



Instructions for filing your Guardian – Massachusetts Paid Family Leave (PFL) Claim (form MA PFL-1). If you are filing a claim for Massachusetts Paid Medical Leave, use form (MA PML-1).

This packet contains the forms that are needed to process your claim for Massachusetts Paid Family Leave Benefits. Please keep this page for future reference and for the Guardian contact information.

**Note:** If you are filing a claim for intermittent leave (periods of less than a full workday), benefits are only considered after you have satisfied the required 7 day wait period, and, the earlier of the date you have accumulated an additional full workday of leave, or, a period of 30 calendar days have elapsed since your benefits commenced. **As such, we encourage you to not file your claim until you have used a full day of leave time following satisfaction of the 7 day wait period, or, 30 days have elapsed since your benefits have commenced.**

#### **Employee / Claimant Responsibilities:**

- 1). It is your responsibility to file your claim within 30 days following the start of your leave. Late filing could result in a claim denial or delay. See above **Note**.
- 2). Your employer should complete and sign their portion (Part B) of the claim form and return it to you for your completion and filing of the remaining sections.
- 3). You should fully complete your portions of the claim form (Part A), as well as the certificate for the type of leave you are requesting (Bonding, Family, Military)
- 4). We recommend that you submit ALL sections of the claim (employee, employer and certificate) at the same time. Separate submissions could delay the handling of your claim.
- 5). If you would like to enroll in direct deposit, please complete and include the attached GG016672 PFML form.  
**Note:** Direct deposit **is not** available for intermittent leaves, or for situations where your employer is continuing to pay you wages and they are requesting reimbursement.
- 6). It is very important that ALL sections are completed fully, accurately, and legibly.
- 7). Your signature acknowledges that, to the best of your knowledge, the forms have been completed accurately.

#### **Employer Responsibilities:**

- 1) Your employer should fully complete their portion (Part B) of the claim form and return it to you for further completion and submission. This ensures that your information remains private.
- 2) It is very important that ALL sections are completed fully, accurately, and legibly. Missing, incomplete, or illegible information could delay payment of your claim
- 3) To ensure the accurate calculation of your MA PFL benefit amount, your employer should be sure to follow the instructions and example in Part B, question #9, for recording your earnings under the PFL program.

**I am unable to provide a signature due to the COVID-19 pandemic. I understand that my typewritten name has the same force and effect as my signature.**

#### **Guardian Contact / Claim Filing Information**

**Guardian Insurance  
Paid Leave Claims  
P.O. Box 14806  
Lexington KY 40512**

**Customer Service # 1-800-268-2525 Fax # 610-807-2684 Email: [paid\\_leave\\_claims@glic.com](mailto:paid_leave_claims@glic.com)**



## MASSACHUSETTS – PAID FAMILY LEAVE CLAIM FORM

Telephone # 1-800-268-2525 Fax # 610-807-2684 Email: paid\_leave\_claims@glic.com

