

PAID FAMILY LEAVE CLAIMANT CHECKLIST – BONDING

Have you taken time off from work to bond with your newborn, adopted child or foster child?



PRE-FILE A CLAIM

STEP 1: COMPLETE NYSIF PFL-1

- Check the "Bond with child" box in Question 1.
- Check the "Pre-file a Claim" box in Question 3.

STEP 2: PROVIDE NYSIF PFL-1 TO EMPLOYER Employer completes NYSIF PFL-1, Part B, and returns to you within three days.

STEP 3: COLLECT SUPPORTING DOCUMENTATION

Health Care Provider Certification of Pregnancy – it must be a letter from the health care provider that includes the mother's name and expected due date.

STEP 4: SUBMIT NYSIF PFL-1 & HEALTH CARE PROVIDER CERTIFICATION TO NYSIF

STEP 5: FIRST DAY TAKEN TO BOND WITH YOUR NEWBORN, ADOPTED OR FOSTER CHILD

STEP 6: COMPLETE NYSIF PFL-2

Once baby is born/leave begins, complete the Bonding Certification, including the relationship to the child, on NYSIF PFL-2.

STEP 7: PROVIDE NYSIF PFL-2 TO EMPLOYER Employer completes NYSIF PFL-2, Part B, and returns to you within three days.

STEP 8: COLLECT SUPPORTING DOCUMENTATION

Supporting Documentation is defined on page 1 of NYSIF PFL-2 instructions.

STEP 9: SUBMIT NYSIF PFL-2 AND ADDITIONAL SUPPORTING DOCUMENTATION TO NYSIF



FILE A CLAIM

STEP 1: FIRST DAY TAKEN TO BOND WITH YOUR NEWBORN, ADOPTED OR FOSTER CHILD

STEP 2: COMPLETE NYSIF PFL-1

- Check the "Bond with child" box in Question 1.
- Check the "File a Claim" box in Question 3.

STEP 3: COMPLETE NYSIF PFL-2

Complete the Bonding Certification, including the relationship to the child, on NYSIF PFL-2.

STEP 4: PROVIDE FORMS NYSIF PFL-1 & NYSIF PFL-2 TO YOUR EMPLOYER

Employer completes Part B on both forms and returns to you within three days.

STEP 5: COLLECT SUPPORTING DOCUMENTATION

Supporting Documentation is defined on page 1 of NYSIF PFL-2 instructions.

STEP 6: SUBMIT NYSIF PFL-1, NYSIF PFL-2 AND SUPPORTING DOCUMENTATION TO NYSIF



Send completed forms to: NYSIF Document Control Center, Disability Claims 1 Watervliet Ave Ext, Albany, NY 12206 or fax to 518-437-5201.

You must submit all claims forms to NYSIF within 30 days after the start of the leave. Failure to do so may affect benefits. NYSIF accepts or denies claim within 18 days. You do not need to wait for this decision to start your leave. Please keep a copy of all pages for your records.



NEW YORK STATE INSURANCE FUND Notice and Proof of Claim for Paid Family Leave

Request For Paid Family Leave (NYSIF Form PFL-1) Instructions

- Be sure to follow the instructions on the NYSIF PFL Claim checklist for the type of leave you are requesting.
- Complete Part A and sign.
- Provide Part B to your employer for completion. If the employer does not complete any of Part B, you must provide the missing information.
- Additional forms are required depending on the type of leave being requested. You must submit *NYSIF PFL-1* with the required additional form(s) to NYSIF within 30 days after the start of leave. Failure to do so may affect benefits. Please retain a copy of each submitted form for your records.

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

The employee requesting PFL must complete all fields, unless otherwise noted as optional.

Question 2: 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 3: To pre-file a claim, the following has not yet occurred:

- First date care is needed for family member with a serious health condition; **OR**
- Birth date, placement or adoption date, or date leave begins to facilitate placement or adoption; **OR**
- First date leave needs to be taken to assist with a military call to duty or active deployment.

Question 14:

- 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 dates are "Intermittent," enter the dates PFL will be taken. Please be as specific as possible.
- If uncertain, estimate the start and end dates and indicate "Dates are estimated." If dates are estimated, NYSIF 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 15: If the employee is submitting a 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.

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

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

Question 3: Enter the employer's Standard Industrial Classification (SIC) Code. Visit the U.S. Department of Labor to determine your SIC code: www.osha.gov/pls/imis/sic_manual.html

Question 8: The employee occupation code can be found at: www.bls.gov/soc/2018/major_groups.htm

Questions 9 & 10: Please ensure the employer's policy number is provided, along with NYSIF's information.

Question 11: 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 must sign and date, and return to the employee requesting PFL within three business days.

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.

