TheStandard®

Reset

Standard Insurance Company
866.756.8116 Tel 866.751.5174 Fax
PO Box 3877 Portland OR 97208

Applying For Colorado Paid Family And Medical Leave (CO PFML)

To Use Colorado Paid Family And Medical Leave To:
Care for a family member with a serious health condition

Complete Form CO PFML-1
- ☐ Complete CO PFML-1, Part A
- ☐ Provide CO PFML-1 to employer
- ☐ Employer completes CO PFML-1, Part B and returns to you within 3 days

Complete Form CO PFML-3
- ☐ Care recipient completes CO PFML-3 and provides to Health Care Provider
- ☐ Care recipient's Health Care Provider keeps CO PFML-3

Complete Form CO PFML-4
- ☐ Complete "Employee" information at the top of CO PFML-4
- ☐ Provide CO PFML-4 to care recipient's Health Care Provider
- ☐ Care recipient's Health Care Provider completes CO PFML-4 and returns to you

Send forms and documents
- ☐ Send completed forms and supporting documentation to The Standard
- ☐ The Standard accepts or denies claim within 5 days once a complete claim is received.

Please keep a copy of all pages for your records.

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Request For Colorado Paid Family And Medical Leave (Form CO PFML-1) Instructions

- To request Colorado Paid Family And Medical Leave (CO PFML), the employee requesting CO PFML must complete Part A of the *Request For Colorado Paid Family And Medical Leave* (Form CO PFML-1). All items on the form are required unless noted as optional. The employee then provides the form to the employer to complete Part B.
- The employer completes Part B of the *Request For Colorado Paid Family And Medical Leave* (Form CO PFML-1) and returns it to the employee within three days.
- Additional forms are required depending on the type of leave being requested. The employee requesting leave is responsible for the completion of these forms.
- The employee submits the completed *Request For Colorado Paid Family And Medical Leave* (Form CO PFML-1) with the required additional form to The Standard. The employee should retain a copy of each submitted form for their records.

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

The employee requesting CO PFML must complete all required information.

Colorado Paid Family And Medical Leave (CO PFML) Request (to be completed by the employee)

Question 9: Bond with child means to care for and bond with a Child during the first year after the Child's birth.
Adoption/Foster child means to care for and bond with a Child during the first year after the placement of the Child through Foster Care or adoption.
Care for Family Member with a Serious Health Condition means physical or psychological assistance as used for leave taken to care for a Family Member with a Serious Health Condition.
Safe leave means any period of leave because the Covered Individual or the Covered Individual's Family Member is the victim of Domestic Violence, the victim of Stalking, or the victim of sexual assault or abuse.
Military exigency means a period of leave needed to accommodate a Family member on active duty military service or being called to active duty military service.
Own Serious Health Condition due to pregnancy means any period of disability due to pregnancy or childbirth or related complications.
Own Serious Health Condition (other) means an illness, injury, impairment, or physical or mental condition of an Eligible Employee.

Question 10: Family Member means a Child, Parent, Spouse, Grandparent, Grandchild or Sibling; or any other individual with whom the Covered Individual has a significant personal bond that is or is like a family relationship.

Child means biological children (regardless of age), step-children, legal wards, or a child to whom the employee stands in loco parentis to the employee or the employee's spouse or domestic partner when they were minors.

Grandchild means a child of the employee's child.

Grandparent means a parent of the employee's parent.

Parent means the biological, step-parent, or an individual who stood in loco parentis to the employee or the employee's spouse or domestic partner when they were minors.

Sibling means the Covered Individual's, or the Covered Individual's Spouse's sibling or step-siblings.

Spouse means a husband or wife or domestic partner of an employee.

Significant Personal Bond means any other individual with whom the covered individual has a family relationship, regardless of biological or legal relationship.

The following factors will be considered:

Shared financial responsibility, including shared leases, common ownership of real or personal property, joint liability for bills, or beneficiary designations;
Emergency contact designations;
The expectation of care created by the relationship;
Cohabitation and the duration thereof; and
Geographical proximity.

Question 11: If dates are "Continuous", the employee must provide the start and end dates of the requested CO PFML. These dates should be the actual dates that the CO PFML will begin and end. If uncertain, estimate the start and end dates and indicate "Dates are estimated".

If dates are "Intermittent", enter the dates CO PFML will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate "Dates are estimated".

If the employee is working a consistent but reduced work schedule for multiple weeks, provide the days/hours of leave needed for CO PFML. If uncertain, estimate the frequency of leave and indicate "Dates are estimated".

