请假申请材料清单

带薪家庭假和病假申请材料清单

当您有迫切需要时，可申请带薪家庭假和病假。请根据本材料清单准备相关材料，并根据必要流程申请带薪假期。

带薪家庭假和病假福利申请指南
本带薪家庭假和病假福利申请指南提供了有关如何申请本福利及如何提交每周申请的信息。同时，本指南还说明了您的相关法律权利与责任。申请人有责任了解本指南中的信息。 请前往 paidleave.wa.gov/benefit-guide 下载本指南。

申请任何类型的假期均需：
向您的雇主提供书面通知，并保存一份副本。

- 如果您提前知道自己需要休假，请在假期开始前至少 30 天书面通知您的雇主。
- 如果您突然需要申请带薪假期，则请在知道自己需要休假后尽快书面通知您的雇主。
- 通知可通过邮件、书信或短信形式发出。请务必保存一份副本。

申请假期时，请收集所需的以下信息：

- 社会安全号码。
- 身份证明文件（请参见合格文件清单）
- 您在过去 12 个月内的所有雇主清单。

其他请假所需文件：
申请带薪假期时，您还需要提交一些特定文件，具体取决于您的请假原因：

- **病假：**
  - **如果您因自己生病而请假，您需提交：**
    - 由您的医疗服务提供者填写的严重疾病证明，*或*
    - 《家庭假和病假法案》(Family Medical Leave Act) 文件资料，或由您的医疗服务提供者提供的可证明您的确患有严重疾病的其他证明文件。
- **家庭假：**
  - **如果您因家人生病而请假，您需提交：**
    - 由该家庭成员的医疗服务提供者填写的严重疾病证明，*或*
    - 《家庭假和病假法案》(Family Medical Leave Act) 文件资料，或由该家庭成员的医疗服务提供者提供的可证明其的确患有严重疾病的其他证明文件。

    - 如果我们对您的申请有疑问，我们可能会要求您提供家庭关系证明文件。
- **如果您因婴儿出生、儿童领养或成为养父/母而需与儿童建立关系等事宜而请假：**
    - 申请亲子假时，您无需提供婴儿出生、儿童领养或寄养的证明文件。如果我们对您的申请有疑问，我们可能会要求您提供该等文件。
- **如果您因要参加军事部署或军事行动而需请假与家人团聚，您需提交：**
    - 现役命令或其他正式军事文件，及
    - 您可能需要提交家庭关系证明文件

Washington Paid Family & Medical Leave
Employment Security Department

身份证明文件

用于申请带薪家庭假和病假的合格身份证明文件

在提交带薪家庭假和病假申请表时，您必须同时提供身份证明文件。此外，您还必须提供任何指定授权代表的身份证明文件。**请提交下列一种独立文件或两种替代文件。**请勿发送原件。

独立文件（请提供其中一种）

- 由美国政府（联邦或州）签发的**有效**身份证件（即，护照、护照卡、身份证、加强版或标准驾照、B1/B2 签证/过境卡等）
- **有效的**美国公民身份证及美国移民身份证件。合格证件如下：
  - 表格 I-327 - 美国再入境许可旅行证件
  - 表格 I-551 - 永久居民卡
  - 表格 I-571 - 美国难民旅行证件
  - 表格 I-766 - 工作许可
- 由外国政府签发的**有效**身份证件（即，护照、领事身份证、国民身份证或含有签名和照片的"证件"等）
- 来自获得联邦认可的印第安部落的**有效**登记身份证（必须含有您的签名和照片）
- 由美国印第安事务局签发的**有效**身份证（必须含有您的签名和照片）

