How to Request Paid Family Leave

To care for a family member with a serious health condition

NYSIF

Eligibility

- **You can take job-protected paid time off** to care for a spouse, domestic partner, child/stepchild, parent/stepparent, parent-in-law, grandparent, grandchild or sibling with a serious health condition, to provide physical care, emotional support, transportation, daily assistance and more. The benefit rate is 67% of your average weekly wage up to 67% of the NYS average weekly wage.
- **Most employees** who work in New York State for private employers are covered under PFL.
  - ❑ If you regularly work 20 or more hours per week for a covered employer, you are eligible after working 26 weeks for your employer.
  - ❑ If you regularly work less than 20 hours per week for a covered employer, you are eligible after working 175 days for your employer.
- **Citizenship and/or immigration status** is not a factor in employee eligibility.
- **For more information**, visit www.paidfamilyleave.ny.gov.

Before you apply

- ✓ **Plan your leave.** It may be taken all at once or intermittently, but must be taken in full-day increments.
- ✓ **Notify your employer at least 30 days *before* the start of leave, if foreseeable**; otherwise, notify them as soon as possible. (The claim is due to NYSIF by 30 days *after* your leave begins.)
- ✓ **Is NYSIF your employer's DB/PFL carrier?** Go to https://www.wcb.ny.gov/icpocinq/icpocdisclaimer.jsp to find out their Disability Benefits/Paid Family Leave insurance company and policy number.

Complete your forms and attach the required documentation

- ✓ **Complete the Request for Paid Family Leave (Form PFL-1).**
  - ❑ Fill out your section, make a copy, and give the form to your employer to fill out Part B.
  - ❑ Your employer is required to return form PFL-1 to you within *three business days*. If there is a delay, send form PFL-1 and the completed PFL-4 directly to NYSIF.
- ✓ **Your family member completes the Release of Personal Health Information (Form PFL-3).**
  - ❑ Your family member (the care recipient) completes Form PFL-3 and submits it to their health care provider to keep on file. This authorizes the release of health information.
- ✓ **Complete the Health Care Provider Certification (Form PFL-4).**
  - ❑ Fill out your section and have your family member's provider complete and return it to you.

Submit the PFL-1 and PFL-4 to NYSIF

- ✓ **Submit your completed request** within 30 days after the start of your leave to avoid losing benefits. Submit in *one way only*: fax to 518.437.5201, e-mail to DBClaims@nysif.com, or mail to NYSIF, PO Box 66699, Albany, NY 12206. Keep a copy of all documents for your records.
- ✓ **It is *your* responsibility** to submit the forms to NYSIF. It is *not* your employer's responsibility.

Pre-filing complicates the process

- **If you file your claim before your leave begins,** you will need to complete additional steps. It is simplest to wait until shortly after your leave starts to complete and submit your forms.

Notification Pursuant to the NY 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.

Notification Pursuant to the NY Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a)
The personal information requested on this form, including your social security number, is collected by NYSIF in order to manage your claim and distribute your benefits, and to complete and verify tax documentation related to your benefits. Your personal information is confidential and will not be disclosed to anyone except for these purposes, in accordance with state and federal law. To access or correct your personal records, please contact: Records Access Officer, NYSIF, PO Box 66699, Albany, NY 12206 Email: freedominfo@nysif.com

Request for Paid Family Leave
(Form NYSIF PFL-1)

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

1. **Your name** (first name, middle initial, last name)

2. **Other last names, if any, under which you have worked**

3. **Your mailing address**

Street address

Apt/Unit #

City, State

Zip code | Country (If not USA)

4. **Your Social Security Number or TIN**

5. **Your date of birth** (M/D/YY)

6. **Your primary telephone number** (with area code)

7. **Your preferred e-mail address while on PFL** (if available)

8. **Your gender**

☐ Male/M ☐ Female/F ☐ Non-binary or third gender/X

9. **Your preferred language**

☐ English ☐ Español ☐ Русский ☐ Polski

☐ 中文 ☐ Italiano ☐ Kreyòl ayisyen ☐ 한국어

☐ Other

Optional (for research purposes)

10. **Your ethnicity/race**

For purposes of health demographic only. (U.S. Centers for Disease Control and Prevention (CDC) code set, version1.0.)

Are you 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 your 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 your:**

☐ Child ☐ Spouse ☐ Domestic partner ☐ Parent ☐ Parent-in-law ☐ Grandparent ☐ Grandchild ☐ Sibling

Form NYSIF PFL-1 continued on next page

Send **completed** form either by fax (518-437-5201) OR e-mail (DBClaims@nysif.com)
OR mail: NYSIF, PO Box 66699, Albany, NY 12206

TO BE COMPLETED BY THE EMPLOYEE

Your name (first name, middle initial, last name)

Your Social Security Number or TIN

Your preferred e-mail address while on PFL

Your primary telephone number

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

Form NYSIF PFL-1 continued from prior page

13. Will PFL be for a single, continuous period of time or intermittent?

☐ Continuous* PFL start date (M/D/YY) _____ — PFL end date (M/D/YY) _____ ☐ Dates are estimated**

☐ Intermittent* (PFL must be taken in full-day increments.) Dates intermittent PFL will be taken: ☐ Dates are estimated**

* If this application form is received more than 30 days after the first date of leave, part or all of your claim may be denied.
** You must confirm any estimated dates with NYSIF prior to receiving payment.

