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**

Paid Family Medical and Leave Insurance Request Form

Faster, Easier Claim Filing

File your claims through your online or mobile account. You can also check claim statuses, sign up for notifications, enroll in direct deposit, view your policy, and more!

Two Ways to Register

1. Online at **americanfidelity.com/register**
2. Download AFmobile® from the **Apple App Store** or **Google Play**

Stop here! Paper claim filing is not the fastest option. Receive your money faster when you file online or through AFmobile.

Claim Filing Instructions for Mail or Fax:

Please complete this packet in full to avoid delays in your claim processing.

1. Complete the Statement of the Insured section.
2. Submit the documentation indicated under Verification Requirements based on your type of leave.
3. Have your employer complete the Employer's Report of Claim section and return it to you.
4. If you would like us to communicate directly with your provider, complete the Authorization to Obtain Information including Protected Health Information section.
5. Mail or fax the completed forms to American Fidelity at the address or fax number listed above.

To receive claim status updates, log in to your account at **americanfidelity.com/login** and select your communication preferences.

Your Money Direct, Your Money Faster. Enroll in Direct Deposit.

To set up direct deposit with American Fidelity, provide all required information below with your submitted claim. You may also enroll in direct deposit through your online account.

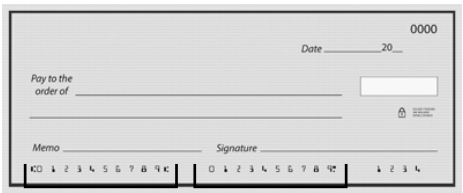
I authorize American Fidelity Assurance Company to initiate credit entries to my account as indicated. I also authorize American Fidelity to debit my account for any deposits made in error. This authorization remains effective and in full force until American Fidelity receives written notification from me of its termination at such time and in such manner as to afford American Fidelity and the Depository a reasonable opportunity to act on it. Please notify us immediately if your depository information has changed. This authorization applies to benefits payable under all benefit plans with American Fidelity.

Signature: _____

You must provide the following information:

Routing Number: _____

Account Number: _____



Routing Number Account Number

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**

Statement of the Insured To be filled out by applicant.

Full Name: (last, first, middle initial)	
Date of Birth: (MM/DD/YYYY)	Social Security Number:
Customer Number:	
Mailing Address: (street, city, state, zip)	
Phone Number: (with area code)	Email:
Work Schedule:	Job Title:

Leave Reason:

☐ Medical Leave ☐ Family Leave (Relationship: _____) ☐ Neonatal Intensive Care Leave ☐ Safe Leave

☐ Qualifying Exigency Leave

Medical Leave: Caring for your own serious health condition, including the applicant's own medical treatment or injury due to domestic violence, stalking, sexual assault, bias crimes, or abuse

Family Leave: Bonding with a child or caring for a family member with a serious health condition (including parents caring for their own infant child during inpatient care in a neonatal intensive care unit or other qualifying medical facility)

Neonatal Intensive Care Leave: Providing care to an infant receiving inpatient treatment in a neonatal intensive care unit

Safe Leave: Seeking non-medical help related to domestic violence, harassment, sexual assault, bias crimes, or stalking, including assisting a minor child/dependent due to same

Military Qualifying Exigency: Dealing with a Qualifying Exigency when a family member is on active military service or being called to active duty

Date(s) of Leave:	Leave Type: ☐ Intermittent ☐ Continuous ☐ Reduced Schedule
Have you returned to work?:	On what date did you return to work?:
If not returned to work, when do you anticipate returning?:	

For employee's own serious health condition (including pregnancy leave) only

If your request for benefits is approved, do you want us to withhold federal taxes from each benefit check? ☐ Yes ☐ No

If yes, amount per week (minimum $20.00): $_____

If your request for benefits is approved, do you want us to withhold state taxes from each benefit check? ☐ Yes ☐ No

I authorize American Fidelity to use the data in any claim submission for processing leave requests and benefits under other insurance policies or certificates issued by the company.

