NYSIF New York State Insurance Fund

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.

NYSIF®

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) 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

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

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 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) / /

Employee Signature

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

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 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 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

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

NYSIF®

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

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.

NYSIF®

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:

Other last names, if any, under which employee has worked

Employee's Social Security Number or TIN - -

Employee's mailing address

Mailing address

City | State | Zip code | Country (if not U.S.A.)

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

1. **Name of military member on covered active duty or impending call to covered active duty status (international deployment)** (first name, middle initial, last name)

2. **Military member's date of birth** (MM/DD/YYYY) / /

3. **Military member's gender** ◯ Male ◯ Female ◯ Not designated/Other

4. **Military member's mailing address**

Mailing address

City | State | Zip code | Country (if not U.S.A.)

5. **Period of military member's covered active duty** (MM/DD/YYYY)

/ / to / /

6. **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.)

☐ Childcare & school activities
☐ Counseling
☐ Financial & legal arrangements
☐ Military events & related activities
☐ Parental care
☐ Post-deployment activities, including bereavement
☐ Rest & recuperation
☐ Short-notice deployment
☐ Other:

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

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. MILITARY QUALIFYING EVENT (to be completed by the employee) - continued from prior page

8. Are you receiving any of the following: workers' compensation, disability or unemployment insurance benefits? Yes No

9. Is written documentation supporting this request for leave available and attached? Yes No None Available

Note: A complete and sufficient certification to support a request for PFL leave due to a qualifying event includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. If leave is requested to meet with a third party, the employee must provide the supporting documentation of the meeting that includes the name, address, appropriate contact information of the individual or entity with whom you are meeting (i.e., either telephone number, fax number, or email address of the individual or entity).

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's 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

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:**

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

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) - continued from previous page

10. Is the employee a: ◯ **Member of an LLP or LLC** ◯ **Self-Employed** ◯ **None**

If "None" is selected, please go to Question 11. For Member of an LLP/LLC or Self-Employed, please use the following calculation to determine wages and enter it in the "Calculated average gross weekly wage" box. Divide: <the total net income in the 52-week period immediately preceding the period of leave> by <52>. Please provide documentation to support the last 52 weeks of wages, such as pay stubs or your most recent tax return.

11. Enter the last 8 weeks of gross wages for the employee and calculate the average gross weekly wage:

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

12. In the preceding 52 weeks, has the employee taken leave for: ☐ NYS Disability ☐ PFL ☐ Both Disability & PFL ☐ None

13. Enter the total number of weeks and days taken for both Disability and PFL in the last 52 weeks:

Disability: Weeks / Days — Please provide specific dates for Disability

PFL: Weeks / Days — Please provide specific dates for PFL

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.

Employer's authorized signature

Date signed (MM/DD/YYYY)

Title

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

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

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:

Submit this form when applicable to:
NYSIF Document Control Center, Disability Claims, 1 Watervliet Ave Ext, Albany, NY 12206;
or fax to 518-437-5201.