Paid Family & Medical Leave Certification Form

Metropolitan Life Insurance Company

Things to Know Before You Begin

- Please complete Section 1 before giving this form to the medical provider.
- To ensure benefit payments and/or *(where applicable)* job protection, MetLife requires that you submit a timely and complete certification based on your leave reason.
- Remember to add your First and Last Name along with the claim form number to all pages so that we can match this certification with your absence request.

Reminder: Forms marked as lifetime, unknown, as needed, indeterminate or the like, may be returned as incomplete.

SECTION 1: Employee Information

Employee - First Name	Middle Name	Last Name	Claim Number

Employer Name

Dates of Leave: Starting *(mm/dd/yyyy)* _____ To *(mm/dd/yyyy)* _____

☐ Continuous ☐ Intermittent/Reduced Schedule

Reason for Leave

Qualified Leave reason may vary by state

☐ My own serious health condition *(including disability, or medical care related to pregnancy)*
☐ To bond with a child
☐ Military Exigency
☐ Safe Leave
☐ Organ/Bone Marrow Donor
☐ To care for a family member due to a serious health condition

1. Relationship to Employee: *(approved family member may vary by state and program)*

☐ Self	☐ Parent in law	☐ Grandparent in Law
☐ Child *(under 18)*	☐ Spouse	☐ Grandchild
☐ Child *(18 & over)*	☐ Domestic Partner	☐ Sibling
☐ Parent	☐ Grandparent	☐ Other

Description If Other _____

2. If care of Family member, was the Illness, Injury, or death incur in the line of military duty?

☐ Yes ☐ No

Authorization and Signatures

By signing below, I certify that the intent of the information in this document is to support my need to be absent from work due to the qualifying reason checked above.

Sign Here

Signature	Date *(mm/dd/yyyy)*

Employee - First Name	Middle Name	Last Name	Claim Number

SECTION 2: Certification of Serious Health Condition *(Employee's own medical or family member)*

To be completed by the healthcare provider.

Patient's - First Name	Middle Name	Last Name

Date of Birth *(mm/dd/yyyy) (required)*	Gender

Does the patient have a serious health condition that prevents them from performing the material and substantial duties of their job?

☐ Yes ☐ No

Check and complete all that apply:

☐ Condition due to pregnancy Estimated Due Date *(mm/dd/yyyy)* _____

Child's Date of Birth *(mm/dd/yyyy)* | Place of Birth *(city, state)*

_____ | _____

☐ Is the claimant pregnant *(when condition itself is not pregnancy)*? ☐ Yes ☐ No

☐ Is the condition due to organ or bone marrow donation? ☐ Yes ☐ No

☐ Dates you treated patient for condition: Starting *(mm/dd/yyyy)* _____ To *(mm/dd/yyyy)* _____

Will patient need treatment visits at least twice per year due to condition? ☐ Yes ☐ No

☐ Condition lead to hospital admittance: Starting *(mm/dd/yyyy)* _____ To *(mm/dd/yyyy)* _____

Continuous Absence Details: Will the employee listed above need to be absent from work to care for your patient's *(the empoloyee/'s family member)* serious health condition? If so, please select the checkbox below and provide accurate or estimated dates for this period of absence.

☐ Single Continuous Absence Period Start Date *(mm/dd/yyyy)* _____ End Date *(mm/dd/yyyy)* _____

Intermittent/Reduced Schedule Absence Details: Will the employee listed above require an intermittent absence and/or reduced work schedule to care for your patient's *(the employee/'s family member)* serious health condition? If so, please check the box below and provide approximately how long your patient will need the intermittent support outlined below.

☐ Intermittent Absence/Reduced Work Schedule Start Date *(mm/dd/yyyy)* _____

End Date *(mm/dd/yyyy)* _____

Frequency: ____ times per ☐ Week, ☐ Month ☐ Year

Length of Episode _____ Minutes____ Hours_____ Fully Day(s)

In the space provided below or in an attached page, please describe relevant medical facts, if any, related to the condition for which the employee seeks leave from work (*i.e., pregnancy complications, or any regimen of continuing treatment such as the use of specialized equipment).*

Employee - First Name	Middle Name	Last Name	Claim Number

In the space provided below or in an attached page, please describe the care needed for the patient and why such care is medically necessary. If care is for an adult child, List ADLs or IADLs your patient requires support to perform *(i.e., cooking, toileting, travel to appointments)*.

Please Read:

GINA Disclaimer: 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, 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.

Fraud Notice: Any person who knowingly and with intent to injure, defraud, or deceive any person, or knowing that they are facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information is/may be guilty of a crime and may be prosecuted and punished. Penalties may include fines, civil damages and criminal penalties, including confinement in prison.

