Application for Paid Family and Medical Leave

Before you begin
When you apply for benefits online, you can choose how to submit your weekly benefit claims (online or over the phone) and how to receive your benefit payments (direct deposit to your bank account or on a prepaid debit card). When you apply for benefits with a paper application, you are limited to:

1. Submitting weekly benefit claims over the phone by calling 833-717-2273.
2. Receiving your benefit payments on a prepaid debit card.

If you would like to file your weekly claims online or receive your benefit payments through direct deposit, you must submit your application online. Go to www.paidleave.wa.gov for more information.

The Paid Family and Medical Leave Benefit Guide provides information on how to apply for benefits and submit weekly claims. It also explains your rights and responsibilities under the law. Download the guide at paidleave.wa.gov/benefit-guide or request a copy by calling 833-717-2273.

Benefit application instructions

Personal and contact information section
Provide your name, Social Security (SSN) or Individual Taxpayer Identification Number (ITIN), birthdate and contact information. The address you provide is where we will mail your prepaid debit card and other correspondence.

Employment information section
We’ll use the information you provide to confirm you’ve worked enough hours to be eligible for leave.

- Employer name. The name of the business or organization you worked for.
- Unified Business Identifier (UBI) or Federal Employer Identification Number (FEIN). Find your employer’s UBI by asking them for it, or by using the UBI look-up tool on the Department of Revenue’s website (www.DOR.wa.gov).
- Employment start and end dates. If they’re your current employer, leave the end date blank and check the box to indicate they’re your current employer.

Leave information section
We’ll ask for information about your leave request, including the type of leave you’re requesting (medical, family, bonding after birth or placement of a child, or military exigency) and your expected start and end dates.
Can someone else complete this form for me?
You can authorize another individual to act on your behalf for the purposes of Paid Family and Medical Leave benefits. To do this, complete the Designated Authorized Representative form. Contact us at 833-717-2273 to get a copy of the form.

Submitting your application
Mail your completed application, copies of your identifying documents, and any other supporting documents (certification of a serious health condition, designated authorized representative form, etc.) to:

Employment Security Department
Paid Family and Medical Leave Care Center
P.O. Box 19020
Olympia, WA 98507-0020

Questions?
If you have any questions, please contact us at 833-717-2273 or paidleave@esd.wa.gov.
### Benefit application

#### Section one: Personal information

<table>
<thead>
<tr>
<th>Name (first, middle initial, last)*:</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSN/ITIN*:</td>
</tr>
<tr>
<td>Date of birth*:</td>
</tr>
<tr>
<td>Phone number*:</td>
</tr>
<tr>
<td>Email address:</td>
</tr>
<tr>
<td>Preferred contact method*:</td>
</tr>
<tr>
<td>□ Phone</td>
</tr>
<tr>
<td>□ Email</td>
</tr>
<tr>
<td>□ Mail</td>
</tr>
<tr>
<td>Mailing address*:</td>
</tr>
<tr>
<td>☐ Female</td>
</tr>
<tr>
<td>☐ Male</td>
</tr>
<tr>
<td>☐ Non-binary</td>
</tr>
<tr>
<td>☐ Prefer not to say</td>
</tr>
<tr>
<td>Which of the following best describes your ethnic heritage? Check all that apply.</td>
</tr>
<tr>
<td>□ White</td>
</tr>
<tr>
<td>□ Black or African American</td>
</tr>
<tr>
<td>□ American Indian or Alaska Native</td>
</tr>
<tr>
<td>□ South Asian or South Asian American</td>
</tr>
<tr>
<td>□ East Asian or East Asian American</td>
</tr>
<tr>
<td>□ Southeast Asian or Southeast Asian American</td>
</tr>
<tr>
<td>□ Native Hawaiian or other Pacific Islander</td>
</tr>
<tr>
<td>□ Hispanic or Latinx</td>
</tr>
<tr>
<td>□ Middle Eastern or Arab American</td>
</tr>
<tr>
<td>□ Prefer not to say</td>
</tr>
<tr>
<td>□ Other</td>
</tr>
</tbody>
</table>

* Indicates required field
## Section two: Employment information

We need your employment history to determine whether you’ve worked enough hours to qualify for leave. Please list each employer you’ve worked for since January 1, 2019.

