

**Please note:** these documents are provided in Word format for your convenience – for easier completion of fillable fields, minor formatting changes (such as the addition of a company logo), or additions about company-specific policies. Employers are responsible for any edits, revisions, additions, or deletions they make to these forms. The Department disclaims any responsibility for modifications made to these forms and cannot guarantee that a form that has been modified from this original version will be compliant.

### **Fewer than 25 Employees Notice- Instructions for Use**

As a Massachusetts employer, you are required to inform your Massachusetts employees and covered contract workers about their rights and obligations under the Massachusetts Paid Family and Medical Leave (PFML) law. To do so, you may provide this form to your employees and covered contract workers. You may also create or use a different notice of your choosing as long as the notice you use provides the same information as required by law.

This form is for employers who have fewer than 25 Massachusetts employees and covered contract workers. If you have more than 25 Massachusetts employees and covered contract workers, please use the [Employer notice for a workforce with 25 or more covered individuals form](#). Likewise, if you engage with self-employed individuals who are *not* covered contract workers, you may provide them the [Employer notice to self-employed individuals for a workforce with 25 or more covered individuals form](#) to notify them of their option to elect coverage for themselves.

To use this form, first complete:

1. The chart on page 2 indicating whether you have an approved private plan;
2. The chart on page 5 indicating what percentage of the employee contribution will be deducted from your employees' wages, and what percentage (if any) you will pay;
3. The employer information chart on page 6;
4. The check boxes on page 2 indicating where employees can find information on your private plan, if any. (Check N/A if you are participating in the state Trust Fund.)

Once you have filled out these sections, provide pages 2-6 of this form to your employees and covered contract workers for them to review and sign.

## PAID FAMILY AND MEDICAL LEAVE NOTICE TO EMPLOYEES (less than 25 Workers)

***Please read this notice carefully. It contains important information about your rights, obligations, and eligibility under the Massachusetts Paid Family and Medical Leave law. Please keep this notice for your records.***

The Massachusetts Paid Family and Medical Leave (PFML) law provides most Massachusetts employees the right to paid family and medical leave. These rights are described further below and include both (1) job protection when the employee returns to work and (2) partial wage-replacement benefits while the employee is out of work. Employers can provide these benefits either by (1) participating in the PFML Trust Fund operated by the Massachusetts Department of Family and Medical Leave (the Department), or (2) providing an exempt private plan that offers benefits at least as generous as those available through the Department.

Regardless of whether your employer participates in the state Trust Fund or has a private plan, you will be entitled to certain benefits and protections. You may be required to make contributions to the Trust Fund or to fund your employer's private plan, but only up to a certain amount. You will also need to tell your employer when you need leave, and you will need to submit an application for benefits with the Department or through your employer's private plan.

An employer may apply for an exemption from the medical leave contribution, family leave contribution, or both. Your employer must provide you information about the private plan and the application process. Your employer has elected to provide benefits as follows:

- In the box below
- As an attachment to this Notice
- Other: \_\_\_\_\_
- N/A (Employer contributes to Trust Fund)

_____	<input type="checkbox"/> Does not have an approved private plan and is providing all leave benefits through the Department;
(Employer Name)	
_____	<input type="checkbox"/> Has an approved private plan for both family and medical leave benefits;
(Private Plan Name)	
_____	<input type="checkbox"/> Has an approved private plan for family leave benefits only, and is providing medical leave benefits through the Department;
(Private Plan Phone Number)	
_____	<input type="checkbox"/> Has an approved private plan for medical leave benefits only and is providing family leave benefits through the Department.
(Private Plan Address)	
_____	
(Private Plan Website)	

## I. Explanation of Benefits

**Leave Allotments.** Under the PFML Law, you may be entitled to up to:

- 12 weeks of paid family leave in a benefit year for the birth, adoption, or foster care placement of a child; to care for a family member with a serious health condition; or because of a qualifying exigency arising out of the fact that a family member is on active duty or has been notified of an impending call to active duty in the Armed Forces;
- 20 weeks of paid medical leave in a benefit year if they have a serious health condition that incapacitates them from work;
- 26 weeks of paid family leave in a benefit year to care for a family member who is a covered service member undergoing medical treatment or otherwise addressing consequences of a serious health condition relating to the family member's military service;
- 26 total weeks, in the aggregate, of paid family and medical leave in a single benefit year.

