MINNESOTA PFML EMPLOYEE STATEMENT

The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Phone 1-866-779-1054 Fax: 1-866-249-3831
Monday through Friday, 8 a.m. to 8 p.m. Eastern Time

INSTRUCTIONS to the EMPLOYEE: The Minnesota Paid Family and Medical Leave permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for benefits. Failure to provide a complete and sufficient certification may result in a denial or closure of your request.

EMPLOYEE STATEMENT (PLEASE PRINT)

Information About You

Last Name | Suffix | First Name | MI

Date of Birth (mm/dd/yy) | Social Security Number | Gender ☐ Male ☐ Female

Home Address

City | State | Zip

Home Telephone Number | Work Telephone Number | Cellular Telephone Number

Information About Your Leave Request

What is the reason for your leave? (Please check the applicable reason).

☐ Your own serious health condition

☐ Serious health condition of family member: Name:_____ DOB: (mm/dd/yyyy) _____

Relationship: ☐ Spouse ☐ Child ☐ Parent ☐ Other:_____

☐ Pregnancy - if yes, please provide Expected/Actual Date of Birth: _____ DOB: (mm/dd/yyyy) _____

☐ Newborn Bonding - if yes, please provide Expected/Actual Date of Birth:

Name: _____ DOB: (mm/dd/yyyy) _____

☐ Adoption/Foster Care Placement - if yes, please provide Expected/Actual Date of Placement:

Name: _____ DOB: (mm/dd/yyyy) _____

Date of Placement: _____

☐ Safe Leave ("Safe Leave" means any leave because the employee or the employee's family member is the victim of domestic violence, the victim of stalking, or the victim of sexual assault or abuse.)

☐ Military Qualifying Exigency

Please indicate the schedule of leave you are requesting:
☐ Continuous Leave — leave taken for a continuous period of time.
☐ Intermittent Leave — leave taken in separate blocks of time due to a single qualifying reason.
☐ Reduced Schedule — a leave schedule that reduces the usual number of hours you work per work day or hours you work per week.

If intermittent, have you taken intermittent time? ☐ Yes ☐ No | If yes, please provide the dates/hours you missed work. (Ex: 1/16/09 8:00-5:00)

If a reduced schedule, how many hours per week will you miss work?

Information About Your Medical Condition(s). (For Bonding, Adoption or Foster Care, skip this section and sign at the bottom of the page.)

1. For **pregnancy**

Were there any complications causing you to stop work prior/after to your expected delivery date? ☐ Yes ☐ No
If yes, please explain:

Have you already delivered? ☐ Yes ☐ No If yes, what type of delivery? ☐ Vaginal ☐ C-Section If yes, date of delivery (mm/dd/yyyy):

2. For a **serious health condition**

Is your leave the result of a **work related accident?** ☐ Yes ☐ No ☐ Unknown
If work related, have you filed a workers' compensation claim? ☐ Yes ☐ No If no, do you intend to file a workers' compensation claim? ☐ Yes ☐ No

INDICATE THE DOCUMENTS INCLUDED IN YOUR SUBMISSION:
☐ Employee Section
☐ Authorization to Collect and Disclose Information
☐ Employer Section
☐ Certification of Health Care Provider
☐ Official documentation (in lieu of medical certification) to verify the event and requested reason for leave

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EMPLOYEE STATEMENT (Continued)

3. If related to a family member:

Name of family member for whom you will provide care: (First, Middle, Last)

Relationship of family member to you:

Describe the care you will provide to your family member:

Information About Your Employment

Employer Name: A u g s b u r g U n i v e r s i t y

Telephone Number: 6 1 2 3 3 0 1 0 5 8

Date Last Worked (mm/dd/yyyy):

First day you missed work due to this reason for leave (mm/dd/yyyy):

Please check the days of the week you normally work. ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Does your schedule vary from week to week? ☐ Yes ☐ No

If yes, please provide the average number of weekly hours worked over the last two calendar quarters preceding leave (includes holidays and hours missed due to other types of leave).

