



## To Use Paid Family Leave To:

<b>Bond with a newborn, a newly adopted or fostered child</b>	<b>Care for a family member with a serious health condition</b>	<b>Assist family members due to another family member's active military duty or impending active duty abroad</b>
<input checked="" type="checkbox"/> <b>Complete Form PFL-1</b> <ul style="list-style-type: none"> <li>• Complete PFL-1, Part A</li> <li>• Provide PFL-1 to employer</li> <li>• Employer completes PFL-1, Part B and returns to you within 3 days</li> </ul>	<input checked="" type="checkbox"/> <b>Complete Form PFL-1</b> <ul style="list-style-type: none"> <li>• Complete PFL-1, Part A</li> <li>• Provide PFL-1 to employer</li> <li>• Employer completes PFL-1, Part B and returns to you within 3 days</li> </ul>	<input checked="" type="checkbox"/> <b>Complete Form PFL-1</b> <ul style="list-style-type: none"> <li>• Complete PFL-1, Part A</li> <li>• Provide PFL-1 to employer</li> <li>• Employer completes PFL-1, Part B and returns to you within 3 days</li> </ul>
<input checked="" type="checkbox"/> <b>Complete Form PFL-2</b> <ul style="list-style-type: none"> <li>• Complete PFL-2 and collect supporting documentation</li> </ul>	<input checked="" type="checkbox"/> <b>Complete Form PFL-3</b> <ul style="list-style-type: none"> <li>• Care recipient completes PFL-3 and provides to health care provider</li> <li>• Care recipient's health care provider keeps PFL-3</li> </ul>	<input checked="" type="checkbox"/> <b>Complete Form PFL-5</b> <ul style="list-style-type: none"> <li>• Complete PFL-5 and collect supporting documentation</li> </ul>
<input checked="" type="checkbox"/> <b>Send forms and documents</b> <ul style="list-style-type: none"> <li>• Send completed forms and supporting documentation to Guardian</li> <li>• Guardian accepts or denies claim within 18 days</li> </ul>	<input checked="" type="checkbox"/> <b>Complete Form PFL-4</b> <ul style="list-style-type: none"> <li>• Complete "Employee" information at the top of PFL-4</li> <li>• Provide PFL-4 to care recipient's health care provider</li> <li>• Care recipient's health care provider completes PFL-4 and returns to you</li> </ul>	<input checked="" type="checkbox"/> <b>Send forms and documents</b> <ul style="list-style-type: none"> <li>• Send completed forms and supporting documentation to Guardian</li> <li>• Guardian accepts or denies claim within 18 days</li> </ul>
	<input checked="" type="checkbox"/> <b>Send forms and documents</b> <ul style="list-style-type: none"> <li>• Send completed forms and supporting documentation to Guardian</li> <li>• Guardian accepts or denies claim within 18 days</li> </ul>	

Please keep a copy of all pages for your records.

Mail to: Guardian P.O. Box 14332 Lexington KY 40512 Fax: 610- 807-2950  
Documents can be returned electronically at [www.GuardianAnytime.com](http://www.GuardianAnytime.com). Click on "Secure Channel" on the Guardian Anytime home page.



## Request For Paid Family Leave (Form PFL-1) Instructions

- To request PFL, the employee requesting PFL must complete Part A of the *Request For Paid Family Leave (Form PFL-1)*. All items on the form are required unless noted as optional. The employee then provides the form to the employer to complete Part B.
- The employer completes Part B of the *Request For Paid Family Leave (Form PFL-1)* and returns it to the employee within three days.
- Additional forms are required depending on the type of leave being requested. The employee requesting leave is responsible for the completion of these forms.
- **The employee submits the completed *Request For Paid Family Leave (Form PFL-1)* with the required additional form to Guardian Life Insurance listed on Part B of *Request For Paid Family Leave (Form PFL-1)*. The employee should retain a copy of each submitted form for their records.**

### PART A - EMPLOYEE INFORMATION (to be completed by the employee)

The employee requesting PFL must complete all required information.

