NYSIF
New York State Insurance Fund

PAID FAMILY LEAVE CLAIMANT CHECKLIST – CARE

Have you taken time off from work to care for a family member with a serious health condition?

NO

PRE-FILE A CLAIM

STEP 1: COMPLETE NYSIF PFL-1

- Check "Care for family member" 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: COMPLETE EMPLOYEE PORTION OF NYSIF PFL-3 & PROVIDE TO CARE RECIPIENT FOR REVIEW & SIGNATURE
Once signed, NYSIF PFL-3 enables the health care provider to complete NYSIF PFL-4A & release to you.

STEP 4: COMPLETE EMPLOYEE PORTION OF NYSIF PFL-4A & PROVIDE NYSIF PFL-3 & NYSIF PFL-4A TO PATIENT'S HEALTH CARE PROVIDER
Submit NYSIF PFL-3 to the health care provider, who will retain for their records. The provider must complete the *Patient Information* and *Health Care Provider* sections of NYSIF PFL-4A. The provider signs and dates, and then returns NYSIF PFL-4A to you.

STEP 5: SUBMIT NYSIF PFL-1 & NYSIF PFL-4A TO NYSIF

STEP 6: FIRST DAY TAKEN TO CARE FOR YOUR FAMILY MEMBER

STEP 7: COMPLETE NYSIF PFL-4B
Once leave begins, complete NYSIF PFL-4B.

STEP 8: PROVIDE NYSIF PFL-4B TO EMPLOYER
Employer completes NYSIF PFL-4B, Part B, and returns to you within three days. DO NOT GIVE NYSIF PFL-4A TO YOUR EMPLOYER.

STEP 9: SUBMIT NYSIF PFL-4B TO NYSIF

YES

FILE A CLAIM

STEP 1: FIRST DAY TAKEN TO CARE FOR YOUR FAMILY MEMBER

STEP 2: COMPLETE NYSIF PFL-1

- Check "Care for family member" in Question 1.
- Check the "File a Claim" box in Question 3.

STEP 3: COMPLETE EMPLOYEE PORTION OF NYSIF PFL-3 & PROVIDE TO CARE RECIPIENT FOR REVIEW & SIGNATURE
Once signed, NYSIF PFL-3 enables the health care provider to complete NYSIF PFL-4A & release to you.

STEP 4: COMPLETE EMPLOYEE PORTION OF NYSIF PFL-4A & PROVIDE NYSIF PFL-3 & NYSIF PFL-4A TO PATIENT'S HEALTH CARE PROVIDER
Submit NYSIF PFL-3 to the health care provider, who will retain for their records. The provider must complete the *Patient Information* and *Health Care Provider* sections of NYSIF PFL-4A. The provider signs and dates, and then returns NYSIF PFL-4A to you.

STEP 5: COMPLETE NYSIF PFL-4B & PROVIDE NYSIF PFL-1 & NYSIF PFL-4B TO YOUR EMPLOYER
Employer completes Part B on both forms and returns to you within three days. DO NOT GIVE NYSIF PFL-4A TO YOUR EMPLOYER.

STEP 6: SUBMIT NYSIF PFL-1, NYSIF PFL-4A & NYSIF PFL-4B 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.

Release Of Personal Health Information Under Paid Family Leave Law (NYSIF Form PFL-3) Instructions

- **Be sure to follow the instructions on the NYSIF PFL Claim Checklist - Care.**
- **If an employee is requesting PFL to care for a family member with a serious health condition, the care recipient or an authorized representative must complete a *Release Of Personal Health Information Under The Paid Family Leave Law (NYSIF PFL-3).***
- **Submit *NYSIF PFL-3* to the patient's health care provider, along with a copy of the *Health Care Provider Certification: For Care Of Family Member With Serious Health Condition (NYSIF PFL-4A)*.**
- **The *Release Of Personal Health Information Under The Paid Family Leave Law (NYSIF PFL-3)* enables the health care provider to complete *Health Care Provider Certification: For Care Of Family Member With Serious Health Condition (NYSIF PFL-4A)* and release it to the employee seeking PFL benefits.**
- **Before completing and signing, the care recipient must read the *Release Of Personal Health Information Under The Paid Family Leave Law (NYSIF PFL-3)* in its entirety.**

NOTE: *NYSIF Form PFL-3* will be retained by the health care provider.

