

Application for Paid Family Leave Benefits		Paid Family Leave		Mail or Fax to: Innovative Care Systems, Inc. Integrated Disability Claims Dept. PO Box 11433 , Torrance, CA 90510 Phone: 800-965-1444 Fax: 310/943-0348	
To be completed by the Employee (Incomplete forms will be returned)		<hr/> Employer Name			
Claimant's Name (First, Middle, Last)				Social Security Number	
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Address					
City		State		Zip Code	
Telephone Number			E-Mail Address		
Date of Birth		Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		Date you last worked	Date you want PLF to begin
What is your occupation?			Did you work or will you continue to work during your family leave period? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Why did you or will you reduce your work hours or stop working?					
<input type="checkbox"/> Care for family member <input type="checkbox"/> Bond with Child <input type="checkbox"/> Other (Explain): _____					
Legal name of person for whom you are caring (First, Middle, Last) or with whom you are bonding (care or bonding recipient)					
The above named care or bonding recipient is your: <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Registered Domestic Partner <input type="checkbox"/> Parent <input type="checkbox"/> Other (Explain) _____ Please provide evidence of relationship such as Child Birth Certificate, Claimant Birth Certificate, Marriage License, Domestic Partnership Registration Certificate from the California Secretary of State Office.					
Is any other family member able and available to provide care for the same period you are claiming PFL benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes					
Have you claimed or do you plan to claim Workers' Compensation Benefits for any portion of the period covered by this claim?					
Do you have more than one employer? <input type="checkbox"/> No <input type="checkbox"/> Yes If YES please explain: _____					
If your employer(s) continue or will continue to pay you during your Paid Family Leave, indicate type of pay. <input type="checkbox"/> Sick Pay <input type="checkbox"/> Vacation Pay <input type="checkbox"/> Other (Explain): _____					
Describe any other income you are receiving or are eligible to receive during this period of Paid Family Leave, such as Social Security, Workers' Comp, Pension Disability/Retirement, Group Disability, etc.					
Source of Income	Amount of Income	Date Application Filed	Date Income Began	Date Income Ended	
I certify that for the period covered by this claim I was providing care for or bonding with the care recipient named above.					
Signature:				Date:	