Reset

TheStandard®

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

Applying For
Oregon Paid Family And Medical Leave (OR PFML)

To Use Oregon Paid Family And Medical Leave To:
Bond with a newborn, a newly adopted or fostered child

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

Complete Form OR PFML-2
- ☐ Complete OR PFML-2 and collect supporting documentation

Send forms and documents
- ☐ Send completed forms and supporting documentation to The Standard

Note: The Standard accepts or denies claim within 14 days once a complete claim is received.

Please keep a copy of all pages for your records.

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Request For Oregon Paid Family And Medical Leave (Form OR PFML-1) Instructions

- To request Oregon Paid Family And Medical Leave (OR PFML), the employee requesting OR PFML must complete Part A of the *Request For Oregon Paid Family And Medical Leave* (Form OR 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 Oregon Paid Family And Medical Leave* (Form OR 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 Oregon Paid Family And Medical Leave* (Form OR PFML-1) with the required additional form(s) 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 OR PFML must complete all required information.

Oregon Paid Family And Medical Leave (OR 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 Family Member 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 Assistance or Psychological Assistance as used for leave taken to care for a Family Member with a Serious Health Condition.

Safe Leave means leave for any purpose described in ORS 659A.272, including leave to:

- Seek legal or law enforcement assistance or remedies to ensure the health and safety of the Eligible Employee or the Eligible Employee's minor Child or dependent, including preparing for and participating in protective order proceedings or other civil or criminal legal proceedings related to Domestic Violence, Harassment, Sexual Assault or Stalking.
- Seek medical treatment for or to recover from injuries caused by Domestic Violence or Sexual Assault to or Harassment or Stalking of the Eligible Employee or the Eligible Employee's minor Child or dependent.
- Obtain, or to assist a minor Child or dependent in obtaining, counseling from a licensed mental health professional related to an experience of Domestic Violence, Harassment, Sexual Assault or Stalking.
- Obtain services from a victim services provider for the Eligible Employee or the Eligible Employee's minor Child or dependent.
- Relocate or take steps to secure an existing home to ensure the health and safety of the Eligible Employee or the Eligible Employee's minor Child or dependent.

Own Serious Health Condition due to Covered Employee serving as a Bone Marrow Donor

Own Serious Health Condition due to Covered Employee serving as an Organ Donor

Own Serious Health Condition due to pregnancy means any period of disability due to pregnancy, childbirth, miscarriage or stillbirth, or period of absence for prenatal care.

Own Serious Health Condition (other) means an illness, injury, impairment, or physical or mental condition of an Eligible Employee.

Question 10: Family Member means an employee's spouse, sibling, child, grandparent, grandchild, parent or an individual related to the employee by blood or affinity whose close association with an eligible employee is the equivalent of a family relationship.

Sibling means the Eligible Employee's, or the Eligible Employee's Spouse's or Domestic Partner's, sibling or stepsiblings.

Child means a biological, adopted or foster child, a stepchild or legal ward, a child to whom the employee stands in *loco parentis*.

Grandchild means an Eligible Employee's, or an Eligible Employee's Spouse's or Domestic Partner's, child of the Child.

Grandparent means an Eligible Employee's, or an Eligible Employee's Spouse's or Domestic Partner's, parent of the Parent.

Parent means (a) the biological, adoptive, step or foster mother or father of the Eligible Employee; (b) a person who was a foster parent of an Eligible Employee when the Eligible Employee was a minor; (c) a person designated as the legal guardian of an Eligible Employee at the time the Eligible Employee was a minor or required a legal guardian; (d) a person with whom an Eligible Employee was or is in a relationship of in loco parentis; or (e) a parent of an Eligible Employee's Spouse or Domestic Partner.

Spouse means a person to whom an Eligible Employee is legally married.

Family Member Equivalent means an Eligible Employee's Spouse, Domestic Partner, Child, Parent, Sibling, Grandparent, Grandchild, or any individual related by blood or affinity whose close association with an Eligible Employee is the equivalent of a family relationship.

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Question 11: If dates are "Continuous", the employee must provide the start and end dates of the requested OR PFML. These dates should be the actual dates that the OR 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 OR PFML will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate "Dates are estimated".

Intermittent Leave means leave taken in separate periods of time due to a single Qualifying Reason, rather than for one continuous period of time. Intermittent leave shall be taken in increments of no less than one Work Day and will be paid in increments that are equivalent to one Work Week.

If dates are estimated, The Standard may require you to submit a request for payment after the OR PFML day is taken. Payment for approved claims will be due 7 calendar days from the date of the claim decision.

PFML benefits will not be payable if the employee would not be performing their employment duties for reasons including but not limited to circumstances related to:

(a) An employer's business operations, such as: a lapse in seasonal operations; school break periods; or other suspensions or cessations of an employer's business operations.
(b) A period of incarceration, in which an individual is unable to perform their employment duties as a result of being an adult in custody.