Question 12: Date employer was notified. If the employee is submitting the CO PFML request to their employer with less than 30 days' advance notice from the start date of the CO PFML, the employee must explain why 30 days' notice could not be given. 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 and their date of birth at the top of the attachment.

Employment Information (to be completed by the employee)

Question 14: Enter the date of hire to the best of the employee's recollection. If it has been more than a year since the date of hire, entering the year in which employment started is sufficient.

Question 19: List all other income you will be receiving while on CO PFML. Include the type/name of income and how much. Example PTO from employer for $500.00 a week.

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Payment for approved claims will be due 14 calendar days from the date of the claim decision.
Employee signs and dates, before giving this form to their employer to complete Part B.

PART B - EMPLOYER INFORMATION (to be completed by the employer)

The employer of the employee requesting CO PFML must complete all information in Part B.

Question 2: If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number.

Question 8: "Wages" include, but are not limited to, salary, wages, tips, commissions, and other compensation.

"Average Weekly Wage" means the Covered Individual's weekly Wages in effect with the Employer on the Day immediately preceding the date PFML begins.

For Covered Individuals who are paid hourly, the Average Weekly Wage is based on the hourly pay rate multiplied by the number of hours regularly scheduled to work for the Employer per week. If the Covered Individual does not have regular work hours, the Average Weekly Wage is based on the average number of hours worked per week for the Employer during the preceding 52 calendar weeks (or during the period of Employment with the Employer if less than 52 weeks). If a Covered Individual is paid on an annual contract basis, the Average Weekly Wage is based on one-fifty-second (1/52nd) of the Covered Individual's annual contract salary with the Employer.

Question 9: Regular Work Schedule means the Days of the week and the number of hours typically worked by the Covered Individual in the job or jobs held by the Covered Individual as of the first date of the PFML. Regular work schedule shall be determined by taking an average of the schedule worked during the 4 weeks prior to the last Day worked. If the Covered Individual has worked fewer than 4 weeks, the average shall only include the weeks in which the Covered Individual was employed by the Employer. For purposes of calculating a regular work schedule, Days missed due to paid sick leave, paid time off, holiday pay, or other Employer-provided leave must be included.

Question 11: Wage Continuation is an employer's continued payment of an employee's regular salaried wages during a period of PFML leave.

Internally sponsored paid family and medical leave is a separate bank of time off solely for the purpose of paid family and medical leave provided by an employer which may only be used for CO PFML qualifying reasons.

Employer-Provided Paid Leave means vacation leave, paid sick leave, paid personal leave, and any other employer-paid time off. Employer-provided paid leave does not include benefits under a short-term disability policy, long term disability policy, or a separate bank of time off solely for the purpose of paid family and medical leave.

Question 12: To qualify for reimbursement the Employer must pay Wage continuation or from a separate bank of time off solely for the purpose of paid family and medical leave to the covered Individual that is equal to or greater than the Weekly Benefit Amount. The Employer is not eligible for reimbursement for Employer-Provided Paid Leave paid to the Eligible Employee.

Question 13: If leave is caused by circumstances that entitle an individual to Workers' Compensation Benefits, the employee is not entitled to PFML.

If leave is caused by circumstances that entitle an individual to Unemployment Insurance Benefits, the employee is not entitled to intermittent or reduced schedule PFML.

Employer signs and dates, and then returns to the employee requesting CO PFML within three business days.

Be sure to complete the appropriate additional CO PFML form(s) based on the type of CO PFML leave being requested.

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Request For Colorado Paid Family And Medical Leave (Form CO PFML-1)

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

1. Employee's legal name (first name, middle initial, last name)	2. Other last names, if any, under which employee has worked

3. Employee's mailing address Street	City	State	Zip Code	Country (if not USA)

4. Employee's Social Security Number or TIN	5. Employee's date of birth (MM/DD/YYYY)	6. Employee's primary telephone number ( )

7. Employee's preferred email address while on CO PFML (if available)	8. Employee's gender ☐ Male ☐ Female ☐ Not designated/Other

9. Reason for CO PFML request:
Bonding: ☐ New child ☐ Adoption/Foster child
☐ Care for Family Member with a Serious Health Condition ☐ Safe Leave ☐ Military exigency
☐ Own Serious Health Condition due to pregnancy ☐ Own Serious Health Condition (other)

10. The family member is employee's: ☐ Child ☐ Spouse ☐ Sibling ☐ Parent ☐ Grandparent ☐ Grandchild
☐ Significant Personal Bond (affirm & provide detail in a. and b. below)

a. I hereby assert that a family-like relationship exists between _____
Your Name

