Paid Family Leave for DC37 Represented Employees

Collective Bargaining Units (CBUs) Covered by DC 37 Agreement

Policy Number: TDL10281278

<table>
<thead>
<tr>
<th>CBU Number</th>
<th>CBU Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>003</td>
<td>Social Services Titles</td>
</tr>
<tr>
<td>004</td>
<td>Engineering/Scientific</td>
</tr>
<tr>
<td>124</td>
<td>Hospital Technicians</td>
</tr>
<tr>
<td>127</td>
<td>Institutional Services Title</td>
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<td>128</td>
<td>Clerical Titles</td>
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<tr>
<td>129</td>
<td>Accounting/EDP Titles</td>
</tr>
<tr>
<td>130</td>
<td>Health Services</td>
</tr>
<tr>
<td>131</td>
<td>Supervisory Maintenance Titles</td>
</tr>
<tr>
<td>132</td>
<td>Non-Supervisory Maintenance Titles</td>
</tr>
<tr>
<td>134</td>
<td>Motor Vehicle Operators</td>
</tr>
</tbody>
</table>

January 2019
Applying For Paid Family Leave – Bonding
(Form PFL-1)

To Use Paid Family Leave To:

Bond with a newborn, a newly adopted or fostered child

Complete Form PFL-1
- Complete PFL-1, Part A
- Provide PFL-1 to employer
  - Employer completes PFL-1, Part B and returns to you within 3 days

Complete Form PFL-2
- Complete PFL-2 and collect supporting documentation

Send forms and documents
- Send completed forms and supporting documentation to insurance carrier
- Insurance carrier accepts or denies claim within 18 days

Please keep a copy of all pages for your records.

Send completed form to:

Technology Insurance Company
C/O AbSolve
P.O. Box 1328
Mt. Laurel, NJ 08054

Email: AmTrustNYDLPFL@absencesolved.com
or Fax: 800.728.7028

For inquiries:
Please call 800.401.2691
Request For Paid Family Leave – Bonding (Form PFL-1) Instructions

- To request PFL, the employee requesting PFL must complete Part A of the Request For Paid Family Leave (Form PFL). All items on the form are required unless noted as optional. The employee then provides the form to the employer to complete Part B.
- The employer completes Part B of the Request For Paid Family Leave (Form PFL-1) and returns it to the employee within three days.
- Additional forms are required depending on the type of leave being requested. The employee requesting leave is responsible for the completion of these forms.
- The employee submits the completed Request For Paid Family Leave (Form PFL-1) with the required additional form to the employer’s PFL insurance carrier listed on Part B of Request For Paid Family Leave (Form PFL-1). The employee should retain a copy of each submitted form for their records.

**PART A - EMPLOYEE INFORMATION** (to be completed by employee)

The employee requesting PFL must complete all required information.

**Paid Family Leave (PFL) Request (to be completed by the employee)**

**Question 12:** A child is defined as a biological, adopted, or foster son or daughter, a stepson or stepdaughter, a legal ward, a son or daughter of a domestic partner, or the person to whom the employee stands in loco parentis. A parent is defined as a biological, foster, or adoptive parent, parent-in-law, a stepparent, a legal guardian, or other person who stood in loco parentis to the employee when the employee was a child.

**Question 13:** If dates are “Continuous,” the employee must provide the start and end dates of the requested PFL. These dates should be the actual dates that the PFL will begin and end. If uncertain, estimate the start and end dates and indicate “Dates are estimated.” If dates are “Periodic,” enter the dates PFL will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate “Dates are estimated.”

If dates are estimated, the PFL carrier may require you to submit a request for payment after the PFL day is taken. Payment for approved claims will be due as soon as possible but in no event more than 18 days from the date of the completed request.

**Question 14:** If the employee is submitting the PFL request to their employer with less than 30 days’ advance notice from the start date of the PFL, the employee must explain why 30 days’ notice could not be given. If the explanation will not fit in the space provided on the form, enter “See Attached” and add an attachment with the explanation. Be sure to include the employee’s full name and their date of birth at the top of the attachment.

**Employment Information** (to be completed by the employee)

**Question 16:** Enter the date of hire to the best of the employee’s recollection. If it has been more than a year since the date of hire, entering the year in which employment started is sufficient.

**Question 18:** Enter the best estimate of average gross weekly wage. Include only the wages earned from the employer listed on this request form. The gross weekly wage is the total weekly pay - including overtime, tips, bonuses and commissions - before any deductions are made by the employer, such as federal and state taxes. If the employer is not able to supply this information, the employee can calculate their gross weekly wage as follows:

**Step 1:** Add all gross wages received (before any deductions) over the last eight weeks prior to the start of PFL, including overtime and tips earned. (See Step 3 for instructions for calculating bonuses and/or commissions.)

**Step 2:** Divide the gross wages calculated in step one by eight (or the number of weeks worked if less than eight) to calculate the average weekly wage.

**Step 3:** If the employee received bonuses and/or commissions during the 52 weeks preceding PFL, add the prorated weekly amount to the average weekly wage. To determine the prorated weekly amount, add all bonuses/commissions earned in the preceding 52 weeks and then divide by 52.

**Example of a gross weekly wage calculation:**

Week 1 - Gross wage including overtime $550
Week 2 - Gross wage $500
Week 3 - Gross wage $500
Week 4 - Gross wage $500
Week 5 - Gross wage $500
Week 6 - Gross wage $500
Week 7 - Gross wage, including overtime $600
Week 8 - Gross wage, including overtime $550

Total: $4,200
Divide by 8: + $525
Average Weekly Wage = $525

Bonus earned in preceding 52 weeks: $2,800
Divide by 52: + $50
Prorated Weekly Bonus = $50
Average Weekly Wage = $525
Prorated Weekly Bonus = $50

Average Weekly Wage (including bonus) = $575

Please note that the employer is also required to provide this information in Part B of the Request For Paid Family Leave (Form PFL-1).

Form PFL-1 Instructions continued on next page

If you need assistance, please call 800.401.2691
www.amtrustdb.com DO NOT SCAN
PART A - EMPLOYEE INFORMATION (to be completed by employee)

Form PFL-1 Instructions continued from prior page

If you are pre-submitting form: Indicate if the employee is pre-submitting their PFL request. Pre-submitting is defined as submitting the application in advance of an upcoming qualifying event, with certain required information missing due to the information being unknown at the time of the submitting. If pre-submitting is permitted by the carrier or self-insured employer, the missing information must be supplied as soon as it is known. Benefits cannot be determined until all of the required information is provided.

The PFL insurance carrier or self-insured employer will provide the employee a notice within five days which 1) states the claim is pending; 2) identifies what information is missing; 3) instructs how to submit the missing information. Once all information is supplied, the PFL insurance carrier or self-insured employer has 18 days to pay or deny the claim.

If the carrier or self-insured employer does not permit pre-submitting, the carrier or self-insured employer must return the Request for Paid Family Leave within five days to the employee with an explanation that the claim should be re-submitted when all information is available.

Employee signs and dates, before giving this form to their employer to complete Part B.

PART B - EMPLOYER INFORMATION (to be completed by employer)

The employer of the employee requesting PFL must complete all information in Part B.

Questions 2: If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number.

Questions 3: Enter the employer’s Standard Industrial Classification (SIC) Code. Contact your carrier if you don’t know your SIC code.

Question 8: The employee occupation code can be found at: www.bls.gov/soc/2010/soc_alph.htm

Question 9: Enter the wages earned by the employee during the last eight weeks preceding the PFL start date. The gross amount paid is the employee’s gross weekly pay, including any overtime and tips earned for that week, plus the weekly prorated amount of any bonus or commission received during the preceding 52 weeks. (For detailed steps, see Question 18 on page 1 of the instructions.) Calculate the gross average weekly wage by adding up the gross amounts paid, and then divide by eight (or number of weeks worked if less than eight).

Affirmation employee is eligible for PFL: An employee who regularly works 20 hours or more per week must have been in employment for at least 26 consecutive weeks. An employee who regularly works less than 20 hours per week must have worked 175 days.

Employee signs and dates, before giving this form to their employer to complete Part B.

Be sure to complete the appropriate additional PFL form(s) based on the type of PFL leave being requested.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).

The Workers’ Compensation Board’s (Board’s) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board’s administrative authority under Workers’ Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.
Applying For Paid Family Leave – Bonding
(Form PFL-1)

INSTRUCTIONS INCLUDED WITH FORM

PART A - EMPLOYEE INFORMATION (to be completed by employee)

1. Employee’s legal name (first name, middle initial, last name)

2. Other last names, if any, under which employee has worked

3. Employee’s mailing address
   Street address: ________________________________
   City, State: ________________________________
   Zip code: __________________Country (if not U.S.A.)

4. Employee’s Social Security Number or TIN
   X X X - X X X

5. Employee’s date of birth (MM/DD/YYYY)
   / /

6. Employee’s primary telephone number
   ( ) ________ - ________

7. Employee’s preferred email address while on PFL (if available)

8. Employee’s gender
   ☐ Male ☐ Female ☐ Not designated / Other

9. Employee’s preferred language
   ☐ English ☐ Español ☐ Русский ☐ Polski
   ☐ 中文 ☐ Italiano ☐ Kreyol ayisyen ☐ 한국어
   ☐ Other: __________________________

10. Employee’s ethnicity/race
    For purposes of health demographic only, U.S. Centers for Disease Control and Prevention (CDC) code set, version 1.0.
    Is employee of Hispanic, Latino/a, or Spanish origin? (One or more categories may be selected)
    ☐ Mexican
    ☐ Mexican American
    ☐ Chicano/a
    ☐ Puerto Rican
    ☐ Dominican
    ☐ Cuban
    ☐ Another Hispanic, Latino/a, or Spanish origin
    ☐ Not of Hispanic, Latino/a, or Spanish origin
    ☐ Unknown

    What is employee’s race? (One or more categories may be selected)
    ☐ American Indian or Alaska Native
    ☐ Black or African American
    ☐ Asian Indian
    ☐ Chinese
    ☐ Filipino
    ☐ Japanese
    ☐ Korean
    ☐ Vietnamese
    ☐ Other Asian
    ☐ White
    ☐ Native Hawaiian
    ☐ Guamanian or Chamorro
    ☐ Samoan
    ☐ Other Pacific Islander
    ☐ Other race

Paid Family Leave (PFL) Request (to be completed by the employee)

11. Reason for PFL request:
    ☐ Bond with child ☐ Care for family member ☐ Military qualifying event

12. The family member is employee’s:
    ☐ Child ☐ Spouse ☐ Domestic partner ☐ Parent ☐ Parent-in-law ☐ Grandparent ☐ Grandchild

Form PFL-1 Instructions continued on next page
TO BE COMPLETED BY THE EMPLOYEE

Employee’s name
(first name, middle initial, last name)

Employee’s date of birth (MM/DD/YYYY)
/
/

PART A - EMPLOYEE INFORMATION (to be completed by employee) - continued from prior page

Form PFL-1 Instructions continued on next page

13. Will PFL be for a continuous period of time and/or periodic?

☐ Continuous

PFL start date (MM/DD/YYYY)
/
/

PFL end date (MM/DD/YYYY)
/
/

☐ Dates are estimated

☐ Periodic

Identify dates periodic PFL will be taken:

☐ Dates are estimated

14. If providing less than 30 day’s advance notice to the employer, please explain:

Employment Information (to be completed by the employee)

15. Business name

16. Employee’s date of hire (MM/DD/YYYY)
/
/

17. Employee’s work location

Street address

City, State Zip code Country (If not U.S.A.)

