Statement of Care Recipient	Paid Family Leave _______________ Employer Name	**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

STATEMENT OF CARE RECIPIENT (MAY BE COMPLETED BY CLAIMANT IF CARE RECIPIENT IS MENTALLY OR PHYSICALLY UNABLE TO DO SO. MUST BE SIGNED BY CARE RECIPIENT OR CARE RECIPIENT'S AUTHORIZED REPRESENTATIVE)

PFL Claimant Name (First, Middle, Last)	PFL Claimant Social Security Number
Legal name of care recipient (First, Middle, Last):	Care Recipient Social Security Number

Recipient's date of birth:	Recipient's Gender: ☐ Male ☐ Female	Recipient's Telephone Number:

Care recipient's residence address:	City, State, Zip

I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements or documents, is to the best of my knowledge and belief true, correct, and complete.

Care Recipient's Signature:	Date signed:

Personal Representative signing on behalf of care recipient must complete the following:
I ______________________________ represent the care or bonding recipient in this matter as authorized by

☐ Parental right ☐ Power of attorney (attach copy) ☐ Court order (attach copy)

Personal Representative's Signature:	Date Signed