

## PAID FAMILY LEAVE CLAIMANT CHECKLIST – BONDING

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

**NO**

### 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

**YES**

### 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](http://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](http://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.



**Employee's phone number**

|   |  |  |                       |
|---|--|--|-----------------------|
| Continuous  | PFL start date (MM/DD/YYYY)<br><input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | PFL end date (MM/DD/YYYY)<br><input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Dates are estimated** |
| Intermittent<br>(PFL must be<br>taken in full-day<br>increments.) | Identify dates of intermittent PFL:<br><div style="border: 1px solid black; height: 100px; width: 100%;"></div>  |  | Dates are estimated** |

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Street address

|      |       |          |
|------|-------|----------|
| City | State | Zip code |
|------|-------|----------|

|  |   |  |   |  |
|--|---|--|---|--|
|  | / |  | / |  |
|--|---|--|---|--|

Submit completed form to:  
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 <b>copy</b> of the certificate issued by the city or county office in which the child is born.   |
| Health care provider certification of birth            | An <b>original</b> 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 <b>copy</b> of the form that establishes legal fatherhood when the parents are unmarried. Completed by both mother and father. For more information, visit <a href="https://childsupport.ny.gov">childsupport.ny.gov</a> .   |
| Court Order of Filiation                               | A <b>copy</b> 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 <a href="https://childsupport.ny.gov/dcse/aop_howto.html">childsupport.ny.gov/dcse/aop_howto.html</a> |
| Marriage Certificate                                   | A <b>copy</b> 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 <b>copy</b> 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 <b>copy</b> 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 <b>copy</b> 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.

**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       | \$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       |
| <b>Average Weekly Wage (including bonus):</b> | <b>\$575</b> |

**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)**

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**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 by the employee)**

1. Are you requesting Paid Family Leave to bond with a: Newborn Newly placed adopted child Newly placed foster child

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

3. Child's gender Male Female Not designated/Other

4. The child's relationship to you is:

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

5. I have attached the following evidence of the event and the 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 name)

**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:**

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)   /   /



**TO BE COMPLETED BY THE EMPLOYEE**

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

Employee's date of birth

Employee's phone number

|  |   |   |
|--|---|---|
|  | <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
|--|---|---|

**BONDING CERTIFICATION** (to be completed by the employee) - continued from prior page
**7. Are you receiving any of the following: workers' compensation, disability or unemployment insurance benefits?** Yes No
**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. This includes any information I may provide in Part B - Employer Information.

**Employee Signature:**

Date signed (MM/DD/YYYY)

|                      |                      |   |                      |                      |   |                      |                      |                      |                      |
|----------------------|----------------------|---|----------------------|----------------------|---|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | / | <input type="text"/> | <input type="text"/> | / | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
|----------------------|----------------------|---|----------------------|----------------------|---|----------------------|----------------------|----------------------|----------------------|

**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)**

|                      |                      |                      |                      |                      |                      |                      |                      |                      |                      |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|

**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:**   /   /     **Employee'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 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: \_\_\_\_\_

**Employee's phone number**

| Week no.                                     | Week ending date (MM/DD/YYYY) | Number of days worked | Gross amount paid |
|--|-------------------------------|-----------------------|-------------------|
| 1  |                               |                       |                   |
| 2  |                               |                       |                   |
| 3  |                               |                       |                   |
| 4  |                               |                       |                   |
| 5  |                               |                       |                   |
| 6  |                               |                       |                   |
| 7  |                               |                       |                   |
| 8  |                               |                       |                   |
| Calculated <u>average</u> gross weekly wage: |                               |                       |                   |

|                    |       |   |
|--------------------|-------|---|
| <b>Disability:</b> | Weeks | Please provide specific dates for Disability<br><div></div> |
|                    | Days  |   |
| <b>PFL:</b>        | Weeks | Please provide specific dates for PFL<br><div></div>        |
|                    | Days  |   |

## Title