_____
Name of person you have a family-like bond with

b. Describe how this relationship demonstrates a family relationship: _____

11. Will CO PFML be used for a Continuous period of time, Intermittently and/or on a Reduced Leave Schedule?

☐ Continuous _____ / _____ / _____ _____ / _____ / _____ ☐ Dates are estimated
start date (MM/DD/YYYY) end date (MM/DD/YYYY)

☐ Intermittent (separate, non-consecutive time)
Days/hours(s) requested: _____ ☐ Dates are estimated

☐ Reduced Leave Schedule (consistent but reduced work schedule for multiple weeks)
Days/hours(s) requested: _____ ☐ Dates are estimated
(example: 2 days per week, or 4 hours per day, or every Monday)

Employment Information (to be completed by the employee)

12. Date employer was notified. If providing less than 30 day's advance notice to the employer, please explain:

13. Business name	14. Employee's date of hire (MM/DD/YYYY)	14a. Employee's last day of work (MM/DD/YYYY)

15. Has your employment ended? If so, what was your termination date?

16. Employee's work location Street address

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

17. Employer's telephone number for contact regarding this request. ( )	18. Are you receiving Workers' Compensation or Unemployment Insurance Benefits? ☐ Yes ☐ No

19. List income you will be receiving while on CO PFML, source of pay and amount.

20. Have you had a decrease in wages during the last 12 months? ☐ Yes ☐ No
If yes, was it with your current Employer? ☐ Yes ☐ No

21. Have you taken any leave in the last 12 months? ☐ Yes ☐ No	22. If yes list dates and type of leave.

Disclosure statement: Information regarding CO PFML benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

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Request For Colorado Paid Family And Medical Leave (Form CO PFML-1)

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)

Declaration and signature
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Employee's signature	Date signed (MM/DD/YYYY)

☐ I am submitting this form in advance (see instructions about pre-submitting). I understand the insurance carrier will contact me to advise how to submit the required missing information.

PART B - EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address

Mailing address

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

2. Employer's FEIN

3. Employer's EIN	4. Employer's contact name for questions related to CO PFML

5. Employer's contact telephone number ( )	6. Employer's contact email address

7a. Employee's date of hire (MM/DD/YYYY)	7b. Employee's last day of work (MM/DD/YYYY)

8a. Employee's Average Weekly Wage _____

8b. Is employee subject to Social Security taxes? ☐ Yes ☐ No Medicare taxes? ☐ Yes ☐ No

8c. Has employee met the annual limit to Social Security max. contribution? ☐ Yes ☐ No ☐ N/A

9. Check Days Normally Worked ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Indicate Hours Normally Worked _____ _____ _____ _____ _____ _____ _____

10. List the dates of any period a week or longer that the employee is not scheduled to work due to lapses in seasonal operations, school breaks, or other suspensions or cessations of business operations while on PFML leave, excluding holidays:
(example: December 18 - January 1 and March 25 - March 31 or N/A if not applicable)

_____

11. Will wage continuation or internally sponsored paid family and medical leave be paid during the CO PFML leave period/dates? ☐ Yes ☐ No
If yes, provide dates: _____

12. If employee received or will receive wage continuation or internally sponsored paid family and medical leave while on CO PFML, will employer be requesting reimbursement? ☐ Yes ☐ No
If yes, provide dates: _____

13. Has the employee filed for Workers' Compensation Benefits or Unemployment Benefits? ☐ Yes ☐ No
If yes, provide benefit dates: _____

14. CO PFML policy number

CO PFML insurance carrier's name and mailing address
Standard Insurance Company PO Box 3877, Portland, OR 97208 866-751-5174 Fax

Declaration and signature
☐ It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Employer's authorized signature	Date signed (MM/DD/YYYY)

Title

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Colorado Paid Family And Medical Leave Release Of Personal Health Information For Family Member (Form CO PFML-3)

- If an employee is requesting Colorado Paid Family And Medical Leave (CO PFML) to care for a family member with a serious health condition, the family member or an authorized representative must complete a *Release Of Personal Health Information For Family Member* (Form CO PFML-3) and submit it to their Health Care Provider, along with a copy of the *Certification For Care Of Family Member* (Form CO PFML-4).
- The *Release Of Personal Health Information For Family Member* (Form CO PFML-3) enables the Health Care Provider to complete *Certification For Care Of Family Member* (Form CO PFML-4) and release it to the employee seeking CO PFML benefits.
- Before completing and signing, the family member must read the *Release Of Personal Health Information For Family Member* (Form CO PFML-3) in its entirety.
- The employee requesting CO PFML submits both the *Request For Colorado Paid Family And Medical Leave* (Form CO PFML-1) and the *Certification For Care Of Family Member* (Form CO PFML-4) to their employer's CO PFML insurance carrier, for CO PFML benefit determination.