What is your current employment status?*

- [ ] Full-time salaried employee
- [ ] Part-time or hourly employee
- [ ] Unemployed

### Employer name*:

### UBI or FEIN:

Is this your current employer?*

- [ ] Yes
- [ ] No

Are you planning to take leave from this employer?*

- [ ] Yes
- [ ] No

Did you notify this employer that you plan to take leave?*

- [ ] Yes
- [ ] No
- [ ] Requirement waived

If yes, on what date did you notify them?* _____________________________________________

Employment start date*: Employment end date:

Employer phone number*:

Employer address*:

Employer name:

### UBI or FEIN:

Is this your current employer?*

- [ ] Yes
- [ ] No

Are you planning to take leave from this employer?*

- [ ] Yes
- [ ] No
**Did you notify this employer that you plan to take leave?**
- Yes
- No
- Requirement waived

If yes, on what date did you notify them? ________________________________

<table>
<thead>
<tr>
<th>Employment start date:</th>
<th>Employment end date:</th>
</tr>
</thead>
</table>

Employer phone number:

**Employer address:** __________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Employer name:

**UBI or FEIN:**

**Is this your current employer?**
- Yes
- No

**Are you planning to take leave from this employer?**
- Yes
- No

**Did you notify this employer that you plan to take leave?**
- Yes
- No
- Requirement waived

If yes, on what date did you notify them? ________________________________

<table>
<thead>
<tr>
<th>Employment start date:</th>
<th>Employment end date:</th>
</tr>
</thead>
</table>

Employer phone number:

**Employer address:** __________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

* Indicates required field
Section three: Leave information

Select the type of leave requested*:  
- **Medical leave for yourself**  
  If yes, are you unable to work due to a serious health condition related to pregnancy?  
  - Yes  
  - No

- **Leave to care for a family member**  
  If yes, which family member are you taking leave for?  
  - Parent (or parent of spouse)  
  - Spouse  
  - Child  
  - Sibling  
  - Grandchild  
  - Grandparent (or grandparent of spouse)  
  - Other: __________________________________________

- **Bonding after birth or placement of a child**  
  If yes, date of birth or placement: ____________________________

- **Military exigency**

  How long do you expect to be on leave?*  
  Start date: ____________________________  
  End date: ____________________________

  Did you or will you receive workers’ compensation or unemployment benefits for the time period for which you are requesting leave?*  
  - Yes  
  - No

  Did you know you would need to take leave beforehand?*  
  - Yes  
  - No

* Indicates required field
**Section four: Consent and signature**

Paid Family and Medical Leave may share and receive information about you (or your claim) with other agencies, departments, or your employers. We may need to verify information you provide and may request additional information as needed.

If you misrepresent yourself, or knowingly withhold information from us, it will be considered fraud. If you provide inaccurate information, we may deny your benefit application or require that you pay back benefits you were given. You could face fines or criminal prosecution.

☐  _I consent to the disclosure of my information and have answered the application questions truthfully._

<table>
<thead>
<tr>
<th>Signature*:</th>
<th>Date*:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed name*:</td>
<td></td>
</tr>
</tbody>
</table>

* Indicates required field

---

If the person applying for benefits is unable to sign this form because of a serious health condition or injury, an authorized representative may sign on their behalf, provided they also submit a Designated Authorized Representative form.

**Authorized representative name:**

<table>
<thead>
<tr>
<th>Authorized representative signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**Phone number:**

**Email:**
Certification of Serious Health Condition form

Instructions for person applying for leave

Who should use this form?
The information included on this form is required when you are applying for:

- Medical leave due to your own serious health condition.
- Family leave to take care of a family member with a serious health condition.

We cannot approve your application for medical leave or family leave without certification from a healthcare provider. Upload the completed form through your Paid Leave account or include it with your application. You do not need to set up your Paid Leave account before your healthcare provider completes this form.

