How to Request Paid Family Leave

to bond with a newly born, adopted or fostered child

Eligibility

- **Mothers and fathers**, including same-sex parents, may take job-protected, paid time off to bond with their new child within the first 52 weeks of the child's birth, adoption or foster placement. 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.** Leave may be taken all at once or intermittently but must be 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 see 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 rest of your request package directly to NYSIF.
- ✓ **Complete the Bonding Certification (Form PFL-2).**
- ✓ **Attach the required proof-of-relationship documentation** (see list on Form PFL-2).

Submit the entire package (PFL-1, PFL-2 and proof of relationship) 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 and documentation 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 more steps after the leave starts. It is best to wait until shortly after your leave starts to complete and submit 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

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) 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

Request for Paid Family Leave
Bonding Certification (Form NYSIF PFL-2)

TO BE COMPLETED BY THE EMPLOYEE

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

Your date of birth (M/D/YY)

Other last names, if any, under which you have worked

Your Social Security Number or TIN

Your mailing address

Street address	Apt #	City, State	Zip Code	Country (if not USA)

Your primary telephone number

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

Bonding Certification (to be completed by the employee)

1. Child's date of birth (M/D/YY) _____

2. Child's gender ☐ Male/M ☐ Female/F ☐ Non-binary or third gender/X

3. Does child live with you? ☐ Yes ☐ No

4. Child is your:

☐ Biological child ☐ Stepchild ☐ Foster Child ☐ Adopted child ☐ Legal ward ☐ Spouse/Domestic partner's child ☐ Loco parentis

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

Parent of newborn child:

Birth parent:

- ☐ Health care provider certification of pregnancy (include expected due date AND birth parent's name); OR
- ☐ Health care provider certification of birth (include date of birth of child AND birth parent'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 parent 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 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) _____

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)

Once the form is **completed**, submit it **once** by faxing it to 518-437-5201, **OR** emailing it to DBClaims@nysif.com, **OR** mailing it to NYSIF, PO Box 66699, Albany, NY