Question 12: The Claimant must provide written notice to the Employer at least 30 calendar days in advance of foreseeable PFML. Verbal notice by the Claimant or a Family Member must be provided to the Employer within 24 hours of unforeseeable leave. In the context of Safe Leave, if it is not possible to provide notice in these timeframes, notice should be provided as soon as practicable. If the explanation will not fit in the space provided, 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 OR PFML. Include the type/name of income and how much. Example PTO from employer for $500.00 a week.

If you are pre-submitting form: Indicate if the employee is pre-submitting their OR PFML request. Pre-submitting is defined as submitting the application in advance of an upcoming qualifying event, with certain required information missing due to the information being unknown at the time of the submitting. If pre-submitting is permitted by The Standard, the missing information must be supplied as soon as it is known. Benefits cannot be determined until all of the required information is provided.

The Standard will provide the employee a notice within five days which 1) states the claim is pending; 2) identifies what information is missing; 3) instructs how to submit the missing information. **Payment for approved claims will be due 7 calendar days from the date of the claim decision.** If a Complete Application is approved more than 7 calendar days before the onset of PFML, we will commence payment of PFML Benefits as soon as PFML begins.

If The Standard does not permit pre-submitting, The Standard must return the Request for Oregon Paid Family And Medical Leave within five days to the employee with an explanation that the claim should be re-submitted when all information is available.

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 OR 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 9: PFML benefits will not be payable if an employee is not scheduled to work on those days.

PFML benefits will not be payable if the employee would not be performing their employment duties for reasons including but not limited to circumstances related to:

(a) An employer's business operations, such as: a lapse in seasonal operations; school break periods; or other suspensions or cessations of an employer's business operations.
(b) A period of incarceration, in which an individual is unable to perform their employment duties as a result of being an adult in custody.

Question 10a: "Wage" or "wages": For the purpose of payment of benefits, means a Covered Employee's remuneration from the Employer for employment and dismissal payments.

Average Weekly Wage means the Eligible Employee's weekly Subject Wages in effect with the Employer on the day immediately preceding the date PFML begins. For Eligible Employees 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 Eligible Employee 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 an Eligible Employee is paid on an annual contract basis, the Average Weekly Wage is based on one-fifty-second (1/52nd) of the Eligible Employee's annual contract salary with the Employer. If an Eligible Employee has multiple Employers, the Average Weekly Wage will be calculated for each employer separately.

Question 10b: An example of employees not subject to Social security and/or Medicare are certain public employees contributing to their own program and student employees of colleges and universities.

Question 11a-b: OR PFML employer reimbursement is only permitted for Wage continuation, including a paid family and/or medical leave policy of the employer, not for Accrued Paid Leave. Wage continuation is an employer's continued payment of an employee's wages during a period of PFML leave. Accrued Paid Leave is not wage continuation.

The Employer is not eligible for reimbursement for Accrued Paid Leave paid to the Eligible Employee.

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

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

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Request For Oregon Paid Family And Medical Leave (Form OR 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 OR PFML (if available)	8. Employee's gender ☐ Male ☐ Female ☐ Not designated/Other

9. Reason for OR PFML request:
Bonding: ☐ New child ☐ Adoption/Foster child
☐ Care for Family Member with a Serious Health Condition ☐ Safe Leave
☐ Own Serious Health Condition due to Covered Employee serving as a Bone Marrow Donor
☐ Own Serious Health Condition due to Covered Employee serving as an Organ Donor
☐ Own Serious Health Condition due to pregnancy ☐ Own Serious Health Condition (other)

10. The Family Member is employee's: ☐ Child ☐ Spouse or registered domestic partner ☐ Family Member Equivalent ☐ Sibling ☐ Parents and legal guardians (or spouse's parent) ☐ Grandparent ☐ Grandchild

11. Will OR PFML be for a continuous period of time and/or Intermittent?
☐ Continuous _____ / _____ / _____ _____ / _____ / _____ ☐ Dates are estimated
OR PFML start date (MM/DD/YYYY) OR PFML end date (MM/DD/YYYY)

Identify dates Intermittent OR PFML will be taken:
☐ Intermittent _____ ☐ Dates are estimated

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

Employment Information (to be completed by the employee)

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. Is employee currently receiving Workers' Compensation Benefits? ☐ Yes ☐ No

19. List all other employment or Employers in last 12 months:

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

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 OR PFML benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Declaration and signature

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

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)

☐ 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.

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Request For
Oregon Paid Family And Medical Leave
(Form OR 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 B - EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address
Southern Oregon University

Mailing address
1250 Siskiyou Blvd.