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                  |  |                           |  |
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| PART A - Please Print                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | TO BE COMPLETED BY THE EMPLOYEE / CLAIMANT                       |  | Guardian Plan # _____     |  |
| 1. Claimant's Name: Last First Middle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 2. Birth Date                                                    |  | 3. Social Security Number |  |
| 4. Home Address – <u>required</u> (Street, Apt #, City, State, Zip Code)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                  |  | 5. County                 |  |
| 6. Mailing Address – if different (Street, Apt #, City State, Zip Code)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 7. <input type="checkbox"/> Male <input type="checkbox"/> Female |  | 8. Occupation             |  |
| 9. Phone No. (____) _____ E-Mail Address _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                  |  |                           |  |
| 10. Reason for PFL request: <input type="checkbox"/> Bond with Child <input type="checkbox"/> Care for Family Member <input type="checkbox"/> Military Qualifying event                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                  |  |                           |  |
| 11. The Family Member is:<br><input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Parent <input type="checkbox"/> Parent in Law <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                  |  |                           |  |
| 12. Is Family Member a service member <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                  |  |                           |  |
| 13. What type of leave claim are you filing? <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                  |  |                           |  |
| 14. Please supply dates of leave: FROM ____/____/____ THROUGH ____/____/____ <input type="checkbox"/> Estimated <input type="checkbox"/> Actual                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                  |  |                           |  |
| 15. If intermittent leave is being used, please describe the leave schedule (days and times) you will be using. (ie. 2 hours every M, W and F)<br>_____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                  |  |                           |  |
| 16. Do you have more than one employer? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>a. If yes, are you taking PFL with the other employer? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>b. If yes, are you taking PFL with the other employer for the same period of time you are making this leave claim? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                  |  |                           |  |
| 17. Other Income – You must answer each question listed below for the period of Leave covered by this claim:<br><br>a. Have you been paid for any days since your leave began? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, give dates _____ to _____ and amount \$ _____ per ____.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                  |  |                           |  |
| 18. Since your last day of work have you received, claimed, or applied for any sources of income listed below:<br><br>If yes, give dates _____ to _____ and amount \$ _____ per _____. Check box(es) below for type of pay received<br><br>a. Any governmental benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>b. Any other benefits provided by your employer or union? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>c. Unemployment Insurance Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>d. Workers Compensation or similar benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>e. Other _____                                                                                                                                                                                                      |  |                                                                  |  |                           |  |
| <b>Certification and Signature.</b> Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.<br><br>I am hereby making a request for paid family leave benefits under the Massachusetts Paid Family Leave Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.<br><br>I am unable to provide a signature due to the COVID-19 pandemic. I understand that my typewritten name has the same force and effect as my signature.<br><br>Sign Here _____ Date _____ |  |                                                                  |  |                           |  |