A "benefit year" is the 12 months preceding the Sunday immediately before your leave begins.

**Other Leaves.** Any leave you take – paid or unpaid – for the same qualifying reasons listed above will count towards your amount of leave for that benefit year.

**Eligibility.** You will be eligible for leave and wage-replacement benefits if you meet the earnings test. You must have earned at least 30 times the expected benefit amount and [met the minimum earnings requirement established annually by the Department of Unemployment Assistance \(DUA\)](#), which is \$6,300 for 2025, during the last 4 completed calendar quarters. (This is the amount calculated in the "Wage Replacement Payments" section below.)

**Wage Replacement Payments.** When you take leave for any of the reasons described above, you will be eligible to apply to the Department or to your employer's private plan for wage replacement benefits. These benefits will be a proportion of your average weekly earnings. Your maximum potential benefit amount will be as follows:

- 80% of earnings up to 50% of the State Average Weekly Wage
- 50% of earnings above the State Average Weekly Wage
- In no event more than a maximum amount. For 2025, this maximum benefit amount is \$1,170.64. This amount will be adjusted annually based on increases in the State Average Weekly Wage.

Private plans may choose to provide higher benefits but may not provide lower amounts than what the Department would pay.

**Concurrent Benefits Payments.** If you receive benefits from other sources while you are also receiving benefits from the Department, the benefits you receive from the Department may be reduced. Certain types of other benefits will cause a one-for-one reduction in benefits you receive from the Department. This means that for each dollar you receive from these benefits, your benefit from the Department will decrease by a dollar. Benefits that will have this effect include:

- Workers' Compensation
- Unemployment Insurance
- Permanent Disability Policies or Programs
- Extended Illness Leave Bank Leave

Other forms of benefits will not reduce the benefits you receive from the Department unless you are receiving more than your average weekly wage in total benefits. Benefits that will have this effect include:

- Temporary Disability Policies or Programs (including both Short-Term Disability and Long-Term Disability)
- Employer-run Family and/or Medical Leave Policies or Programs

**Topping off PFML benefit payments.** In general, employees may use their paid leave (sick time, vacation, or other PTO) to top off their PFML benefits up to a certain amount, but you will need to follow your employer’s policies regarding earning and using time off. Your employer’s PTO policy may not discriminate against you for exercising a right to which you are entitled under the PFML program (M.G.L. c 175M). For employees who choose to supplement their PFML benefits in this way, the combined weekly sum of PFML benefits and employer-provided paid leave benefits cannot exceed the employee’s Individual Average Weekly Wage (IAWW). Employers will be responsible for monitoring and ensuring that the combined weekly sum of employer-provided paid leave benefits and PFML benefits does not exceed an employee’s IAWW. Employers are also responsible for managing any payments made to an employee that exceed the employee’s IAWW. The Department is not involved in the repayment process for top off overages. This process is solely the responsibility of the employer and the employee.

## II. Employee Rights and Protections

**Job Protection.** Generally, if you take family or medical leave, once you return to work, your employer must restore you to your previous position or to an equivalent position, with the same status, pay, employment benefits, length-of-service credit, and seniority as of the date you started your leave. This may not apply if your position was eliminated due to economic reasons unrelated to your use of leave.

**Continuation of Health Insurance.** Your employer must continue to provide for and contribute to your employment-related health insurance benefits, if any, at the level and under the conditions coverage would have been provided if you had continued working for the duration of such leave. Your employer may require you to continue to pay your portion of your health insurance premium on the same terms and conditions as before your leave.