Have you earned at least $3,900 in the most recent completed 4 earnings quarters prior to your leave start date? ☐ Yes ☐ No

Information About Your Return-to-Work

Have you returned to work? ☐ Yes ☐ No

If yes, indicate date below.
Part Time (mm/dd/yyyy): Full Time (mm/dd/yyyy): Hours per week:

If you have not returned to work, when do you expect to return? (mm/dd/yyyy):

Fraud Warning: Any person who knowingly and with the intent to injure, defaud or deceive an insurance company presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning: For your protection, New York law requires the following to appear on this claim form: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the state value of the claim for each such violation.

Signature of Employee

The above statements are true and complete to the best of my knowledge and belief. If I receive an overpayment, I acknowledge that I am responsible for reimbursing Unum for the full amount of the overpayment through reasonable methods of repayment that may include reducing my weekly benefit amount or applying any weekly benefit amount toward recovery of the overpayment. If Unum cannot receive full reimbursement through reduction of my weekly benefit amount or by applying any weekly benefit amount to recovery of the overpayment, I will be required to reimburse Unum in a lump sum payment. **(Your signature is required for benefit consideration.)**

X

Signature **Date**

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Please sign and return this authorization to The Benefits Center at the address above. You are entitled to receive a copy of this authorization. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Authorization to Collect and Disclose Information

(Not for FMLA Requests)

I authorize the following persons: health care professionals, hospitals, clinics, laboratories, pharmacies and all other medical or medically related providers, facilities or services, rehabilitation professionals, vocational evaluators, health plans, insurance companies, third party administrators, insurance producers, insurance service providers, consumer reporting agencies including credit bureaus, GENEX Services, LLC, The Advocator Group, Brown & Brown Absence Services Group and other Social Security advocacy vendors, professional licensing bodies, employers, attorneys, financial institutions and/or banks, and governmental entities;

To disclose information, whether from before, during or after the date of this authorization, about my health, including HIV, AIDS or other disorders of the immune system, information on the diagnosis, treatment, and testing results related to sexually transmitted diseases, unless further restricted by state law, use of drugs or alcohol, mental or physical history, condition, advice or treatment (except this authorization does not authorize release of psychotherapy notes), prescription drug history, earnings, financial or credit history, professional licenses, employment history, insurance claims and benefits, and all other claims and benefits, including Social Security claims and benefits ("My Information");

To Unum Group and its subsidiaries, Unum Life Insurance Company of America, First Unum Life Insurance Company*, Unum Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company*, The Paul Revere Life Insurance Company*, and persons who evaluate claims for any of those companies ("Unum");

So that Unum may evaluate and administer my claims, including providing assistance with return to work. For such evaluation and administration of claims, this authorization is valid for two years, or the duration of my claim for benefits (to include any subsequent financial management and/or benefit recovery review), whichever is shorter. Use of this authorization will be limited to what is permitted under applicable law(s). I understand that once My Information is disclosed to Unum, any privacy protections established by HIPAA may not apply to the information, but other privacy laws continue to apply. Unum may then disclose My Information only as permitted by law, including, state fraud reporting laws or as authorized by me.

I authorize Unum to disclose Claim Information as well as any relevant documentation to support my claims to my employer as required under applicable law ("Claim Information").

I also authorize Unum to disclose My Information to the following persons (for the purpose of reporting claim status or experience, or so that the recipient may carry out health care operations, claims payment, administrative or audit functions related to any benefit, plan or claim): any employee benefit plan sponsored by my employer; any person providing services or insurance benefits to (or on behalf of) my employer, any such plan or claim, or any benefit offered by Unum; or, the Social Security Administration. Unum will not condition the payment of insurance benefits on whether I authorize the disclosures described in this paragraph. For the purposes of these disclosures by Unum, this authorization is valid for one year or for the length of time otherwise permitted by law.

If I do not sign this authorization or if I alter or revoke it, except as specified above, Unum may not be able to evaluate or administer my claim(s), which may lead to my claim(s) being denied. I may revoke this authorization at any time by sending written notice to the address above. I understand that revocation will not apply to any information that Unum requests or discloses prior to Unum receiving my revocation request.

_____ _____

Insured's Signature Date Signed

_____ _____

Printed Name Social Security Number

I signed on behalf of the Insured as _____ (Relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

*Only First Unum Life Insurance Company, Provident Life and Casualty Insurance Company and The Paul Revere Life Insurance Company are admitted in and conduct business in New York.