18. Employee’s average gross weekly wage (This data will be requested of both employee and employer)

19. Employer’s telephone number for contact regarding this request ( ) -

20a. Does employee have more than one employer? ☐ Yes ☐ No

20b. If yes, is employee taking PFL from the other employer? ☐ Yes ☐ No

21. Is employee currently receiving Workers’ Compensation Lost Wage Benefits? ☐ Yes ☐ No

Disclosure statement: Information regarding PFL benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Declaration and signature

Any person who knowingly and with intent to defraud presents, causes to be presented, or procures with knowledge or belief that it will be presented to or by an insurer, or self-insurer, any information containing any false material statement or conceals any material fact shall be guilty of a crime and subject to substantial fines and imprisonment.

I am hereby making a request for paid family leave benefits under the NYS Workers’ Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee’s signature

Date signed (MM/DD/YYYY)
/
/

☐ I am submitting this form in advance (see instructions about pre-submitting). I understand the insurance carrier will contact me to advise how to submit the required missing information.

If you need assistance, please call 800.401.2691
www.amtrustdb.com
FORM PFL-1 - CONTINUED FROM PRIOR PAGE

TO BE COMPLETED BY THE EMPLOYEE

Employee’s name

(first name, middle initial, last name)

Employee’s date of birth (MM/DD/YYYY)

/
/

PART B - EMPLOYER INFORMATION (to be completed by the employer)

If employee contribution is withheld, indicate taxable % (employer portion) for the FICA deductions =

%  

1. Business’s full legal name and mailing address
   
   Business name
   
   Mailing address
   
   City, State
   Zip code
   Country (if not U.S.A.)

2. Employer’s FEIN

3. Employer’s Standard Industrial Classification (SIC) Code

4. Employer’s contact name for questions related to PFL

5. Employer’s contact telephone number ( )

6. Employer’s contact email address

7. Employee’s date of hire (MM/DD/YYYY)

/
/

7a. Employee’s last day worked (MM/DD/YYYY)

/
/

8. Employee’s occupation Codes are available at: www.bls.gov/soc/2018/major_groups.htm

9. Enter the last 8 weeks of gross wages for the employee and calculate the average gross weekly wage

<table>
<thead>
<tr>
<th>Week no.</th>
<th>Week ending date (MM/DD/YYYY)</th>
<th>Number of days worked</th>
<th>Gross amount paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
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<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Calculated average gross weekly wage:

9a. Is the employee Full-time or Part-time?
   ☐ Full-time ☐ Part-time

9b. If Part-time, is employee on PFL waiver?
   ☐ Yes ☐ No

9c. Check usual days worked:
   ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

10. If employee received or will receive full wages while on PFL, will employer be requesting reimbursement?
   ☐ Yes ☐ No

Form PFL-1 continued on next page
**PART B - EMPLOYER INFORMATION (to be completed by employer) - continued from prior page**

Form PFL-1 Instructions continued on next page

11a. In the preceding 52 weeks has the employee taken leave for: ☐ NYS Disability ☐ PFL ☐ Both Disability and PFL ☐ None

11b. Enter the total number of weeks and days taken for both Disability and PFL in the last 52 weeks:

<table>
<thead>
<tr>
<th>Weeks</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please provide specific dates for Disability:

<table>
<thead>
<tr>
<th>Weeks</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. Is the employee taking Family Medical Leave Act (FMLA) concurrently with PFL? ☐ Yes ☐ No

13. PFL insurance carrier's name and mailing address

PFL insurance carrier's name

Technology Insurance Company C/O AbSolve

Mailing address

P.O. Box 1328

City, State

Mt. Laurel, NJ 08054

14. PFL insurance carrier's telephone number (800) 401-2691

15. PFL policy number TDL10281278

Declaration and signature

☐ I affirm the employee regularly works 20 or more hours per week and has been in employment for at least 26 consecutive weeks OR the employee regularly works less than 20 hours per week and has worked at least 175 days.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I am the person authorized to sign as the employer of the employee requesting PFL. My signature affirms that to the best of my knowledge and belief, the information I have provided is true and accurate.

/ /

Employer's authorized signature

Date signed (MM/DD/YYYY)

Title
Bonding Certification (Form PFL-2) Instructions

If the employee is requesting PFL to bond with a newborn, an adopted child or a foster child, the employee must submit the Bonding Certification (Form PFL-2) with the Request For Paid Family Leave (Form PFL-1).

BONDING CERTIFICATION (to be completed by employee)

The employee requesting PFL must complete all applicable requested information.
Send completed forms and supporting documentation to insurance carrier.

If this form is being submitted in advance (pre-submitting) and some information is unknown, the insurance carrier will contact the employee and explain how to provide the required additional information.

Questions 1 & 2: If the form is submitted to the PFL insurance carrier prior to the birth of a child, this is considered presubmitting. The employee is then required to provide the required documentation of the child's birth to the PFL insurance carrier. The PFL carrier will tell the employee how to provide the required additional documentation.

There may be instances where PFL can be taken before the adoption or foster care is finalized. For example, the employee may be required to appear in court or travel to another country as part of the adoption or foster care process. The employee should include documentation to show that the PFL is necessary to further the adoption or foster care.

Question 5: See chart below for documentation details. Unless specified, do not send the original documents.

<table>
<thead>
<tr>
<th>Bonding Form/Certification</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care provider certification of pregnancy</td>
<td>An original letter obtained from the birth mother's health care provider that certifies pregnancy. It should include the mother's name and the expected due date.</td>
</tr>
<tr>
<td>Health care provider certification of birth</td>
<td>An original letter obtained from the birth mother's health care provider that includes the mother's name and child's date of birth.</td>
</tr>
<tr>
<td>Birth Certificate</td>
<td>A copy of the certificate issued by the city or county office in which the child is born.</td>
</tr>
<tr>
<td>Voluntary Acknowledgment of Paternity (Form LDSS-4418)</td>
<td>A copy of the form that establishes legal fatherhood when the parents are unmarried. Completed by both mother and father. For more information, see childsupport.ny.gov/dcsse/aop_howto.html</td>
</tr>
<tr>
<td>Court Order of Filiation</td>
<td>A copy of the order from the family court that names the father of a child. Establishes legal fatherhood when the parents are unmarried. Completed by both mother and father. For more information, visit childsupport.ny.gov/dcsse/aop_howto.html</td>
</tr>
<tr>
<td>Marriage Certificate</td>
<td>A copy of the official statement issued by the town or city clerk from which the marriage certificate was issued.</td>
</tr>
<tr>
<td>Civil union/domestic partner's documentation</td>
<td>A copy of the certificate of civil union or domestic partnership.</td>
</tr>
<tr>
<td>Foster care placement letter</td>
<td>A copy of the letter of foster care placement issued by the county or city department of social services or authorized voluntary foster care agency.</td>
</tr>
<tr>
<td>Court documents of adoption</td>
<td>A copy of the court document finalizing adoption or documentation in furtherance or court order finalizing adoption.</td>
</tr>
<tr>
<td>Other documentation</td>
<td>Other documentation of parental relationship may be accepted if none of the others listed apply.</td>
</tr>
</tbody>
</table>

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (9 USC 552a).

The Workers' Compensation Board's Board's authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board's administrative authority under Workers' Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expeditious manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.
Request For Paid Family Leave
Bonding Certification (Form PFL-2)

TO BE COMPLETED BY THE EMPLOYEE

Employee’s name (first name, middle initial, last name)

Employee’s date of birth (MM/DD/YYYY)

Other last names, if any, under which employee has worked

Employee’s Social Security Number or TIN

Employee’s mailing address

Mailing address

City, State Zip code Country (if not U.S.A.)

BONDING CERTIFICATION (to be completed by the employee)

1. Child’s date of birth (MM/DD/YYYY)

2. Child’s gender □ Male □ Female □ Not designated/Other

3. Does child live with the employee requesting PFL? □ Yes □ No

4. Child is employee’s □ Biological child □ Stepchild □ Foster child □ Adopted child □ Legal ward □ Spouse/Domestic partner’s child

5. Select one of the following and attach the document as required as evidence of the relationship.

Parent of newborn child:

Birth mother:
□ Health care provider certification of pregnancy (include expected due date AND mother’s name); OR
□ Health care provider certification of birth (include date of birth of child AND mother’s name); OR
□ Child’s birth certificate

Other parent:
□ Copy of birth certificate naming second parent; OR
□ Voluntary acknowledgment of paternity; OR
□ Court order of filiation; OR
□ Birth mother documents (see above) PLUS one of the following:
□ Marriage certificate; OR
□ Certificate of civil union; OR
□ Evidence of domestic partnership
□ OR, Other documentation of parental relationship

Foster parent:
□ Letter of foster care placement or anticipated placement issued by county or city department of Social Services or authorized voluntary foster care agency

Adoptive parent:
□ Court document finalizing adoption
□ Documentation in furtherance of adoption

6. Date of foster care or adoption placement, if applicable (MM/DD/YYYY)

Form PFL-2 continued on next page
BONDING CERTIFICATION (to be completed by the employee) - continued from prior page

Declaration and signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I am hereby making a request for paid family leave benefits under the NYS Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

/ / 

Employee's signature  Date signed (MM/DD/YYYY)
## Applying For Paid Family Leave – Care for Family Member
(Form PFL-1)

### To Use Paid Family Leave To:

<table>
<thead>
<tr>
<th>Care for a family member with a serious health condition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complete Form PFL-1</strong></td>
</tr>
<tr>
<td>• Complete PFL-1, Part A</td>
</tr>
<tr>
<td>• Provide PFL-1 to employer</td>
</tr>
<tr>
<td>• Employer completes PFL-1, Part B and returns to you within 3 days</td>
</tr>
<tr>
<td><strong>Complete Form PFL-3</strong></td>
</tr>
<tr>
<td>• Care recipient completes PFL-3 and provides to health care provider</td>
</tr>
<tr>
<td>• Care recipient's health care provider keeps PFL-3</td>
</tr>
<tr>
<td><strong>Complete Form PFL-4</strong></td>
</tr>
<tr>
<td>• Complete &quot;Employee&quot; information at the top of PFL-4</td>
</tr>
<tr>
<td>• Provide PFL-4 to care recipient's health care provider</td>
</tr>
<tr>
<td>• Care recipient's health care provider completes PFL-4 and returns to you</td>
</tr>
<tr>
<td><strong>Send forms and documents</strong></td>
</tr>
<tr>
<td>• Send completed forms and supporting documentation to insurance carrier</td>
</tr>
<tr>
<td>• Insurance carrier accepts or denies claim within 18 days</td>
</tr>
</tbody>
</table>

Please keep a copy of all pages for your records.

