

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, PO Box 66699, 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.



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) Request

1. **Bond with child** **Care for family member** **Military qualifying event**
2. **The family member is the employee's:**
Child Spouse Domestic partner Parent Grandparent Grandchild
3. **Are you submitting this form to:** **Pre-file a Claim** **File a Claim** (See NYSIF PFL Claim Checklist for more information.)

4. **Employee's legal name** (first name, middle initial, last name)

5. **Other last names, if any, under which employee has worked**

6. **Employee's mailing address**

Street address

City

State

Zip code

Country (if not U.S.A.)

7. **Employee's Social Security Number or TIN**

□ □ □ - □ □ - □ □ □ □

8. **Employee's date of birth** (MM/DD/YYYY)

□ □ / □ □ / □ □ □ □

9. **Employee's primary telephone number**

□ □ □ □ □ □ □ □

10. **Employee's preferred email address while on PFL** (if available)

11. **Employee's gender**

Male Female Not designated/Other

12. **Employee's preferred language**

English Español Русский Język polski

繁體字 Italiano Kreyòl ayisyen 한국어

Other

Optional (for research purposes)

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.)

Is employee 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 employee's 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

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

14. Will PFL be used for a continuous period of time or intermittent (non-consecutive)?

Continuous	PFL start date (MM/DD/YYYY)	PFL end date (MM/DD/YYYY)	Dates are estimated**
	/ /	/ /	
Intermittent (PFL must be taken in full-day increments.)	Identify dates of intermittent PFL:		Dates are estimated**

****Note: You must confirm any estimated dates with NYSIF prior to receiving payment.**

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

16. Business name

17. Employee's work location:

Street address		
City	State	Zip code

Disclosure statement: Information regarding PFL benefits received by the employee, such as payments 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. This includes any information I may provide in Part B - Employer Information.

Date signed (MM/DD/YYYY)

	/		/	
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Employee Signature

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 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 Standard Industrial Classification (SIC) Code**www.osha.gov/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:**[BLS 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 Insurance Fund

Mailing address

**NYSIF
PO Box 66699
Albany, NY 12206**

Fax Number

(518) 437-5201**11. Declaration and signature**

☐ I affirm the employee regularly works 20 or more hours per week and has been in employment for at least 26 consecutive weeks OR the employee regularly works less than 20 hours per week and has worked at least 175 days.

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 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.

Date signed (MM/DD/YYYY)

Employer's authorized signature

Title



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 childsupport.ny.gov .
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 childsupport.ny.gov/dcse/aop_howto.html
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.

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
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.



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

	/	/	
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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)

/	/	
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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)

/	/	
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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:

/	/	
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Employee's last work day prior to leave:

/	/	
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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:			

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

Title