| Claimant's Name: _____ Plan # _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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| <b>PART B</b> <b>TO BE COMPLETED BY YOUR EMPLOYER OR COMPANY REPRESENTATIVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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| <p>1. Private Plan Coverage (Guardian approved plan replaces State Plan)</p> <p>a. Is claimant covered under your Guardian MA PFL Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         If Yes, employee's coverage effective date ____/____/____</p> <p>a. Is claimant also covered by a Guardian Short Term Disability plan? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         If Yes, please supply the Guardian 6-digit STD plan # _____</p> <p>b. Claimant's hire date: ____/____/____</p> <p>2. Last Actual Day Worked before this leave ____/____/____<br/>         Number of hours worked that day _____</p> <p>a. Reason for separation from work if other than Family Leave _____</p> <p>b. Has claimant Returned To Work (RTW)? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         If "Yes", give date ____/____/____</p> <p>c. If the RTW was intermittent, list dates/hours: _____</p> <p>3. Check the hours and days of the week the employee normally works.<br/>         (ie. 0_SUN _8_MON _8_TUE _8_WED _0_THUR _8_FRI _8_SAT __VARIES)<br/>         __SUN __MON __TUE __WED __THUR __FRI __SAT __VARIES</p> <p>4. In the preceding 52 weeks has the employee taken leave for:<br/> <input type="checkbox"/> PML <input type="checkbox"/> PFL <input type="checkbox"/> Both PML and PFL <input type="checkbox"/> None</p> <p>5. Enter the total PFL and PML time taken in the last 52 weeks:<br/>         PFL = _____ Dates ____/____/____ THROUGH ____/____/____<br/>         PML = _____ Dates ____/____/____ THROUGH ____/____/____</p> <p>6. Is the claimant taking FML concurrently with PFL? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Continued Pay (do not enter wages earned prior to leave)</p> <p>a. Have you paid or expect to pay the claimant for any period after the last day of work?<br/> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. If "yes" give dates: FROM ____/____/____ THROUGH ____/____/____</p> <p>c. Amount \$_____ per <input type="checkbox"/> week <input type="checkbox"/> day <input type="checkbox"/> hour, <input type="checkbox"/> Other _____<br/>         if amount varies attach list of dates and amounts.</p> <p>d. Check the box that best describes the monies paid in items a – c above.</p> <p>1. <input type="checkbox"/> Regular weekly wages / sick pay / PTO</p> <p>2. <input type="checkbox"/> Regular vacation (if designated for a specific time period)</p> <p>3. <input type="checkbox"/> Difference between regular weekly wage and PML benefits</p> <p>4. <input type="checkbox"/> Other _____</p> | <p>8. If paying full wages to your employee, are you requesting reimbursement through the MA PFL benefits payable to your employee?<br/> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. How to determine Base Period gross wage:</p> <p>A BASE PERIOD is the last four completed calendar quarters preceding the start date of disability.</p> <p><i>Example: Disability began 1/23/2021, the BASE Period is 1/1/2020 through 12/31/2020. See below</i></p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="padding: 5px;">Completed Quarter</th> <th style="padding: 5px;">Quarter End Date</th> <th style="padding: 5px;">Gross Wages</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">1<sup>st</sup> Q prior to disability</td> <td style="padding: 5px;">12/31/20</td> <td style="padding: 5px;">\$15,000.00</td> </tr> <tr> <td style="padding: 5px;">2<sup>nd</sup> Q</td> <td style="padding: 5px;">9/30/20</td> <td style="padding: 5px;">\$22,500.00</td> </tr> <tr> <td style="padding: 5px;">3<sup>rd</sup> Q</td> <td style="padding: 5px;">6/30/20</td> <td style="padding: 5px;">\$17,250.00</td> </tr> <tr> <td style="padding: 5px;">4<sup>th</sup> Q</td> <td style="padding: 5px;">3/31/20</td> <td style="padding: 5px;">\$19,200.00</td> </tr> </tbody> </table> <p style="margin-top: 10px;">Please complete the below with "actual" Base Period Gross Wages:</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="padding: 5px;">Completed Quarter</th> <th style="padding: 5px;">Quarter End Date</th> <th style="padding: 5px;">Gross Wages</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">1<sup>st</sup> Q prior to disability</td> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> </tr> <tr> <td style="padding: 5px;">2<sup>nd</sup> Q</td> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> </tr> <tr> <td style="padding: 5px;">3<sup>rd</sup> Q</td> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> </tr> <tr> <td style="padding: 5px;">4<sup>th</sup> Q</td> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> </tr> </tbody> </table> <p style="margin-top: 10px;"><input type="checkbox"/> Please affirm that, to the best of your knowledge, this employee has satisfied the employment and eligibility requirements of the State of Massachusetts Paid Leave program.</p> | Completed Quarter | Quarter End Date | Gross Wages | 1 <sup>st</sup> Q prior to disability | 12/31/20 | \$15,000.00 | 2 <sup>nd</sup> Q | 9/30/20 | \$22,500.00 | 3 <sup>rd</sup> Q | 6/30/20 | \$17,250.00 | 4 <sup>th</sup> Q | 3/31/20 | \$19,200.00 | Completed Quarter | Quarter End Date | Gross Wages | 1 <sup>st</sup> Q prior to disability |  |  | 2 <sup>nd</sup> Q |  |  | 3 <sup>rd</sup> Q |  |  | 4 <sup>th</sup> Q |  |  |
| Completed Quarter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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| 1 <sup>st</sup> Q prior to disability                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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| 2 <sup>nd</sup> Q                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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| 3 <sup>rd</sup> Q                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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| 4 <sup>th</sup> Q                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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| 1 <sup>st</sup> Q prior to disability                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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| 2 <sup>nd</sup> Q                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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| 3 <sup>rd</sup> Q                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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| 4 <sup>th</sup> Q                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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| Employer Name / Division # _____ Phone: _____<br>Address _____ Signed _____ Date _____<br>City, State, Zip _____ Print or Type Name _____<br>Federal EIN: _____ Email Address _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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## Bonding Certification (Form MA PFL-2) Instructions

If the employee is requesting PFL to bond with a newborn, an adopted child or a foster child, the employee must submit the *Bonding Certification (Form MA PFL-2)* with the *Paid Family Leave Claim (Form MA PFL-1)*.