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### Send completed form to:

Technology Insurance Company  
C/O AbSolve  
P.O. Box 1328  
Mt. Laurel, NJ 08054  

Email: AmTrustNYDBL.PFL@absencesolved.com  
or Fax: 800.728.7028  

For inquiries:  
Please call 800.401.2691
Request For Paid Family Leave – Care for Family Member (Form PFL-1) Instructions

- To request PFL, the employee requesting PFL must complete Part A of the Request For Paid Family Leave (Form PFL-1). All items on the form are required unless noted as optional. The employee then provides the form to the employer to complete Part B.

- The employer completes Part B of the Request For Paid Family Leave (Form PFL-1) and returns it to the employee within three days.

- Additional forms are required depending on the type of leave being requested. The employee requesting leave is responsible for the completion of these forms.

- The employee submits the completed Request For Paid Family Leave (Form PFL-1) with the required additional form to the employer's PFL insurance carrier listed on Part B of Request For Paid Family Leave (Form PFL-1). The employee should retain a copy of each submitted form for their records.

**PART A - EMPLOYEE INFORMATION (to be completed by employee)**

The employee requesting PFL must complete all required information.

**Paid Family Leave (PFL) Request (to be completed by the employee)**

**Question 13:** If dates are "Continuous", the employee must provide the start and end dates of the requested PFL. These dates should be the actual dates that the PFL will begin and end. If uncertain, estimate the start and end dates and indicate "Dates are estimated". If dates are "Periodic", enter the dates PFL will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate "Dates are estimated".

If dates are estimated, the PFL carrier may require you to submit a request for payment after the PFL day is taken. Payment for approved claims will be due as soon as possible but in no event more than 18 days from the date of the completed request.

**Question 14:** If the employee is submitting the PFL request to their employer with less than 30 days' advance notice from the start date of the PFL, the employee must explain why 30 days' notice could not be given. If the explanation will not fit in the space provided on the form, enter "See Attached" and add an attachment with the explanation. Be sure to include the employee's full name and their date of birth at the top of the attachment.

**Employment Information (to be completed by the employee)**

**Question 16:** Enter the date of hire to the best of the employee's recollection. If it has been more than a year since the date of hire, entering the year in which employment started is sufficient.

**Question 18:** Enter the best estimate of average gross weekly wage. Include only the wages earned from the employer listed on this request form. The gross weekly wage is the total weekly pay including overtime, tips, bonuses and commissions - before any deductions are made by the employer, such as federal and state taxes. If the employer is not able to supply this information, the employee can calculate their gross weekly wage as follows:

1. **Step 1:** Add all gross wages received (before any deductions) over the last eight weeks prior to the start of PFL, including overtime and tips earned. (See Step 3 for instructions for calculating bonuses and/or commissions.)

2. **Step 2:** Divide the gross wages calculated in step one by eight (or the number of weeks worked if less than eight) to calculate the average weekly wage.

3. **Step 3:** If the employee received bonuses and/or commissions during the 52 weeks preceding PFL, add the prorated weekly amount to the average weekly wage. To determine the prorated weekly amount, add all bonuses/commissions earned in the preceding 52 weeks and then divide by 52.

Example of a gross weekly wage calculation:

- Week 1 - Gross wage including overtime: $500
- Week 2 - Gross wage: $500
- Week 3 - Gross wage: $500
- Week 4 - Gross wage: $500
- Week 5 - Gross wage: $500
- Week 6 - Gross wage: $500
- Week 7 - Gross wage, including overtime: $600
- Week 8 - Gross wage, including overtime: $550

Total: $4,200

Average Weekly Wage = $525

Bonus earned in preceding 52 weeks: $2,600

Average Weekly Wage = $525

Prorated Weekly Bonus = $50

Average Weekly Wage (including bonus) = $575

Please note that the employer is also required to provide this information in Part B of the Request For Paid Family Leave (Form PFL-1).

*Form PFL-1 Instructions continued on next page*
PART A - EMPLOYEE INFORMATION (to be completed by employee) – continued from prior page

Form PFL-1 Instructions continued from prior page

If you are pre-submitting form: Indicate if the employee is pre-submitting their PFL request. Pre-submitting is defined as submitting the application in advance of an upcoming qualifying event, with certain required information missing due to the information being unknown at the time of the submitting. If pre-submitting is permitted by the carrier or self-insured employer, the missing information must be supplied as soon as it is known. Benefits cannot be determined until all of the required information is provided.

The PFL insurance carrier or self-insured employer will provide the employee a notice within five days which: 1) states the claim is pending; 2) identifies what information is missing; 3) instructs how to submit the missing information. Once all information is supplied, the PFL insurance carrier or self-insured employer has 18 days to pay or deny the claim.

If the carrier or self-insured employer does not permit pre-submitting, the carrier or self-insured employer must return the Request for Paid Family Leave within five days to the employee with an explanation that the claim should be re-submitted when all information is available.

Employee signs and dates, before giving this form to their employer to complete Part B.

PART B - EMPLOYER INFORMATION (to be completed by employer)

The employer of the employee requesting PFL must complete all information in Part B.

Questions 2: If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number.

Questions 3: Enter the employer’s Standard Industrial Classification (SIC) Code. Contact your carrier if you don’t know your SIC code.

Question 8: The employer occupation code can be found at: www.bls.gov/soc/2010/soc_alph.htm

Question 9: Enter the wages earned by the employee during the last eight weeks preceding the PFL start date. The gross amount paid is the employee’s gross weekly pay, including any overtime and tips earned for that week, plus the weekly prorated amount of any bonus or commission received during the preceding 52 weeks. (For detailed steps, see Question 18 on page 1 of the instructions.) Calculate the gross average weekly wage by adding up the gross amounts paid, and then divide by eight (or number of weeks worked if less than eight).

Question 10: Failure to select “Yes” for requesting reimbursement from the insurance carrier, will result in a waiver of the right to reimbursement.

Question 11a: ‘Disability’ refers to NYS statutory required disability. If the answer is “none,” enter a “0” for total weeks and days in Question 12b.

Question 11b: The maximum number of weeks available for NYS statutory disability and PFL in any 52 week period is 26 weeks. Specify the total number of weeks, as well as the number of additional days if the leave includes a partial week, taken for NYS statutory disability and PFL during the preceding 52 weeks.

Question 13, 14 & 15: Enter the Paid Family Leave or Disability/PFL insurance carrier’s name, address and PFL policy number. If this employer is self-insured, enter the name and address of where the PFL request should be submitted for processing.

Affirmation employee is eligible for PFL: An employee who regularly works 20 hours or more per week must have been in employment for at least 26 consecutive weeks. An employee who regularly works less than 20 hours per week must have worked 175 days.

Employee signs and dates, before giving this form to their employer to complete Part B.

Be sure to complete the appropriate additional PFL form(s) based on the type of PFL leave being requested.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).

The Workers’ Compensation Board’s (Board’s) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board’s administrative authority under Workers’ Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.
Applying For Paid Family Leave – Care for Family Member
(Form PFL-1)

PART A - EMPLOYEE INFORMATION (to be completed by employee)

1. Employee’s legal name (first name, middle initial, last name)

2. Other last names, if any, under which employee has worked

3. Employee’s mailing address
   Street address:
   City, State:
   Zip code:
   Country (if not U.S.A.)

4. Employee’s Social Security Number or TIN
   (XXX-XX-XXXX)

5. Employee’s date of birth (MM/DD/YYYY)
   ( / / )

6. Employee’s primary telephone number
   ( )

7. Employee’s preferred email address while on PFL (if available)

8. Employee’s gender
   ☐ Male ☐ Female ☐ Not designated / Other

9. Employee’s preferred language
   ☐ English ☐ Spanish ☐ Русский ☐ Polski
   ☐ 中文 ☐ Italiano ☐ Kreyòl ayisyen ☐ 한국어
   ☐ Other:

Optional (for research purposes)

10. Employee’s ethnicity/race
    For purposes of health demographic only, (U.S. Centers for Disease Control and Prevention (CDC) code set, version 1.0.)

Is employee of Hispanic, Latino/a, or Spanish origin?
(One or more categories may be selected.)
   ☐ Mexican
   ☐ Mexican American
   ☐ Chicano/a
   ☐ Puerto Rican
   ☐ Dominican
   ☐ Cuban
   ☐ Another Hispanic, Latino/a, or Spanish origin
   ☐ Not of Hispanic, Latino/a, or Spanish origin
   ☐ Unknown

What is employee’s race?
(One or more categories may be selected.)
   ☐ American Indian or Alaska Native
   ☐ Black or African American
   ☐ Asian Indian
   ☐ Chinese
   ☐ Filipino
   ☐ Japanese
   ☐ Korean
   ☐ Vietnamese
   ☐ Other Asian
   ☐ White
   ☐ Native Hawaiian
   ☐ Guamanian or Chamorro
   ☐ Samoan
   ☐ Other Pacific Islander
   ☐ Other race

Paid Family Leave (PFL) Request (to be completed by the employee)

11. Reason for PFL request:
   ☐ Bond with child ☐ Care for family member ☐ Military qualifying event

12. The family member is employee’s:
   ☐ Child ☐ Spouse ☐ Domestic partner ☐ Parent ☐ Parent-in-law ☐ Grandparent ☐ Grandchild

Form PFL-1 continued on next page

If you need assistance, please call 800.401.2691
www.amtrustdb.com
TO BE COMPLETED BY THE EMPLOYEE
Employee's name
(first name, middle initial, last name)

Employee's date of birth (MM/DD/YYYY)

PART A - EMPLOYEE INFORMATION (to be completed by employee) - continued from prior page

Form PFL-1 Instructions continued on next page

13. Will PFL be for a continuous period of time and/or periodic?

☐ Continuous

PFL start date (MM/DD/YYYY)

PFL end date (MM/DD/YYYY)

☐ Dates are estimated

☐ Periodic

Identify dates periodic PFL will be taken:

☐ Dates are estimated

14. If providing less than 30 day's advance notice to the employer, please explain:

Employment Information (to be completed by the employee)

15. Business name

16. Employee's date of hire (MM/DD/YYYY)

17. Employee's work location

Street address

City, State

Zip code

County (if not U.S.A.)

