FAMILY LEAVE CLAIM FORM

YOU MUST BE ON LEAVE FOR A MINIMUM OF 30 CONSECUTIVE DAYS BEFORE BENEFITS MAY BE CONSIDERED.

INSTRUCTIONS FOR COMPLETING THIS FORM:

1. Complete **SECTION 1**
2. Read, sign and date **SECTION 2**
3. Have your employer complete **SECTION 3**
4. Print your name and your account number in **SECTION 4**
5. Read, sign and date **SECTION 5**
6. Send **BOTH PAGES** of the completed, signed claim form to Yosemite Insurance Claims Department. Keep a copy for your records.

   If you need assistance with this form, contact Yosemite Insurance Company at 1-800-325-2147, ext 5113297, or your lender.

SECTION 1 TO BE COMPLETED BY CLAIMANT (PLEASE PRINT)

ACCOUNT #	**CHECK ONE** **NEW CLAIM** ☐ **CONTINUING CLAIM** ☐
CUSTOMER NAME	
MAILING ADDRESS **IS THIS A NEW ADDRESS? YES** ☐ **NO** ☐	
DAYTIME PHONE # ( )	SOCIAL SECURITY #
EMAIL ADDRESS (OPTIONAL)	
DATE FAMILY LEAVE BEGAN	REASON FOR FAMILY LEAVE
ARE YOU RECEIVING EMPLOYER PAID COMPENSATION WHILE ON FAMILY LEAVE	YES ☐ NO ☐
ARE YOU CURRENTLY ON FAMILY LEAVE YES ☐ NO ☐	IF NO, WHEN DID YOU RETURN TO WORK

SECTION 2 AUTHORIZATION TO RELEASE INFORMATION

I authorize any employer, insurer, or other individual or organization, having any records, files, reports, etc., concerning me to release the information to the Insurance Company or its duly authorized representative for the purpose of determining my eligibility for the benefits I have requested. This authorization shall remain valid for one year from the date I have signed below. However, I have the right to revoke this authorization in writing within one year from the date of my signature. A photocopy of this authorization shall be valid as the original.

CLAIMANT SIGNATURE _____ **DATE** _____

SECTION 3 TO BE COMPLETED BY EMPLOYER (PLEASE PRINT)

EMPLOYER NAME	
MAILING ADDRESS	
CITY	STATE ZIP
EMPLOYER PHONE # ( )	EMPLOYER FAX # ( )
CLAIMANT'S DATE OF EMPLOYMENT	WAS CLAIMANT'S FAMILY LEAVE APPROVED YES ☐ NO ☐
BEGINNING LEAVE DATE	REASON FOR FAMILY LEAVE
IS CLAIMANT CURRENTLY ON FAMILY LEAVE YES ☐ NO ☐	EXPECTED RETURN DATE
IS CLAIMANT RECEIVING A SALARY OR WAGE WHILE ON FAMILY LEAVE	YES ☐ NO ☐
REPRESENTATIVE PRINTED NAME FIRST	LAST

EMPLOYER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ DATE _____

SECTION 4 TO BE COMPLETED BY CLAIMANT (PLEASE PRINT)

CLAIMANT NAME _____ **ACCOUNT#** _____

SECTION 5 INSURANCE FRAUD WARNING

For your protection, where applicable, State law requires the following statement to appear on this form. Any person who knowingly and with intent to defraud, files an application for insurance or statement of claim containing any materially false or fraudulent information, or knowingly conceals material information for the purpose of misleading, may be guilty of a crime and subject to denial of coverage, fines, confinement in prison and/or civil penalties.

CALIFORNIA

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY AND PENNSYLVANIA

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 subjects such person to criminal and civil penalties.

I HAVE READ AND UNDERSTAND THE INFORMATION ON BOTH PAGES OF THIS FORM. I AFFIRM THE INFORMATION I HAVE PROVIDED HEREIN IS ACCURATE AND COMPLETE.

CLAIMANT SIGNATURE: _____ **DATE:** _____

YOU MAY RECEIVE A 1099 - MISCELLANEOUS INCOME TAX FORM FOR FAMILY LEAVE BENEFITS PAID ON YOUR BEHALF.

MAIL TO: **YOSEMITE INSURANCE CO.**
P.O. BOX 39
EVANSVILLE, IN 47701

OR FAX TO: **1-800-350-9582**

OR EMAIL TO: **InsClaims@onemainfinancial.com**