



**Claim for Paid Family Leave (PFL) Benefits  
Care of a Family Member**

CASE NUMBER: 00588975

**CARE RECIPIENT'S AUTHORIZATION FOR DISCLOSURE OF PERSONAL-HEALTH INFORMATION**

I authorize my physician or practitioner, as identified on Part D of this claim, to disclose my current personal-health information to my care provider, as identified on Part A of this claim, and to Zurich Life and Absence Management.

I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and an estimation of the amount of care that I require from my care provider as a result of my current condition. I further understand that disclosure of my personal-health information may include my AIDS/HIV status, drug or alcohol addiction, or any other physical or mental condition.

I understand that Zurich Life and Absence Management may disclose this information as authorized by the California Unemployment Insurance Code and that such re-disclosed information may no longer be protected. I agree that photocopies of the authorization form in conjunction with my signature on Page 3 in Item 6 of Part C shall be as valid as the original.

I understand that unless I inform Zurich Life and Absence Management in writing at P.O. Box 1725, Grand Rapids MI 49501, that I wish to revoke this authorization, it will be valid for 10 years from the date Zurich Life and Absence Management receives it or the effective date of this claim, whichever is later. I understand that I have the right to receive a copy of an authorization form from Zurich Life and Absence Management if I request one in writing.

I make this authorization to support my care provider's claim for Paid Family Leave benefits. I understand that I may not revoke my authorization to avoid prosecution or to prevent Zurich Life and Absence Management's recovery of monies to which it is legally entitled.

**WE CANNOT PROCESS THIS CLAIM UNLESS YOU SIGN BOTH THIS PAGE AND PAGE 3 IN ITEM C6 OF PART C.**

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Care recipient's name (Print your name)

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Date signed

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Care recipient's signature (Sign your name)



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**PART C – 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.)**C1. RECIPIENT'S DATE OF BIRTH**  
M M D D Y Y YY**C2. RECIPIENT'S TELEPHONE NUMBER****C3. RECIPIENT'S GENDER**  
MALE      FEMALE**C4. LEGAL NAME OF CARE RECIPIENT (FIRST [ ] MIDDLE INITIAL [ ] LAST)****C5. CARE RECIPIENT'S RESIDENCE ADDRESS**

CITY

STATE/PROV. ZIP OR POSTAL CODE

COUNTRY (IF NOT U.S.A.)

**C6. CONFIRMATION OF MEDICAL DISCLOSURE AUTHORIZATION.** I have read and signed the Care Recipient's Authorization for Disclosure of Personal-Health Information on page 2 of this claim form. I understand that by signing it I have agreed to all its provisions and terms. I further understand that copies of my signature below are as valid as the original.

Care Recipient's Signature (DO NOT PRINT) Date Signed ( MM | DD | YYYY )

C7. Authorized Representative signing on behalf of care recipient must complete the following: I, \_\_\_\_\_, represent the care recipient in this matter as authorized  parental  power of attorney (attach  court order (attach copy))

Authorized Representative's Signature (DO NOT PRINT) Date Signed ( MM | DD | YYYY )