NYSIF

Request For Paid Family Leave

(NYSIF Form PFL-1)

NEW YORK STATE INSURANCE FUND

PART A - EMPLOYEE INFORMATION (to be completed by the employee)									
Reason for Paid Family Leave (PFL) Rec	quest								
1. Bond with child Care	for family member Military qualifying event								
2. The family member is the employee's:									
ÁÔ@4å ÁÙ][˘∙^ ÁÖ[{^•œã	&A,/æd;)^¦ ÁÚæ}^}c Ő¦æ)å]æ}^}oÁ Ő¦æ)å&@4å								
3. Are you submitting this form to: Pr	Pre-file a Claim File a Claim (See NYSIF PFL Claim Checklist for more information.)								
4. Employee's legal name (first name, middle initial									
4. Employee's legal name (institutie, mode initial	Optional (for research purposes)								
5. Other last names, if any, under which emp	bloyee has worked 13. Employee's ethnicity/race For purposes of health demographic only. (U.S. Centers for Disease Control and Prevention (CDC) code set, version 1.0.)								
6. Employee's mailing address	Is employee of Hispanic, Latino/a, or Spanish origin? (One or more categories may be selected.)								
Street address	Mexican								
	Mexican American								
City	State Chicano/a								
	Puerto Rican								
Zip code Country (if not U.S.A	A.) Dominican								
	Cuban								
7. Employee's Social Security Number or TIN	Another Hispanic, Latino/a, or Spanish origin								
	Not of Hispanic, Latino/a, or Spanish origin								
	Unknown								
8. Employee's date of birth (MM/DD/YYYY)	What is employee's race?								
	(One or more categories may be selected.)								
	American Indian or Alaska								
9. Employee's primary telephone number	Native Black or African								
	American Asian Indian								
10. Employee's preferred email address while	Chinese								
To. Employee's preferred email address white	Filipino								
	Japanese								
11. Employee's gender	Korean								
Male Female Not designated/Other	Vietnamese								
	Other Asian								
12. Employee's preferred language	White								
English Español Русский									
繁體字 Italiano Kreyòl a									
Other	Samoan								
	Other Pacific Islander								
	Other race								

го <u>ве сс</u>	OMPLETED	BY THE EMPLOYEE			
		st name, middle initial, last name)	Employee's date of	birth E	mployee's phone number
PART A -	- EMPLOYE	EE INFORMATION (to be complet	ed by the employee) - (continued from	prior page
4. Will P	PFL be used	for a continuous period of time or	intermittent (non-conse	cutive)?	
C	Continuous	PFL start date (MM/DD/YYYY) I	PFL end date (MM/DD/YYYY) /		Dates are estimated**
(l ta	ntermittent PFL must be aken in full-day ncrements.)	Identify dates of intermittent PFL:			Dates are estimated**
5. If pro	viding less	**Note: You must confirm any es than 30 days' advance notice to the		·	eiving payment.
6. Busir	ness name				
7. Emplo	oyee's work	location:			
•	address				
City			State	Zip code	
	e statement: o the employe	Information regarding PFL benefits rece	eived by the employee, suc	h as payments a	nd types of leave, will be
eclaratio	on and signa	ature			
atement ny fact m	of claim con aterial there	ngly and with intent to defraud any ins taining any materially false information to, commits a fraudulent insurance act dollars and the stated value of the claim	n, or conceals for the purp t, which is a crime, and sh	bose of misleadir nall also be subje	ng, information concerning
am hereb	ation I am p	request for paid family leave benefits roviding is true and accurate to the b ployer Information.		-	
	Part B - Emp	5			
	Part B - Emp		Date signe	ed (MM/DD/YYYY)	
	Part B - Emp	-		ed (MM/DD/YYYY)	
	Part B - Emp	Employee Signature			

NYSIF PFL-1 - CONTINUED FROM PRIOR PAGE

NEW YORK STATE INSURANCE FUND

TO BE COMPLETED BY THE EMPLOYEE		
Employee's name (first name, middle initial, last name)	Employee's date of birth	Employee's phone number
PART B - EMPLOYER INFORMATION (to be complete	ed by the employer)	
1. Business's full legal name and mailing address		
Business name		
Mailing address		
City	State	Zip code
2. Employer's FEIN (or Social Security Number)		
3. Employer's Standard Industrial Classification (SIC) Cod	e www.osha.go	ov/pls/imis/sic_manual.html
4. Employer's contact name for questions related to PFL:		
5. Employer's contact telephone number:	Ext.	
6. Employer's contact email address:		
7. Employee's date of hire:		
8. Employee's occupation code:	Occupational Codes Occupation:	
9. Employer's DB/PFL policy number:		
10. PFL insurance carrier's name and mailing address:		
PFL insurance carrier's name New York State Insur	ance Fund	
Mailing address NYSIF Document Contro 1 Watervliet Avenue External Albany, NY 12206	l Center - Disability Claims ension	
Fax Number (518) 437-5201		
11. Declaration and signature		
I affirm the employee regularly works 20 or more hour consecutive weeks OR the employee regularly works		
Any person who knowingly and with intent to defraud any insurance conclaim containing any materially false information, or conceals for the p commits a fraudulent insurance act, which is a crime, and shall also be stated value of the claim for each such violation.	urpose of misleading, information concer	rning any fact material thereto,
I am the person authorized to sign as the employer of the employee re and belief, the information I have provided is true and accurate.	questing PFL. My signature affirms that	to the best of my knowledge
	Date signed (MM/DD/	YYYY)
Employer's authorized signature		
Title		
NYSIF PFL-1 (6/18)	Submit completed form to:	