Signature: _____ Date: _____

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**

For Safe Leave Only: Attestation of Need for Safe Leave

- **Domestic violence:** Any conduct that constitutes "domestic violence" as set forth in C.R.S. § 18-6-800.3 (1) or § 14-10-124 (1.3)(a) or "domestic abuse" as set forth in § 13-14-101 (2)
- **Stalking:** Any act as described in C.R.S. § 18-3-602
- **Sexual assault or abuse:** Any offense as described in C.R.S. § 16-11.7-102 (3), or sexual assault, as described in § 18-3-402, committed by any person against another person regardless of the relationship between the actor and the victim

ATTESTATION: I attest that I am in need of Safe Leave as follows (check those that apply):

☐ I am a victim of domestic violence, stalking, sexual assault, or abuse as defined above.

☐ My family member(s) identified below is a victim of domestic violence, stalking, sexual assault, or abuse as defined above.

Name: _____ Relationship to me: _____

Employee Signature: _____ Date: _____

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 Requirements

Medical Leave: Applicant's Own Serious Health Condition

☐ Have the treating health care provider complete the Health Care Provider Certification on page 7 of this packet

Family Leave: Bonding

One of the following is required:

☐ The child's birth certificate or Consular Report of Birth Abroad
☐ A document issued by a health care provider of the child or pregnant parent
☐ A hospital admission form associated with delivery
☐ Another document approved by the Colorado Employment Department for this purpose
☐ Other vital records showing birth
☐ A written statement establishing in loco parentis status

Family Leave: Bonding Adoption or Placement

One of the following is required:

☐ A copy of a court order verifying placement
☐ A letter signed by the attorney representing the prospective foster or adoptive parent that confirms the placement
☐ A document from the foster care, adoption agency, or social worker involved in the placement that confirms the placement
☐ A document for the child issued by the United States Citizenship and Immigration Services
☐ Another document approved by the Colorado Employment Department for this purpose
☐ Other proof of adoption or foster care placement

Verification of family leave must show the following:

- The applicant's first and last name as parent or guardian of the child after birth or placement of the child through foster care or adoption
- The child's first and last name
- The date of the child's birth or placement
- The health care provider's name, signature, and contact information as applicable

Family Leave: Family Member with a Serious Health Condition

☐ Have the treating health care provider complete the Health Care Provider Certification on page 7 of this packet

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 Requirements *Continued*

Family Leave: Parents Caring for Child in Neonatal Intensive Care Unit (NICU)

All of the following is required:

- ☐ A document confirming the infant's admission to a neonatal intensive care unit, issued by the treating facility
- ☐ A document establishing parental status or in *loco parentis* status, which may include but is not limited to: neonatal intensive care unit admission forms listing the claimant, a birth certificate, records from a health care provider who provided care during the birth or recovery, other vital records verifying parenthood, or a signed written statement attesting to in loco parentis status
- ☐ Any other reasonable information or documentation requested by American Fidelity that is necessary to adjudicate the claim

Note: This leave is only available for parents (or those who hold in *loco parentis* status) during their infant's inpatient treatment in a neonatal intensive care unit or other qualifying medical facility.

Note: Additional documentation relating to discharge or continuation of treatment may be required after leave is approved as described in your explanation of benefits.

Qualifying Exigency Leave: Applicant with impending active duty orders in the armed forces or certification for leave due to a family member on active military duty

For leave due to a need for qualifying exigency leave, the claimant must submit the following documentation with their application:

- ☐ An Attestation of Need for Qualifying Exigency Form completed by the claimant (see page 6)

One of the following is required:

- ☐ A copy of the family member's active duty orders
- ☐ A letter of impending activation from the family member's commanding officer
- ☐ Other documentation when, for good cause shown, the applicant is unable to produce the active duty orders or letter of impending activation

Verification must show the following:

- A statement of the relationship between the family member on active military duty and the applicant requesting benefits
- The family member's name and address
- The dates or period of time that leave is requested
- The underlying reason for the Qualifying Exigency Leave

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**

For Qualifying Exigency Leave Only: Attestation of Need for Qualifying Exigency Leave

QUALIFYING EXIGENCY LEAVE means leave based on a need arising out of a covered individual's family member's active duty service or notice of an impending call or order to active duty in the armed forces, including, but not limited to, providing for the care or other needs of the military member's child or other family member, making financial or legal arrangements for the military member, attending counseling, attending military events or ceremonies, spending time with the military member during a rest and recuperation leave or following return from deployment, or making arrangements following the death of the military member.

