Connecticut Paid Leave
Employment Verification

Administrative Office
PO Box 84077
Columbus GA, 31908-4077

Phone: (877) 499-8606
Fax: (888) 485-0973
Email: CTPFL@Aflac.com

Employee Information (To be completed by the Employee)

First Name:	Last Name:	Case Number:	
Phone Number:	Last 4 Digits of SSN:	Date of Birth:	
Street Address:	City:	State:	Zip Code:
Beginning Date of Leave:	End Date of Leave:		

Leave type: ☐ Continuous ☐ Intermittent ☐ Reduced schedule

Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate, and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution. I further certify that if benefits are paid in excess of the amount to which I am entitled, I will return to the Authority the amount that was overpaid, and I acknowledge that failure to do so may result in the accrual of interest and other penalties.

Employee Signature and Title	**Date**

Employer Information (To be completed by the Employer)

Instructions to the employer: Please complete the following information and return to Aflac within **10 calendar days** of receipt from your employee. You can send it by email at CTPFL@Aflac.com or fax to **(888) 485-0973**.

Employer Name:		
FEIN:	Tax ID:	SIC/NAICS code:
Address:		
City:	State:	Zip Code:
Contact Name:	Communication Preference: ☐ Email (Preferred method) ☐ USPS mail	
Contact Phone Number:	Contact Email:	
Employee's Date of Hire:	Employee's Date of Termination (If Applicable):	
Employee's Job Title:	Date Last Worked:	

Has the employee returned to work? ☐ Yes ☐ No Return to Work Date: _____ (☐ Actual ☐ Estimated)

Please select the work days that the employee **typically** works:

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

** Claims administered by American Family Life Assurance Company of Columbus or its affiliates.*

Employee First Name:	Employee Last Name:	Case Number:

Employer Information (continued)

Please provide the scheduled work hours (including regular and overtime hours combined) from the last 12 weeks that the employee reported to work:

Week 1:	Week 2:	Week 3:
Week 4:	Week 5:	Week 6:
Week 7:	Week 8:	Week 9:
Week 10:	Week 11:	Week 12:

Other Potential Sources of Income:

Is the leave request a result of employee's injury on the job? ☐ Yes ☐ No

- If yes, has the employee applied for Worker's Compensation payments/benefits? ☐ Yes ☐ No
  - If yes, is the employee receiving Worker's Compensation payments/benefits? ☐ Yes ☐ No
    Effective date of benefits: _____

In the event CT Paid Leave benefits are approved, will the employee receive any Employer-Provided income replacement benefits (ex: PTO, Sick Leave, other Short-Term Disability benefits, etc.) while on leave? ☐ Yes ☐ No

If yes, will the Employer-Provided income replacement benefits be paid to top-off or supplement the CT PL benefits (i.e., be secondary) or will they be paid before the CT PL benefits are received (i.e. be primary)? ☐ Secondary ☐ Primary

If any of the Employee-Provided benefits are **primary**, what percentage of employee weekly wages are you planning to pay and for how many weeks, days or hours? _____

Note: If percentage will change over time, please indicate separate percentages on each line below as applicable:

Percentage: _____ Start date: _____ End Date: _____

Percentage: _____ Start date: _____ End Date: _____

Percentage: _____ Start date: _____ End Date: _____

Percentage: _____ Start date: _____ End Date: _____

Please advise if there are Company shutdowns scheduled and, if so, provide the dates:

Please advise if there are Company holidays scheduled. ☐ Yes ☐ No

- If yes, what are the holiday dates? _____

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Employer Signature and Title	**Date**

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