  NOTE: This 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.

Family member or authorized representative signs and dates.

This form is given to the family member's Health Care Provider along with the *Certification For Care Of Family Member* (Form CO PFML-4).

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the family member or authorized representative and submitted to family member's Health Care Provider with Form CO PFML-4)

Employee enters their name, and family member's name and date of birth at the top of each page.

The CO PFML insurance carrier name requested at the top of the form is the same as the CO PFML insurance carrier identified in *Request For Colorado Paid Family And Medical Leave* (Form CO PFML-1) Part B line 13.

Family member or authorized representative must complete all applicable requested information.

If a family member is unable to fill out this form, an authorized representative must attach a copy of legal documentation, such as a health care proxy or power of attorney, permitting the representative to sign on behalf of the family member. The Health Care Provider will require this documentation of authorization unless the authorized representative is a parent signing on behalf of a minor child.

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Colorado Paid Family And Medical Leave Release Of Personal Health Information For Family Member (Form CO PFML-3)

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first name, middle initial, last name)	
Family member's legal name	Family member's date of birth (MM/DD/YYYY))
Relationship of family member to employee	If family member is employee's son or daughter, 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 family member or authorized representative and submitted to family member's Health Care Provider with Form CO PFML-4)

I, _____ , authorize my Health Care Provider listed on this form to
Family member's legal name

release my personal health information to _____ and Standard Insurance Company.
Employee's legal name

Records Subject to Release: This form gives the Health Care Provider listed 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 Colorado Paid Family And Medical 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 family member 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 CO PFML benefits.

1. Health Care Provider's name			
2. Health Care Provider's mailing address			
City	State	Zip Code	Country (if not U.S.A.)
3. Health Care Provider's telephone number (provide area or country code) ( )			

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Colorado Paid Family And Medical Leave Release Of Personal Health Information For Family Member (Form CO PFML-3)

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first legal name, middle initial, last name)	
Family member's legal name (first name, middle initial, last name)	Family member'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 family member or authorized representative and submitted to family member's Health Care Provider with Form CO PFML-4)

Family member Information (to be completed by the family member or authorized representative)

4. Family member's mailing address			
City	State	Zip Code	Country (if not U.S.A.)
5. Family member's Social Security Number		6. Family member's telephone number (provide area or country code) ( )	

READ AND SIGN BELOW

I have a serious health condition and thereby request that the Health Care Provider listed give a completed *Health Care Provider Certification For Care Of Family Member With Serious Health Condition* (Form CO PFML-4) to the employee identified on Form CO PFML-4, 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 CO PFML benefits as a result of my current condition.

Family member's signature	Date signed (MM/DD/YYYY)

Authorized representative

I, _____ , represent the family member in this matter as authorized by:
Print legal name

☐ 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.

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Colorado Paid Family And Medical Leave Certification For Care Of Family Member (Form CO PFML-4) Instructions

To Be Completed by Employee

INSTRUCTION to the EMPLOYEE: **The employee requesting Colorado Paid Family And Medical Leave (CO PFML) to care for family member with a serious health condition must submit the *Certification For Care Of Family Member* (Form CO PFML-4) with *Request For Paid Family and Medical Leave* (Form CO PFML-1). Fill out the employee information of this form and give to the Health Care Provider along with *Release Of Personal Health Information For Family Member* (Form CO PFML-3). When you receive the completed *Certification For Care Of Family Member* (Form CO PFML-4) from the Health Care Provider, send the completed forms and supporting documentation to The Standard.**

Employee's Name				
Employee's Address	City	State	ZIP	Phone No.
Family member's Name	Relationship of family member to employee	Family member date of birth		
Family member's Address	City	State	ZIP	Phone No.

To Be Completed By Health Care Provider

INSTRUCTIONS for HEALTH CARE PROVIDERS

This form is used to certify a serious health condition in order to qualify for Colorado Paid Family and Medical Leave (CO PFML). Qualifying serious health conditions and authorized Health Care Providers are described below. Answer each question to the best of your medical knowledge, based on your examination of the patient.