You may submit a complete FMLA form or similar certification to substantiate your own or your family member’s serious health condition instead of this form. However, we may require additional documentation if there is a question about certification provided.

How to complete this form?
The person applying for leave completes section one, and their healthcare provider (or their family member’s healthcare provider) completes section two.

The healthcare provider must be able to certify your or your family member’s serious health condition.

Healthcare providers who are authorized to sign this form are defined in RCW 50A.05.010 and WAC 192-500-090. Generally, “healthcare provider” means:

- A physician or an osteopathic physician who is licensed to practice medicine or surgery, as appropriate, by the state in which the physician practices;
- Nurse practitioners, nurse-midwives, midwives, clinical social workers, physician assistants, podiatrists, dentists, clinical psychologists, optometrists, and physical therapists licensed to practice under state law and who are performing within the scope of their practice as defined under state law by the state in which they practice.

Can someone else complete this form for me?
You may authorize another individual to act on your behalf for the purposes of Paid Family and Medical Leave benefits by having them complete a Designated Authorized Representative form. Your authorized representative can sign this form on your behalf with appropriate documentation. Your authorized representative cannot substitute for a healthcare provider in completing section two. Contact us at 833-717-2273 to request a copy of the form.

Questions?
If you have any questions, please contact us at 833-717-2273 or paidleave@esd.wa.gov.
Instructions for healthcare providers

This form is used to certify a serious health condition in order to qualify for Paid Family and Medical Leave. Your patient may be applying due to their own serious health condition or to care for a family member with a serious health condition. Qualifying serious health conditions and authorized healthcare providers are described below. Answer each question to the best of your medical knowledge, based on your examination of the patient.

SERIOUS HEALTH CONDITION

A “serious health condition” is defined in RCW 50A.05.010 and healthcare providers should review the complete definition before certifying a patient’s condition. Generally, a serious health condition could include an illness, injury, impairment, or physical or mental condition that involves:

Inpatient care: Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity; or

Continuing treatment by a healthcare provider: A serious health condition involving continuing treatment by a healthcare provider includes any one or more of the following:

- Incapacity: A period of incapacity of more than three consecutive days and subsequent treatment or period of incapacity relating to the same condition. Incapacity means an inability to work, attend school, or perform other regular daily activities because of a serious health condition, treatment of that condition or recovery from it, or subsequent treatment in connection with such inpatient care.
- Pregnancy: Any period of incapacity due to pregnancy, or for prenatal care;
- Chronic conditions: Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which:
  - Continues over an extended period of time, including recurring episodes of a single underlying condition;
  - Requires periodic visits to a health care provider; and
  - May cause episodic rather than a continuing period of incapacity, including asthma, diabetes, and epilepsy
- Permanent/Long-term: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider, including Alzheimer’s, a severe stroke, or the terminal stages of a disease; or
- Multiple treatments: Any period of absence to receive multiple treatments, including any period of recovery from the treatments.
- Substance abuse may be a serious health condition if the treatment meets other requirements in this definition.

HEALTHCARE PROVIDERS

Healthcare provider is defined in RCW 50A.05.010 and WAC 192-500-090 and means:

- A physician or an osteopathic physician who is licensed to practice medicine or surgery, as appropriate, by the state in which the physician practices;
- Nurse practitioners, nurse-midwives, midwives, clinical social workers, physician assistants, podiatrists, dentists, clinical psychologists, optometrists, and physical therapists licensed to practice under state law and who are performing within the scope of their practice as defined under state law by the state in which they practice;
- A health care provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is performing within the scope of the health care provider’s practice as defined under such law; or
- Any other provider permitted to certify the existence of a serious health condition under the federal FMLA (Act Feb. 5, 1993, P.L. 103-3, 107 Stat. 6, as it existed on October 19, 2017).
**Certification of serious health condition**

**Instructions:** Complete section one of this form, then have your or your family member’s healthcare provider complete section two. Upload the completed form to your Paid Leave account or include it with your application. Please include your name on each page.

