MetLife

Request for Paid Family & Medical Leave *(MET-PFML)* - Part A

Metropolitan Life Insurance Company

SECTION 1: Employee Information *(To be completed by Employee)*

1. Legal First Name | Legal Middle Name | Legal Last Name

2. Other Last Names, if Any, Under Which Employee Has Worked

3. Mailing Address | City | State | ZIP

Country *(If not U.S.A.)* | 4. Social Security Number | Employee ID | 5. Date of Birth *(mm/dd/yyyy)*

6. Primary Phone Number | 7. Email | 8. Gender ☐ Male ☐ Female ☐ X

9. Preferred Language if Other Than English

Other

Paid Family and Medical Leave (PFL or PML) Request

10. **a. Reason for Leave:**

- ☐ My Own Serious Health Condition *(including disability)*
- ☐ Bond With Child
- ☐ Safe Leave
- ☐ Care for Family Member
- ☐ Military Qualifying Event

• If care of Family member, did the Illness or Injury incurred in the line of military duty? ☐ Yes ☐ No

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

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

Description If Other _____

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

Please complete the PFML Certification to support the qualifying leave reason.

12. Will the leave include a reduced leave schedule or intermittent leaves? ☐ Yes ☐ No

13. **Notice**

a. Did you provide notice to your employer? ☐ Yes ☐ No

b. If so, when and to whom?

_____

Name of Employee Requesting PFML

First Name	Middle Name	Last Name

Employee ID

14. If providing less than 30 days advance notice from the estimated PFML start date, please explain.

SECTION 2: Employment Information *(To be completed by Employee)*

15. Business Name	16. Date of Hire *(mm/dd/yyyy)*	17. Phone Number

18. Work Location - Street Address	City	State	ZIP

19. Are you still actively at work? ☐ Yes ☐ No Termination Date *(mm/dd/yyyy)* _____

20. Average Quarterly Wage *(This data will be requested of both employee and employer)*

21. Scheduled Work Week: ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa ☐ Su

22. Is your schedule: ☐ Regular ☐ Variable ?

23. Will you receive company paid leave or benefits during the leave? ☐ Yes ☐ No

If yes, list leave types and start and end dates of such leaves.

24: Are you currently receiving Unemployment? ☐ Yes ☐ No

25. Are you currently receiving Workers' Compensation Benefits? ☐ Yes ☐ No

Disclosure Statement: Information regarding PFML benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

SECTION 3: Declaration and Signature

Any person who files an application for leave or benefits containing any materially false information, or conceals information for the purpose of misleading MetLife concerning any material fact may be subject to penalties.

I am hereby making a request for paid family and medical leave benefits under applicable state law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

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

Name of Employee Requesting PFML

First Name	Middle Name	Last Name

Employee ID

Request for Paid Family & Medical Leave *(MET-PFML)* - Part B

SECTION 4: Employer Information *(To be completed by Employer)*

1. Business Name

Business Mailing Address	City	State	ZIP

Country *(If not U.S.A.)*	2. FEIN

Sub-Code Number *(Sub-division)*/Sub-Point Number *(Branch)*	Group Report Number

3. Employer's Contact Name for Questions Related to PFML

4. Phone Number	5. Email Address	6. Employee's Date of Hire *(mm/dd/yyyy)*

7. Employee's Date of Termination, if Applicable *(mm/dd/yyyy)* _____

8. Employee's Occupation

9. How many hours per week does the Employee normally work? _____

Please share the normal work schedule *(Please provide hours worked each day)*

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Does the work schedule above frequently change? ☐ Yes ☐ No

10. Enter the last 5 quarters of gross wages for the employee and calculate the gross annualized wage:

Quarter	Quarter Ending Date *(mm/dd/yyyy)*	Number of Days Worked	Gross Amount Paid
1			
2			
3			
4			
5			
	Average Days Worked/Week	Average Hours Worked/Week	Average Weekly Wage