替代文件（请提供其中两种）

- 由美国政府（联邦或州）签发的、但**已过期的**身份证件（即，护照、护照卡、身份证、加强版或标准驾照、B1/B2 签证/过境卡等）
- **已过期的**美国公民身份证及美国移民身份证件。合格证件如下：
  - 表格 I-327 - 美国再入境许可旅行证件
  - 表格 I-551 - 永久居民卡
  - 表格 I-571 - 美国难民旅行证件
  - 表格 I-766 - 工作许可
- 由外国政府签发的、但**已过期的**身份证件（即，护照、领事身份证、国民身份证或含有签名和照片的"证件"等）
- 领养文件
- 经认证的美国或外国出生证明
- 经认证的出生登记卡（必须包含您的姓名、出生日期、出生地、提交日期及签发日期）
- 由州或郡机关签发的有效隐蔽武器许可证
- 外国出生领事报告
- 法院监护令/抚养令
- 无犯罪证明或由州机动车辆管理局 (DMV) 出具的驾驶记录
- 经认证的离婚令
- 经认证的结婚证/结婚证明
- 职业证明（护士、医师、工程师等）
- 学校成绩单
- 由国家认可的高等院校签发的有效学生证
- 运输工人鉴定证书 (TWIC)
- 车辆登记证或所有权证（不接受快速所有权证）
- 家庭费用账单（煤气、电、水、垃圾、下水管道、固定电话、电视、网络、ISTA）
- 社会与健康服务部 (DSHS) 福利函（医疗、食品等）
- 自有产权住房证明（按揭文件、房产税文件、房产证、所有权证等）
- 由州、联邦、部落、郡或市政府机构寄送的商业信函
- 由美国国家税务局 (IRS) 提供的关于个人纳税识别号码 (ITIN) 的信函
- 房主或出租人保险单
- 汽车保险单或账单
- 含有雇主名称及电话号码或地址的工资支票或工资单
- 来自雇主的 W-2 表格，或 1099 表格
- 泊车文件（账单、合同等）

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带薪家庭假和病假申请表

申请前

当您选择在线申请福利时，您可以选择提交每周福利申请的方式（在线或通过电话），以及接收福利款项的方式（直接存入您的银行账户或使用预付借记卡）。当您选择提交纸质版文件来申请福利时，您只能：

1. 通过拨打电话 833-717-2273 来提交每周福利申请。
2. 通过预付借记卡来接收福利款项。

若您想要在线提交每周申请，或通过直接存入银行账户的方式来接收福利款项，您必须在线提交福利申请表。如需了解更多信息，请前往 www.paidleave.wa.gov。

本带薪家庭假和病假福利申请指南提供了有关如何申请本福利及如何提交每周申请的信息。同时，本指南还说明了您的相关法律权利与责任。请前往 paidleave.wa.gov/benefit-guide 下载本指南，或拨打电话 833-717-2273 索取本指南副本。

福利申请说明

个人信息及联系方式部分

请提供您的姓名、社会安全号码 (SSN)、出生日期以及联系方式。我们将根据您提供的地址邮寄您的预付借记卡及其他信件。

就业信息部分

我们将使用您提供的信息来确认您是否已经工作了足够长的时间以符合请假资格。

- 雇主名称。您工作过的公司或组织名称。
- 统一业务标识符 (UBI) 或联邦雇主识别号码 (FEIN)。可通过询问您的雇主或使用税务局网站 (www.DOR.wa.gov) 上的 UBI 查找工具来获得雇主的 UBI。
- 入职日期与离职日期。若某雇主是您当前的雇主，请将离职日期一栏留空，并勾选表明其是您的当前雇主的方框。

请假信息部分

我们将针对您的请假申请询问一些信息，包括您所申请假期的类型（病假、家庭假、婴儿出生或儿童寄养后的亲子假、紧急军事假），以及您希望的假期开始和结束日期。

本表格能否由他人代写?

您可以授权任何个人来代替您填表申请带薪家庭假和病假福利，但您必须填写"指定授权代表"表格。如需获取表格，请拨打 833-717-2273 与我们联系。

提交申请

请将您填妥的申请表、身份证明文件副本及任何其他证明文件（严重疾病证明、"指定授权代表"表格等）寄送至以下地址：

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

有疑问?