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EMPLOYER STATEMENT - To be completed by the Employer (PLEASE PRINT)

Information About the Employer

Employer Name: Augsburg University

Employer's Telephone Number: 6123301058

Employer Address: 2211 Riverside Ave

City: Minneapolis State: MN Zip: 55454 -

Information About the Employee

Employee Name (Last Name, Suffix, First Name, MI)

Employee Address

City State Zip -

Home Telephone Number

Work Telephone Number

Cellular Telephone Number

Date of Birth (mm/dd/yy)

Gender
☐ Male
☐ Female

Social Security Number

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner ☐ Widowed ☐ Civil Union

Date of Hire (mm/dd/yy):

Date Last Worked (mm/dd/yy):

Number of hours worked on date last worked:

Requested first date of leave (mm/dd/yy):

Please check all types of coverage this employee has with Unum and provide the information requested:

Short Term Disability ☐ Yes ☑ No	Policy Number	Division Number (PEG No. if applicable)	Digital Date of Coverage
Long Term Disability ☐ Yes ☑ No	Policy Number	Division Number (PEG No. if applicable)	Digital Date of Coverage

Information About the Employee's Work Schedule

Regular Work Schedule (please check regular workdays): ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Hours Worked Per Week (include hours worked per quarter in Earnings Table on page 8):

Effective Date of Regular Work Schedule (mm/dd/yy):

Does the employee work a variable schedule (schedule changes week to week)? ☐ Yes ☐ No

If yes, effective date of variable schedule (mm/dd/yy):

If yes, and if applicable, how do the days worked per week vary:

If yes, and if applicable, how do the hours worked per week vary:

Has the employee taken leave for any Minnesota PFML qualifying reason in the past 12 months? ☐ Yes ☐ No

If yes, provide dates of leave:

MN PFML Policy Number: 992287

Division Number (PEG No. if applicable):

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EMPLOYER STATEMENT (Continued)

Information About the Employee's Employment

Has the employee's employment been terminated? ☐ Yes ☐ No	If yes, termination date (mm/dd/yy):	
Has employee returned to work? ☐ Yes ☐ No	If yes, date (mm/dd/yy): ☐ Full Time ☐ Part Time	Hours Per Week:

Information About the Employee's Salary

The below salary income should be the same as provided for unemployment to the state via UIMN.

What are the employee's earnings in the most recent 4 completed calendar quarters prior to the start of leave?

Earnings Table	Total Earnings	Total Hours Worked
Quarter 4	$	
Quarter 3	$	
Quarter 2	$	
Quarter 1	$	

What percentage of the Minnesota PML benefit is taxable? _____%

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer portions of the claim form.

Signature of Benefit Administrator (Please Print)

The above statements are true and complete to the best of my knowledge and belief.

Name of Person Completing Form

Title of Person Completing Form

Telephone Number	Fax Number

E-mail Address

Signature **Date Signed**

X

MINNESOTA PFML CERTIFICATION OF HEALTH CARE PROVIDER

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CERTIFICATION OF HEALTH CARE PROVIDER

Note: If the certification is not completed in English, the employee may be asked to furnish a translation.

INSTRUCTIONS FOR THE EMPLOYEE: Minnesota Paid Family and Medical Leave permits your employer to require that you submit a timely, complete, and sufficient medical certification to support a request for leave due to your own or family member's serious health condition. Failure to provide a sufficient medical certification may result in a denial of leave. If the certification is not completed in English, you may be asked to furnish a translation.

Patient's Name (Last Name, Suffix, First Name, MI)

RELATIONSHIP TO YOU: ☐ Self ☐ Minor child ☐ Adult disabled child ☐ Parent ☐ Spouse ☐ Other:

If caring for a family member, briefly describe the care you will provide (check all that apply):
☐ Medical, hygiene, nutritional, or safety needs ☐ Transportation ☐ Psychological Comfort ☐ Other:

Estimated duration and schedule of leave:

Employee Signature **Date Signed**
X

INSTRUCTIONS FOR HEALTHCARE PROVIDER: The employee has requested leave under Minnesota Paid Family and Medical Leave. Answer, fully and completely, all applicable parts as missing information may cause delays. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine Minnesota Paid Family and Medical Leave coverage. Limit your responses to the condition for which your patient is seeking leave.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

MEDICAL FACTS

1. Approximate date symptoms/medical condition started:

2. Probable duration of medical condition:_____ or ☐ Recurs over an extended period of time

3. Is this health condition a job-related injury? ☐ Yes ☐ No

4. Expected/actual delivery date:_____ or ☐ Condition not pregnancy

5. If the employee is the patient, provide appropriate medical facts to allow an understanding of how the condition may affect the patient's ability to work.
(Examples may include symptoms, hospitalizations, medical visits, relevant side effects to medication, and referrals for evaluation or treatment.)