### Section one: Your information

To be completed by the person applying for leave before having the healthcare provider complete section two

<table>
<thead>
<tr>
<th>Paid Leave Customer ID number (if known):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Date of birth:</td>
<td></td>
</tr>
</tbody>
</table>

**Reason for taking Paid Family and Medical Leave**

- **For my own serious health condition**
  - **Instructions:** Have your healthcare provider complete this medical certification, listing yourself as the patient.

- **To care for a family member during their serious health condition**
  - **The family member needing care is my:**
    - [ ] Child
    - [ ] Spouse or registered domestic partner
    - [ ] Parent (or spouse’s parent)
    - [ ] Sibling
    - [ ] Grandparent (or spouse’s grandparent)
    - [ ] Grandchild
  - **Instructions:** Have your family member’s healthcare provider complete this medical certification, listing your family member as the patient.

### Authorization and signatures

I authorize Paid Family and Medical Leave to use the information on this form to determine my eligibility for paid family or medical leave benefits and I attest that I am applying for Paid Leave due to my own serious health condition or to take care of a family member with a serious health condition.

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

If the person applying for benefits is unable to sign this form because of a serious health condition or injury, an authorized representative may sign on their behalf, provided they also submit a Designated Authorized Representative form.

<table>
<thead>
<tr>
<th>Authorized representative name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>
### Section two: Description of the serious health condition

To be completed by a healthcare provider as defined in RCW 50A.05.010

Answer all questions fully and completely. Limit your responses to the condition for which the person applying for Paid Leave is seeking leave. Please be sure to sign the form.

<table>
<thead>
<tr>
<th>Patient’s name:</th>
<th>Date of birth: _____ / _____ / _____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the patient have a serious health condition that necessitates care? (as defined in RCW 50A.05.010)</td>
<td>Yes □ No □</td>
</tr>
</tbody>
</table>

**Diagnosis:**

What is the expected duration of the serious health condition?

Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as “unknown,” or “indeterminate” may not be sufficient to determine Paid Leave eligibility.

<table>
<thead>
<tr>
<th>Start date:</th>
<th>End date:</th>
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</table>

**PROVIDER’S INFORMATION AND CERTIFICATION**

I declare under penalty of perjury that the information provided in this form is true and correct, that the patient’s condition meets the definition of “serious health condition” [RCW 50A.05.010], and that I am a healthcare provider authorized to certify their condition [RCW 50A.05.010; WAC 192-500-090].

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
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<table>
<thead>
<tr>
<th>Name and title:</th>
<th></th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Certificate license and state:</th>
<th></th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>License area/area of practice:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Business name:</th>
<th></th>
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</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th></th>
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</table>

<table>
<thead>
<tr>
<th>Phone number:</th>
<th></th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Email address:</th>
<th></th>
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</thead>
</table>
IDENTITY VERIFICATION DOCUMENTS

Acceptable identification documents for Paid Family and Medical Leave

You must provide identification verification documents with your Paid Family and Medical Leave application. Identification verification documents must also be provided for any authorized designated representative. Please submit one stand-alone document OR two alternate documents from the list below. Do not send originals.

Stand-alone documents (one of these)

- Valid United States government (federal or state) issued form of identification (i.e., passport, passport card, ID card, enhanced or standard driver’s license, B1/B2 Visa Border Crossing Card, etc.)
- Valid United States Citizenship and Immigration Service ID. Acceptable forms are:
  - I-327 U.S. Permit to Re-Enter Travel Document
  - I-551 Permanent Resident Card
- Valid foreign government issued form of identification (i.e. passport, consular ID card, national identification card or “cedula” with signature and photo, etc.)
- Valid enrollment ID card from a federally recognized Indian tribe (must include your signature and photo)
- Valid U.S. Bureau of Indian Affairs issued ID card (must include your signature and photo)

Alternate documents (two of these)