#### Paid Family Leave (PFL) Request (to be completed by the employee)

**Questions 13:** 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 uncertain, estimate the start and end dates and indicate “Dates are estimated”. If dates are “Periodic”, enter the dates PFL will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate “Dates are estimated”.

If dates are estimated, the PFL carrier 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 14:** If the employee is submitting the 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.

#### Employment Information (to be completed by the employee)

**Question 16:** Enter the date of hire to the best of the employee’s recollection. If it has been more than a year since the date of hire, entering the year in which employment started is sufficient.

**Question 18:** Enter the best estimate of average gross weekly wage. Include only the wages earned from the employer listed on this request form. **The gross weekly wage is the total weekly pay - including overtime, tips, bonuses and commissions - before any deductions are made by the employer**, such as federal and state taxes.

If the employer is not able to supply this information, the employee can calculate their gross weekly wage as follows:

**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**

Please note that the employer is also required to provide

this information in Part B of the *Request For Paid Family Leave (Form PFL-1)*.

**The employee requesting PFL must complete all required information.**

**Form PFL-1 Instructions continued on next page**

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

*Form PFL-1 Instructions continued from prior page*

**If you are pre-submitting form:** Indicate if the employee is pre-submitting their PFL request. Pre-submitting is defined as submitting the application in advance of an upcoming qualifying event, with certain required information missing due to the information being unknown at the time of the submitting. If pre-submitting is permitted by the carrier or self-insured employer, the missing information must be supplied as soon as it is known. Benefits cannot be determined until all of the required information is provided.

The PFL insurance carrier or self-insured employer will provide the employee a notice within five days which 1) states the claim is pending; 2) identifies what information is missing; 3) instructs how to submit the missing information. **Once all information is supplied, the PFL insurance carrier or self-insured employer has 18 days to pay or deny the claim.**

If the carrier or self-insured employer does not permit pre-submitting, the carrier or self-insured employer must return the Request for Paid Family Leave within five days to the employee with an explanation that the claim should be re-submitted when all information is available.

**Employee signs and dates, before giving this form to their employer to complete Part B.**

**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 2:** If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number.

**Question 3:** Enter the employer's Standard Industrial Classification (SIC) Code. Contact your carrier if you don't know your SIC code.

**Question 8:** The employee occupation code can be found at: [www.bls.gov/soc/2010/soc\\_alpha.htm](http://www.bls.gov/soc/2010/soc_alpha.htm)

**Question 9:** 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, plus the weekly prorated amount of any bonus or commission received during the preceding 52 weeks. (For detailed steps, see Question 18 on page 1 of the instructions.) 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).

**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.

**Question 10:** Failure to select "Yes" for requesting reimbursement from the insurance carrier, will result in a waiver of the right to reimbursement.

**Question 11a:** 'Disability' refers to NYS statutory required disability. If the answer is "none," enter a "0" for total weeks and days in Question 12b.

**Question 11b:** 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.

**Question 13, 14 & 15:** Enter the Paid Family Leave or Disability/PFL insurance carrier's name, address and PFL policy number. If this employer is self-insured, enter the name and address of where the PFL request should be submitted for processing.

**Employer signs and dates, and then returns to the employee requesting PFL within three business days.**

**Be sure to complete the appropriate additional PFL form(s)  
based on the type of PFL leave being requested.**

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.