18. Employee's average gross weekly wage (This data will be requested of both employee and employer)

19. Employer's telephone number for contact regarding this request

( ) -

20a. Does employee have more than one employer? ☐ Yes ☐ No

20b. If yes, is employee taking PFL from the other employer? ☐ Yes ☐ No

21. Is employee currently receiving Workers' Compensation Lost Wage Benefits? ☐ Yes ☐ No

Disclosure statement: Information regarding PFL benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Declaration and signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I am hereby making a request for paid family leave benefits under the NYS Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee's signature

Date signed (MM/DD/YYYY)

☐ I am submitting this form in advance (see instructions about pre-submitting). I understand the insurance carrier will contact me to advice how to submit the required missing information.
PART B - EMPLOYER INFORMATION (to be completed by the employer)

If employee contribution is withheld, indicate taxable % (employer portion) for the FICA deductions = %

1. Business's full legal name and mailing address
   Business name

   Mailing address

   City, State   Zip code   Country (if not U.S.)

2. Employer's FEIN

3. Employer's Standard Industrial Classification (SIC) Code

4. Employer's contact name for questions related to PFL

5. Employer's contact telephone number (______-______) ______-

6. Employer's contact email address

7. Employee's date of hire (MM/DD/YYYY) ______/______/______

7a. Employee's last day worked (MM/DD/YYYY) ______/______/______

8. Employee's occupation Codes are available at: [www.bls.gov/soc/2018/major_groups.htm](http://www.bls.gov/soc/2018/major_groups.htm)

9. Enter the last 8 weeks of gross wages for the employee and calculate the average gross weekly wage

<table>
<thead>
<tr>
<th>Week no.</th>
<th>Week ending date (MM/DD/YYYY)</th>
<th>Number of days worked</th>
<th>Gross amount paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
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<tr>
<td>8</td>
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</tr>
</tbody>
</table>

Calculated average gross weekly wage:

9a. Is the employee Full-time or Part-time? [ ] Full-time  [ ] Part-time

9b. If Part-time, is employee on PFL waiver? [ ] Yes  [ ] No

9c. Check usual days worked:

   [ ] S  [ ] M  [ ] T  [ ] W  [ ] T  [ ] F  [ ] S

10. If employee received or will receive full wages while on PFL, will employer be requesting reimbursement? [ ] Yes  [ ] No

Form PFL-1 continued on next page
PART B - EMPLOYER INFORMATION (to be completed by employer) - continued from prior page

Form PFL-1 Instructions continued on next page

11a. In the preceding 52 weeks has the employee taken leave for: ☐ NYS Disability ☐ PFL ☐ Both Disability and PFL ☐ None
11b. Enter the total number of weeks and days taken for both Disability and PFL in the last 52 weeks:

Weeks
Disability:
Days

Weeks
Disability:
Days

12. Is the employee taking Family Medical Leave Act (FMLA) concurrently with PFL? ☐ Yes ☐ No

13. PFL insurance carrier's name and mailing address

PFL insurance carrier's name
Technology Insurance Company C/O AbSolve

Mailing address
P.O. Box 1328

City, State Zip code Country (if not USA)
Mt. Laurel, NJ 08054

14. PFL insurance carrier's telephone number (800) 401-2691

15. PFL policy number TDL10281278

Declaration and signature

☐ I affirm the employee regularly works 20 or more hours per week and has been in employment for at least 26 consecutive weeks OR the employee regularly works less than 20 hours per week and has worked at least 175 days.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I am the person authorized to sign as the employer of the employee requesting PFL. My signature affirms that to the best of my knowledge and belief, the information I have provided is true and accurate.

Employer's authorized signature

Date signed (MM/DD/YYYY)

Title
Release Of Personal Health Information Under The Paid Family Leave Law (Form PFL-3) Instructions

- If an employee is requesting PFL to care for a family member with a serious health condition, the care recipient or an authorized representative must complete a Release Of Personal Health Information Under The Paid Family Leave Law (Form PFL-3) and submit it to their health care provider, along with a copy of the Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4).
- The Release Of Personal Health Information Under The Paid Family Leave Law (Form PFL-3) enables the health care provider to complete Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4) and release it to the employee seeking PFL benefits.
- Before completing and signing, the care recipient must read the Release Of Personal Health Information Under The Paid Family Leave Law (Form PFL-3) in its entirety.
- The employee requesting PFL submits both the Request For Paid Family Leave (Form PFL-1) and the Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4) to their employer's PFL insurance carrier, or to their employer if the employer is self-insured, for PFL benefit determination.

NOTE: This form will be retained by the health care provider. The employee should make a copy for their records before giving it to the health care provider.

Care recipient or authorized representative signs and dates.

This form is given to the care recipient’s health care provider along with the Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4).

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or authorized representative and submitted to care recipient’s health care provider with Form PFL-4)

Employee enters their name, and care recipient’s (patient’s) name and date of birth at the top of each page.

The PFL insurance carrier name requested at the top of the form is the same as the PFL insurance carrier identified in Request For Paid Family Leave (Form PFL-1) Part B line 13.

Care recipient or authorized representative must complete all applicable requested information.

If a care recipient is unable to fill out this form, an authorized representative must attach a copy of legal documentation, such as a health care proxy or power of attorney, permitting the representative to sign on behalf of the care recipient. The health care provider will require this documentation of authorization unless the authorized representative is a parent signing on behalf of a minor child.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a). The Workers’ Compensation Board’s (Board’s) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board’s administrative authority under Workers’ Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.
Request For Paid Family Leave
Release Of Personal Health Information
Under The Paid Family Leave Law (Form PFL-3)

INSTRUCTIONS INCLUDED WITH FORM

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)

Care recipient's (patient's name) (first name, middle initial, last name)

Care recipient's (patient's) date of birth (MM/DD/YYYY)

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A
FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or
authorized representative and submitted to care recipient's health care provider with Form PFL-4)

Care recipient's (patient's name)

I,

Employee name

release my personal health information to

PFL insurance carrier's name

employer's PFL insurance carrier

Records Subject to Release: This form gives the health care provider listed permission to include information from your health care records on the
attached medical certification. This form gives your health care provider permission to release only the information in your health care records that relate
to your current condition, which is the subject of the employee's request for Paid Family Leave benefits.

Duration of Revocable Release: This authorization ends after one year, or when you revoke the release. You can cancel this release at any time. To
cancel, send a letter to the health care provider listed on this form.

This form does NOT allow your health care provider to release the following types of information, unless you specifically permit such release. Put an “X”
next to any information your health provider MAY release:

☐ HIV/AIDS related information  ☐ Mental health information  ☐ Alcohol/drug treatment  ☐ Psychotherapy notes

Health Care Provider Information (to be completed by the care recipient or authorized representative)

Identify the health care provider who is currently providing you with treatment for a condition that is subject to the employee's
request for PFL benefits.

1. Health care provider's name

2. Health care provider's mailing address

Mailing address

City, State  Zip code  Country (if not USA)

3. Health care provider's telephone number (provide area or country code)

Form PFL-3 continued on next page
**RECEIVE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION** (to be completed by the care recipient or authorized representative and submitted to care recipient’s health care provider with Form PFL-4) - continued from prior page

**Care Recipient Information**

1. **Employee's name** (first name, middle initial, last name)
   - Care recipient's (patient's) date of birth (MM/DD/YYYY)

2. **Care recipient's (patient's) name** (first name, middle initial, last name)
   - Care recipient's (patient's) date of birth (MM/DD/YYYY)

3. **Care Recipient Information** (to be completed by the care recipient or authorized representative)

   4. **Care recipient's mailing address**
      - Mailing address
      - City, State
      - Zip Code
      - Country (if not U.S.A.)

   5. **Care recipient's Social Security Number**

   6. **Care recipient's telephone number** (provide area or country code)

---

**READ AND SIGN BELOW**

I hereby request that the health care provider listed give a completed Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4) to the employee identified on the PFL-4 form. I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and any estimation of the amount of care that I require from the employee requesting PFL benefits as a result of my current condition.

- **Care recipient's signature**
- **Date signed (MM/DD/YYYY)**

**Authorized representative**

- **Full name**
- **I,**

- **Authorized representative's signature**
- **Date signed (MM/DD/YYYY)**

The employee should retain a copy for their own records.
Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4) Instructions

The employee requesting PFL to care for a family member with a serious health condition must submit the Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4) with the Request For Paid Family Leave (Form PFL-1).

Employee:

- Employee enters their name, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, mailing address, and care recipient's (patient's) name and date of birth at the top of page 1.
- Employee enters their name and date of birth, and care recipient's (patient's) name and date of birth at the top of page 2.
- Employee gives the Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4) to the health care provider.

HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

The patient's health care provider must complete all applicable requested information unless noted as optional.

Patient Information / family member with serious health condition (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

**Question 2:** Providing the optional ICD-10 code is recommended.

The patient's health care provider must complete the Patient Information and Health Care Provider sections of the Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4).

Health care provider signs and dates, and then returns the form to the employee requesting PFL.

If you believe the patient is the victim of abuse or neglect caused by the employee requesting PFL, you may decline to provide this certification.

Employee:

- When you receive the completed Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4) form from the health care provider, send the completed forms and supporting documentation to the insurance carrier.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).