ATTESTATION: I attest that I am in need of Qualifying Exigency Leave as follows (check those that apply):

☐ My family member(s) identified below is a service member of the U.S. Armed Forces on active duty service, or has received notice of an impending call or order to active duty.

Name: _____ Relationship to me: _____

Employee Signature: _____ Date: _____

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**

Employer's Report of Claim To be filled out by the employer.

Name of Employer:	
Phone Number: (with area code)	Fax Number: (with area code)
Mailing Address: (street, city, state, zip)	
Type of leave approved:	Dates approved: ☐ Intermittent ☐ Continuous
Approved leave period:	Wage earnings*:
Any current breaks from work or anticipated future breaks from work that are unrelated to leave?:	

Employer Signature: _____ Date: _____

***Those earnings are gross wages during the last five completed calendar quarters immediately preceding the employee's benefit year, which is the 12-month period measured forward from the date the claim is filed. Gross wages include:**

- Salary
- Hourly wage
- Overtime
- Tips
- Bonus
- Commissions
- Piece rate
- Employer-provided paid leave (PTO, sick, vacation, etc.)
- Disability benefits paid by the employer and not by a third-party
- Parental leave paid by the employer and not by a third party
- The value of lodging or meals used as a credit toward the minimum wage

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**

Health Care Provider Certification To be filled out by the health care provider.

This certification should be completed by the treating health care provider and returned to the applicant. Information requested is related only to the condition for which the applicant is taking leave.

Applicant's Full Name: (last, first, middle initial)	Applicant's Date of Birth: (MM/DD/YYYY)
Patient's Name (if different than applicant):	Patient's Date of Birth: (MM/DD/YYYY)

Descriptions of serious health conditions that qualify under the Colorado FAMLI program are available on page 8. Please check the appropriate category or categories for your leave request.

☐ Inpatient Care
☐ Conditions requiring multiple treatments
☐ Continuing treatment by a health care provider
☐ Chronic condition
☐ Permanent or long-term condition
☐ Pregnancy
Did the patient have a serious health condition related to pregnancy or childbirth complications?
☐ Yes ☐ No

Describe the medical facts that support your certification and explain how they meet the criteria of the selection(s) above:

Approximate date condition began and probable duration: From (MM/DD/YYYY) _____ through (MM/DD/YYYY) _____

Probable duration of patient's present incapacity (if different): From (MM/DD/YYYY) _____ through (MM/DD/YYYY) _____

If this is a chronic condition or pregnancy, is the patient presently incapacitated? *(see page 8 for definition)* ☐ Yes ☐ No

If yes, duration and frequency of incapacity:

Will it be necessary for the patient to take leave intermittently or to work on a less than full-time schedule basis because of the condition or treatment? ☐ Yes ☐ No

If yes, duration: Over the next 6 months, episodes of incapacity are estimated to occur _____ times

per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ per episode.

If other, please explain how the applicant will use leave intermittently or work a less-than-full-time schedule. Be specific about the frequency and duration of absences:

If the patient requires a treatment regimen, describe the treatments, estimated number of treatments, and intervals between treatments. *(see page 8 for definition)*

Does the patient require basic medical or personal needs, safety, or transportation assistance? ☐ Yes ☐ No

If no, would the applicant's presence to provide psychological comfort benefit the patient's recovery? ☐ Yes ☐ No

If the patient needs care only intermittently or on a part-time basis, please indicate the probable duration and frequency of this need:

Printed Name of Health Care Provider: _____ Date Signed: _____

Signature of Health Care Provider: _____ Type of Practice/Field of Specialization: _____

Health Care Provider's Certification License Number & State: _____ NPI Number *(Required if practicing outside of CO):* _____

Phone Number: (with area code) _____ Fax Number: (with area code) _____

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

Definitions

A **Serious Health Condition** is defined as an illness, injury, impairment, pregnancy, recovery from childbirth, or physical/mental condition that involves one of the following:

- **Inpatient Care**

  Inpatient care (i.e., overnight stay) 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 the overnight stay.