# Paid Family Leave

# Request For Paid Family Leave (Form PFL-1)

Plan # \_\_\_\_\_ INSTRUCTIONS INCLUDED WITH FORM

## PART A - EMPLOYEE INFORMATION (to be completed by the employee)

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

\_\_\_\_\_

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

\_\_\_\_\_

3. Employee's mailing address

Street address  
\_\_\_\_\_

City, State  
\_\_\_\_\_

Zip code \_\_\_\_\_ Country (if not U.S.A.) \_\_\_\_\_

4. Employee's Social Security Number or TIN

□□□□ - □□ - □□□□□□

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

□□ / □□ / □□□□□□

6. Employee's primary telephone number

( □□□□ ) □□□□ - □□□□□□

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

\_\_\_\_\_

8. Employee's gender

Male  Female  Not designated/Other

9. Employee's preferred language

English  Español  Русский  Polski  
 □ □  Italiano  Kreyòl ayisyen  한국어  
 Other \_\_\_\_\_

### Optional (for research purposes)

10. 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

## Paid Family Leave (PFL) Request (to be completed by the employee)

11. Reason for PFL request:  Bond with child  Care for family member  Military qualifying event

12. The family member is employee's:

Child  Spouse  Domestic partner  Parent  Parent-in-law  Grandparent  Grandchild

Form PFL-1 continued on next page

Documents can be returned electronically at [www.GuardianAnytime.com](http://www.GuardianAnytime.com). Click on "Secure Channel" on the Guardian Anytime home page.



TO BE COMPLETED BY THE EMPLOYEE <b>Employee's name</b> (first name, middle initial, last name) _____	Employee's social security # _____ <b>Employee's date of birth</b> (MM/DD/YYYY) [ ][ ] / [ ][ ] / [ ][ ][ ][ ]
--	--

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

Form PFL-1 continued from prior page

**13. Will PFL be for a continuous period of time and/or periodic?**

<input type="checkbox"/>	Continuous	PFL start date (MM/DD/YYYY) [ ][ ] / [ ][ ] / [ ][ ][ ][ ]	PFL end date (MM/DD/YYYY) [ ][ ] / [ ][ ] / [ ][ ][ ][ ]	<input type="checkbox"/> Dates are estimated
<input type="checkbox"/>	Periodic	Identify dates periodic PFL will be taken: _____		<input type="checkbox"/> Dates are estimated

**14. If providing less than 30 day's advance notice to the employer, please explain:**

\_\_\_\_\_

**Employment Information** (to be completed by the employee)

**15. Business name**

\_\_\_\_\_

**16. Employee's date of hire** (MM/DD/YYYY) [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

**17. Employee's work location**

Street address  
 \_\_\_\_\_

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

**18. Employee's average gross weekly wage** (This data will be requested of both employee and employer) \_\_\_\_\_

**19. Employer's telephone number for contact regarding this request** ( [ ][ ][ ] ) [ ][ ][ ] - [ ][ ][ ][ ]

**20a. Does employee have more than one employer?**  Yes  No

**20b. If yes, is employee taking PFL from the other employer?**  Yes  No

**21. Is employee currently receiving Workers' Compensation Lost Wage Benefits?**  Yes  No

Disclosure statement: Information regarding PFL benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

<b>Guardian Specific Information</b>	Normal work schedule:	MON	TUES	WED	THURS	FRI	SAT	SUN	_____ HOURS/DAY
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ HOURS/WEEK

**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.

Employee's signature \_\_\_\_\_

Date signed (MM/DD/YYYY)  
 [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

I am submitting this form in advance (see instructions about pre-submitting). I understand the insurance carrier will contact me to advise how to submit the required missing information.

TO BE COMPLETED BY THE EMPLOYEE <b>Employee's name</b> (first name, middle initial, last name) _____	Employee's social security # _____ Employee's date of birth (MM/DD/YYYY) <span style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 40px; height: 20px;"></span>
--	---

**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	Country (if not U.S.A.)

**2. Employer's FEIN**  -

**3. Employer's Standard Industrial Classification (SIC) Code**

**4. Employer's contact name for questions related to PFL**

\_\_\_\_\_

**5. Employer's contact telephone number** (    )  -

**6. Employer's contact email address**

\_\_\_\_\_

**7. Employee's date of hire** (MM/DD/YYYY)  /  /

**8. Employer's occupation** Codes are available at: [www.bls.gov/soc/2010/soc\\_alpha.htm](http://www.bls.gov/soc/2010/soc_alpha.htm)  -

**9. 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			
<b>Calculated average gross <u>w</u>weekly wage:</b>			

**10. If employee received or will receive full wages while on PFL, will employer be requesting reimbursement?**  YES  NO

*Form PFL-1 continued on next page*

Plan # \_\_\_\_\_

TO BE COMPLETED BY THE EMPLOYEE	Employee's social security # _____
Employee's name (first name, middle initial, last name) _____	Employee's date of birth (MM/DD/YYYY) □□ / □□ / □□□□

**PART B - EMPLOYER INFORMATION** (to be completed by the employer) - continued from prior page

Form PFL-1 continued from prior page

11a. In the preceding 52 weeks has the employee taken leave for:  NYS Disability  PFL  Both Disability and PFL  None

11b. Enter the total number of weeks and days taken for both Disability and PFL in the last 52 weeks:

<b>Disability:</b>	Weeks □□□□	Please provide specific dates for Disability: □□□□□□□□□□
	Days □□□□	

<b>PFL:</b>	Weeks □□□□	Please provide specific dates for PFL: □□□□□□□□□□
	Days □□□□	

12. Is the employee taking Family Medical Leave Act (FMLA) concurrently with PFL?  Yes  No

13. PFL insurance carrier's name and mailing address

PFL insurance carrier's name  
Guardian Life Insurance

Mailing address  
PO Box 14332

City, State Lexington, KY	Zip code 40512	Country (if not U.S.A.)
------------------------------	-------------------	-------------------------

14. PFL insurance carrier's telephone number ( 8 0 0 ) 2 6 8 - 2 5 2 5

15. PFL policy number \_\_\_\_\_

<b>Guardian Specific Information</b>	If employee received or will receive full wages while on PFL and employer is requesting reimbursement, please indicate the dates employee is paid from _____ through _____.
--------------------------------------	---

**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  
\_\_\_\_\_





## Bonding Certification (Form PFL-2) Instructions

If the employee is requesting PFL to bond with a newborn, an adopted child or a foster child, the employee must submit the *Bonding Certification (Form PFL-2)* with the *Request For Paid Family Leave (Form PFL-1)*.

### BONDING CERTIFICATION (to be completed by the employee)

**The employee requesting PFL must complete all applicable requested information.  
Send completed forms and supporting documentation to insurance carrier.**

**If this form is being submitted in advance (pre-submitting) and some information is unknown, the insurance carrier will contact the employee and explain how to provide the required additional information.**

**Questions 1 & 2:** If the form is submitted to the PFL insurance carrier prior to the birth of a child, this is considered pre-submitting. The employee is then required to provide the required documentation of the child's birth to the PFL insurance carrier. The PFL carrier will tell the employee how to provide the required additional documentation.

There may be instances where PFL can be taken before the adoption or foster care is finalized. For example, the employee may be required to appear in court or travel to another country as part of the adoption or foster care process. The employee should include documentation to show that the PFL is necessary to further the adoption or foster care.

