Statement of Care Recipient **To be completed by Care Recipient (Incomplete forms will be returned)**	**Paid Family Leave** Employer Name	**Email or Fax to: TRISTAR** Tel: 844/702-2352 Fax: 562/495-6687 Emal: ICSFax@tristargroup.net

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):

Legal Name of Care Recipient (First, Middle, Last):		Care Recipient is PFL Claimant's: ☐ Child ☐ Spouse ☐ Partner ☐ Parent ☐ Parent-in-law ☐ Grandparent ☐ Grandchild ☐ Sibling ☐ Other (Explain): _____
Recipient's Date of Birth:	Recipient's Gender: ☐ Male ☐ Female	Recipient's Telephone Number:
Care Recipient's Residence Address:		City, State, Zip:

CONFIRMATION OF MEDICAL DISCLOSURE AUTHORIZATION. I authorize my physician/practitioner to disclose my current personal health information to my care provider and to TRISTAR Benefit Administrators. 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)

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

☐ Parental right ☐ Power of attorney (attach copy) ☐ Court order (attach copy)

Personal Representative's Signature (DO NOT PRINT):	Date Signed: (MM/DD/YYYY)