如果您有任何疑问，请拨打电话 833-717-2273 或发送邮件至 paidleave@esd.wa.gov 与我们联系。

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Paid Family & Medical Leave
Employment Security Department

福利申请表

第 1 部分：个人信息

姓名（名字、中间名首字母缩写、姓氏）*：

社会安全号码 (SSN)*：

出生日期*：

电话号码*：

邮箱地址：

首选联系方式*：

- ☐ 电话
- ☐ 邮件
- ☐ 邮寄

邮寄地址*： _____

_____

_____

_____

性别*：

- ☐ 女
- ☐ 男
- ☐ 非二元性别
- ☐ 不愿意透露

以下哪一项最能体现您的种族血统？请勾选所有适用项。

- ☐ 白人
- ☐ 黑人或非裔美国人
- ☐ 美洲印第安人或阿拉斯加原住民
- ☐ 南亚人或南亚裔美国人
- ☐ 东亚人或东亚裔美国人
- ☐ 东南亚人或东南亚裔美国人
- ☐ 夏威夷原住民或其他太平洋岛民
- ☐ 西班牙裔或拉丁裔
- ☐ 中东或阿拉伯裔美国人
- ☐ 不愿意透露
- ☐ 其他

*** 表示必填项**

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第 2 部分：就业信息

我们需要您以往的就业信息，以确定您是否工作了足够长的时间以符合请假资格。请列出您从 2019 年 1 月 1 日以来的所有雇主。

您当前处于何种就业状况？ *

- □ 全职受薪雇员
- □ 兼职雇员或钟点工
- □ 待业

雇主名称*：

统一业务标识符 (UBI) 或联邦雇主识别号码 (FEIN)：

该雇主是您当前的雇主吗？ *

- □ 是
- □ 否

您有打算从这个雇主离职吗？ *

- □ 是
- □ 否

您已经把离职打算告诉这个雇主了吗？ *

- □ 是
- □ 否
- □ 无此要求

若是，您是在什么时候告诉雇主的？ （请填写具体日期） * _____

入职日期*：	**离职日期：**

雇主联系电话*：

雇主地址*： _____

_____

_____

_____

雇主名称：

统一业务标识符 (UBI) 或联邦雇主识别号码 (FEIN)：

该雇主是您当前的雇主吗？

- □ 是
- □ 否

您有打算从这个雇主离职吗？

- □ 是
- □ 否

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您已经把离职打算告诉这个雇主了吗?

- □ 是
- □ 否
- □ 无此要求

若是，您是在什么时候告诉雇主的？（请填写具体日期） _____

入职日期:	**离职日期:**

雇主联系电话:

雇主地址: _____

_____

_____

_____

雇主名称:

统一业务标识符 (UBI) 或联邦雇主识别号码 (FEIN):

该雇主是您当前的雇主吗?

- □ 是
- □ 否

您有打算从这个雇主离职吗?

- □ 是
- □ 否

您已经把离职打算告诉这个雇主了吗?

- □ 是
- □ 否
- □ 无此要求

若是，您是在什么时候告诉雇主的？（请填写具体日期） _____

入职日期:	**离职日期:**

雇主联系电话:

雇主地址: _____

_____

_____

_____

*** 表示必填项**

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第 3 部分：请假信息

请选择所申请的请假类型*：

- ☐ **因自己生病而请病假**

  若是，那么您是否是因为怀孕而导致严重疾病，而无法工作？
  - ☐ 是
  - ☐ 否

- ☐ **为照顾家人而请家庭假**

  若是，您将要照顾的家人与您是何种关系？
  - ☐ 父母（或配偶的父母）
  - ☐ 配偶
  - ☐ 子女（女婿/儿媳）
  - ☐ 兄弟姐妹
  - ☐ 孙子/孙女/外孙/外孙女
  - ☐ 祖父/祖母/外祖父/外祖母（或配偶的祖父/祖母/外祖父/外祖母）
  - ☐ 妯娌/姨子/姑子/嫂子/弟媳/连襟/内兄/内弟/大伯/小叔/堂兄弟/姐夫/妹夫/姑兄/姑弟
  - ☐ 其他：_____

