AMERICAN FIDELITY
a different opinion

Benefits Department | P.O. Box 248929 | Oklahoma City, OK 73124
American Fidelity Assurance Company | 800-662-1113 | Fax: 855-651-1294 | **americanfidelity.com**

Verification of Birth Instructions

Instructions For Applicant (To be completed by the applicant who is the parent or guardian of the child)

Use this verification if you are applying for family leave to care for and bond with a child during the first year after birth. You can also use this verification if you are the parent that gave birth and would like to request two additional weeks of family leave.

The health care provider who signs this verification must be authorized to certify the birth or expected birth of the applicant's child. See the list of authorized health care providers in the Instructions for Health Care Provider section below.

Instructions:

- **Part A:** Complete this section with your information. You must include your full name as the parent or guardian of your child.
- **Parts B and C:** Provide the verification and Instructions for Health Care Providers to the health care provider. Make sure the health care provider (who is authorized to certify your child's birth or expected birth) has completed and signed their sections.

Important:

- You and the health care provider must sign this verification no more than 60 days before your child's expected birth date, and no more than one year after birth. We do not accept verifications signed outside of this time frame.
- You or the health care provider may not alter this verification after it is filled out and signed (for example, no strikeouts or whiteouts). We cannot accept verifications that have been altered.

You must provide all required information. Missing information can cause a delay in processing your benefit claim or a denial of your claim. Upload this completed verification and any other documents to your online account at **americanfidelity.com/login** or our mobile app **AFmobile ®**, or mail the completed verification to the address at the top of this page.

The fastest way to send this document is through your online account.

AMERICAN FIDELITY
a different opinion

Benefits Department | P.O. Box 248929 | Oklahoma City, OK 73124
American Fidelity Assurance Company | 800-662-1113 | Fax: 855-651-1294 | **americanfidelity.com**

Verification of Birth Instructions *Continued*

Instructions For Health Care Providers

Applicants use this verification to demonstrate that they qualify for leave to care for and bond with a child during the first year after birth. They may also use this verification if they are the parent that gave birth and are requesting an additional two weeks of family leave.

This verification must be signed by the authorized health care provider of the child or the parent who gave birth. The provider must be authorized to certify the birth or expected birth of the applicant's child.

To certify the birth or expected birth:

- Review the information below to make sure you meet the definition of an authorized health care provider.
- **Only** complete Parts B and C of this verification.
- **Part B:** Include the child's name, if known, and the birth date or expected birth date.
- **Part C:** Complete this section with your information. You must also sign and date this section. By signing this verification, you confirm that you are a health care provider as defined in OAR 471-070-1000.

Important:

- We accept handwritten or electronic signatures. The verification must be signed no more than 60 days before the child's expected birth date, and no more than one year after birth. We cannot accept verifications signed outside of this time frame.
- You must not alter this verification after you fill it out and sign it (for example, no strikeouts or whiteouts). We cannot accept verifications that have been altered in any way. If you need to fill out a new verification, you can find one at **americanfidelity.com/leave-or** on the **Leave Documentation** page.
- Return the completed and signed verification to the applicant. They will send this verification with their application for benefits.

Health care provider definition:

OAR 471-070-1000 defines a "health care provider" as:

1. A person who is primarily responsible for providing health care to the applicant or the family member of the applicant before or during a period of Paid Leave, who is licensed or certified to practice in accordance with the laws of the state or country in which they practice, who is performing within the scope of the person's professional license or certificate, and who is a(n):
   - Chiropractic physician (but only to the extent the chiropractic physician provides treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated to exist by X-rays)
   - Dentist
   - Direct entry midwife
   - Naturopathic physician
   - Nurse Practitioner
   - Nurse Practitioner specializing in nurse-midwifery
   - Optometrist
   - Physician
   - Physician associate
   - Psychologist
   - Registered nurse
   - Regulated social worker
2. A person who is primarily responsible for the treatment of the applicant or the family member of the applicant solely through spiritual means before or during a period of Paid Leave, including but not limited to a Christian Science practitioner.

AMERICAN FIDELITY
a different opinion

Benefits Department | P.O. Box 248929 | Oklahoma City, OK 73124
American Fidelity Assurance Company | 800-662-1113 | Fax: 855-651-1294 | **americanfidelity.com**

Verification of Birth

Part A: Applicant Information

(To be completed by the applicant who is the parent or guardian of the child)

First Name	Last Name:
Social Security Number: (optional)	or Individual Taxpayer Identification Number (ITIN): (optional)
Date of Birth: MM/DD/YYYY (optional)	

Part B: Health Care Provider Certification

(To be completed by the authorized health care provider of either the parent that gave birth or the child)

An authorized health care provider must complete and sign this section. **All fields are required unless noted.** Incomplete or altered verifications may cause a delay or denial of the applicant's benefits.

Child's First Name (if known):	Child's Last Name (if known):
Child's Date of Birth: (MM/DD/YYYY)	or Expected Delivery Date: (MM/DD/YYYY)
Applicant's Relationship to Child: ☐ The parent who gave birth or will give birth ☐ A parent/guardian who did not or will not give birth	

Part C: Health Care Provider Information and Signature

(To be completed by the authorized health care provider)

☐ I have read the definition of health care provider (OAR 471-070-1000). I declare that the information provided in this verification is true and correct and that I am an authorized health care provider as defined in OAR 471-070-1000.		
Health Care Provider Signature (handwritten or electronic)		Date: (MM/DD/YYYY)
Name (First and Last):		Title or Specialization:
Certificate License Number: (optional)		U.S. State or Country:
Phone Number: (with area code)	Fax Number: (with area code)	Email Address: (optional)
Business Name:		Address: (street, city, state, zip)