**Question 5:** See chart below for documentation details. Unless specified, do not send the original documents.

Bonding Form/Certification	Description
Health care provider certification of pregnancy	An <b>original</b> letter obtained from the birth mother's health care provider that certifies pregnancy. It should include the mother's name and the expected due date.
Health care provider certification of birth	An <b>original</b> letter obtained from the birth mother's health care provider that includes the mother's name and child's date of birth.
Birth Certificate	A <b>copy</b> of the certificate issued by the city or county office in which the child is born.
Voluntary Acknowledgment of Paternity (Form LDSS-4418)	A <b>copy</b> of the form that establishes legal fatherhood when the parents are unmarried. Completed by both mother and father. For more information, see <a href="http://childsupport.ny.gov/dcse/aop_howto.html">childsupport.ny.gov/dcse/aop_howto.html</a>
Court Order of Filiation	A <b>copy</b> of the order from the family court that names the father of a child. Establishes legal fatherhood when the parents are unmarried. Completed by both mother and father. For more information, visit <a href="http://childsupport.ny.gov/dcse/aop_howto.html">childsupport.ny.gov/dcse/aop_howto.html</a>
Marriage Certificate	A <b>copy</b> of the official statement issued by the town or city clerk from which the marriage certificate was issued.
Civil union/domestic partner's documentation	A <b>copy</b> of the certificate of civil union or domestic partnership.
Foster care placement letter	A <b>copy</b> of the letter of foster care placement issued by the county or city department of social services or authorized voluntary foster care agency.
Court documents of adoption	A <b>copy</b> of the court document finalizing adoption or documentation in furtherance or court order finalizing adoption.
Other documentation	Other documentation of parental relationship may be accepted if none of the others listed apply.

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.



# Paid Family Leave

# Request For Paid Family Leave Bonding Certification (Form PFL-2)

INSTRUCTIONS INCLUDED WITH FORM

TO BE COMPLETED BY THE EMPLOYEE Plan #

**Employee's name** (first name, middle initial, last name) \_\_\_\_\_

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

**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.)

## BONDING CERTIFICATION (to be completed by the employee)

- Child's date of birth** (MM/DD/YYYY)  /  /
- Child's gender**  Male  Female  Not designated/Other
- Does child live with the employee requesting PFL?**  Yes  No
- Child is employee's:**  
 Biological child  Stepchild  Foster child  Adopted child  Legal ward  Spouse/Domestic partner's child  Loco parentis
- Select one of the following and attach the document as required as evidence of the relationship.**  
**Parent of newborn child:**  
 Birth mother:  
 Health care provider certification of pregnancy (include expected due date AND mother's name); OR  
 Health care provider certification of birth (include date of birth of child AND mother's name); OR  
 Child's birth certificate  
 Other parent:  
 Copy of birth certificate naming second parent; OR  
 Voluntary acknowledgment of paternity; OR  
 Court order of filiation; OR  
 Birth mother documents (see above) PLUS one of the following:  
 Marriage certificate; OR  
 Certificate of civil union; OR  
 Evidence of domestic partnership  
 OR; Other documentation of parental relationship  
**Foster parent:**  
 Letter of foster care placement or anticipated placement issued by county or city department of Social Services or authorized voluntary foster care agency  
**Adoptive parent:**  
 Court document finalizing adoption  
 Documentation in furtherance of adoption
- Date of foster care or adoption placement, if applicable** (MM/DD/YYYY)  /  /

Form PFL-2 continued on next page

Documents can be returned electronically at [www.GuardianAnytime.com](http://www.GuardianAnytime.com). Click on "Secure Channel" on the Guardian Anytime home page.



<p><b>TO BE COMPLETED BY THE EMPLOYEE</b></p> <p><b>Employee's name</b> (first name, middle initial, last name)</p> <p>_____</p>	<p><b>Employee's social security #</b> _____</p> <p><b>Employee's date of birth</b> (MM/DD/YYYY)</p> <p><input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>
--	---

**BONDING CERTIFICATION** (to be completed by the employee) - continued from prior page

*Form PFL-2 continued from prior page*

---

**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.

Employee's signature \_\_\_\_\_

Date signed (MM/DD/YYYY)

/   /



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

- 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 (Form PFL-3)* and submit it to their health care provider, along with a copy of the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)*.
- The *Release Of Personal Health Information Under The Paid Family Leave Law (Form PFL-3)* enables the health care provider to complete *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* 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 (Form PFL-3)* in its entirety.
- The employee requesting PFL submits both the *Request For Paid Family Leave (Form PFL-1)* and the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* to their employer's PFL insurance carrier, or to their employer if the employer is self-insured, for PFL benefit determination.

