

How to Request Paid Family Leave

To provide assistance when a family member is deployed



Eligibility

- **You can take job-protected, paid time off** to assist a spouse, domestic partner, child/stepchild, parent/stepparent or parent-in-law who is deployed abroad on active military service. PFL is available for the same reasons as military-related leave under FMLA, which include short-notice deployment, military events, military member's Rest and Recuperation, military member's counseling, post-deployment activities, making financial/legal arrangements, and making child care arrangements for the military member's child. 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 forms PFL-1 and PFL-5 and supporting documentation directly to NYSIF.
- ✓ **Complete the Military Qualifying Event (Form PFL-5).**
- ✓ **Attach the required documentation** (see list on Form PFL-5, question 7).

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 forms 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

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?

<input type="checkbox"/>	Continuous* PFL start date (M/D/YY) _____ PFL end date (M/D/YY) _____	<input type="checkbox"/>	Dates are estimated**
<input type="checkbox"/>	Intermittent* Dates intermittent PFL will be taken: _____ (PFL must be taken in full-day increments.)	<input type="checkbox"/>	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.

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

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

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



Request For Paid Family Leave Military Qualifying Event (Form NYSIF PFL-5)

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

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 □□ / □□ / □□□□

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.)

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

Form NYSIF PFL-5 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) [][] / [][] / [][][][]

MILITARY QUALIFYING EVENT (to be completed by the employee) - continued from prior page

Form PFL-5 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 (i.e., 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.

Employee's 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: