (e.g., Alzheimer's terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Health Conditions requiring Multiple Treatments:** (e.g., chemotherapy, restorative surgery) Due to the condition, it's medically necessary for the patient to receive multiple treatments.

4. Briefly describe other appropriate medical facts related to the condition(s) that demonstrate that your patient has a serious health condition.

CO PML - Certification for Employee's Own Serious Health Condition

Employee First Name:

Employee Last Name:

Plan Number:

Part B: Amount of Leave Needed (completed by the employee's health care provider)

For the medical condition(s) checked in Part A, check the applicable box(es) and complete the information that best describes the type of time away from work that the employee will need for their own health condition.

☐ **Continuous Leave**

My patient has/will be incapacitated for a single continuous period due to their own health condition, including time for treatment and recovery beginning ____/____/____ and ending ____/____/____.

☐ **Reduced Work Schedule**

My patient will need to work a reduced work schedule due to their own health condition and associated treatment and recovery period beginning ____/____/____ and ending ____/____/____.

Patient's work capacity is up to ____ hours per week.

☐ **Intermittent Leave**

My patient is expected to have periodic flare-ups or follow-up treatment appointments where intermittent absence from work will be medically necessary beginning ____/____/____ and ending ____/____/____.

Over the next 6 months, episodes of incapacity or treatment are estimated to occur ____ times per ☐ Day/ ☐ Week/ ☐ Month and are likely to last approximately ____ ☐ Hours/ ☐ Days per episode.

Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate, and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Health Care Provider Signature:

Date:

Certificate License Number and State:

Type of Practice/Medical Specialty: