New Hampshire Paid Family & Medical Leave Certification Form

Metropolitan Life Insurance Company

Things to Know Before You Begin

- Please complete Section 1 before giving this form to the medical provider.
- To ensure benefit payments and/or *(where applicable)* job protection, MetLife requires that you submit a timely and complete certification based on your leave reason.
- Remember to add your First and Last Name along with the claim form number to all pages so that we can match this certification with your absence request.

Reminder: Forms marked as lifetime, unknown, as needed, indeterminate or the like, may be returned as incomplete.

SECTION 1: Employee information

Employee - First Name	Middle Name	Last Name	Claim Number

Employer Name

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

☐ Continuous ☐ Intermittent

Reason for Leave

☐ My own serious health condition *(including medical leave when insured disability does not apply)*

ICD-10 Diagnosis Code _____

☐ To bond with a child

☐ Military Exigency

☐ To care for a family member due to a serious health condition

1. Relationship to Employee:

☐ Child *(under 18)* ☐ Child *(over 18)* ☐ Parent

☐ Spouse ☐ Domestic Partner ☐ Grandparent

☐ Other

Description If Other _____

2. If care of Family member, did the Illness or Injury incur in the line of military duty?

☐ Yes ☐ No

Authorization and Signatures

By signing below, I certify that the intent of the information in this document is to support my need to be absent from work due to the qualifying reason checked above.

Sign Here

Signature	Date *(mm/dd/yyyy)*

Employee - First Name	Middle Name	Last Name	Claim Number

SECTION 2: Certification of Serious Health Condition *(Employee's own medical or family member)*

To be completed by the healthcare provider.

Patient's - First Name	Middle Name	Last Name

Date of Birth *(mm/dd/yyyy) (required)*	Gender	ICD-10 Diagnosis Code

Does the patient have a serious health condition that prevents them from performing the material and substantial duties of their job?

☐ Yes ☐ No

Check and complete all that apply:

☐ Condition due to pregnancy

Estimated Due Date *(mm/dd/yyyy)* _____

Child's Date of Birth *(mm/dd/yyyy)*	Place of Birth *(city, state)*

☐ Is the claimant pregnant *(when condition itself is not pregnancy)*? ☐ Yes ☐ No

Is the condition due to *(check any that apply)*:

☐ aviation *(except as a fare-paying passenger)*
☐ professional sports
☐ incarceration
☐ commission of a felony, riot, or driving under the influence of drugs, alcohol, or a combination thereof
☐ harm to a family member due to willful intention of the insured
☐ Dates you treated patient for condition: Starting *(mm/dd/yyyy)* _____ To *(mm/dd/yyyy)* _____
Will patient need treatment visits at least twice per year due to condition? ☐ Yes ☐ No
☐ Expected duration of condition: Starting *(mm/dd/yyyy)* _____ To *(mm/dd/yyyy)* _____
☐ Condition lead to hospital admittance: Starting *(mm/dd/yyyy)* _____ To *(mm/dd/yyyy)* _____

Intermittent Absence Details: Will the employee listed above require an intermittent absence and/or reduced work schedule to care for your patient's *(the employee/'s family member)* serious health condition? If so, please check the box below and provide approximately how long your patient will need the intermittent support outlined below.

Frequency: ____ times per ☐ Week, ☐ Month ☐ Year

Length of Episode _____ Minutes____ Hours_____ Fully Day(s)

Note: 4 hour minimum requirement.

Employee - First Name	Middle Name	Last Name	Claim Number

In the space provided below or in an attached page, please describe relevant medical facts, if any, related to the condition for which the employee seeks leave from work (*i.e., pregnancy complications, or any regimen of continuing treatment such as the use of specialized equipment).*

In the space provided below or in an attached page, please describe the care needed for the patient and why such care is medically necessary. If care is for an adult child, List ADLs or IADLs your patient requires support to perform *(i.e., cooking, toileting, travel to appointments).*

Please Read:

GINA Disclaimer: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic Information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Fraud Notice: Any person who knowingly and with intent to injure, defraud, or deceive any person, or knowing that they are facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information is/may be guilty of a crime and may be prosecuted and punished. Penalties may include fines, civil damages and criminal penalties, including confinement in prison.

By signing below, I attest that I am the treating health care provider to the listed patient. The clinical information I am providing is in regard to the dates of absences listed above. I certify that my patient's family member (*employee*) must be absent from work or have a modified work schedule due to this condition.

License Number	State
	▼

Business Name

Address	City	State	ZIP
		▼	

Email address	Phone number

Sign Here

Signature of Healthcare Provider	Date *(mm/dd/yyyy)*

Employee - First Name	Middle Name	Last Name	Claim Number

SECTION 3: Child Bonding: *(Only complete if leave reason is to bond with a child)*

Select the type of documentation provided.

- ☐ Copy of Birth Certificate
- ☐ Copy of Placement Documents for Adoption/Foster Care
- ☐ Healthcare Provider Certification of birth date *(Section 2)*

SECTION 4: Military *(Only complete if leave reason is for Military Exigency or Military Caregiver leave)*

Service Member Affiliation:

- ☐ Army
- ☐ Navy
- ☐ Air Force
- ☐ National Guard
- ☐ Marine Corps
- ☐ Other: _____

- ☐ Active
- ☐ Reserves
- ☐ Veteran

Service Member Rank	Unit

Check all that apply

- ☐ Service member is on the Temporary Disability Retired List (TDRL)
- ☐ Service member is on the Permanent Disability Retired List
- ☐ Illness or Injury incurred in the line of duty

Check the appropriate reason for leave

- ☐ Childcare and School Activities
- ☐ Military Events and Related Activities
- ☐ Short Notice Deployment
- ☐ Counseling
- ☐ Post Deployment Activities
- ☐ Financial and Legal
- ☐ Parental Care
- ☐ Rest and Recuperation
- ☐ Bereavement
- ☐ Additional activities as described _____

Check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status:

- ☐ A copy of the covered military member's active duty orders is attached.
- ☐ Other documentation from the military certifying that the covered military member is on active duty orders *(or has been notified of an impending call to active duty)* in support of a contingency operation is attached.
- ☐ I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

SECTION 5: How to submit this form

MetLife offers several methods for submission. You can contact the MetLife NH PFML contact center to discuss options by phone at: 866-595-PFML and following the appropriate prompts.