- ☐ **婴儿出生或儿童寄养后的亲子假**

  若是，则婴儿出生日期或儿童寄养日期为：_____

- ☐ **紧急军事假**

您预计请假多长时间？ *

假期开始日期：_____ 假期结束日期：_____

您在申请假期期间是否收到过或将收到员工补偿或失业津贴?*

- ☐ 是
- ☐ 否

您是否事先知道自己需要请假？ *

- ☐ 是
- ☐ 否

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*** 表示必填项**

第 4 部分：同意与签名

带薪家庭假和病假可与其他机构、部门或您的雇主分享您的信息（或申请），也能从该等机构、部门或您的雇主处接收您的信息（或申请）。我们可能需要核实您提供的信息，必要时也可能要求您提供额外信息。

若您提供个人虚假信息，或故意隐瞒信息，我们会将其视为欺诈。若您提供的信息不准确，我们可能会拒绝您的福利申请，或可能会要求您归还已发放的福利。为此，您可能会面临罚款或刑事诉讼。

☐ *本人同意披露个人信息，且本人已如实回答申请表中的问题。**

签名*：	**日期*：**
正楷姓名*：	
若申请本福利的人士因存在严重疾病或受伤情况而无法签署本表格，申请人可提交"指定授权代表"表格，授权一名授权代表代为签署。	
授权代表姓名：	
授权代表签名：	**日期：**
电话号码：	
邮箱：	

*** 表示必填项**

Forms for Applying for **Paid Family & Medical Leave**

STEP 1:
Select the right form

Use the Certification of Serious Health Condition form to apply for:

- Medical leave due to your own serious health condition, including medical leave for complications during pregnancy or to recover from giving birth
- Family leave to take care of a family member with a serious health condition

Use the Certification of Birth form when applying for:

- Family leave to bond with a new child (birth, adoption or foster placement)

STEP 2:
Fill out the form

The person applying for leave completes section one, and their healthcare provider (or their family member's healthcare provider) completes section two. Healthcare provider instructions are included in this packet.

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 cannot substitute for a healthcare provider in completing section two.
- Contact us at 833- 717-2273 to request a copy of the Designated Authorized Representative form.

STEP 3:
Upload your completed form

Submit your 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.

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

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Instructions for **Healthcare Providers**

The Certification of Serious Health Condition form is used to certify a serious health condition 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.

Healthcare Providers is defined by law in RCW 50A.05.010 and WAC 192-500-090.

SERIOUS HEALTH CONDITION

A serious health condition is defined in RCW 50A.05.010. Generally, a serious health condition could include an illness, injury, impairment, or physical or mental condition that involves:

- **Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity; or**
- **Continuing treatment by a healthcare provider including any 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.
  - **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.

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

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Employment Security Department

Certification of Serious Health Condition Form

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. Please include your name on each page. **Upload both pages to your Paid Leave account, include them with your application, or fax to 833-535-2273.**

Section one: Your information

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

Paid Leave Customer ID number *(if known)*:

Name:

Date of birth: ____ / ____ / ____

Reason for taking Paid Family and Medical Leave

☐ **For my own serious health condition**

Instructions: Have your healthcare provider complete page 2 of this medical certification, listing yourself as the patient.

☐ **For medical reasons related to my own pregnancy**

Instructions: Have your healthcare provider complete page 2 of this medical certification, listing yourself as the patient. If applying for family (bonding) leave following the birth of a child, you and your healthcare provider should also fill out the Certification of Birth form.

☐ **To care for a family member during their serious health condition**

The family member needing care is my:

- ☐ Child, son-in-law, daughter-in-law
- ☐ 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 page 2 of 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.