### BONDING CERTIFICATION (to be completed by the employee)

**The employee requesting PFL must complete all applicable requested information.  
Send completed forms and supporting documentation to Guardian Insurance.**

**Questions 1 & 2:** If the form is submitted prior to the birth of a child, this is considered pre-submitting. The employee is then required to provide the required documentation of the child's actual birth to Guardian.

There may be instances where PFL can be taken before the adoption or foster care is finalized. The employee should include documentation to show that the PFL is necessary to further the adoption or foster care.

**Question 5:** See chart below for documentation details. Unless specified, do not send the original documents.

| Bonding Form/Certification                      | Description                                                                                                                                                                          |
|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Health care provider certification of pregnancy | An <b>original</b> letter obtained from the birth mother's health care provider that certifies pregnancy. It should include the mother's name and the expected due date.             |
| Health care provider certification of birth     | An <b>original</b> letter obtained from the birth mother's health care provider that includes the mother's name and child's date of birth.                                           |
| Birth Certificate                               | A <b>copy</b> of the certificate issued by the city or county office in which the child is born.                                                                                     |
| Voluntary Acknowledgment of Paternity           | A <b>copy</b> of the form that establishes legal fatherhood when the parents are unmarried. Completed by both mother and father.                                                     |
| Court Order of Filiation                        | A <b>copy</b> of the order from the family court that names the father of a child. Establishes legal fatherhood when the parents are unmarried. Completed by both mother and father. |
| Marriage Certificate                            | A <b>copy</b> of the official statement issued by the town or city clerk from which the marriage certificate was issued.                                                             |
| Civil union/domestic partner's documentation    | A <b>copy</b> of the certificate of civil union or domestic partnership.                                                                                                             |
| Foster care placement letter                    | A <b>copy</b> of the letter of foster care placement issued by the county or city department of social services or authorized voluntary foster care agency.                          |
| Court documents of adoption                     | A <b>copy</b> of the court document finalizing adoption or documentation in furtherance or court order finalizing adoption.                                                          |
| Other documentation                             | Other documentation of parental relationship may be accepted if none of the others listed apply.                                                                                     |

|                                     |                            |
|-------------------------------------|----------------------------|
| Claimant's Name: _____ Plan # _____ | SOCIAL SECURITY NUMBER<br> |
|-------------------------------------|----------------------------|

### BONDING CERTIFICATION (to be completed by the employee)

1. Child's date of birth (MM/DD/YYYY)   /   /
2. Child's gender ☐ Male ☐ Female ☐ Not designated/Other
3. Does child live with the employee requesting PFL? ☐ Yes ☐ No
4. Child is employee's:
 

☐ Biological child
☐ Stepchild
☐ Foster child
☐ Adopted child
☐ Legal ward
☐ Spouse/Domestic partner's child
☐ Loco parentis
5. Select one of the following and attach the document as required as evidence of the relationship.
 

**Parent of newborn child:**

Birth mother:

☐ Health care provider certification of pregnancy (include expected due date AND mother's name); OR

☐ Health care provider certification of birth (include date of birth of child AND mother's name); OR

☐ Child's birth certificate

Other parent:

☐ Copy of birth certificate naming second parent; OR

☐ Voluntary acknowledgment of paternity; OR

☐ Court order of filiation; OR

☐ Birth mother documents (see above) PLUS one of the following:

☐ Marriage certificate; OR  
☐ Certificate of civil union; OR  
☐ Evidence of domestic partnership

☐ OR; Other documentation of parental relationship

**Foster parent:**

☐ Letter of foster care placement or anticipated placement issued by county or city department of Social Services or authorized voluntary foster care agency

**Adoptive parent:**

☐ Court document finalizing adoption

☐ Documentation in furtherance of adoption
6. Date of foster care or adoption placement, if applicable (MM/DD/YYYY)

### Declaration and signature

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits. I am hereby making a request for paid family leave benefits under the Massachusetts Paid Family Leave Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee's signature \_\_\_\_\_