**NOTE:** This form will be retained by the health care provider. The employee should make a copy for their records before giving it to the health care provider. **Do not return this form to Guardian.**

**Care recipient or authorized representative signs and dates.**

**This form is given to the care recipient's health care provider along with the  
*Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)*.**

### 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 Form PFL-4)

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 (Form PFL -1)* Part B line 13.

**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.

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.



# Paid Family Leave

## Request For Paid Family Leave Release Of Personal Health Information Under The Paid Family Leave Law (Form PFL-3)

INSTRUCTIONS INCLUDED WITH FORM - DO NOT RETURN THIS FORM TO GUARDIAN

TO BE COMPLETED BY THE EMPLOYEE Plan #

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

---

Care recipient's (patient's) name (first name, middle initial, last name) **Care recipient's (patient's) date of birth** (MM/DD/YYYY)

/  /

### 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 Form PFL-4)

I,  Care recipient's (patient's) name, authorize my health care provider listed on this form to

release my personal health information to  Employee's name and their

employer's PFL insurance carrier  PFL insurance carrier'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 (to be completed by the care recipient or authorized representative)

Identify the health care provider who is currently providing you with treatment for a condition that is subject to the employee's request for PFL benefits.

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

---

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

Mailing address

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

**3. Health care provider's telephone number** (provide area or country code)

---

Form PFL-3 continued on next page



TO BE COMPLETED BY THE EMPLOYEE		Plan # <input style="width: 100px;" type="text"/>
<b>Employee's name</b> (first name, middle initial, last name)		
Care recipient's (patient's) name (first name, middle initial, last name)	<b>Care recipient's (patient's) date of birth</b> (MM/DD/YYYY)	
	<input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 40px; height: 20px;" type="text"/>	

**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 Form PFL-4) - continued from prior page

*Form PFL-3 continued from prior page*

**Care Recipient Information** (to be completed by the care recipient or authorized representative)

**4. Care recipient's mailing address**

Mailing address		
City, State	Zip code	Country (if not U.S.A.)

**5. Care recipient's Social Security Number**  -  -

**6. Care recipient's telephone number** (provide area or country code)

**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 (Form PFL-4)* to the employee identified on the PFL-4 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)

/  /

**The employee should retain a copy for their own records.**





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

The employee requesting PFL to care for a family member with a serious health condition must submit the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* with the *Request For Paid Family Leave (Form PFL-1)*.

### Employee:

- Employee enters their name, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, mailing address, and care recipient's (patient's) name and date of birth at the top of page 1.
- Employee enters their name and date of birth, and care recipient's (patient's) name and date of birth at the top of page 2.
- Employee gives the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* to the health care provider.

### 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)

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

**Patient Information / 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)

**Question 2:** Providing the optional ICD-10 code is recommended.

The patient's health care provider must complete the Patient Information and Health Care Provider sections of the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)*.

**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.**

### Employee:

- When you receive the completed *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* form from the health care provider, send the completed forms and supporting documentation to the insurance carrier.

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.



**Paid Family Leave**

**Request For Paid Family Leave**  
Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)

INSTRUCTIONS INCLUDED WITH FORM

TO BE COMPLETED BY THE EMPLOYEE Plan #

**Employee's name** (first name, middle initial, last name)  **Employee's date of birth** (MM/DD/YYYY)  /  /

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.)

**Care recipient's (patient's) name** (first name, middle initial, last name)  **Care recipient's (patient's) date of birth** (MM/DD/YYYY)  /  /

**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)

**Patient Information / 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)

- 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.
- Primary ICD-10 code (optional)**
- Diagnosis**
- Date patient's condition commenced** (MM/DD/YYYY)  /  /
- First date care for patient is needed** (MM/DD/YYYY)  /  /
- Expected date patient will no longer require care** (MM/DD/YYYY)  /  /
- Estimated number of days per week OR days per month patient requires care**  Days/week **OR**  Days/month