**No Retaliation.** It is unlawful for any employer to discriminate or retaliate against you for exercising any right to which you are entitled under the paid family and medical leave law. An employee or former employee who is retaliated against for exercising rights under the law may, not more than three years after the violation occurs, institute a civil action in the superior court.

## III. Contribution Amounts

To help fund paid leave benefits available under the PFML law, your employer may make a deduction from your wages, which will either be remitted to the Trust Fund or to the operator of your employer’s private plan. Whether your employer has a private plan or participates in the state Trust Fund, the deduction cannot exceed the following amounts:

Family Leave Contribution	Medical Leave Contribution	Total Contribution Amount
0.18% of earnings*	0.28% of earnings*	0.46% of earnings*

Because your employer has fewer than 25 covered workers, your employer is not required by law to make any additional contribution on your behalf. Employers may choose to cover some portion of your contribution amount (0.46%\* of wages) but are not required to do so. Your employer has elected to allocate the contribution amount as follows:

Total Required Contribution: .28%*				
Medical Leave	_____	will contribute	___%	of the medical leave contribution
	(Employer Name)	and the remaining	___%	will be deducted from your earnings

Total Required Contribution: .18%*				
Family Leave	_____	will contribute	___%	of the family leave contribution
	(Employer Name)	and the remaining	___%	will be deducted from your earnings

Please initial here to indicate that you understand that this percentage of your wages earned in a pay period will be deducted from your pay each pay period: \_\_\_\_\_

\* The numbers provided are through 2025. These rates may be adjusted on an annual basis, effective January 1 of each calendar year.

#### IV. Notifying your Employer

**BEFORE** you take leave or apply for benefits, you **MUST** notify your employer that you need to take leave. You are required to provide at least 30 days’ notice of your need for leave. If 30 days’ notice is not possible due to circumstances beyond your control, you must provide notice as soon as practicable, and in any event, before you file any application for benefits.

When you notify your employer of your need for leave, you must provide the following information:

1. The anticipated start date of leave;
2. The anticipated length of the leave;
3. The expected date of return from leave;
4. Whether you will need intermittent leave (leave taken in separate blocks of two or more) or reduced leave (leave that involves a reduced schedule of fewer hours or days per week), and;
5. If you need intermittent or reduced leave schedule, the expected frequency of leave and expected duration of each instance of leave.

If any of this information changes, you must tell your employer as soon as you are aware of the change.

## V. Submitting an application

To apply for Paid Family and Medical Leave benefits, you will need the following information about your employer:

_____
(Employer Name)
_____
(Employer Street Address)
_____
(Employer City, State, Zip)
_____
(Federal Employer ID Number) (FEIN)

If your employer contributes to the Trust Fund, you must submit an application for benefits with the Department. You may file this application in one of two ways:

1. You can create an account to apply online through the Department's Application Website at [paidleave.mass.gov/login/](https://paidleave.mass.gov/login/)
2. You can call the Department's call center at (833) 344-7365 to complete an application over the phone.

Forms and application instructions are available on the Department's website at [www.mass.gov/info-details/get-ready-to-apply-for-paid-family-and-medical-leave-pfml-benefits](https://www.mass.gov/info-details/get-ready-to-apply-for-paid-family-and-medical-leave-pfml-benefits)

## VI. For More Information

For more detailed information, please consult the Department's website: [www.mass.gov/DFML](https://www.mass.gov/DFML). You may contact the Department of Family and Medical Leave at:

**The Massachusetts Department of Family and Medical Leave**  
PO Box 838  
Lawrence, MA 01842  
Contact Center: (833) 344-7365

### **ACKNOWLEDGMENT**

Your signature below acknowledges your receipt of the information above within 30 days from the start date of your employment.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name (Print)**

Your signed acknowledgement will be retained by your employer. Please retain a copy for your own reference.