Signature *(required)*:	**Date:**

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:

Signature:	**Date:**

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Certification of Serious Health Condition Form

Name of person applying for leave:_____

Instructions: *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.* ***Return to patient or fax to 833-535-2273.***

Section two: Description of the serious health condition

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

Patient's name:	**Date of birth:** ____ / ____ / ____

Does the patient have a serious health condition? *(as defined in RCW 50A.05.010)*

☐ No ☐ Yes. If yes, provide a brief description of the diagnosis: _____

_____

Is the patient pregnant or recovering from giving birth?

☐ No ☐ Yes. Expected due date: ____ / ____ / ____ or Child's date of birth: ____ / ____ / ____

If yes, is the patient experiencing a pregnancy-related serious health condition?

This can include but is not limited to severe morning sickness, prenatal complications resulting in bedrest, preeclampsia, infections or recovery after a cesarean delivery or other postnatal complications.

☐ Yes ☐ No

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.

Start date: ____ / ____ / ____

End date: ____ / ____ / ____ **or** ☐ **Condition is chronic or permanent**

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].

Signature *(required)*: _____ **Date** *(required)*: ____ / ____ / ____

Name and title *(required)*: _____

Certificate license number and state: *(required)*:_____

License area/area of practice *(required)*: _____

Business name *(required)*: _____

Address: *(required)*: _____

Phone number *(required)*: _____

Email address: _____

Washington
Paid Family & Medical Leave
Employment Security Department

Certification of Birth Form

Who should use this form?

Parents applying for bonding leave following the birth of a child. If you are applying for family leave to bond with your child, you must provide documentation showing your child's date of birth. Documentation can include any one of the following documents:

- A copy of your child's birth certificate,
- A copy of documentation from the hospital showing your child's date of birth, or
- This form completed and signed by a healthcare provider.

Do not use this form for family leave for adoption, foster care, or other approved placement types. Visit PaidLeave.wa.gov for information about required documentation for family leave for placement.

Instructions: Provide the name and date of birth of the parent that gave birth; include their Paid Leave Customer ID number (if known). Provide the other parent's information if they are applying for leave. Have a healthcare provider complete and sign the certification of birth section. Documentation is required for each family leave application.

Parent's information

To be completed by the parent(s) applying for leave

Information about parent that gave birth *(required)*:

Name: _____

Date of birth: ____ / ____ / ____ **Paid Leave Customer ID number** *(if known)*: _____

Information about the other parent *(optional)*:

Name: _____

Date of birth: ____ / ____ / ____ **Paid Leave Customer ID number** *(if known)*: _____

Certification of birth

To be completed by a healthcare provider as defined in RCW 50A.05.010 to certify the date of birth in order for the applicant to qualify for family leave under Paid Family and Medical Leave. Please be sure to sign the form.

Child's date of birth: ____ / ____ / ____ **Place of birth** *(city, state)*: _____

PROVIDER'S INFORMATION AND CERTIFICATION

I declare under penalty of perjury that the information provided in this form is true and correct, and that I am a healthcare provider as defined in RCW 50A.05.010.

Signature *(required)*: _____ **Date** *(required)*: ____ / ____ / ____

Name and title *(required)*: _____

Certificate license number and state: _____

License area/area of practice *(required)*: _____

Business name *(required)*: _____

Address: _____

Phone number: _____

Email address: _____

Upload this form to your Paid Leave account, include it with your application, or fax it to 833-535-2273.