By signing below, I attest that I am the treating health care provider to the listed patient. The clinical information I am providing is in regard to the dates of absences listed above. I certify that my patient or my patient's family member (*i.e., the employee*) must be absent from work or have a modified work schedule due to this condition.

Healthcare Provider Name	License Number	State
		▼

Business Name

Address	City	State	ZIP
		▼	

Phone Number	Email

Sign Here	Signature of Healthcare Provider	Date *(mm/dd/yyyy)*

Employee - First Name	Middle Name	Last Name	Claim Number

SECTION 3: Child Bonding: *(Only complete if leave reason is to bond with a child)*

Select the type of documentation provided.

- ☐ Copy of Birth Certificate
- ☐ Copy of Placement Documents for Adoption/Foster Care
- ☐ Healthcare Provider Certification *(Section 2)*
- ☐ Other: _____

SECTION 4: Military *(Only complete if leave reason is for Military Exigency or Military Caregiver leave)*

Service Member Affiliation:

- ☐ Army
- ☐ Navy
- ☐ Air Force
- ☐ National Guard
- ☐ Marine Corps
- ☐ Other: _____

- ☐ Active
- ☐ Reserves
- ☐ Veteran

Service Member Rank	Unit

Check all that apply

- ☐ Service member is on the Temporary Disability Retired List (TDRL)
- ☐ Service member is on the Permanent Disability Retired List
- ☐ Illness or Injury incurred in the line of duty

Check the appropriate reason for leave

- ☐ Childcare and School Activities
- ☐ Military Events and Related Activities
- ☐ Short Notice Deployment
- ☐ Counseling
- ☐ Post Deployment Activities
- ☐ Financial and Legal
- ☐ Parental Care
- ☐ Rest and Recuperation
- ☐ Bereavement
- ☐ Additional activities as described _____

Check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status:

- ☐ A copy of the covered military member's active duty orders is attached.
- ☐ Other documentation from the military certifying that the covered military member is on active duty orders *(or has been notified of an impending call to active duty)* in support of a contingency operation is attached.
- ☐ I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

SECTION 5: Safe Leave *(To be used if the employee is impacted by family violence or other qualifying safe leave event. If you have a medical reason, please also complete Section 1.)*

Attestation: I attest that I am in need of Safe Leave. *(Check those that apply.)*

- ☐ I am a victim of domestic violence, stalking, sexual assault or abuse, or other qualifying safe leave event.
- ☐ My family member, identified below, is a victim of domestic violence, stalking, sexual assault or abuse, or other qualifying safe leave event.

Name : _____ Relationship to me: _____

Sign Here	Signature	Date *(mm/dd/yyyy)*

Employee - First Name	Middle Name	Last Name	Claim Number

Third Party Signature *(If this form is being completed by someone other than the employee, please provide this Third Party Signature.)*
I attest I am

- ☐ an Attorney,
- ☐ an employee of the Judicial Branch's Office of the Victim Services or the Office of the Victim Advocate, or
- ☐ a licensed medical professional or
- ☐ other licensed professional

I am attesting that the applicant named in this document is a victim of family violence or other qualifying safe leave event.

Print - First Name	Middle Name	Last Name

Organization Name

Sign Here	Signature	Date *(mm/dd/yyyy)*

Check one of the following and attach the indicated document to support your leave:

- ☐ Documents for a civil or criminal proceeding relating to family violence or other qualifying safe leave event
- ☐ Other documentation to support your claim such as proof of care from a victim service organization or relocation due to safety or supporting medical documentation
- ☐ Signed written statement from applicant certifying that the applicant is taking leave for one of the following reasons:
  1. To obtain services from a victim services organization,
  2. To relocate due to such family violence, or other qualifying safe leave event.
  3. To participate in any civil or criminal proceedings related to or resulting from such family violence or other qualifying safe leave event.

Description of the purpose for this leave *(To be completed by the employee)*:

SECTION 6: How to submit this form

Preferred Option

1) **Providers**, return a copy of this form to the employee/patient

2) **Employees**, Log Into the MyBenefits online portal
Navigate to the My Accounts tab → Select the List View menu →
Click on View Details in your claim → Click **Add Comment/Document**
at the bottom of the page (under Additional Actions)

3) **Employees**, give a copy of the form to your HR department

Secondary Option (if necessary)

Mail:
MetLife Disability
P.O. Box 14590
Lexington KY 40512-4590

Fax:
1-800-230-9531
Cover Page Must Include First & Last Name and/or Claim Number