

PAID FAMILY LEAVE CLAIMANT CHECKLIST – MILITARY

Have you taken time off from work to assist with matters arising from a family member's call to active duty or deployment?

NO

PRE-FILE A CLAIM

STEP 1: COMPLETE NYSIF PFL-1

- Check "Military Qualifying Event" 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

Proof of your relationship to the military member **AND:**

- Covered active duty orders; **OR**
- Letter from the military unit documenting impending call or order to covered duty; **OR**
- Documentation of military leave signed by the approving authority for military member's Rest and Recuperation.

STEP 4: SUBMIT NYSIF PFL-1 AND SUPPORTING DOCUMENTATION TO NYSIF

STEP 5: FIRST DAY TAKEN TO ASSIST WITH MATTERS ARISING FROM A FAMILY MEMBER'S CALL TO ACTIVE DUTY OR DEPLOYMENT

STEP 6: COMPLETE NYSIF PFL-5

Once leave begins, complete NYSIF PFL-5.

STEP 7: PROVIDE NYSIF PFL-5 TO EMPLOYER

Employer completes NYSIF PFL-5, Part B, and returns to you within three days.

STEP 8: SUBMIT NYSIF PFL-5 AND ADDITIONAL SUPPORTING DOCUMENTATION TO NYSIF

AS NEEDED: SUBMIT NYSIF PFL-5T TO NYSIF

YES

FILE A CLAIM

STEP 1: FIRST DAY TAKEN TO ASSIST WITH MATTERS ARISING FROM A FAMILY MEMBER'S CALL TO ACTIVE DUTY OR DEPLOYMENT

STEP 2: COMPLETE NYSIF PFL-1

- Check "Military Qualifying Event" in Question 1.
- Check the "File a Claim" box in Question 3.

STEP 3: COMPLETE NYSIF PFL-5

Once leave begins, complete NYSIF PFL-5.

STEP 4: PROVIDE NYSIF PFL-1 & NYSIF PFL-5 TO YOUR EMPLOYER

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

STEP 5: COLLECT SUPPORTING DOCUMENTATION

Proof of your relationship to the military member **AND:**

- Covered active duty orders; **OR**
- Letter from the military unit documenting impending call or order to covered duty; **OR**
- Documentation of military leave signed by the approving authority for military member's Rest and Recuperation.

STEP 6: SUBMIT NYSIF PFL-1, NYSIF PFL-5 AND SUPPORTING DOCUMENTATION TO NYSIF

AS NEEDED: SUBMIT NYSIF PFL-5T 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.



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:

Spouse Child Parent Sibling Grandchild Grandparent Other

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

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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**

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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**																		
	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>												<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>								
Intermittent (PFL must be taken in full-day increments.)	Identify dates of intermittent PFL:		Dates are estimated**																		
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****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

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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

A horizontal number line with boxes for digits. The boxes are arranged as follows: a box for the tens digit, followed by a box for the ones digit, then a box for the tenths digit, followed by a box for the hundredths digit, then a box for the thousandths digit, followed by a box for the ten-thousandths digit, then a box for the hundred-thousandths digit, and finally a box for the millionths digit. The number line is labeled with 0 at the left end and 10 at the right end.

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 Standard Industrial Classification (SIC) Code

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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:

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8. Employee's occupation code:

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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 Document Control Center - Disability Claims
1 Watervliet Avenue Extension
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



Military Qualifying Event (NYSIF Form PFL-5) Instructions

If an employee is requesting PFL because of a family member's covered active military duty or impending covered active duty, the employee must submit *Military Qualifying Event (NYSIF Form PFL-5)*.

- **Be sure to follow the instructions on the NYSIF PFL Claim Checklist - Military.**
- **You must identify the family member, provide a copy of the member's covered active duty orders or impending active duty orders, and describe the reason leave is being requested.**
- **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-5, please submit proof of your relationship to the military member. Acceptable documentation includes but is not limited to marriage license; court documents for adoption, foster care, guardianships; birth certificates; affidavit; proof of common ownership or property; etc.**
- **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. MILITARY QUALIFYING EVENT (to be completed by the employee)

The employee requesting PFL must complete all applicable requested information.

Questions 1-4: Enter the military member's information.

Question 5: Enter dates of expected military covered active duty.

Question 6: Documentation that shows that the military member is on covered active duty or has been notified of an impending call or order to covered active duty is required and must be attached to this form. Select the type of documentation that is attached from the list below.

Required documentation includes one of the following:

- Covered active duty orders; **OR**
- Letter from the military unit documenting impending call or order to covered duty; **OR**
- Documentation of military leave signed by the approving authority for military member's Rest and Recuperation.

Question 7: Check the box(es) that describe the need for PFL because of the Military Qualifying Event. If the reason does not appear here, please check other and elaborate in the box provided.

Question 9: Include one or more of the qualifying supporting documents:

- Meeting announcement for informational briefing sponsored by the military; or
- Document(s) confirming an appointment with a school official, doctor, attorney or financial advisor; or
- Copy of a bill for services for the handling of legal or financial affairs.

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.

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
Military Qualifying Event (NYSIF Form PFL-5)
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:	
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	
Other last names, if any, under which employee has worked	Employee's Social Security Number or TIN		
<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>		
Employee's mailing address			
<input type="text"/>			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
City	State	Zip code	Country (if not U.S.A.)

PART A. MILITARY QUALIFYING EVENT (to be completed by the employee)

- Name of military member on covered active duty or impending call to covered active duty status (international deployment)** (first name, middle initial, last name)
- Military member's date of birth** (MM/DD/YYYY) / /
- Military member's gender** Male Female Not designated/Other
- Military member's mailing address**

 City State Zip code Country (if not U.S.A.)
- Period of military member's covered active duty** (MM/DD/YYYY)
 / / to / /
- 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)

7. What is the reason employee is requesting PFL? (One or more reasons may be selected.)

<input type="checkbox"/> Childcare & school activities	<input type="checkbox"/> Post-deployment activities, including bereavement
<input type="checkbox"/> Counseling	Rest & recuperation
<input type="checkbox"/> Financial & legal arrangements	<input type="checkbox"/> Short-notice deployment
<input type="checkbox"/> Military events & related activities	Other:
<input type="checkbox"/> Parental care	<input type="text"/>

Employee's phone number

A horizontal number line from 0 to 100. The line is divided into 10 equal segments by vertical tick marks. Below the line, the numbers 0, 10, 20, 30, 40, 50, 60, 70, 80, 90, and 100 are written. Above the line, there are boxes for tens and ones. The first box is labeled '10' and contains the number '10'. The second box is labeled '20' and contains the number '20'. The third box is labeled '30' and contains the number '30'. The fourth box is labeled '40' and contains the number '40'. The fifth box is labeled '50' and contains the number '50'. The sixth box is labeled '60' and contains the number '60'. The seventh box is labeled '70' and contains the number '70'. The eighth box is labeled '80' and contains the number '80'. The ninth box is labeled '90' and contains the number '90'. The tenth box is labeled '100' and contains the number '100'.

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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

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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Other last names, if any, under which employee has worked**Employee's Social Security Number or TIN**

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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 to NYSIF.

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: