Application for Paid Family Leave Benefits **To be completed by the Employee (Incomplete forms will be returned)**	**Paid Family Leave** ____________________ Employer Name	**Mail or Fax to:** **TRISTAR Benefit Administrators** PO Box 32363, Long Beach, CA 90832 Tele: 877/874-3518 Fax: 562/495-6687

Claimant's Name (First, Middle, Last)			Social Security Number -- --
Address			
City		State	Zip Code
Telephone Number		E-Mail Address	
Date of Birth	Gender ☐ Female ☐ Male	Date you last worked	Date you want PFL to begin
What is your occupation?		Did you work or will you continue to work during your family leave period? ☐ Yes ☐ No	

Why did you or will you reduce your work hours or stop working?

☐ Care for family member ☐ Bond with Child ☐ 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:
☐ Child ☐ Spouse ☐ Registered Domestic Partner ☐ Parent ☐ Other (Explain)________________

Is any other family member able and available to provide care for the same period you are claiming PFL benefits?
☐ No ☐ 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?
☐ No ☐ 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.

☐ Sick Pay ☐ Vacation Pay ☐ 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:

TRISTAR SM BENEFIT ADMINISTRATORS