Page 8 contains a description of what constitutes a "serious health condition" under Minnesota Paid Family Medical Leave.

6. Does the patient's condition qualify as a serious health condition? ☐ Yes ☐ No

If yes, please select all that apply to the patient's serious health condition.

☐ Inpatient Care
☐ Incapacity Plus Treatment
☐ Pregnancy
☐ Chronic Conditions Requiring Treatment
☐ Permanent/Long Term Conditions Requiring Supervision
☐ Multiple Treatments

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Patient's Name (Last Name, Suffix, First Name, MI)

Your name: (First Name, MI, Last Name)

NEED FOR LEAVE DUE TO THE SERIOUS HEALTH CONDITION

7. Is it medically necessary for the employee to work less than their normal work schedule for care/treatment of self or a family member? ☐ Yes ☐ No

   If yes, provide an estimate of the total amount of leave needed on a continuous and/or intermittent basis:

   a. **Continuous period of incapacity/need for care:** From _____ Through _____

   b. **Expected periodic flare-ups or follow-up treatment appointments** where intermittent absence from work will be medically necessary beginning ____/____/____ and ending ____/____/____. Patients incapacity may occur up to ____ hours per week OR

      1. **Medical visits/treatment:** _____ times per ☐ week ☐ month ☐ year, lasting _____ ☐ hours ☐ days for each appointment, including any recovery period

      2. **Recurring episodes:** _____ times per ☐ day ☐ week ☐ month, lasting _____ ☐ hours ☐ days

   c. **Reduced schedule:** Employee is able to work ____ hour(s) per day; ____ day(s) per week
      From _____ Through _____

* Incapacity - An inability to perform regular work, attend school, or perform regular daily activities due to a serious health condition, treatment therefore, or recovery therefrom.

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes the Healthcare Provider portions of the claim form.

SIGNATURE OF HEALTHCARE PROVIDER/PROFESSIONAL

Signature of Health Care Provider/Professional	Date of Signature
X	

Printed name of Health Care Provider/Professional

Type of medical practice or job title

Telephone Number	Fax Number

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SERIOUS HEALTH CONDITIONS

"Serious Health Condition" means a physical or mental illness, injury, impairment, condition, or substance use disorder that involves one or more of the following:

1. Inpatient Care
Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity. "Inpatient care" means an overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity, or any subsequent treatment in connection with such inpatient care.

2. Incapacity Plus Treatment
Continuing treatment or supervision by a health care provider which includes a period of incapacity of seven or more days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:
(1) Treatment two or more times, within 30 days of the first day of incapacity, unless extenuating circumstances beyond the individual's control prevent a follow-up visit from occurring as planned, by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider; or
(2) Treatment by a health care provider on at least one occasion that results in a regimen of continuing treatment under the supervision of the health care provider.

3. Pregnancy
Continuing treatment or supervision by a health care provider which includes a period of incapacity due to medical care related to pregnancy.

4. Chronic Conditions Requiring Treatment
Continuing treatment or supervision by a health care provider which includes a period of incapacity or treatment for a chronic health condition that:
(1) Requires periodic visits, defined as at least twice a year, for treatment by a health care provider, or under orders of, or on referral by, a health care provider;
(2) Continues over an extended period of time including recurring episodes of a single underlying condition; and
(3) May cause episodic rather than continuing periods of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

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

6. Multiple Treatments
Continuing treatment or supervision by a health care provider which includes a period of absence to receive multiple treatments, including any period of recovery from the treatments, by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, for either:
(1) Restorative surgery after an accident or other injury, or
(2) A condition that would likely result in a period of incapacity of more than seven full calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).