Name of Employee Requesting PFML

First Name	Middle Name	Last Name

Employee ID

Other Income

11. Will the employee/has the employee asked for paid leave or receiving other income for the same days?

Type of Paid Leave/Benefit	Start Date *(mm/dd/yyyy)*	Amount
Sick Leave		
Paid Time Off/Accrued Leave		
Short-Term Disability		
Salary Continuation		
Maternity		
Other		

12. Will the employer be asking for reimbursement? ☐ Yes ☐ No

If yes, what dates

13. Has the employee taken leave in the past 52 weeks for a PFML qualifying reason? ☐ Yes ☐ No

If yes, what dates

14. Is the employee taking Family Medical Leave Act (FMLA) concurrently with PFML? ☐ Yes ☐ No

15. **Notice**

a. Did the employee provide notice to you? ☐ Yes ☐ No

b. If so, when and to whom?

PFML Carrier/Administrator **Metropolitan Life Insurance Company**			Fax Number **1-800-230-9531**
Mailing Address **P.O. Box 14590**	City **Lexington**	State **KY**	ZIP **40512**

SECTION 5: Declaration and Signature

I am the person authorized to sign as the employer of the employee requesting PFML. My signature affirms that to the best of my knowledge and belief, the information I have provided is true and accurate.

Sign Here	Signature of Employer's Authorized	Title	Date *(mm/dd/yyyy)*

Request for Paid Family & Medical Leave *(MET-PFML)* Form Instructions

Under applicable state law, eligible employees are entitled to request Paid Family and Medical Leave (PFML) benefits to:

- Bond with a newborn, a newly adopted or fostered child;
- Care for a family member with a serious health condition, additional benefits for military caregivers in select states;
- Address a qualifying military exigency; or
- For the employee's own serious health condition
- Safe Leaves due to Family Violence

Read below for instructions on how to request Paid Family and Medical Leave (PFML).

Request for Paid Family and Medical Leave *(MET-PFML)*

To request leave, the employee requesting leave completes all items in Part A of the Request for Paid Family and Medical Leave *(MET-PFML)*. All items on the form are required unless noted as optional. The employee then provides the form and instructions to the employer to complete Part B.

Additional forms are required depending on the type of PFML leave being requested. The employee requesting leave is responsible for the completion of these forms.

A PFML Certification is required to support paid leaves	PFML-CERT-FORM (01/23) PFML

SECTION 1: Employee Information *(To be completed by Employee)*

The employee requesting PFML must complete all required information.

Question 1: Provide your legal first name, middle name and last name.

Question 2: Enter other name(s) you have used, professionally or personally, in the past year.

Question 3: Enter your mailing address. This will be the address on file to receive correspondence and benefit payments.

Question 4: Social Security number or TIN: If you have a Taxpayer Identification Number (TIN), you should enter your TIN.

Question 5: Tell us your date of birth.

Question 6: Enter your primary phone number.

Question 7: Enter your email address.

Question 8: Check the box for your gender affiliation. Gender X means you do not identify as exclusively male or female *(e.g., non-binary, agender, intersex, or gender non-conforming)*.

Question 9: Check the box for your preferred language, if not English.

Paid Family and Medical Leave Request

Questions 10a, b, and c: Indicate the reason for the PFML request and your relationship to the family member, if applicable.

Questions 11: You must provide the start and end dates of the requested PFML. These dates should be the actual dates that the PFML will begin and end. If uncertain, estimate the start and end dates.

Questions 12: Tell us if the leave will be taken using a reduced leave schedule or time taken intermittently. **If this is not selected, we will process the claim as a continuous leave.**

Question 13: Tell us when you notified your employer about your need for leave and to whom you gave this notice.

Question 14: If you are submitting the PFML request to your employer with less than 30 days advance notice from the start date of the leave, you must explain why 30 days notice could not be given. If the explanation will not fit in the space provided on the form, enter "See Attached" and add an attachment with the explanation. If you attach additional information, be sure to include your full name and claim number *(if available)* at the top of the attachment.

SECTION 2: Employment Information

Question 15: Enter the employer's business name.

Question 16: Enter your hire date.

Question 17: Enter the best contact phone number to verify employment.

Question 18: Enter the address of your work location.

Question 19: Answer Yes or No if you are still actively employed with the employer. And, if no, please provide the termination date.

Question 20: Enter your average quarterly wages. Quarterly wages can include bonuses, commissions or other income from your employment. We will use this information to calculate your weekly wage replacement benefit. Below are the date ranges for each quarter:

January 1 – March 31 **July 1** – September 30
April 1 – June 30 **October 1** – December 31

Question 21: Select the days of the week you usually work.

Question 22: Select if the work schedule is fixed, meaning it is the same every week, or variable, meaning your work schedule changes throughout the month.

Question 23: Select Yes if you will receive company leave or benefits such as short term disability, paid sick leave, parental leave, or vacation pay during your PFML. Please list the leave or benefits you anticipate receiving.

Question 24: Select the box indicating if you are receiving Unemployment Benefits.

Question 25: Select the box indicating if you are receiving Workers Compensation Benefits.

Declaration and Signature: You must sign and date the claim form for MetLife as a requirement of the claim process. Failure to sign and date may delay or be the cause of a claim denial.

SECTION 3: Employer Information *(To be completed by the Employee's Employer)*

STATE OF MASSACHUSETS ONLY- As part of the MetLife claim process, we will be requesting the claimant's authorization to share with you certification documentation relevant to their leave. If you would like a copy of the certification, please contact MetLife.

The employer of the employee requesting PFML must complete all information in Part A and Part B.

Question 1: Enter the business' full legal name and address.

Question 2: If a Social Security number is used for the Federal Employer Identification Number (FEIN), enter the Social Security number.

Question 3, 4 & 5: Enter the name, phone number and email address of a contact person at the employer who can answer questions regarding this form.

Question 7: Enter the termination date of the employee filing claim, if applicable.

Question 8: The employee occupation code can be found at: **http://www.bls.gov/soc/**.

Question 9: Provide the hours worked each week and the weekly work schedule of the employee. If former employee, please provide the number of hours per week the employee worked prior to termination.

Question 10: Enter the last 5 quarters of gross wages and the number of days worked. And, the average days, hours, and weekly wage based on the last 5 quarters of gross wages. This will be used to calculate the average weekly benefit amount, subject to the state's wage and calculation rules.

Question 11: If the employee will be receiving other paid leave benefits paid by the employer, please list the start date and the weekly benefit amount.

Question 12: Some states allow an employer to be reimbursed for 'like' benefits paid to the employee. Examples include parental leave, company paid medical leave, etc. If you have a qualifying benefit that is reimbursable, please list the name of the benefit and the dates that overlap for the reimbursement to be processed. Reimbursement must be set up prior to payments made to the employee. Not available in all PFML states.

Question 13: Some states allow an employer to decrement entitlement for time absent from work due to a PFML qualifying reason. In the last 52 weeks, please list the days that the employee used leave for a PFML-qualifying reason, so MetLife can reduce the employee's PFML allotment.

Question 14: Check the box to validate an employee will be taking FMLA concurrently with PFML, where applicable and permitted by law.

Question 15: Tell us when the employee notified you about their need for leave and to whom the employee gave this notice.

Employer signs and dates, and then returns to the employee requesting PFML. **As a best practice, we recommend the employer return this form to their employee within three business days** to allow the employee to file timely for the benefit with MetLife. If this information is not provided at time of claim submission, the MetLife Claims specialist will reach out as part of the claim adjudication process.

State laws may require employers to validate employment details within a specific timeframe for timely payments. If an employer chooses not to complete Part B of the Paid Family and Medical Leave, the employee information provided in Part A will be used to adjudicate the claim.

SECTION 4: How to Submit This Form

The employee submits the completed Request for Paid Family and Medical Leave (MET-PFML), with the required additional form(s) to:

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

Fax:
1-800-230-9531

The employee should retain a copy of each submitted form for his or her records.