**Health Care Provider Information** (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

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

Form PFL-4 continued from prior page

<p><b>TO BE COMPLETED BY THE EMPLOYEE</b></p> <p><b>Employee's name</b> (first name, middle initial, last name)</p> <p>_____</p>	<p><b>Employee's social security #</b> _____</p> <p><b>Employee's date of birth</b> (MM/DD/YYYY)</p> <p>□□ / □□ / □□□□</p>
<p><b>Care recipient's (patient's) name</b> (first name, middle initial, last name)</p> <p>_____</p>	<p><b>Care recipient's (patient's) date of birth</b> (MM/DD/YYYY)</p> <p>□□ / □□ / □□□□</p>

**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)  
 - continued from prior page

*Form PFL-4 continued from prior page*

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

<input type="checkbox"/> Medical Doctor (MD)	<input type="checkbox"/> Dentist (DDS/DDM)	<input type="checkbox"/> Licensed Social Worker (LMSW/LCSW)
<input type="checkbox"/> Doctor of Osteopathy (DO)	<input type="checkbox"/> Physician's Assistant (PA)	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Doctor of Podiatric Medicine (DPM)	<input type="checkbox"/> Nurse Practitioner (NP)	
<input type="checkbox"/> Doctor of Chiropractic Medicine (DC)	<input type="checkbox"/> Licensed Psychologist	

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

Mailing address  
 \_\_\_\_\_

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

- 11. Health care provider's telephone number** (provide area or country code) \_\_\_\_\_
- 12. Health care provider's fax number** (provide area or country code) \_\_\_\_\_
- 13. Health care provider's email address** (if available) \_\_\_\_\_
- 14. State or country (if not U.S.A.) in which health care provider is licensed to practice** \_\_\_\_\_
- 15. Specialty** \_\_\_\_\_
- 16. Health care provider's license number** \_\_\_\_\_

**Certification 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.

My signature attests that the information I have provided in this form is based on my professional assessment within my licensed scope of practice.

Health care provider's signature	Date signed (MM/DD/YYYY)
_____	□□ / □□ / □□□□



## Military Qualifying Event (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 the *Military Qualifying Event (Form PFL-5)* with the *Request For Paid Family Leave (Form PFL-1)*.

The employee 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.

### MILITARY QUALIFYING EVENT (to be completed by the employee)

**The employee requesting PFL must complete all applicable requested information.**

Employee enters their name, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, and mailing address at the top of page 1.

Employee enters their name and date of birth at the top of page 2.

**Questions 1-5:** Enter the military member's information, and indicate the military member's relationship to the employee.

**Question 6:** Enter dates of expected military covered active duty.

**Question 7:** 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.

### Qualifying Reason for Leave (to be completed by the employee)

**Question 8:** Explain the need for PFL because of the Military Qualifying Event. For example: "My spouse was just called on short notice to covered active duty status, and will be deployed to (country) in five days. I need to take PFL to be with them and make arrangements for while they are away on active duty." 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, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, and mailing address at the top of the attachment.

**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.



# Paid Family Leave

# Request For Paid Family Leave Military Qualifying Event (Form PFL-5)

INSTRUCTIONS INCLUDED WITH FORM

TO BE COMPLETED BY THE EMPLOYEE Plan #

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

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

**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.)

## 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, lastname)

**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. The above-named military member is employee's:**  Spouse  Domestic partner  Child  Parent

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

**7. 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)

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

Arranging for child care  Acting as military member's representative before a federal, state, or local agency for purpose of obtaining, arranging, or appealing military service benefits

Arranging for parental care  Attending any event sponsored by the military or military service organizations

Counseling  Other

Making financial arrangements

Making legal arrangements

Form PFL-5 continued on next page

Documents can be returned electronically at [www.GuardianAnytime.com](http://www.GuardianAnytime.com). Click on "Secure Channel" on the Guardian Anytime home page.



## TO BE COMPLETED BY THE EMPLOYEE

Employee's social security # \_\_\_\_\_

Employee's name (first name, middle initial, last name)  
\_\_\_\_\_Employee's date of birth (MM/DD/YYYY)  
 /  / **MILITARY QUALIFYING EVENT** (to be completed by the employee) - continued from prior page*Form PFL-5 continued from prior page***9. Written documentation supporting this request for leave is 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.