U.S. Bank ReliaCard® 购买前披露
计划名称：Washington Paid Family & Medical Leave

您可以选择接收付款的方式，
包括直接存入您的银行账户或此预付卡。
向您的代理询问可用方案并选择您的方案。

月费	每次购买	ATM 取款	现金充值
$0	**$0**	网络内**$0** 网络外**$2.50**	不适用

ATM 余额查询（网络内或网络外）	$0
客户服务（自动或实时代理）	每次通话$0
无活动	$0
我们收取 3 种其他类型的费用。其中一种：	
换卡费（标准或加急快递）	$0 或 $15.00

有关免费访问您的资金和余额信息的方式，请参阅随附的费用表。

无透支 / 赊购功能。
您的资金有资格获得 FDIC 保险。

了解有关预付账户的一般信息，请访问 *cfpb.gov/prepaid*（英文）。
查看卡套餐内所有费用和服务的详细信息及条件，或致电 **1-888-964-0359** 或访问 **usbankreliacard.com**（英文）。

U.S. Bank ReliaCard®费用表

计划名称：Washington Paid Family & Medical Leave

所有费用	金额	详细信息
获取现金		
ATM 取款（网络内）	$0	这是我们对每次取款收取的费用。“网络内”指 U.S. Bank 或 MoneyPass® ATM 网络。地点可参见*usbank.com/locations*（英文）或*moneypass.com/atm-locator.html*（英文）。
ATM 取款（网络外）	$2.50	这是我们对每次取款收取的费用。“网络外”指 U.S. Bank 或 MoneyPass ATM 网络之外的所有 ATM。即使您没有完成交易，ATM 运营商也可能向您收取费用。
柜员现金取款	$0	这是当您从接受 Visa®的银行或信用合作社中的柜员处提取卡内现金时的费用。
信息		
ATM 余额查询（网络内）	$0	这是我们对每次查询收取的费用。“网络内”指 U.S. Bank 或 MoneyPassATM 网络。地点可参见*usbank.com/locations*（英文）或*moneypass.com/atm-locator.html*（英文）。
ATM 余额查询（网络外）	$0	这是我们对每次查询收取的费用。“网络外”指 U.S. Bank 或 MoneyPass ATM 网络之外的所有 ATM。ATM 运营商也可能向您收取费用。
在美国境外使用您的卡		
国际交易	3%	这是我们在您使用您的卡在外国商家购物和从外国 ATM 提取现金时收取的费用，并且是按任何货币兑换后交易美元金额收取的百分比费用。即使您和 / 或商家或 ATM 位于美国，某些交易在适用的网络规则下也被视为外国交易，我们无法控制这些商家、ATM 和交易就此如何分类。
国际 ATM 取款	$3.00	这是我们对每次取款收取的费用。即使您没有完成交易，ATM 运营商也可能向您收取费用。
其他		
换卡费	$0	这是我们以标准配送方式（最多 10 个工作日）寄卡给您所收取的每次换卡费用。
换卡加急快递	$15.00	这是除任何换卡费用之外我们收取的加急快递费用（最多 3 个工作日）。
无活动	$0	这是我们在您未使用您的卡完成交易后每月收取的费用。

虽然此通信以中文版本提供，但后续的 U.S. Bank 通信以及与您的契约协议、披露信息、通知和结单相关的文件、网上银行和手机银行服务可能仅以英文提供。为了使您能够了解和使用本产品或服务，您必须具备阅读并理解此类文件的能力，或者能够获得翻译协助。可根据要求提供英文文件。

您的资金有资格获得 FDIC 保险。您的资金将存入 U.S. Bank National Association，这是一家由 FDIC 承保的机构，如果 U.S. Bank 破产，FDIC 将为您的资金提供最高 $250,000 的保险。有关详细信息，请参见*fdic.gov/deposit/deposits/prepaid.html*（英文）。

无透支 / 赊账功能。
请致电**1-888-964-0359**，致函 P.O. Box 551617, Jacksonville, FL 32255，或访问***usbankreliacard.com***（英文），联系持卡人服务部。

了解有关预付账户的一般信息，请访问*cfpb.gov/prepaid*（英文）。如果您想要提出有关预付账户的投诉，请拨打 1-855-411-2372 致电消费者金融保护局或访问*cfpb.gov/complaint*（英文）。

CR-19647221