Date signed (MM/DD/YYYY) \_\_\_\_\_

## Release Of Personal Health (Form MA PFL-3) Instructions

- If an employee is requesting PFL to care for a family member with a serious health condition, the care recipient or an authorized representative must complete a *Release Of Personal Health Information (Form MA PFL-3)* and submit it to their health care provider, along with a copy of the *Health Care Provider Certification For Care Of Family Member (Form MA PFL-4)*.
- The *Release Of Personal Health Information (Form MA PFL-3)* enables the health care provider to complete *Health Care Provider Certification For Care Of Family Member (Form MA PFL-4)* and release it to the employee seeking PFL benefits.
- The employee requesting PFL submits both the Paid Family Leave Claim (*Form MA PFL-1*) and the *Health Care Provider Certification For Care Of Family Member (Form MA PFL-4)* to Guardian for PFL benefit determination.

**NOTE:** The MA PFL-3 form will be retained by the health care provider. The employee should make a copy for their records before giving it to the health care provider. **Do not return the MA PFL-3 form to Guardian.**

|                                     |                            |
|-------------------------------------|----------------------------|
| Claimant's Name: _____ Plan # _____ | SOCIAL SECURITY NUMBER<br> |
|-------------------------------------|----------------------------|

**RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION** (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form MA PFL-4)

Care recipient's (patient's) name \_\_\_\_\_

I, \_\_\_\_\_, authorize my health care provider listed on this form to

release my personal health information to \_\_\_\_\_

Employee's name \_\_\_\_\_

and Guardian Insurance

**Records Subject to Release:** This form gives the health care provider listed below permission to include information from your health care records on the attached medical certification. This form gives your health care provider permission to release only the information in your health care records that relate to your current condition, which is the subject of the employee's request for Paid Family Leave benefits.

**Duration of Revocable Release:** This authorization ends after one year, or when you revoke the release. You can cancel this release at any time. To cancel, send a letter to the health care provider listed on this form.

This form does NOT allow your health care provider to release the following types of information unless you specifically permit such release. Put an "X" next to any information your health provider MAY release:

- ☐ HIV/AIDS related information   ☐ Mental health information   ☐ Alcohol/drug treatment   ☐ Psychotherapy notes

**Health Care Provider Information** (to be completed by the care recipient or authorized representative)

Identify the health care provider who is currently providing you with treatment for a condition that is subject to the employee's request for PFL benefits.

**1. Health care provider's name**

\_\_\_\_\_

**2. Health care provider's mailing address**

Mailing address \_\_\_\_\_

City, State \_\_\_\_\_ Zip code \_\_\_\_\_ Country (if not U.S.A.) \_\_\_\_\_

**3. Health care provider's telephone number** (provide area or country code)

\_\_\_\_\_

*Form MA PFL-3 continued on next page*

TO BE COMPLETED BY THE EMPLOYEE

Plan #

**Employee's name** (first name, middle initial, last name)

Care recipient's (patient's) name (first name, middle initial, last name)

Care recipient's (patient's) date of birth (MM/DD/YYYY)

**RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION** (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form MA PFL-4) - continued from prior page

Form PFL-3 continued from prior page

**Care Recipient Information** (to be completed by the care recipient or authorized representative)**4. Care recipient's mailing address**

Mailing address

City, State

Zip code

Country (if not U.S.A.)

**5. Care recipient's Social Security Number****6. Care recipient's telephone number** (provide area or country code)**READ AND SIGN BELOW**

I hereby request that the health care provider listed give a completed *Health Care Provider Certification For Care Of Family Member (MA Form PFL-4)* to the employee identified on the MA PFL-4 form. I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and any estimation of the amount of care that I require from the employee requesting PFL benefits as a result of my current condition.