The Workers' Compensation Board's (Board's) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board's administrative authority under Workers' Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expeditious manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

If you need assistance, please call 800.401.2691  
www.amtrustdb.com
# Request For Paid Family Leave

Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)

**TO BE COMPLETED BY THE EMPLOYEE**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee's name</td>
<td>(first name, middle initial, last name)</td>
</tr>
<tr>
<td>Employee's date of birth</td>
<td>(MM/DD/YYYY)</td>
</tr>
<tr>
<td>Other last names, if any, under which employee has worked</td>
<td></td>
</tr>
<tr>
<td>Employee's Social Security Number or TIN</td>
<td></td>
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<tr>
<td>Employee's mailing address</td>
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<tr>
<td>Mailing address</td>
<td></td>
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<tr>
<td>Zip code</td>
<td></td>
</tr>
<tr>
<td>Country (if not U.S.A.)</td>
<td></td>
</tr>
<tr>
<td>Care recipient's (patient's) name</td>
<td>(first name, middle initial, last name)</td>
</tr>
<tr>
<td>Care recipient's (patient's) date of birth</td>
<td>(MM/DD/YYYY)</td>
</tr>
</tbody>
</table>

**HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION** (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

Patient Information / family member with serious health condition (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

1. Does patient require care by the employee requesting Paid Family Leave (PFL)?
   - ☐ Yes  ☐ No (If no, skip to “Health Care Provider Information.”)
   - Note: For the purposes of this section, “providing care” may include necessary physical care, emotional support, visitation, assistance in treatment, transportation, arranging for a change in care, assistance with essential daily living matters, and personal attendant services.

2. Primary ICD-10 code (optional) |

3. Diagnosis |

4. Date patient's condition commenced (MM/DD/YYYY) |

5. First date care for patient is needed (MM/DD/YYYY) |

6. Expected date patient will no longer require care (MM/DD/YYYY) |
   - Days/week |
   - Days/month

7. Estimated number of days per week OR days per month patient requires care or |

Health Care Provider Information (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

8. Health care provider's name
<table>
<thead>
<tr>
<th>TO BE COMPLETED BY THE EMPLOYEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee's name (first name, middle initial, last name)</td>
</tr>
</tbody>
</table>

| Care recipient's (patient's) name (first name, middle initial, last name) | Care recipient's (patient's) date of birth (MM/DD/YYYY) |

**HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION** (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above) - continued from prior page

**Form PFL-4 continued on next page**

9. **Type of health care provider:**

- [ ] Medical Doctor (MD)
- [ ] Doctor of Osteopathy (DO)
- [ ] Doctor of Podiatric Medicine (DPM)
- [ ] Doctor of Chiropractic Medicine (DC)
- [ ] Dentist (DDS/DCM)
- [ ] Physician's Assistant (PA)
- [ ] Nurse Practitioner (NP)
- [ ] Licensed Psychologist
- [ ] Licensed Social Worker (LMSW/LCSW)
- [ ] Other (specify)

10. **Health care provider's mailing address**

Mailing address

| Mailing address | Zip code | Country (if not U.S.A.) |

11. **Health care provider's telephone number** (provide area or country code)

12. **Health care provider's fax number** (provide area or country code)

13. **Health care provider's email address** (if available)

14. **State or country (if not U.S.A.) in which health care provider is licensed to practice**

15. **Specialty**

16. **Health care provider's license number**

---

**Certification and signature**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereon, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

My signature attests that the information I have provided in this form is based on my professional assessment within my licensed scope of practice.

Health care provider's signature

Date signed (MM/DD/YYYY)

---

PFL-4 (10-17) HCP Certification
Page 2 of 2

MKT0707 11/18
Applying For Paid Family Leave – Military
(Form PFL-1)

To Use Paid Family Leave To:

Assist family members due to another family member’s active military duty or impending active duty abroad

Complete Form PFL-1
• Complete PFL-1, Part A
• Provide PFL-1 to employer
• Employer completes PFL-1, Part B and returns to you within 3 days

Complete Form PFL-5
• Complete PFL-5 and collect supporting documentation

Send forms and documents
• Send completed forms and supporting documentation to insurance carrier
• Insurance carrier accepts or denies claim within 18 days

Please keep a copy of all pages for your records.

Send completed form to:

Technology Insurance Company
C/O AbSolve
P.O. Box 1328
Mt. Laurel, NJ 08054

Email: AmTrustNYDBLPFL@absencesolved.com
or Fax: 800.728.7028

For inquiries:
Please call 800.401.2691
Request For Paid Family Leave – Military (Form PFL-1) Instructions

- To request PFL, the employee requesting PFL must complete Part A of the Request For Paid Family Leave (Form PFL1). All items on the form are required unless noted as optional. The employee then provides the form to the employer to complete Part B.
- The employer completes Part B of the Request For Paid Family Leave (Form PFL-1) and returns it to the employee within three days.
- Additional forms are required depending on the type of leave being requested. The employee requesting leave is responsible for the completion of these forms.
- The employee submits the completed Request For Paid Family Leave (Form PFL-1) with the required additional form to the employer’s PFL insurance carrier listed on Part B of Request For Paid Family Leave (Form PFL-1). The employee should retain a copy of each submitted form for their records.

PART A - EMPLOYEE INFORMATION (to be completed by employee)

The employee requesting PFL must complete all required information.

Paid Family Leave (PFL) Request (to be completed by the employee)

Question 13: If dates are “Continuous”, the employee must provide the start and end dates of the requested PFL. These dates should be the actual dates that the PFL will begin and end. If uncertain, estimate the start and end dates and indicate "Dates are estimated". If dates are “Periodic”, enter the dates PFL will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate "Dates are estimated".

If dates are estimated, the PFL carrier may require you to submit a request for payment after the PFL day is taken. Payment for approved claims will be due as soon as possible but in no event more than 18 days from the date of the completed request.

Question 14: If the employee is submitting the PFL request to their employer with less than 30 days’ advance notice from the start date of the PFL, the employee must explain why 30 days’ notice could not be given. If the explanation will not fit in the space provided on the form, enter “See Attached” and add an attachment with the explanation. Be sure to include the employee’s full name and their date of birth at the top of the attachment.

Employment Information (to be completed by the employee)

Question 16: Enter the date of hire to the best of the employee’s recollection. If it has been more than a year since the date of hire, entering the year in which employment started is sufficient.

Question 18: Enter the best estimate of average gross weekly wage. Include only the wages earned from the employer listed on this request form. The gross weekly wage is the total weekly pay - including overtime, tips, bonuses and commissions - before any deductions are made by the employer, such as federal and state taxes. If the employer is not able to supply this information, the employee can calculate their gross weekly wage as follows:

Step 1: Add all gross wages received (before any deductions) over the last eight weeks prior to the start of PFL, including overtime and tips earned. (See Step 3 for instructions for calculating bonuses and/or commissions.)

Step 2: Divide the gross wages calculated in step one by eight (or the number of weeks worked if less than eight) to calculate the average weekly wage.

Step 3: If the employee received bonuses and/or commissions during the 52 weeks preceding PFL, add the prorated weekly amount to the average weekly wage. To determine the prorated weekly amount, add all bonuses/commissions earned in the preceding 52 weeks and then divide by 52.

Example of a gross weekly wage calculation:

Week 1 - Gross wage including overtime $550
Week 2 - Gross wage $500
Week 3 - Gross wage $500
Week 4 - Gross wage $500
Week 5 - Gross wage $500
Week 6 - Gross wage $500
Week 7 - Gross wage, including overtime $600
Week 8 - Gross wage, including overtime $550

Total: $4,200
Divide by 8: 8
Average Weekly Wage = $525
Bonus earned in preceding 52 weeks: $2,600
Divide by 52: 52
Prorated Weekly Bonus = $50
Average Weekly Wage = $525
Prorated Weekly Bonus = $50

Average Weekly Wage (including bonus) = $575

Please note that the employer is also required to provide this information in Part B of the Request For Paid Family Leave (Form PFL-1).

Form PFL-1 Instructions continued on next page
FORM PFL-1 INSTRUCTIONS - CONTINUED FROM PRIOR PAGE

PART A - EMPLOYEE INFORMATION (to be completed by employee) - continued from prior page

Form PFL-1 Instructions continued from prior page

If you are pre-submitting form: indicate if the employee is pre-submitting their PFL request. Pre-submitting is defined as submitting the application in advance of an upcoming qualifying event, with certain required information missing due to the information being unknown at the time of the submitting. If pre-submitting is permitted by the carrier or self-insured employer, the missing information must be supplied as soon as it is known. Benefits cannot be determined until all of the required information is provided.

The PFL insurance carrier or self-insured employer will provide the employee a notice within five days which 1) states the claim is pending; 2) identifies what information is missing; 3) instructs how to submit the missing information. Once all information is supplied, the PFL insurance carrier or self-insured employer has 18 days to pay or deny the claim.

If the carrier or self-insured employer does not permit pre-submitting, the carrier or self-insured employer must return the Request for Paid Family Leave within five days to the employee with an explanation that the claim should be re-submitted when all information is available.

Employee signs and dates, before giving this form to their employer to complete Part B.

PART B - EMPLOYER INFORMATION (to be completed by employer)

The employer of the employee requesting PFL must complete all information in Part B.

Questions 2: If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number.

Questions 3: Enter the employer’s Standard Industrial Classification (SIC) Code. Contact your carrier if you don’t know your SIC code.

Question 8: The employee occupation code can be found at: www.bls.gov/soc/2010/soc_alph.htm

Question 9: Enter the wages earned by the employee during the last eight weeks preceding the PFL start date. The gross amount paid is the employee’s gross weekly pay, including any overtime and tips earned for that week, plus the weekly prorated amount of any bonus or commission received during the preceding 52 weeks. (For detailed steps, see Question 18 on page 1 of the instructions.) Calculate the gross average weekly wage by adding up the gross amounts paid, and then divide by eight (or number of weeks worked if less than eight).

Affirmation employee is eligible for PFL: An employee who regularly works 20 hours or more per week must have been in employment for at least 26 consecutive weeks. An employee who regularly works less than 20 hours per week must have worked 175 days.

Employer signs and dates, and then returns to the employee requesting PFL within three business days.

Be sure to complete the appropriate additional PFL form(s) based on the type of PFL leave being requested.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).