Employee's signature  
\_\_\_\_\_

Date signed (MM/DD/YYYY)

 /  /

TO BE COMPLETED BY THE EMPLOYEE

Plan #

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

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

Grid for date of birth: MM/DD/YYYY

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

Employee's Social Security Number or TIN

Grid for 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.

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:

Large empty box for describing the nature of the meeting.







# Paid Family Leave

# STATEMENT OF RIGHTS FOR PAID FAMILY LEAVE

## IF YOU NEED TO TAKE TIME OFF FROM WORK TO CARE FOR A FAMILY MEMBER, YOU MAY BE ENTITLED TO PAID FAMILY LEAVE BENEFITS

### **Paid Family Leave is employee funded insurance that provides job-protected, paid time off to:**

- Bond with a newly born, adopted or fostered child;
- Care for a family member with a serious health condition; or
- Assist loved ones when a family member is called to active military service abroad.

### **Eligibility:**

- Employees with a regular work schedule of **20 or more hours per week** are eligible after **26 consecutive weeks** of employment.
- Employees with a regular work schedule of **less than 20 hours per week** are eligible after **175 days worked**.

You are eligible regardless of your citizenship or immigration status.

**Benefits:** In 2018, you can take up to eight weeks of Paid Family Leave and receive 50% of your average weekly wage, capped at 50% of the New York State average weekly wage. Generally, your average weekly wage is the average of your last eight weeks of pay prior to starting Paid Family Leave.

### **Rights and Protections**

- **Job Protection:** Return to the same or comparable job after you take leave.
- You keep your **health insurance** while on leave (you may have to continue paying your portion of the premium costs, if any).
- Your **employer is prohibited from discriminating or retaliating** against you for requesting or taking Paid Family Leave.
- You **do not have to exhaust sick leave or vacation** accruals before using Paid Family Leave.

### **Paid Family Leave Request Process**

1. Notify your employer at least 30 days in advance, if foreseeable, or as soon as possible.
2. Complete and submit the Request for Paid Family Leave (Form PFL-1) to your employer.
3. Complete and attach the additional forms as required and submit to the insurance carrier listed below.
4. The insurance carrier must pay or deny your request within 18 days of receiving your completed request.

You may obtain all forms from your employer, their insurance carrier listed below or online at [www.ny.gov/PaidFamilyLeave](http://www.ny.gov/PaidFamilyLeave).

### **Disputes**

If your Paid Family Leave claim is denied, you may request to have the denial reviewed by a neutral arbitrator. The insurance carrier listed below will provide you with information about requesting arbitration.

### **Discrimination Complaints**

If your employer terminates your employment, reduces your pay and/or benefits, or disciplines you in any way as a result of you taking or asking about Paid Family Leave, you may request to be reinstated by taking these steps:

1. Complete the Formal Request for Reinstatement Regarding Paid Family Leave form (PFL-DC-119)
2. Send your completed form to your employer and a copy of the completed form to: Paid Family Leave, P.O. Box 9030, Endicott, NY 13761-9030
3. If your employer does not reinstate you within 30 days, you may file a discrimination complaint with the Worker's Compensation Board using form PFL-DC-120, available at <http://www.ny.gov/PaidFamilyLeave>. The Worker's Compensation Board will assemble your case and schedule a hearing.

**For more information, forms, and instructions,  
visit [www.ny.gov/PaidFamilyLeave](http://www.ny.gov/PaidFamilyLeave) or call (844)-337-6303.**

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law. Your employer's paid family leave benefits insurance carrier is:

Guardian Life Insurance Company of America  
7 Hanover Square, New York NY 1004  
800-268-2525

**PRESCRIBED BY THE CHAIR,  
WORKERS' COMPENSATION BOARD**