- Expired United States government (federal or state) issued form of identification (i.e. passport, passport card, ID card, enhanced or standard driver’s license, B1/B2 Visa Border Crossing Card, etc.)
- Expired United States Citizenship and Immigration Service ID. Acceptable forms are:
  - I-327 U.S. Permit to Re-Enter Travel Document
  - I-551 Permanent Resident Card
- Expired foreign government issued form of identification (i.e. passport, consular ID card, national identification card or “cedula” with signature and photo, etc.)
- Adoption papers
- Certified U.S. or foreign birth certificate
- Certified birth registration card (must include your name, date of birth, place of birth, file date, and issue date)
- Valid concealed weapons permit issued by a state or county agency
- Consular Report of Birth Abroad
- Ward of the Court decree/Order of Dependency
- Clearance letter or driving record from a state DMV
- Certified divorce decree
- Certified marriage license/certificate
- Professional license (nurse, physician, engineer, etc.)
- School transcript or record
- Valid student identification card issued by a nationally accredited college or university
- Transportation Worker Identification Credential (TWIC)
- Vehicle registration or title (a quick title isn't acceptable)
- Home utility bill (gas, electric, water, garbage, sewer, landline phone, TV, internet, ISTA)
- DSHS benefits letter (medical, food, etc.)
- Proof of home ownership (mortgage documents, property tax documents, deed, title, etc.)
- Business mail from a state, federal, tribal, county, or city government entity
- Individual Tax Identification Number (ITIN) letter from Internal Revenue Service (IRS)
- Home owners or renter’s insurance policy
- Auto insurance policy or bill
- Pay check or pay stub with the employer’s name and phone number or address
- W-2 form from an employer, or form 1099
- Moorage document (bill, contract, etc.)
YOUR PAID FAMILY AND MEDICAL LEAVE CHECKLIST

Paid Family and Medical Leave is here for you when you need it most. Use this checklist to help you gather the information and take the steps you need to apply for paid leave.

Paid Family and Medical Leave Benefit Guide

The Paid Family and Medical Leave Benefit Guide provides information on how to apply for benefits and submit weekly claims. It also explains your rights and responsibilities under the law. Applicants are responsible for knowing the information in this guide. Download the guide at paidleave.wa.gov/benefit-guide.

For All Leave:

Give your employer written notice and save a copy.

- If you know you’ll be taking leave ahead of time, give written notice to your employer at least 30 days before leave starts.
- If you need paid leave unexpectedly, notify your employer in writing as soon as you know you will need leave.
- This can be an email, letter or text. Make sure to save a copy.

Gather the following information that you’ll need when you apply:

- Social Security number or Individual Taxpayer Identification Number.
- Identity verification documents (see the list of acceptable documents)
- List of all employers you have worked for during the past 12 months.

OTHER LEAVE DOCUMENTS:

You’ll also need to submit specific documents when you apply, depending on the reason you are taking paid leave:

MEDICAL LEAVE:

- If you are taking leave for yourself, you’ll need:
  - Certification of Serious Health Condition form completed by your healthcare provider, or
  - Family Medical Leave Act paperwork or other documentation from your healthcare provider that can certify the existence of your serious health condition.

FAMILY LEAVE:

- If you are taking leave for a family member, you’ll need:
  - Certification of Serious Health Condition form completed by their healthcare provider, or
  - Family Medical Leave Act paperwork or other documentation from their healthcare provider that can certify the existence of your serious health condition.
  - We may ask for documentation of familial relationship if we have a question about your application.

- If you are taking leave for the birth of a child, adoption or becoming a foster parent:
  - You do not need to provide documentation to prove birth, adoption or placement to apply for bonding leave. We may ask for it if we have a question about your application.