The Workers’ Compensation Board’s (Board’s) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board’s administrative authority under Workers’ Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expeditious manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

If you need assistance, please call 800.401.2691
www.amtrustdb.com
Applying For Paid Family Leave – Military
(Form PFL-1)

PART A - EMPLOYEE INFORMATION (to be completed by employee)

1. Employee's legal name (first name, middle initial, last name)

2. Other last names, if any, under which employee has worked

3. Employee's mailing address
   Street address
   City, State
   Zip code
   Country (if not USA)

4. Employee's Social Security Number or TIN

5. Employee's date of birth (MM/DD/YYYY)

6. Employee's primary telephone number

7. Employee's preferred email address while on PFL (if available)

8. Employee's gender
   □ Male □ Female □ Not designated / Other

9. Employee's preferred language
   □ English □ Español □ Русский □ Polski
   □ 中文 □ Italiano □ Kreyòl ayisyen □ 한국어
   □ Other:

10. Employee's ethnicity/race
    For purposes of health demographic only. (U.S. Centers for Disease Control and Prevention (CDC) code set, version 1.0)
    Is employee of Hispanic, Latino/a, or Spanish origin?
    (One or more categories may be selected.)
    □ Mexican
    □ Mexican American
    □ Chicano/a
    □ Puerto Rican
    □ Dominican
    □ Cuban
    □ Another Hispanic, Latino/a, or Spanish origin
    □ Not of Hispanic, Latino/a, or Spanish origin
    □ Unknown
    What is employee's race?
    (One or more categories may be selected.)
    □ American Indian or Alaska Native
    □ Black or African American
    □ Asian Indian
    □ Chinese
    □ Filipino
    □ Japanese
    □ Korean
    □ Vietnamese
    □ Other Asian
    □ White
    □ Native Hawaiian
    □ Guamanian or Chamorro
    □ Samoan
    □ Other Pacific Islander
    □ Other race

Paid Family Leave (PFL) Request (to be completed by the employee)

11. Reason for PFL request:
    □ Bond with child □ Care for family member □ Military qualifying event

12. The family member is employee's:
    □ Child □ Spouse □ Domestic partner □ Parent □ Parent-in-law □ Grandparent □ Grandchild

Form PFL-1 continued on next page
PART A - EMPLOYEE INFORMATION (to be completed by employee) - continued from prior page

13. Will PFL be for a continuous period of time and/or periodic?
   - Continuous
     - PFL start date (MM/DD/YYYY): __/__/____
     - PFL end date (MM/DD/YYYY): __/__/____
   - Periodic
     - Usually dates periodic PFL will be taken:
       - Dates are estimated

14. If providing less than 30 day's advance notice to the employer, please explain:

Employment Information (to be completed by the employee)

15. Business name

16. Employee's date of hire (MM/DD/YYYY): __/__/____

17. Employee's work location
   - Street address
   - City, State
   - Zip code
   - Country (If not U.S.A.)

18. Employee's average gross weekly wage (This data will be requested of both employee and employer)

19. Employer's telephone number for contact regarding this request: (____) ____-____

20a. Does employee have more than one employer?  □ Yes  □ No

20b. If yes, is employee taking PFL from the other employer?  □ Yes  □ No

21. Is employee currently receiving Workers' Compensation Lost Wage Benefits?  □ Yes  □ No

Disclosure statement: Information regarding PFL benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Declaration and signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I hereby make a request for paid family leave benefits under the NYS Workers’ Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee's signature: __________________________

Date signed (MM/DD/YYYY): __/__/____

□ I am submitting this form in advance (see instructions about pre-submitting). I understand the insurance carrier will contact me to advise how to submit the required missing information.
PART B - EMPLOYER INFORMATION (to be completed by the employer)

If employee contribution is withheld, indicate taxable % (employer portion) for the FICA deductions = %

1. Business's full legal name and mailing address
   Business name
   Mailing address
   City, State
   Zip Code
   Country (if not U.S.)

2. Employer's FEIN

3. Employer's Standard Industrial Classification (SIC) Code

4. Employer's contact name for questions related to PFL

5. Employer's contact telephone number ( ) - 

6. Employer's contact email address

7. Employee's date of hire (MM/DD/YYYY)

7a. Employee's last day worked (MM/DD/YYYY)


9. Enter the last 8 weeks of gross wages for the employee and calculate the average gross weekly wage

<table>
<thead>
<tr>
<th>Week no.</th>
<th>Week ending date (MM/DD/YYYY)</th>
<th>Number of days worked</th>
<th>Gross amount paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<tr>
<td>8</td>
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</tr>
</tbody>
</table>

Calculated average gross weekly wage:

9a. Is the employee Full-time or Part-time?
   - Full-time
   - Part-time

9b. If Part-time, is employee on PFL waiver?
   - Yes
   - No

9c. Check usual days worked:
   - S
   - M
   - T
   - W
   - T
   - F
   - S

10. If employee received or will receive full wages while on PFL, will employer be requesting reimbursement?
   - Yes
   - No

Form PFL-1 continued on next page
Form PFL-1 continued from prior page

PART B - EMPLOYER INFORMATION (to be completed by employer) - continued from prior page

11a. In the preceding 52 weeks has the employee taken leave for: □ NYS Disability □ PFL □ Both Disability and PFL □ None
11b. Enter the total number of weeks and days taken for both Disability and PFL in the last 52 weeks:

Weeks
Disability:
Days

Weeks
PFL:
Days

12. Is the employee taking Family Medical Leave Act (FMLA) concurrently with PFL? □ Yes □ No

13. PFL insurance carrier's name and mailing address

PFL insurance carrier's name
Technology Insurance Company C/O AbSolve

Mailing address
P.O. Box 1328

City, State
Mt. Laurel, NJ

Zip code
08054

Country (if not USA)

14. PFL insurance carrier's telephone number (800) 401 - 2691

15. PFL policy number TL10261278

Declaration and signature

□ I affirm the employee regularly works 20 or more hours per week and has been in employment for at least 26 consecutive weeks OR the employee regularly works less than 20 hours per week and has worked at least 176 days.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I am the person authorized to sign as the employer of the employee requesting PFL. My signature affirms that to the best of my knowledge and belief, the information I have provided is true and accurate.

Employee's authorized signature

Date signed (MM/DD/YYYY)

Title
Military Qualifying Event (Form PFL-5) Instructions

If an employee is requesting PFL because of a family member’s covered active military duty or impending covered active duty, the employee must submit the Military Qualifying Event (Form PFL-5) with the Request For Paid Family Leave (Form PFL-1). The employee must identify the family member, provide a copy of the member’s covered active duty orders or impending active duty orders, and describe the reason leave is being requested.

MILITARY QUALIFYING EVENT (to be completed by employee)

The employee requesting PFL must complete all applicable requested information.

Employee enters their name, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, and mailing address at the top of page 1.

Employee enters their name and date of birth at the top of page 2.

Questions 1 - 5: Enter the military member’s information, and indicate the military member’s relationship to the employee.

Question 6: Enter dates of expected military covered active duty.

Question 7: Documentation that shows that the military member is on covered active duty or has been notified of an impending call or order to covered active duty is required and must be attached to this form. Select the type of documentation that is attached from the list below.

Required documentation includes one of the following:
- Covered active duty orders; OR
- Letter from the military unit documenting impending call or order to covered duty; OR
- Documentation of military leave signed by the approving authority for military member’s Rest and Recuperation.

Qualifying Reason for Leave (to be completed by the employee)

Question 8: Explain the need for PFL because of the Military Qualifying Event. For example: “My spouse was just called on short notice to covered active duty status, and will be deployed to (country) in five days. I need to take PFL to be with them and make arrangements for while they are away on active duty.” If the explanation will not fit in the space provided on the form, enter “See Attached” and add an attachment with the explanation. Be sure to include the employee’s full name, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, and mailing address at the top of the attachment.

Question 9: Include one or more of the qualifying supporting documents:
- Meeting announcement for informational briefing sponsored by the military; or
- Document(s) confirming an appointment with a school official, doctor, attorney or financial advisor; or
- Copy of a bill for services for the handling of legal or financial affairs.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).

The Workers’ Compensation Board’s (Board’s) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board’s administrative authority under Workers’ Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expeditious manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.
Request For Paid Family Leave
Military Qualifying Event (Form PFL-5)

INSTRUCTIONS INCLUDED WITH FORM

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)

Employee's date of birth (MM/DD/YYYY)

Other last names, if any, under which employee has worked

Employee's Social Security Number or TIN

Employee's mailing address

Mailing address

City, State Zip code Country (if not U.S.A.)

MILITARY QUALIFYING EVENT (to be completed by the employee)

1. Name of military member on covered active duty or impending call to covered active duty status (international deployment) (first name, middle initial, last name)

2. Military member's date of birth (MM/DD/YYYY)

3. Military member's gender  Male  Female  Not designated/Other

4. Military member's mailing address

Mailing address

City, State Zip code Country (if not U.S.A.)

5. The above-named military member is employee's:  Spouse  Domestic partner  Child  Parent

6. Period of military member's covered active duty (MM/DD/YYYY) to (MM/DD/YYYY)

7. Please select one of the following and attach the indicated document to support that the military member is on covered active duty or impending call or order to covered active duty status:

   - Covered active duty orders
   - Letter of impending call or order to covered duty
   - Documentation of military leave signed by the approving authority for military member's Rest and Recuperation

Qualifying Reason for Leave (to be completed by the employee)

8. What is the reason employee is requesting PFL? (One or more reasons may be selected):

   - Arranging for child care
   - Arranging for parental care
   - Counseling
   - Making financial arrangements
   - Making legal arrangements
   - Acting as military member's representative before a federal, state, or local agency for purpose of obtaining, arranging, or appealing military service benefits
   - Attending any event sponsored by the military or military service organizations
   - Other

Form PFL-5 continued on next page
MILITARY QUALIFYING EVENT (to be completed by the employee) - continued from prior page

9. Written documentation supporting this request for leave is available and attached?
   ☐ Yes ☐ No ☐ None Available

Note: A complete and sufficient certification to support a request for PFL leave due to a qualifying event includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member’s Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. If leave is requested to meet with a third party, the employee must provide the supporting documentation of the meeting that includes the name, address, appropriate contact information of the individual or entity with whom you are meeting (e.g., either telephone number, fax number, or email address of the individual or entity).

Declaration and signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I am hereby making a request for paid family leave benefits under the NYS Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

[Signature]

Date signed (MM/DD/YYYY)
TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)

Employee's date of birth (MM/DD/YYYY)

Other last names, if any, under which employee has worked

Employee's Social Security Number or TIN

Employee's mailing address

Mailing address

City, State Zip code Country (if not U.S.A.)

