GROUP DISABILITY INCOME INSURANCE
COMPASSIONATE CARE BENEFIT CLAIM FORM

POLICYHOLDER THE CIVIL SERVICE EMPLOYEES ASSOCIATION, INC. (CSEA) **POLICY NUMBER** G-11628-0

To qualify for the CSEA Compassionate Care Benefit, an Insured Member must:

- Have been out of full-time work due to a leave granted under state law or by the Family and Medical Leave Act of 1993 (FMLA) to care for an ill spouse, domestic partner, child or parent for at least 30 days, whether continuous or intermittent;
- Have been insured continuously under the Policy for at least one year prior to the first day of the approved FMLA leave; and
- Have not received any benefits for a Covered Disability for the one-year period immediately preceding the approved FMLA leave.

PROOF OF FMLA LEAVE TAKEN MUST ACCOMPANY THIS CLAIM FORM to avoid a delay in processing this claim. A copy of *Form WH-382 Designation Notice (Family and Medical Leave Act)* or equivalent form used by your Employer for approval of FMLA leave is required.

SECTION A - MEMBER INFORMATION

Member Name (Last, First, MI) Social Security Number Date of Birth

Mailing Address (Street, Apt #, City, State, Zip)

Email Address Daytime Phone (check one) ☐ Mobile ☐ Home ☐ Work

SECTION B - CLAIM INFORMATION

First day of FMLA leave: ______________________ Last day of FMLA leave: ______________________

Type of leave: ☐ Continuous ☐ Intermittent

If intermittent, total number of hours taken in FMLA leave period above: ______________________

SECTION C - EMPLOYER INFORMATION

Employer Name

Employer Address (Street, City, State, Zip)

Human Resources Department Contact Name / Title

Human Resources Contact Email Address Human Resources Contact Phone

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Member's Signature Date

Return completed form and proof of FMLA leave to:

PEARL INSURANCE – CLAIMS DEPARTMENT, 13 AIRLINE DRIVE, ALBANY, NY 12205

Claims may be faxed to **518-640-8105** or emailed to **CUSTOMERCARE@PEARLINSURANCE.COM**