- If you are taking leave to spend time with a family member because of a military deployment or event, you’ll need:
  - Active duty orders or other formal military documentation, and
  - You may need documentation of familial relationship
## U.S. Bank ReliaCard® Pre-Acquisition Disclosure

**Program Name:** Washington Paid Family & Medical Leave

<table>
<thead>
<tr>
<th>Monthly fee</th>
<th>Per purchase</th>
<th>ATM withdrawal</th>
<th>Cash reload</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0 in-network</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$2.50 out-of-network</td>
<td></td>
</tr>
</tbody>
</table>

ATM Balance Inquiry (in-network or out-of-network) $0

Customer Service (automated or live agent) $0 per call

Inactivity $0

**We charge 3 other types of fees.** Here are some of them:

- **International ATM Withdrawal** $3.00
- **International Transaction** 3%

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**No overdraft/credit feature.**

Your funds are eligible for FDIC insurance.

For general information about prepaid accounts, visit [cfpb.gov/prepaid](http://cfpb.gov/prepaid). Find details and conditions for all fees and services inside the card package or call **1-888-964-0359** or visit [usbankreliacard.com](http://usbankreliacard.com).
## All fees

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Get cash</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ATM Withdrawal (in-network)</td>
<td>$0</td>
<td>This is our fee per withdrawal. “In-network” refers to the U.S. Bank or MoneyPass® ATM networks. Locations can be found at usbank.com/locations or moneypass.com/atm-locator.</td>
</tr>
<tr>
<td>ATM Withdrawal (out-of-network)</td>
<td>$2.50</td>
<td>This is our fee per withdrawal. “Out-of-network” refers to all the ATMs outside of the U.S. Bank or MoneyPass ATM networks. You may also be charged a fee by the ATM operator even if you do not complete a transaction.</td>
</tr>
<tr>
<td>Teller Cash Withdrawal</td>
<td>$0</td>
<td>This is our fee for when you withdraw cash off your card from a teller at a bank or credit union that accepts Visa®.</td>
</tr>
<tr>
<td><strong>Information</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ATM Balance Inquiry (in-network)</td>
<td>$0</td>
<td>This is our fee per inquiry. “In-network” refers to the U.S. Bank or MoneyPass ATM networks. Locations can be found at usbank.com/locations or moneypass.com/atm-locator.</td>
</tr>
<tr>
<td>ATM Balance Inquiry (out-of-network)</td>
<td>$0</td>
<td>This is our fee per inquiry. “Out-of-network” refers to all the ATMs outside of the U.S. Bank or MoneyPass ATM networks. You may also be charged a fee by the ATM operator.</td>
</tr>
<tr>
<td><strong>Using your card outside the U.S.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>International Transaction</td>
<td>3%</td>
<td>This is our fee which applies when you use your card for purchases at foreign merchants and for cash withdrawals from foreign ATMs and is a percentage of the transaction dollar amount, after any currency conversion. Some merchant and ATM transactions, even if you and/or the merchant or ATM are located in the United States, are considered foreign transactions under the applicable network rules, and we do not control how these merchants, ATMs and transactions are classified for this purpose.</td>
</tr>
<tr>
<td>International ATM Withdrawal</td>
<td>$3.00</td>
<td>This is our fee per withdrawal. You may also be charged a fee by the ATM operator even if you do not complete a transaction.</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Card Replacement</td>
<td>$0</td>
<td>This is our fee per replacement of a lost card mailed to you with standard delivery (up to 10 business days).</td>
</tr>
<tr>
<td>Card Replacement Expedited Delivery</td>
<td>$15.00</td>
<td>This is our fee for expedited delivery (up to 3 business days) charged in addition to any Card Replacement fee.</td>
</tr>
</tbody>
</table>

Your funds are eligible for FDIC insurance. Your funds will be held at U.S. Bank National Association, an FDIC-insured institution, and are insured up to $250,000 by the FDIC in the event U.S. Bank fails. See fdic.gov/deposit/deposits/prepaid.html for details.

No overdraft/credit feature.
Contact Cardholder Services by calling 1-888-964-0359, by mail at P.O. Box 551617, Jacksonville, FL 32255 or visit usbankreliacard.com.

For general information about prepaid accounts, visit cfpb.gov/prepaid. If you have a complaint about a prepaid account, call the Consumer Financial Protection Bureau at 1-855-411-2372 or visit cfpb.gov/complaint.