QUALIFYING REASON FOR LEAVE - DOCUMENTATION

If leave is requested to meet with a third party, the employee must provide supporting documentation of the meeting that includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone number, fax number or email address of the individual or entity). The reason for a meeting can include arranging for child or parental care, counseling, making financial or legal arrangements, acting as the military member's representative before a federal, state or local agency for purposes of obtaining, arranging or appealing military service benefits, or attending any event sponsored by the military or military service organizations.

Please submit this documentation for each required meeting/event.

Name of individual with whom employee is meeting

Title

Organization

Telephone number (provide area or country code)

Fax number (provide area or country code)

Email address

Mailing address

Mailing address

City, State Zip code Country (if not U.S.A.)

Describe nature of meeting, include dates, if known:
How to Apply for Paid Family Leave

There are four basic steps for an employee to request PFL:

a. When the PFL is foreseeable, an employee must give their department and the insurance carrier at least 30-calendar-days-notice before the leave begins. When the need for a leave is not foreseeable, the employee must give notice as soon as possible.

b. The employee visits ESS.nydhc.org to review application forms and calls the toll free number (1-800-401-2691) to begin an application with the carrier. The carrier explains the process to the employee and will complete the application by asking the employee questions. The carrier sends the employee the application to sign and certify its accuracy and also sends the form to HRSS Leaves to verify the information. Once completed, the forms are signed by HRSS Leaves and sent back to the carrier for processing.

c. The carrier provides HRSS Leaves Administration with access to data on leave requests and the status of claims so PeopleSoft can be updated.

d. The insurance carrier must pay or deny the employee’s request within 18 calendar days of receiving the completed request.
NOTICE OF TOTAL OR PARTIAL DENIAL OF REQUEST/CLAIM FOR PAID FAMILY LEAVE BENEFITS

Your request/claim for Paid Family Leave has been denied. The reason for denial is listed in the below check box and in the Explanation (Box 13). Important information is attached to this form, including what you should do if you disagree with the denial (Instructions for Disputing the Denial of a Request/Claim).

<table>
<thead>
<tr>
<th>Employee</th>
<th>Date of this Notice</th>
<th>Social Security No. (Last 4 Digits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee's Address</td>
<td>First Day of Leave</td>
<td>Carrier No. (Claim/File)</td>
</tr>
<tr>
<td>Employer</td>
<td>Employer's Address</td>
<td>Type of Leave</td>
</tr>
<tr>
<td>Policy Holder or Union (if different from Employer)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You are hereby notified that your request/claim for Paid Family Leave benefits is denied for the reason(s) checked below:

- □ 1. You failed to furnish the information necessary to process your request and did not provide the requested missing claim information within 30 days of beginning leave on:

- □ 2. Your record of employment is not sufficient to establish your eligibility for Paid Family Leave benefits.

- □ 3. You are not a covered employee of this employer.

- □ 4. Your employer is not a covered employer.

- □ 5. We are not your employer's Paid Family Leave Benefits Insurance carrier. Your request/claim has been returned and a copy of this notice has been sent to the Workers' Compensation Board. We suggest you contact the Paid Family Leave toll-free Helpline at (844) 337-8503.

- □ 6. Family member's health condition does not qualify as a serious health condition.

- □ 7. Person requiring care is not a qualifying family member.

- □ 8. Another employee of the same employer is taking Paid Family Leave during the same period to bond/care for the same family member.

- □ 9. You have received the maximum benefits payable during a period of 52 consecutive weeks for Paid Family Leave and/or disability benefits.
  - □ a. No benefits payable.
  - □ b. Partial denial. Benefits are payable from ________ to ________

- □ 10. The request for Paid Family Leave and required documentation was not furnished within 30 days of when the period of Paid Family Leave began (see dates above).
  - □ a. No benefits payable.
  - □ b. Partial denial. Payments are being made beginning two weeks prior to the date your request/claim was received.
    Benefits are payable from ________ to ________

- □ 11. The employer was not given notice of a foreseeable reason for Paid Family Leave at least 30 days in advance.
  - □ a. No benefits payable.
  - □ b. Partial denial. Payments are being made beginning 30 days after notice was given.
    Benefits are payable from ________ to ________

- □ 12. Other.

13. Explanation:

________________________________________
Signature

________________________________________
Name and Title

________________________________________
Telephone Number and Extension

Email Address

PFL-CR-001 (1-18) Page 1 of 2    READ IMPORTANT INSTRUCTIONS ATTACHED
EMPLOYEE INSTRUCTIONS

INSTRUCTIONS FOR WHEN AN INSURANCE CARRIER INDICATES THEY ARE NOT YOUR EMPLOYER'S CURRENT CARRIER

If Box #5 is checked on the previous page, it means that the insurance carrier you submitted your request/claim to is not providing Paid Family Leave coverage to your employer. Call the Paid Family Leave toll-free Helpline at (844) 337-6303 to determine the proper insurance carrier:

1. If another insurance carrier provides coverage for your employer, re-file the request/claim with that carrier.
2. If your employer does not have Paid Family Leave coverage, you may file your request/claim with the Board. Call (844) 337-6303, or visit www.ny.gov/PaidFamilyLeave for more information on filing an uninsured employer claim.
3. If the Board’s records indicate that the carrier with whom the request/claim was originally filed does provide coverage to your employer, follow the directions below to request an arbitrator review the denial.

INSTRUCTIONS FOR DISPUTING THE DENIAL OF A REQUEST/CLAIM

If you disagree with the insurance carrier or self-insured employer's reason for the full or partial denial of your request/claim for Paid Family Leave, you have the right to request that a neutral arbitrator review your request/claim within six months of it being denied. Instructions are below. For more information, call National Arbitration and Mediation at (516) 941-3250 or visit www.nysspfa.com.

You may request arbitration by mail or online:

By Mail:

1. Complete the included Request for Arbitration form (PFL-ARBN) and attach:
   - a copy of this notice of total or partial denial of Paid Family Leave request/claim,
   - a copy of your request for Paid Family Leave and any supporting documentation submitted to the carrier or self-insured employer, and
   - any other evidence to support why your request should be granted.
2. Include a money order or credit card authorization form to pay a $25 filing fee. You will be reimbursed if your request/claim is found to be valid.
3. Send the request to:
   National Arbitration and Mediation
   990 Stewart Avenue, 1st Floor
   Garden City, NY 11530
   Attn.: PFL Arbitrations
4. Send a copy of the Request for Arbitration and supporting documentation to the insurance carrier's and employer's addresses on the first page of the notice of denial.

Online:

1. Go to www.nysspfa.com
2. Complete a Request for Arbitration on the website. You will need to upload:
   - a copy of this notice of total or partial denial of Paid Family Leave request/claim,
   - a copy of your request for Paid Family Leave and any supporting documentation submitted to the carrier or self-insured employer, and
   - any other evidence to support why your request should be granted.
3. Pay a $25 filing fee online. You will be reimbursed if your request/claim is found to be valid.
4. Send a copy of the Request for Arbitration and supporting documentation to the insurance carrier's and employer's addresses on the first page of the notice of denial.
INSTRUCTIONS FOR SELF-INSURED EMPLOYER OR INSURANCE CARRIER:

Do not send to employee

An insurance carrier or self-insured employer will put its name, address, and any other contact information in the blank at the top of the page, including the address for services of arbitration requests. Acceptable reasons for denial of a request/claim for Paid Family Leave are described below and are found in 12 NYCRR 380-5.4. Attach to the Total or Partial Denial of Request/Claim the employee instructions.

BOX 1: You should check this box if the request/claim for Paid Family Leave was denied without prejudice and the employee failed to furnish the missing information within 30 days from beginning of leave.

BOX 2: Please check this box as a denial reason if the employee requesting Paid Family Leave has not worked for the employer long enough to establish eligibility. In order to be eligible under 12 NYCRR 380-2.5, the employee:
- Regularly works less than 20 hours per week and has worked 175 days for the covered employer, OR
- Regularly works 20 or more hours per week and has been in employment for at least 26 consecutive weeks with the covered employer.

BOX 3: This box should be checked if the employee is not an employee or in employment of the covered employer. The employee may not work for the employer as he or she claimed, or has filed a waiver, or is not required to be and is not covered voluntarily by the employer's policy. Examples of this include but are not limited to ministers, teachers or professional employees of religious, charitable or educational institutions, golf caddies, farm laborers - complete list found in the Workers' Compensation Law (WCL) section 201.

BOX 4: If the employer is not a covered employer according to the definition in the WCL section 202, please mark this box as a denial reason.

BOX 5: This box should be checked if the carrier receiving the request for Paid Family Leave is not the covered employer's Paid Family Leave insurance carrier.

BOX 6: Mark here if the family member's health condition does not fit the definition of serious health condition contained in 12 NYCRR 355.9(16). Some examples include the common cold or flu without complications, cosmetic treatments, or routine dental or orthodontia work.

BOX 7: Check this as a denial reason if the person listed in the request for Paid Family Leave as requiring the employee's care is not a qualifying family member under WCL section 201. WCL section 201 defines family member as a child, parent, grandparent, grandchild, spouse or domestic partner of the employee.

BOX 8: This box should be marked if multiple employees from the same covered employer request to take paid family leave during the same period to care for the same family member and the employer has not permitted this. Section 206 (5) of the Workers' Compensation Law states that "a covered employer is not required to permit more than one employee to use the same period of family leave to care for the same family member."

BOX 9: Check this box as a denial reason if the employee has used his or her maximum benefit for Paid Family Leave in a 52-week period and/or the maximum disability benefit. The maximum combined disability and paid family leave benefit may not exceed 26 weeks in a 52 week period under section 205 of the WCL. If the employee has not exhausted his or her benefits, benefits are payable up to the maximum and a partial denial may be issued.

BOX 10: If the employee's request for Paid Family Leave was not timely made within 30 days of the beginning of leave, mark this box. Section 217 of the WCL allows a partial denial for up to two weeks prior to when the proof was furnished.

BOX 11: This box should be checked if the employer was not given notice for foreseeable leave at least 30 days in advance. Partial denials may be issued for up to 30 days from when notice was given if not 30 days in advance (12 NYCRR 380-3.5).