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

_____

Employment Information (to be completed by the employee)

15. Business name

_____

16. Your date of hire (M/D/YY) _____

17. Your work location

Street address

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

18. Your average gross weekly wage (This data will be requested of both the employee and employer) _____

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

20. Do you have more than one employer? ☐ Yes ☐ No

20a. If yes, are you taking PFL from the other employer? ☐ Yes ☐ No

21. Are you 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 (M/D/YY) _____

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

Send **completed** form either by fax (518-437-5201) OR e-mail (DBClaims@nysif.com)
OR mail: NYSIF, PO Box 66699, Albany, NY 12206

TO BE COMPLETED BY THE EMPLOYEE

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

Employee's Social Security Number or TIN

Employee's preferred e-mail address while on PFL

Employee's primary telephone number

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

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 ☐☐☐☐ See https://www.naics.com/search/#sic

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

5. Employer's contact telephone number _____ **Ext.** _____

6. Employer's contact e-mail address _____

7. Employee's date of hire (M/D/YY) _____

8a. Employee's occupation _____ **8b. Employee's occupation code** ☐☐ - ☐☐☐☐
See https://www.bls.gov/soc/2018/major_groups.htm

9a. Has the leave started? ☐ **Yes, their last day worked was (M/D/YY)** _____

☐ **No, this claim is being pre-filed.** (Skip to 11. Questions 9b & 10 must be filled out after the employee has stopped working.)

9b. Enter the last 8 weeks* of gross wages for the employee and calculate the average gross weekly wage.
These must be the 8 weeks up to and including the last day worked before Paid Family Leave. For biweekly or semi-monthly pay, enter only 4 periods.

Week no.	Week ending date (M/D/YY)	Number of days worked	Gross amount paid
1			
2			
3			
4			
5			
6			
7			
8			
Calculated average gross weekly wage			

* For self-employed persons, LLC or LLP members, divide the total net income for the 52 weeks prior to PFL by 52. Provide documentation to support wages.

10a. Will the employee receive continued pay (wage, vacation, PTO or other) during PFL? ☐ **Yes** (Answer 10b, 10c & 10d.)
☐ **No** (Skip to question 11.)

10b. What period are wages being continued? _____ **to** _____

10c. What percentage of their usual pay will the employee receive during PFL? _____

10d. Are you requesting reimbursement for continued wages? ☐ Yes ☐ No

Form NYSIF PFL-1 continued on next page

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TO BE COMPLETED BY THE EMPLOYEE

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

Employee's Social Security Number or TIN

Employee's preferred e-mail address while on PFL

Employee's primary telephone number

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

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

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

NYS Disability:	Weeks Days	Please provide specific dates for Disability:
NYS PFL:	Weeks Days	Please provide specific dates for PFL:

12. Is the employee taking Family Medical Leave Act (FMLA) at the same time as PFL? ☐ Yes ☐ No

13. PFL insurance carrier's name and mailing address:

PFL insurance carrier's name: NYSIF

Mailing address:
NYSIF
PO Box 66699
Albany, NY 12206

14. PFL insurance carrier's phone number: 866-697-4332

15. Employer's NYSIF DB/PFL policy number _____

Declaration and signature

(Select One)

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

☐ I affirm the employee regularly works less than 20 hours per week and has worked at least 175 individual days.

☐ I affirm the employee ***HAS NOT*** worked 26 consecutive weeks at 20 or more hours per week or 175 days at less than 20 hours per week.

Any person who knowingly and with intent to defraud an 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 (M/D/YY)

Title

Send **completed** form either by fax (518-437-5201) OR e-mail (DBClaims@nysif.com)
OR mail: NYSIF, PO Box 66699, Albany, NY 12206

NYSIF

Request For Paid Family Leave
Release of Personal Health Information
under the Paid Family Leave Law (Form NYSIF PFL-3)

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 (M/D/YY)

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 the care recipient's health care provider with Form NYSIF PFL-4)

I, Care recipient's (patient's) name **, authorize my health care provider listed on this form to release my personal health information to** Employee's name **and their employer's PFL insurance carrier** PFL insurance carrier's name NYSIF **.**

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 U.S.A.)

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

Form NYSIF PFL-3 continued on next page

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) - continued from prior page

Form NYSIF PFL-3 continued from prior page

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

I, Print name **, represent the care recipient in this matter as authorized by:**

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

Authorized representative's signature

Date signed (MM/DD/YYYY)

The employee should retain a copy for their own records.

NYSIF

Request For Paid Family Leave

Health Care Provider Certification for Care of Family Member with Serious Health Condition (Form NYSIF PFL-4)

INSTRUCTIONS INCLUDED WITH FORM

TO BE COMPLETED BY THE EMPLOYEE

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

Employee's Social Security Number or TIN

Employee's preferred e-mail address while on PFL

Employee's primary telephone number

Employee's mailing address

Mailing address

City, State

Zip code

Country (if not U.S.A.)

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

Care recipient's (patient's) date of birth (M/D/YY)

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** (M/D/YY)

5. **First date care for patient is needed** (M/D/YY)

6. **Expected date patient will no longer require care** (M/D/YY)

7. **Estimated number of days per week OR days per month patient requires care** Days per week **OR** Days per month

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

8. **Health care provider's name**

Form NYSIF PFL-4 continued on next page

Send **completed** form either by fax (518-437-5201) OR e-mail (DBClaims@nysif.com)
OR mail: NYSIF, PO Box 66699, Albany, NY 12206

TO BE COMPLETED BY THE EMPLOYEE

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

Employee's Social Security Number or TIN

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

Care recipient's (patient's) date of birth (M/D/YY)

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

Form NYSIF PFL-4 continued from prior 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/DDM)
- ☐ 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

City, State | 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 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.

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 (M/D/YY)

Send **completed** form either by fax (518-437-5201) OR e-mail (DBClaims@nysif.com)
OR mail: NYSIF, PO Box 66699, Albany, NY 12206