Care recipient's signature

Date signed (MM/DD/YYYY)

|  |  |  |   |  |  |  |   |  |  |  |  |
|--|--|--|---|--|--|--|---|--|--|--|--|
|  |  |  | / |  |  |  | / |  |  |  |  |
|--|--|--|---|--|--|--|---|--|--|--|--|

**Authorized representative**

Print name

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

☐ Parental right   
 ☐ Power of attorney (attach copy)   
 ☐ Court order (attach copy)   
 ☐ Health care proxy (attach copy)

Authorized representative's signature

Date signed (MM/DD/YYYY)

|  |  |  |   |  |  |  |   |  |  |  |  |
|--|--|--|---|--|--|--|---|--|--|--|--|
|  |  |  | / |  |  |  | / |  |  |  |  |
|--|--|--|---|--|--|--|---|--|--|--|--|

**The employee should retain a copy for their own records.**

## Health Care Provider Certification for Care of Family Member (Form MA PFL-4) Instructions

The employee requesting PFL to care for a family member with a serious health condition must submit the *Health Care Provider Certification for Care of Family Member (Form MA PFL-4)* with the Paid Family Leave Claim (*Form MA PFL-1*).

- Employee enters their name, Guardian plan number, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, mailing address, and care recipient's (patient's) name and date of birth.
- Employee gives the *Health Care Provider Certification for Care of Family Member (Form MA PFL-4)* to the health care provider.
- Health care provider completes, signs, dates, and then returns the MA PFL-4 form to the employee requesting PFL.
- When you receive the completed *Health Care Provider Certification For Care Of Family Member (Form MA PFL-4)* from the health care provider, send the completed forms and supporting documentation, along with a fully completed MA PFL-1 to Guardian.

### TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name) \_\_\_\_\_ Plan # \_\_\_\_\_

Employee's date of birth (MM/DD/YYYY) \_\_\_\_\_

Employee's Social Security Number or TIN \_\_\_\_\_

Care recipient's (patient's) name (first name, middle initial, last name) \_\_\_\_\_

Care recipient's (patient's) date of birth (MM/DD/YYYY) \_\_\_\_\_

### CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION

(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

#### 1. Does patient require care by the employee requesting Paid Family Leave(PFL)?

☐ Yes ☐ No (If no, skip to "Certification and Signature")

Note: For the purposes of this section, "providing care" may include necessary physical care, emotional support, visitation, assistance in treatment, transportation, arranging for a change in care, assistance with essential daily living matters, and personal attendant services.

#### 2. Primary ICD-10 code (optional)

#### 3. Diagnosis

4. Date patient's condition commenced (MM/DD/YYYY)      /      /

5. First date care for patient is needed (MM/DD/YYYY)      /      /

6. Expected date patient will no longer require care (MM/DD/YYYY)      /      /

#### 7. Describe the schedule for which patient requires care – please supply dates, days, hours needed below.

8. Is this condition in any way related to, or aggravated by the family member's military service? ☐ Yes ☐ No

### Certification and signature

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

My signature attests that the information I have provided in this form is based on my professional assessment within my licensed scope of practice.

\_\_\_\_\_  
(Print Doctor's Name and Medical Degree)      (Original Signature of Doctor Required)      (Date Signed)

\_\_\_\_\_  
(Address)      (Certificate License No. and State)

\_\_\_\_\_  
(City)      (State)      (Zip Code)      (Specialty of Treating Physician)

Telephone Number: (      )      FAX Number: (      )

## Military Qualifying Event (Form MA PFL-5) Instructions

If an employee is requesting PFL because of a family member's covered active military duty or impending covered active duty, the employee must submit the *Military Qualifying Event (Form MA PFL-5)* with the Paid Family Leave Claim (*Form MA PFL-1*).

The employee must identify the family member, provide a copy of the member's covered active duty orders or impending active duty orders, and describe the reason leave is being requested.

### The employee requesting PFL must complete all applicable requested information.

- Employee enters their name, Guardian Plan number, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, and mailing address at the top of each page.
- Questions 1-5: Enter the military member's information and indicate the military member's relationship to the employee.
- Question 6: Enter dates of expected military covered active duty.
- Question 7: Documentation that shows that the military member is on covered active duty or has been notified of an impending call or order to covered active duty is required and must be attached to this form. Select the type of documentation that is attached from the list below.