BOX 12: Only check this box if the reason(s) for denial do not fit into one of the categories listed.
BOX 13: Write a detailed explanation of why the request for paid family leave is denied, including a list of any missing information if the denial is based on Box 1. Include one of the denial reasons below:

1a. Claim incomplete - Claim form incomplete, missing item number:
1b. Claim incomplete - No certification submitted, the missing certification is:
1c. Claim incomplete - Certification incomplete, missing item number:
1d. Claim incomplete - Certification submitted but missing birth certificate or medical pregnancy documentation
1e. Claim incomplete - Certification submitted but missing evidence of employee's relationship with mother
1f. Claim incomplete - Certification submitted but missing documentation of adoption or foster care
1g. Claim incomplete - Certification submitted but no documentation of family member's military deployment
1h. Claim incomplete - Certification submitted but no information provided concerning reason for military leave
2. Employee not eligible due to length of employment. The employee was employed:
3a. Employee not required to be covered because:
3b. Employee not required to be covered - Not an employee of the employer
3c. Employee not required to be covered - Independent contractor
3d. Employee not required to be covered - Employee filed waiver for working less than 175 days a year
3e. Employee not required to be covered - Employee filed waiver for Social Security eligibility
3f. Employee not required to be covered - Out of state employee
3g. Employee not required to be covered - Domestic worker who works less than 40 hours a week
3h. Employee not required to be covered - Farm laborer
3i. Employee not required to be covered - Minister, teacher, or professional employee of non-profit
4. Employer not required to have coverage - Public or other exempt employer type without voluntary coverage
5a. Incorrect carrier - Carrier not the employer's insurer
5b. Incorrect carrier - Carrier not the employer's insurer - Coverage canceled prior to claim
6a. Family Member's Health Condition does not qualify as serious, due to:
6b. Family Member's Health Condition does not qualify as serious - Common cold or flu without complication
6c. Family Member's Health Condition does not qualify as serious - Cosmetic treatment
6d. Family Member's Health Condition does not qualify as serious - Routine dental or orthodontia
7a. Person requiring care not a qualifying family member because:
7b. Person requiring care not a qualifying family member - Brother or sister
7c. Person requiring care not a qualifying family member - Aunt or uncle
7d. Person requiring care not a qualifying family member - Friend
8. Another employee of the employer took leave to care for the same person at the same time
9a. Employee received the maximum benefit in a 52-week period, prior period of benefits:
9b. Employee received the maximum benefit in a 52-week period - Partial denial, prior period of benefits:
10a. Request for Paid Family Leave not timely filed, request filed more than two weeks after end of leave period
10b. Request for Paid Family Leave not timely filed - Partial denial
11a. Employer was not given advance notice of foreseeable leave, employer received notice on:
11b. Employer was not given advance notice of foreseeable leave - Partial denial, employer received notice on:
12. Other. Explain any other denial reason:
Information on the option to opt-out of paid family leave and directions for completing this form can be found on page 2.

### Employer Information

1. **EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)**

2. **ADDRESS**

3. **CITY, STATE and ZIP CODE**

4. **EMPLOYER FEIN**

5. **TELEPHONE NUMBER**

### Employee Information

6. **EMPLOYEE NAME**

7. **HOME ADDRESS**

8. **CITY, STATE and ZIP CODE**

9. **TELEPHONE NUMBER**

### Employment Information

10. **AVERAGE NUMBER OF HOURS WORKED PER WEEK (BASED ON LAST 8 WEEKS)**

11. **AVERAGE NUMBER OF DAYS WORKED PER WEEK (BASED ON LAST 8 WEEKS)**

12. **IS THIS JOB TEMPORARY?**

   - [ ] YES
   - [ ] NO

   **IF YES, HOW LONG IS THE JOB EXPECTED TO LAST?**

### Employee Affirmation

1. I would like to waive paid family leave coverage at this time because (select one):
   - [ ] I regularly work 20 hours or more per week, but will not work 26 consecutive weeks (6 months) for this employer.
   - [ ] I regularly work less than 20 hours per week, but will not work 175 days in 52 consecutive weeks (a year) for this employer.

2. I understand that this waiver is revoked if my work schedule changes and it is anticipated I will work more than 20 hours per week for 6 months, or will work less than 20 hours per week but at least 175 days in a 52 consecutive week period (1 year).

3. I understand that this waiver is **OPTIONAL AND REVOCABLE**.
   - (a) My employer may not force me to opt out of paid family leave benefits.
   - (b) I may decide later to revoke this waiver even if my schedule does not change.

4. I also understand if this waiver is revoked (either by me or by a change in my work schedule), my employer may take retroactive deductions for the period of time I was covered by this waiver, and this period of time counts towards my eligibility for paid family leave.

### Certification

I certify to the best of my knowledge the foregoing statements are complete and true.

**Employer's Signature:** __________________________  **Date Signed:** ____________

**Employee's Signature:** __________________________  **Date Signed:** ____________

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**Please note:** Employer must keep a copy of the fully executed waiver on file for as long as the employee remains in employment with the covered employer.
Opting Out of Paid Family Leave (12 NYCRR 380-2.6)

(a) An employee of a covered employer shall be provided the option to file a waiver of family leave benefits:
   (i) When his or her regular employment schedule is 20 hours or more per week but the employee will not work 26 consecutive weeks, or
   (ii) When his or her regular employment schedule is less than 20 hours per week and the employee will not work 175 days in a 52 consecutive week period.

(b) Within eight weeks of any change in the regular work schedule for an employee that requires the employee to continue working for 26 consecutive weeks or 175 days in a 52 consecutive week period, any waiver filed under this section shall be deemed revoked. An employee of a covered employer whose waiver has been revoked shall be obligated to begin making contributions to the cost of family leave benefits, including any retroactive amounts due from date of hire, pursuant to Section 209 of the Workers' Compensation Law, as soon as the employee is notified by the covered employer of such obligation.

(c) The covered employer shall keep a copy of the fully executed waiver on file to be produced at the request of the Chair, for as long as the employee remains in employment with the covered employer.

(d) An employee as described in Subsection (a) of this Section who elects not to enter into a waiver shall make regular family benefit contributions for the full duration of his or her employment with the covered employer, and the covered employer shall be obligated to provide family leave benefits for such employee when he or she is eligible pursuant to this Title.

Calculating Average Hours/ Days Worked

To determine the average number of hours worked per week:
Add all hours worked for the past 8 weeks then divide the total by 8.

To determine the average number of days worked per week:
Add all days worked for the past 8 weeks then divide the total by 8.

Example:

<table>
<thead>
<tr>
<th>Week Worked</th>
<th>Hours Worked</th>
<th>Days Worked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td>Week 2</td>
<td>24</td>
<td>3</td>
</tr>
<tr>
<td>Week 3</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td>Week 4</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td>Week 5</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Week 6</td>
<td>24</td>
<td>3</td>
</tr>
<tr>
<td>Week 7</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td>Week 8</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>128</td>
<td>16</td>
</tr>
</tbody>
</table>

Divide by 8  Divide by 8

Average Per Week 16 2
IF YOU NEED TO TAKE TIME OFF FROM WORK TO CARE FOR A FAMILY MEMBER, YOU MAY BE ENTITLED TO PAID FAMILY LEAVE BENEFITS

Paid Family Leave is employee-funded insurance that provides job-protected, paid time off to:
- Bond with a newly born, adopted or fostered child;
- Care for a family member with a serious health condition; or
- Assist loved ones when a spouse, domestic partner, child or parent is called to active military service abroad.

Eligibility:
- Employees with a regular work schedule of **20 or more hours per week** are eligible after **26 consecutive weeks** of employment.
- Employees with a regular work schedule of **less than 20 hours per week** are eligible after **175 days worked**.

Citizenship or immigration status is not a factor in your eligibility.

Benefits: In 2019, you can take up to 10 weeks of Paid Family Leave and receive 55% of your average weekly wage, capped at 55% of the New York State average weekly wage. Generally, your average weekly wage is the average of your last eight weeks of pay prior to starting Paid Family Leave.

Rights and Protections:
- **Job Protection:** Return to the same or comparable job after you take leave.
- You keep your health insurance while on leave (you may have to continue paying your portion of the premium costs, if any).
- Your employer is prohibited from discriminating or retaliating against you for requesting or taking Paid Family Leave.
- You do not have to exhaust sick leave or vacation accruals before using Paid Family Leave.

Paid Family Leave Request Process:
1. Notify your employer at least 30 days in advance, if foreseeable, or as soon as possible.
2. Complete and submit the Request for Paid Family Leave (Form PFL-T) to your employer.
3. Complete and attach the additional forms as required and submit to the insurance carrier listed below within **30 days of starting your leave, to avoid losing benefits**.
4. In most cases, the insurance carrier must pay or deny benefits within **18 calendar days** of receiving your completed request or your first day of leave, whichever is later.

You may obtain all forms from your employer, their insurance carrier listed below or online at PaidFamilyLeave.ny.gov/Forms.

Disputes:
If your Paid Family Leave claim is denied, you may request to have the denial reviewed by a neutral arbitrator. The insurance carrier listed below will provide you with information about requesting arbitraction.

Discrimination Complaints:
If your employer terminates your employment, reduces your pay and/or benefits, or disciplines you in any way as a result of you requesting or taking Paid Family Leave, you may request to be reinstated by taking these steps:
1. Complete the Formal Request for Reinstatement Regarding Paid Family Leave (Form PFL-DC-119)
2. Send your completed form to your employer and a copy of the completed form to: Paid Family Leave, P.O. Box 9030, Endicott, NY 13761-9030
3. If your employer does not reinstate you or take other corrective action within 30 days, you may file a discrimination complaint with the Workers’ Compensation Board using the Paid Family Leave Discrimination/Retaliation Complaint (Form PFL-DC-120), available at PaidFamilyLeave.ny.gov/Forms. The Workers’ Compensation Board will assemble your case and schedule a hearing.
4. There are other state and federal laws that protect employees from discrimination. Additional information is available at PaidFamilyLeave.ny.gov.

For more information, forms, and instructions, visit PaidFamilyLeave.ny.gov or call (844)-337-6303.

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law. Your employer's Paid Family Leave benefits insurance carrier is:

Wesco Insurance Company: POLICY #: TDL10281278
C/O AbSolve Absence Management, P. O. Box 1328, Mt. Laurel, NJ 08054
PHONE: 800-401-2691 HOURS: 8:30AM - 5:00PM
FAX: 800-728-7028 EMAIL: AmTrustNYDBLPFL@absencesolved.com

PREScribed by the chair,
Workers’ Compensation Board

NYS Paid Family Leave - PO Box 9030, Endicott NY 13761
PFL Helpline: (844) 337-6303 • PaidFamilyLeave.ny.gov

PFL-271S (Revised as of October 2018)