Page 3 of 3

NYSIF Document Control Center, Disability Claims, 1 Watervliet Ave Ext, Albany, NY 12206; or fax to 518-437-5201.



Bonding Certification (NYSIF 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 (NYSIF Form PFL-2)*.

- Be sure to follow the instructions on the NYSIF PFL Claim Checklist Bonding.
- Complete Part A and sign.
- Provide Part B to your employer for completion.
- If the employer fails to complete any of Part B, you must provide the missing information. This includes proof of wages if the employer does not complete question 11.
- With your completed NYSIF PFL-2, please submit proof of your relationship as explained below.
- You must submit all forms to NYSIF within 30 days after the start of leave. Failure to do so may affect benefits. Please retain a copy of each submitted form for your records.

PART A. BONDING CERTIFICATION (to be completed by the employee)

The employee requesting PFL must complete all fields, unless otherwise noted as optional.

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. Do not send the original documents.

Bonding Form/Certification	Description
Birth Certificate	A copy of the certificate issued by the city or county office in which the child is born.
Health care provider certification of birth	An original letter obtained from the birth mother's health care provider that includes the mother's name and child's date of birth.
Voluntary Acknowledgment of Paternity (Form LDSS-4418)	A copy of the form that establishes legal fatherhood when the parents are unmarried. Completed by both mother and father. For more information, visit <u>childsupport.ny.gov</u> .
Court Order of Filiation	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 <u>childsupport.ny.gov/dcse/aop_howto.html</u>
Marriage Certificate	A copy of the official statement issued by the town or city clerk from which the marriage certificate was issued.
Civil union/domestic partner's documentation	A copy of the certificate of civil union or domestic partnership.
Other documentation of parental relationship	Other documentation of parental relationship may be accepted if none of the others listed apply.
Foster care placement letter	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.
Court documents of adoption	A copy of the court document finalizing adoption or documentation in furtherance or court order finalizing adoption.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) & 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.

NYSIF PFL-2 Instructions Page 1 of 2

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

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

Question 9: Failure to select "Yes" for requesting reimbursement from NYSIF will result in a waiver of the right to reimbursement. If answering "Yes," the employer must provide the dates that full wages were paid.

Question 11: 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. 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).

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 Week 2 - Gross wage Week 3 - Gross wage Week 4 - Gross wage Week 5 - Gross wage Week 6 - Gross wage, including overtime Week 8 - Gross wage, including overtime Total = Divide by 8	\$550 \$500 \$500 \$500 \$500 \$500 \$600 + \$550 \$4,200 \$ 8			
Average Weekly Wage =	\$525			
Bonus earned in preceding 52 weeks Divide by 52	\$2,600 ÷ 52			
Prorated Weekly Bonus =	\$50			
Average Weekly Wage Prorated Weekly Bonus	\$525 + \$50			
Average Weekly Wage (including bonus):	\$575			

Question 12: "Disability" refers to NYS statutorily-required disability.

Question 13: 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.

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

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.

NYSIF PFL-2 Instructions Page 2 of 2



Request For Paid Family Leave

Bonding Certification (NYSIF Form PFL-2)

NEW YORK STATE INSURANCE FUND

TO BE COMPLETED BY THE EMPLOYEE		
Employee's name (first name, middle initial, last name)	Employee's date of birth:	Employee's phone number:
Other last names, if any, under which employee has worked	Employee's Social Security	Number or TIN
Employee's mailing address		
City	State	Zip code
PART A. BONDING CERTIFICATION (to be completed b	y the employee)	
1. Are you requesting Paid Family Leave to bond with a:	Newborn Newly placed adopted	I child Newly placed foster child
2. Child's date of birth (MM/DD/YYYY)		
3. Child's gender Male Female Not designated/Othe	ſ	
4. The child's relationship to you is:		
Biological child Stepchild Foster child Adopted chil	d Legal ward Spouse/Dome	estic partner's child Loco parentis
5. I have attached the following evidence of the event and t	he relationship to the child:	
Parent of newborn child: Birth mother: Child's birth certificate; OR Health care provider certification of birth (includes date	of birth of child AND mother's na	ıme)
Other parent:		
Child's birth certificate naming second parent; OR		
Voluntary acknowledgment of paternity; OR		
Court order of filiation		
If not available: birth mother documents as explained	above AND one of the following:	
Marriage certificate; OR		
Certificate of civil union; OR		
Evidence of domestic partnership; OR		
Other documentation of parental relationship		
Foster parent:	, or aity department of Casial Carviaca a	s outborized voluntary factor care against
Letter of foster placement or anticipated placement issued by count Adoptive parent:	y or city department of Social Services of	r authorized voluntary toster care agency
Court document finalizing adoption		
Documentation in furtherance of adoption		
6. Date of foster care or adoption placement, if applicable (/M/DD/YYYY) / / /	

