

Statement of Care Recipient	Paid Family Leave <hr/> Employer Name	Mail or Fax to: TRISTAR Benefit Administrators PO Box 32363, Long Beach, CA 90832 Tele: 877/874-3518 Fax: 562/495-6687
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: <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> Parental right <input type="checkbox"/> Power of attorney (attach copy) <input type="checkbox"/> Court order (attach copy)		
Personal Representative's Signature:		Date Signed