Required documentation includes one of the following:

- Covered active duty orders; OR
- Letter from the military unit documenting impending call or order to covered duty; OR
- Documentation of military leave signed by the approving authority for military member's Rest and Recuperation.

### Qualifying Reason for Leave (to be completed by the employee)

**Question 8:** Explain the need for PFL because of the Military Qualifying Event. For example: "My spouse was just called on short notice to covered active duty status and will be deployed to (country) in five days. I need to take PFL to be with them and make arrangements for while they are away on active duty." If the explanation will not fit in the space provided on the form, enter "See Attached" and add an attachment with the explanation. Be sure to include the employee's full name, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, and mailing address at the top of the attachment.

**Question 9:** Include one or more of the qualifying supporting documents:

- Meeting announcement for informational briefing sponsored by the military; or
- Document(s) confirming an appointment with a school official, doctor, attorney or financial advisor; or
- Copy of a bill for services for the handling of legal or financial affairs.

|                                                                                                |                                                                                         |                                                                                                                                   |
|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| TO BE COMPLETED BY THE EMPLOYEE                                                                |                                                                                         | Plan # <span style="border: 1px solid black; display: inline-block; width: 150px; height: 1.2em; vertical-align: middle;"></span> |
| Employee's name (first name, middle initial, last name)<br><br>_____                           | Employee's date of birth (MM/DD/YYYY) _____                                             |                                                                                                                                   |
| Other last names, if any, under which employee has worked<br><br>_____                         | Employee's Social Security Number or TIN<br><br>_____                                   |                                                                                                                                   |
| Employee's mailing address                                                                     |                                                                                         |                                                                                                                                   |
| Mailing address<br><div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div> |                                                                                         |                                                                                                                                   |
| City, State<br><div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>     | Zip code<br><div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div> | Country (if not U.S.A.)<br><div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>                            |

**MILITARY QUALIFYING EVENT (to be completed by the employee)**

1. **Name of military member on covered active duty or impending call to covered active duty status (international deployment)** (first name, middle initial, last name)  
  
\_\_\_\_\_
2. **Military member's date of birth** (MM/DD/YYYY)  
  
\_\_\_\_\_
3. **Military member's gender**    ☐ Male    ☐ Female    ☐ Notdesignated/Other
4. **Military member's mailing address**  
Mailing address  
  
City, State      Zip code      Country (if not U.S.A.)
5. **The above-named military member is employee's:**    ☐ Spouse    ☐ Domestic partner    ☐ Child    ☐ Parent
6. **Period of military member's covered active duty** (MM/DD/YYYY) \_\_\_\_\_ through \_\_\_\_\_
7. **Please select one of the following and attach the indicated document to support that the military member is on covered active duty or impending call or order to covered active duty status:**  

☐ Covered active duty orders

☐ Letter of impending call or order to covered duty

☐ Documentation of military leave signed by the approving authority for military member's Rest and Recuperation

**Qualifying Reason For Leave (to be completed by the employee)**

8. **What is the reason employee is requesting PFL?** (One or more reasons may be selected.)

|                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Arranging for child care<br><input type="checkbox"/> Arranging for parental care<br><input type="checkbox"/> Counseling<br><input type="checkbox"/> Making financial arrangements<br><input type="checkbox"/> Making legal arrangements | <input type="checkbox"/> Acting as military member's representative before a federal, state, or local agency for purpose of obtaining, arranging, or appealing military service benefits<br><input type="checkbox"/> Attending any event sponsored by the military or military service organizations<br><input type="checkbox"/> Other<br><div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

*Form MA PFL-5 continued on next page*

TO BE COMPLETED BY THE EMPLOYEE

Employee's social security # \_\_\_\_\_

Employee's name (first name, middle initial, last name)

Employee's date of birth (MM/DD/YYYY)

**MILITARY QUALIFYING EVENT** (to be completed by the employee) continued from prior page*Form MA PFL-5 continued from prior page***9. Written documentation supporting this request for leave is available and attached?**☐ Yes ☐ No ☐ None Available

**Note:** A complete and sufficient certification to support a request for PFL leave due to a qualifying event includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. If leave is requested to meet with a third party, the employee must provide the supporting documentation of the meeting that includes the name, address, appropriate contact information of the individual or entity with whom you are meeting (i.e., either telephone number, fax number, or email address of the individual or entity).