City	State	Zip code	Country (if not U.S.A.)
Ashland	**OR**	**97520**	

2. Employer's FEIN

3. Employer's EIN	4. Employer's contact name for questions related to OR PFML
47-2963287	**Michele Barlow**

5. Employer's contact telephone number	6. Employer's contact email address
(**541**) **5528119**	**barlowm@sou.edu**

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

8a. Employee's Typical Work Week Hours

8b. Check Days Normally Worked ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

8c. If Employee's Work Hours are rotating, indicate hours and rotation

9. Leave from work: List the dates of any scheduled breaks while the employee is on PFML leave. (example: December 18 - January 1 and March 25 - March 31 or N/A if not applicable). If dates change or are updated, inform The Standard as appropriate.

**not limited to scheduled breaks; see employer information above.*

10a. Employee's Average Weekly Wage: _____

Check one: ☐ We are a private sector employer ☐ We are a public sector government entity/employer

10b. Is employee subject to: Social Security taxes? ☐ Yes ☐ No Medicare taxes? ☐ Yes ☐ No

10c. Has employee met the annual limit to Social Security max. contribution? ☐ Yes ☐ No

11a. Will any full days of Wage continuation, including the employer's own internal paid family and/or medical leave policy, be used by the employee in place of OR PFML benefits? ☐ Yes ☐ No

If so, please provide dates where full days of Wage Continuation are being paid. _____

**Wage continuation is an employer's continued payment of an employee's regular salaried wages during a period of PFML leave. Accrued Paid Leave, which includes sick leave, Oregon Paid Sick Leave, annual leave, vacation leave, personal leave, compensatory leave or paid time off is not Wage continuation. The Employer is not eligible for reimbursement for Accrued Paid Leave paid to the Eligible Employee.*

11b. If employee received or will receive full wages while on OR PFML, will employer be requesting reimbursement? ☐ Yes ☐ No

12a. What type of paid benefits will the employee receive while on OR PFML? Include the last date through which any compensation will be paid.

12b. Is the leave request a result of employee's injury on the job? ☐ Yes ☑ No

If yes, has the employee applied for Worker's Compensation payments/benefits? ☐ Yes ☑ No

If yes, has the employee received Worker's Compensation payments/benefits? ☐ Yes ☑ No

Amount of Weekly Payment/Benefit: $_____ Effective date of benefits: _____

13. OR PFML policy number **762198**

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TO BE COMPLETED BY THE EMPLOYEE

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

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

OR PFML insurance carrier's name and mailing address

Standard Insurance Company
PO Box 3877
Portland, OR 97208
866-751-5174 Fax

Declaration and signature

☐ I affirm the employee meets the eligibility for Oregon Paid Family And Medical Leave.

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

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

Title

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Oregon Paid Family And Medical Leave Bonding Certification (Form OR PFML-2) Instructions

If the employee is requesting Oregon Paid Family And Medical Leave (OR PFML) to bond with a newborn, an adopted child or a foster child, the employee must submit the *Bonding Certification* (Form OR PFML-2) with the *Request For Oregon Paid Family And Medical Leave* (Form OR PFML-1).

BONDING CERTIFICATION (to be completed by the employee)

The employee requesting OR PFML must complete all applicable requested information.
Send completed forms and supporting documentation to The Standard.

If this form is being submitted in advance (pre-submitting) and some information is unknown, the insurance carrier will contact the employee and explain how to provide the required additional information.

Question 1 & 2: If the form is submitted to the OR PFML insurance carrier prior to the birth of a child, this is considered presubmitting. The employee is then required to provide the required documentation of the child's birth to the OR PFML insurance carrier. The OR PFML carrier will tell the employee how to provide the required additional documentation.

There may be instances where OR PFML can be taken before the adoption or foster care is finalized. For example, the employee may be required to appear in court or travel to another country as part of the adoption or foster care process. The employee should include documentation to show that the OR PFML 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 **original** 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 **original** 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 **copy** of the certificate issued by the city or county office in which the child is born.
Voluntary Acknowledgment of Paternity	A **copy** of the form that establishes legal fatherhood when the parents are unmarried. Completed by both mother and father.
Court Order	**Documentation** 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 **copy** 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 **copy** of the certificate of civil union or domestic partnership.
Foster care placement letter	A **copy** 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 **copy** 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.

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Oregon Paid Family And Medical Leave Bonding Certification (Form OR PFML-2)

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal 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 Street			
City	State	Zip Code	Country (if not U.S.A.)

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 OR PFML? ☐ Yes ☐ No

4. Child is employee's:

☐ Biological child ☐ Stepchild ☐ Foster child ☐ Adopted child ☐ Legal ward
☐ *in loco parentis* child ☐ Spouse/Domestic partner's child

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 Paternity; 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

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

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)