SERIOUS HEALTH CONDITION

A "**Serious Health Condition**" means an illness, injury, impairment, pregnancy, recovery from childbirth, or physical or mental condition that involves inpatient care or continuing treatment by a Health Care Provider.

- It does not include taking of over-the-counter medications such as aspirin, antihistamines, or salves, or bed rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a Health Care Provider.

Inpatient Care:

- An overnight stay in a hospital, hospice, or residential medical care facility.

Continuing Treatment by a Health Care Provider (*any one or more of the following*)

Incapacity and Treatment: A period of incapacity of more than three consecutive full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:

- Two or more in-person visits to a Health Care Provider for treatment within 30 days of the first day of incapacity, unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or
- At least one in-person visit to a Health Care Provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the Health Care Provider.

Examples: the Health Care Provider might prescribe a course of prescription medication or therapy requiring special equipment.

Pregnancy: Any period of incapacity due to pregnancy.

"Serious Health Condition resulting in incapacitation that occurs during a pregnancy" means:

- Prenatal medical appointments
- Pregnancy-related complications
- Recovery from pregnancies that do not end in a live birth
- Childbirth and delivery, and
- The period of time after the delivery during which the biological mother is certified by her doctor to be unable to perform the requirements for her job.

Chronic Conditions Requiring Treatments: Any period of incapacity due to or treatment for a chronic Serious Health Condition which:

- Requires periodic visits for treatment by a Health Care Provider at least twice a year; and
- Recurs over an extended period of time; and
- May cause episodic rather than a continuing period of incapacity.

Examples: asthma, migraine headaches, diabetes, epilepsy

Permanent/Long-Term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a Health Care Provider.

HEALTH CARE PROVIDERS

"Health Care Provider" means any person licensed, certified, or registered under federal or Colorado law to provide medical or emergency services, including, but not limited to, physicians, doctors, nurses, emergency room personnel, and midwives. For Applications requiring certification by a health care provider, the health care provider may not be the Claimant or a Family Member.

"Health care provider" is limited to an individual licensed under Colorado law to provide medical services or an individual with a National Provider Identifier ("NPI") number issued by the National Plan and Provider Enumeration Service ("NPPES") who is licensed to provide medical services. A health care provider may only certify the need for FAMLI leave if such certification is within the scope of their licensure.

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Colorado Paid Family And Medical Leave Certification For Care Of Family Member (Form CO PFML-4)

PART A: MEDICAL FACTS

1. Diagnosis _____ Primary ICD Code *(optional)* _____

   Approximate date condition commenced: _____ Probable duration of condition: _____

   Was the family member admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

   If so, dates of admission: _____

   _____

   Date(s) you treated the family member for condition: _____

   _____

   Will the family member need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

   Was the family member referred to other Health Care Provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ Yes ☐ No

   If so, state the nature of such treatments and expected duration of treatment: _____

   _____

2. Is the medical condition pregnancy? ☐ Yes ☐ No If so, expected/actual delivery date: _____

3. Complications with the pregnancy or delivery? ☐ Yes ☐ No Please explain: _____

   _____

   _____

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the family member needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

5. Is the family member an active service member? ☐ Yes ☐ No

   If yes, is the condition a result of military service? ☐ Yes ☐ No

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your family member's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

6. Will the family member be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the family member need care? ☐ Yes ☐ No

   Explain the care needed by the family member and why such care is medically necessary: _____

   _____

   _____

7. Will the family member require follow-up treatments, including any time for recovery? ☐ Yes ☐ No

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

   _____

   _____

   Explain the care needed by the family member, and why such care is medically necessary: _____

   _____

   _____

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Colorado Paid Family And Medical Leave Certification For Care Of Family Member (Form CO PFML-4)

8. Will the family member require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ Yes ☐ No

   Estimate the hours the family member needs care on an intermittent basis, if any:

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

   Explain the care needed by the family member, and why such care is medically necessary: _____

   _____

   _____

9. Will the condition cause episodic flare-ups periodically preventing the family member from participating in normal daily activities?

   ☐ Yes ☐ No

   Based upon the family member's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the family member may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

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

   Duration: _____ hours or ____ day(s) per episode

   Does the family member need care during these flare-ups? ☐ Yes ☐ No

   Explain the care needed by the family member, and why such care is medically necessary _____

   _____

   _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Health Care Provider's Name			Date
Address	City	State	ZIP
Phone No.	Fax No.		
Specialty/Type of Practice	License No.	State	NPI Number

Declaration and signature

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Signature of Health Care Provider	Date

Print