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with NYSIF Form PFL-4A)

Employee enters their name, and care recipient's (patient's) name and date of birth at the top of each page.

The PFL insurance carrier name requested at the top of the form is the same as the PFL insurance carrier identified in *Request For Paid Family Leave (NYSIF PFL -1)* Part B line 10: **NEW YORK STATE INSURANCE FUND**

Care recipient or authorized representative must complete all applicable requested information.

If a care recipient is unable to fill out this form, an authorized representative must attach a copy of legal documentation, such as a health care proxy or power of attorney, permitting the representative to sign on behalf of the care recipient. The health care provider will require this documentation of authorization unless the authorized representative is a parent signing on behalf of a minor child.

THE EMPLOYEE SHOULD KEEP A COPY OF THE SIGNED PFL-3 FOR THEIR RECORDS.

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

Release Of Personal Health Information Under PFL (NYSIF Form PFL-3)

NEW YORK STATE INSURANCE FUND

TO BE COMPLETED BY THE EMPLOYEE

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

Care recipient's (patient's) name (first, middle initial, last)

Care recipient's date of birth / /

Care recipient's SSN - -

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with NYSIF PFL-4A)

I, _____, authorize my health care provider listed below to release my personal health information to
Care recipient's (patient's) name

_____ and the **NEW YORK STATE INSURANCE FUND.**
Employee's name

Records Subject to Release: This form gives the health care provider listed permission to include information from your health care records on the attached medical certification. This form gives your health care provider permission to release only the information in your health care records that relate to your current condition, which is the subject of the employee's request for Paid Family Leave benefits.

Duration of Revocable Release: This authorization ends after one year, or when you revoke the release. You can cancel this release at any time. To cancel, send a letter to the health care provider listed on this form.

This form does NOT allow your health care provider to release the following types of information, unless you specifically permit such release. Put an "X" next to any information your health provider **MAY** release.

☐ HIV/AIDS related information ☐ Mental health information ☐ Alcohol/drug treatment ☐ Psychotherapy notes

Health Care Provider Information (Identify the health care provider currently treating you for a condition subject to the employee's request for PFL.)

1. **Health care provider's name:**

2. **Health care provider's mailing address:**

Mailing address			
City, State	Zip code	Country	Health Care Provider's phone number

3. **Care recipient's mailing address & phone number:**

Mailing address			
City, State	Zip code	Country (if not U.S.A.)	Care recipient's telephone number

READ AND SIGN BELOW

I hereby request that the health care provider listed give a completed *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (NYSIF PFL-4A)* to the employee identified on the *NYSIF PFL-3* form. I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and any estimation of the amount of care that I require from the employee requesting PFL benefits as a result of my current condition.

Care recipient's signature

Date signed (MM/DD/YYYY)

Authorized representative

I, Print name **, represent the care recipient in this matter as authorized by:**

☐ Parental right ☐ Power of attorney (attach copy) ☐ Court Order (attach copy) ☐ Health care proxy (attach copy)

Authorized representative's signature

Date signed (MM/DD/YYYY) / /

Health Care Provider Certification: For Care Of Family Member With Serious Health Condition (NYSIF Form PFL-4A) Instructions

The employee requesting PFL to care for a family member with a serious health condition must submit both the *Health Care Provider Certification: For Care Of Family Member With Serious Health Condition (NYSIF PFL-4A)* and *Employer Certification: Claim For Care Of Family Member With Serious Health Condition (NYSIF PFL-4B).*

Employee:

- **Be sure to follow the instructions on the NYSIF PFL Claim Checklist - Care.**
- **Enter your name, date of birth, other last names, if any, under which you have worked, Social Security or Taxpayer Identification Number (TIN) number and mailing address at the top of *NYSIF Form PFL-4A*, page 1.**
- **Enter the care recipient's (patient's) name, date of birth and mailing address on page 1.**
- **Provide the *Health Care Provider Certification: For Care Of Family Member With Serious Health Condition (NYSIF PFL-4A)* to the health care provider for completion, along with the completed *Release of PHI (NYSIF PFL-3)*.**
- **DO NOT provide NYSIF Form PFL-4A to your employer.**

HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION
(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified)

The patient's health care provider must complete all applicable requested information, unless noted as optional.