- **Incapacity Plus Treatment**

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

  - 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. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

- **Pregnancy**

  Any period of incapacity due to pregnancy, childbirth, or for prenatal care.

- **Chronic Conditions**

  Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic incapacity rather than a continuing period of incapacity.

- **Permanent or 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, such as Alzheimer's disease or the terminal stages of cancer.

- **Conditions Requiring Multiple Treatments**

  Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

Neonatal Intensive Care Unit (NICU) means a hospital-based unit designated by the inpatient facility as a neonatal intensive care unit and equipped to provide continuous, specialized medical care for critically ill or medically fragile infants. This definition excludes well-baby nurseries, pediatric intensive care units (PICUs), and any other inpatient setting not classified explicitly by the treating facility as a neonatal intensive care unit, except that this definition does include other intensive care units into which the infant was transferred directly after birth or from the unit classified as a neonatal intensive care unit if the transfer was due to an escalation in the infant's medical needs.

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

Definitions *Continued*

Neonatal Care Leave means a separate and distinct leave entitlement that provides up to twelve (12) additional weeks of paid family and medical leave benefits to a covered individual who is providing care for their infant receiving inpatient treatment in a neonatal intensive care unit. The leave is available only for the duration that the infant remains admitted to a neonatal intensive care unit. The leave is available for qualifying absences from work on or after January 1, 2026, and neither the fact that an infant was receiving inpatient treatment in a neonatal intensive care unit prior to that date, nor the fact that a covered individual took FAMLI leave to care for that infant prior to that date, precludes an award of neonatal care leave. Neonatal care leave may be taken for as much or as little of an individual's regular work schedule as the individual chooses, and the individual's choice may change from day to day or from week to week. Covered individuals must report their neonatal care leave weekly.

Intermittent Leave means leave taken in separate periods of time due to a single qualifying reason, rather than for one continuous period of time.

Continuous Leave means one non-recurring uninterrupted period of leave.

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**

Authorization to Obtain Information Including Protected Health Information

The purpose of this form is to allow American Fidelity Assurance Company, or business partners acting on behalf of American Fidelity in the administration of American Fidelity products and services to obtain data including but not limited to employment information, financial information, and protected health information about me, from any party holding that information. Once obtained, American Fidelity may use this data to review or process benefits, confirm policy information, or otherwise review or process information related to my customer relationship with them.

I hereby authorize the entities specified below to disclose any information about me or my dependents' health or financial situation, including my or my dependents' entire medical record and history of treatment for physical and/or emotional illness, including psychological testing, except psychotherapy notes, to individuals representing American Fidelity who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics, or medically-related facilities or their business associates; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles, k) banks or financial institutions and l) Workers' Compensation Carrier. American Fidelity will only disclose any data collected pursuant to this authorization as necessary for our legitimate business purposes and only to the extent allowed by law.

Notice: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome), or other conditions for which you may have been treated.

I understand that American Fidelity may not condition payment of claims, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial or an inability to pay benefits under my policy if my failure to sign results in American Fidelity not having enough information to process my benefits. I understand that I may revoke this authorization at any time by writing to American Fidelity, P.O. Box 258897, Oklahoma City, OK 73125-8897 or by calling, toll-free, 1-833-541-0151. I understand that my right to revoke this authorization is limited to the extent that: American Fidelity has taken action in reliance on the authorization; or the law provides American Fidelity with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original.

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by federal privacy regulations. In addition to the types of information described above, I also authorize American Fidelity to access any other type of information deemed necessary to investigate my claim. This information includes but is not limited to financial information, information submitted or related to insurance claim(s) or insurance coverage(s) and employment records. Any party holding this information is hereby authorized to release it to American Fidelity.

For health insurance coverage, this authorization will expire twenty-four months from the date it is signed or upon the termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first.

Customer # | Printed Name of Patient | Patient's Date of Birth

Signature (Patient) or Personal Representative (if applicable) | Date Signed

Relationship of Personal Representative to Patient (if applicable)

If authorization is supplied by a personal representative, a description of the authority to act on behalf of the insured must be included.

Please retain a copy for your personal records, or you may request a copy from our company.