**Declaration and signature**

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits. I am hereby making a request for paid family leave benefits under the Massachusetts Paid Family Leave Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee's signature \_\_\_\_\_

Date signed (MM/DD/YYYY) \_\_\_\_\_

*Form MA PFL-5 continued on next page (if needed)*

TO BE COMPLETED BY THE EMPLOYEE

Plan #

**Employee's name** (first name, middle initial, last name)

**Employee's date of birth** (MM/DD/YYYY)

Other last names, if any, under which employee has worked

**Employee's Social Security Number or TIN**

**Employee's mailing address**

Mailing address

City, State

Zip code

Country (if not U.S.A.)

## QUALIFYING REASON FOR LEAVE - DOCUMENTATION

If leave is requested to meet with a third party, the employee must provide supporting documentation of the meeting that includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone number, fax number or email address of the individual or entity). The reason for a meeting can include: arranging for child or parental care, counseling, making financial or legal arrangements, acting as the military member's representative before a federal, state or local agency for purposes of obtaining, arranging or appealing military service benefits, or attending any event sponsored by the military or military service organizations.

**Please submit this documentation for each required meeting/event.**

**Name of individual with whom employee is meeting** \_\_\_\_\_

**Title** \_\_\_\_\_

**Organization** \_\_\_\_\_

**Telephone number** (provide area or country code) \_\_\_\_\_

**Fax number** (provide area or country code) \_\_\_\_\_

**Email address** \_\_\_\_\_

**Mailing address**

Mailing address

City, State

Zip code

Country (if not U.S.A.)

**Describe nature of meeting. Include dates, if known:**



## Direct Pay Enrollment and Authorization for Paid Leave Claim Programs

To enroll in Direct Deposit, please supply the following information. If unable to physically sign this form, Guardian will accept a typewritten name in lieu of your signature, however, you must check the box below each signature line certifying that you understand that your typewritten name has the same force and effect as your signature.

**NOTE: Direct Deposit is not available if you are filing a claim for intermittent leave, or in situations where Guardian is reimbursing your Employer due to their continued payment of wages. As a result, Direct Deposit will not be implemented in these situations.**

**For faster service please:**

1. Complete this form on-line
2. Print, sign and scan it or use interim accommodation of typing your name in the signature line
3. Save the completed form to your computer
4. Upload via our [Secure Channel](#)

**To mail this form:**

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

**To fax the form:**

(610)-807-2684

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.

**\*\* Please be advised that not all claims and plans are subject to direct deposit availability  
\*\* Complete Required Information below**

**1. Claimant Name:** **Group #:** **Claim Number (if known):**

**2. Account Type:**

☐ Checking Account or ☐ Savings Account

Bank Name:

Bank Routing Number (ABA#):

Bank Account Number:

*\*Required Information*

101

Name on Bank Account  
Street Address  
City, State, Zip

Date: \_\_\_\_\_

Pay to the order of: \_\_\_\_\_ DOLLARS

Memo: \_\_\_\_\_

⑆000067894⑆ 523456789⑆ 0101

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

**3. Sign and date this authorization:**

I authorize Guardian Life Insurance Company of America ("Company") to deposit any benefits I am eligible to receive directly into the account and bank I have 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 cancellation or until I am no longer eligible for or due payments, whichever comes first. **If you are also 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 have the opportunity to view my EOBs and payment history via registration on GuardianAnytime.com.

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

\_\_\_\_\_  
Claimant Signature

\_\_\_\_\_  
Date