Submit completed form to:

NEW YORK STATE INSURANCE FUND

TO BE COMPLETED BY THE EMPLOYEE	
Employee's name (first name, middle initial, last name)	Employee's date of birth Employee's phone number / /
BONDING CERTIFICATION (to be completed by the em	nployee) - continued from prior page
7. Are you receiving any of the following: workers' compensati	ion, disability or unemployment insurance benefits? Yes No
Declaration and signature	
statement of claim containing any materially false information, any fact material thereto, commits a fraudulent insurance act, we exceed five thousand dollars and the stated value of the claim	
	nder the NYS Workers' Compensation Law. My signature affirms that of my knowledge and belief. This includes any information I may
Employee Signature:	
	Date signed (MM/DD/YYYY)
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
2. Employer's FEIN (or Social Security Number)	
3. Employer's NYSIF DB/PFL Policy Number:	
4. Employer's contact name for questions related to PFL:	
5. Employer's contact telephone number	Ext.
6. Employer's contact email address:	
7. Employee's date of hire:	mployee's last work day prior to leave:
8. Is the employee taking Family Medical Leave act (FMLA)) concurrently with PFL? Yes No
9. If employee received or will receive full wages while on I	PFL, will employer be requesting reimbursement? Yes No
If yes, please provide start and end dates for the period	the employee received full wages:
Start date:	End Date:
NYSIF PFL-2 (6/18) NYSIF Document Control Cen Bonding Page 2 of 3	Submit <u>completed</u> form to: nter, Disability Claims, 1 Watervliet Ave Ext, Albany, NY 12206 or fax to 518-437-5201

NYSIF PFL-2 - CONTINUED FROM PRIOR PAGE

NEW YORK STATE INSURANCE FUND

TO BE COMPLETED BY THE EMPLOYEE														
Employee's name (first name, middle initial, last name) Em						ployee's date of birth		Employ	yee's	phor	าe nu	mber		
PAF	RT B - EM	PLOY	er infof		to be	e completed by t	he em	ployer) - continued fro	m prev	ious pa	age			
10. Is the employee a: Member of an LLP or LLC Self-Employed None														
								f-Employed, please use the foll						
	it in the "Calculated average gross weekly wage" box. Divide: <the 52-week="" immediately="" in="" income="" leave="" net="" of="" period="" preceding="" the="" total=""> by <52>. Please provide documentation to support the last 52 weeks of wages, such as pay stubs or your most recent tax return.</the>													
11. Enter the last 8 weeks of gross wages for the employee and calculate the average gross weekly wage:														
	Week no.	Week	ending dat	e (MM/DD/YY	Gross amount paid	-								
-	1													
-	2													
	3													
	4													
-	5													
-	6													
-	7													
	8													
		Calcu	lated <u>ave</u>	erage gross	s wee	ekly wage:								
12	In the pre	cedin	a 52 wee	ks has the	emr	bloyee taken leav	ve for	. NYS Disability P	PFL	Both D	uisahilitv	v & PF	 1	None
			-	-	-	-		ability and PFL in the la				,	_	
		total	Weeks			-								
	Disabi	lity:	WEEKS		Plea	ase provide specific d	ates ioi	Disability						
		,	Days											
Weeks			Please provide specific dates for PFL											
	PFL:		Days											
Dec	laration a	-												
								c and has been in employı nd has worked at least 17		at least	t 26 co	onsec	utive	weeks
	person who	knowin	gly and with	intent to defra	aud ar	ny insurance compan	y or oth	ner person files an application ion concerning any fact mate	n for insur					
								and dollars and the stated va						
				as the employe and accurate.	er of th	ne employee request	ing PFL	My signature affirms that to	the best	of my kn	owledg	je and	belief	, the
			Employe	er's authorized	d sign	nature		Date signe	ed (MM/	DD/YY	YY)			
				Title			<u> </u>							
	PFL-2 (6/18) ng Page 3 of		NYSIF	Document C	ontro	I Center, Disability (Subm Claims	it <u>completed</u> form to: , 1 Watervliet Ave Ext, Albaı	ny, NY 1	2206; or	[.] fax to	518-4	137-52	201.