Health care provider signs and dates, and then returns the form to the employee requesting PFL.

If you believe the patient is the victim of abuse or neglect caused by the employee requesting PFL, you may decline to provide this certification.

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

Health Care Provider Certification: For Care Of Family Member With Serious Health Condition (NYSIF Form PFL-4A)

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

TO BE COMPLETED BY THE EMPLOYEE

Care Recipient (Patient) Information

1. **Care recipient's (patient's) name** (first, middle initial, last)

Care recipient's date of birth / /

2. **Care recipient's mailing address & phone number:**

Mailing address

City, State | Zip code | Country (if not U.S.A.) | Care recipient's telephone number

HEALTH CARE PROVIDER CERTIFICATION: FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION

(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

Care Recipient (Patient) Information

1. **Does patient require care by the employee requesting Paid Family Leave (PFL)?**

◯ Yes ◯ No (If no, skip to "Health Care Provider Information".)

Note: For the purposes of this section, "providing care" may include necessary physical care, emotional support, visitation, assistance in treatment, transportation, arranging for a change in care, assistance with essential daily living matters, and personal attendant services.

2. **Primary ICD-10 code**

3. **Diagnosis**

4. **Date patient's condition commenced** (MM/DD/YYYY) / /

5. **First date care for patient is needed** (MM/DD/YYYY) / /

6. **Expected date patient will no longer require care** (MM/DD/YYYY) / /

7. **Estimated number of days per week OR days per month patient requires care** Days/week: _____ **OR** Days/month: _____

Send 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 phone number

Care recipient's (patient's) name (first, middle initial, last)

Care recipient's (patient's) date of birth / /

HEALTH CARE PROVIDER CERTIFICATION: FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION

(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

Health Care Provider Information

8. **Health care provider's name:**

9. **Type of health care provider:**

- ☐ Medical Doctor (MD)
- ☐ Doctor of Osteopathy (DO)
- ☐ Doctor of Podiatric Medicine (DPM)
- ☐ Doctor of Chiropractic Medicine (DC)
- ☐ Dentist (DDS/DDM)
- ☐ Physician's Assistant (PA)
- ☐ Nurse Practitioner (NP)
- ☐ Licensed Psychologist
- ☐ Licensed Social Worker (LMSW/LCSW)
- ☐ Other: (specify)

10. **Health care provider's mailing address**

Mailing address

City, State | Zip code | Country | Health Care Provider's phone number

11. **Health care provider's fax number** (provide area or country code)

12. **Health care provider's email address** (if available)

13. **State or country (if not U.S.A.) in which health care provider is licensed to practice**

14. **Specialty**

15. **Health care provider's license number**

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.

Health care provider's signature:

Date signed (MM/DD/YYYY) / /

Send 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
Notice and Proof of Claim for Paid Family Leave

Employer Certification: Claim For Care Of Family Member With Serious Health Condition (NYSIF Form PFL-4B) Instructions

The employee requesting PFL to care for a family member with a serious health condition must submit both *Employer Certification: Claim For Care Of Family Member With Serious Health Condition (NYSIF PFL-4B)* and *Health Care Provider Certification: For Care Of Family Member With Serious Health Condition (NYSIF PFL-4A)*.

- **Be sure to follow the instructions on the NYSIF PFL Claim Checklist - Care.**
- **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.**
- **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.**
- **DO NOT provide *NYSIF Form PFL-4A* to your employer.**

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

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.

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

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 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.

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

Employer Certification: Claim For Care Of Family Member (NYSIF Form PFL-4B)

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

Care recipient's (patient's) name (first, middle initial, last)

Care recipient's (patient's) date of birth / /

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

1. **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) / /

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

1. **Business's full legal name and mailing address**

Business name

Mailing address

City | State | Zip code

2. **Employer's FEIN (or Social Security Number)**
3. **Employer's NYSIF DB/PFL Policy Number:**
4. **Employer's contact name for questions related to PFL:**
5. **Employer's contact telephone number** **Ext.**
6. **Employer's contact email address:**
7. **Employee's date of hire:** / / **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.