GUARDIAN®

NEW YORK STATE | Paid Family Leave

Applying For Paid Family Leave

To Use Paid Family Leave To:

Bond with a newborn, a newly adopted or fostered child

Complete Form PFL-1
- Complete PFL-1, Part A
- Provide PFL-1 to employer
- Employer completes PFL-1, Part B and returns to you within 3 days

Complete Form PFL-2
- Complete PFL-2 and collect supporting documentation

Send forms and documents
- Send completed forms and supporting documentation to Guardian
- Guardian accepts or denies claim within 18 days

Care for a family member with a serious health condition

Complete Form PFL-1
- Complete PFL-1, Part A
- Provide PFL-1 to employer
- Employer completes PFL-1, Part B and returns to you within 3 days

Complete Form PFL-3
- Care recipient completes PFL-3 and provides to health care provider
- Care recipient's health care provider keeps PFL-3

Complete Form PFL-4
- Complete "Employee" information at the top of PFL-4
- Provide PFL-4 to care recipient's health care provider
- Care recipient's health care provider completes PFL-4 and returns to you

Send forms and documents
- Send completed forms and supporting documentation to Guardian
- Guardian accepts or denies claim within 18 days

Assist family members due to another family member's active military duty or impending active duty abroad

Complete Form PFL-1
- Complete PFL-1, Part A
- Provide PFL-1 to employer
- Employer completes PFL-1, Part B and returns to you within 3 days

Complete Form PFL-5
- Complete PFL-5 and collect supporting documentation

Send forms and documents
- Send completed forms and supporting documentation to Guardian
- Guardian accepts or denies claim within 18 days

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. Click on "Secure Channel" on the Guardian Anytime home page.

If you need assistance, please call (800) 268-2525
www.ny.gov/PaidFamilyLeave

DO NOT SCAN

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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

If you need assistance, please call (800) 268-2525
www.ny.gov/PaidFamilyLeave

DO NOT SCAN

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_alph.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).

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.

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 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.

GUARDIAN® NEW YORK STATE 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

Plan #

TO BE COMPLETED BY THE EMPLOYEE

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

Employee's social security # _____

Employee's date of birth (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?

☐ Continuous — PFL start date (MM/DD/YYYY) / / — PFL end date (MM/DD/YYYY) / / — ☐ Dates are estimated

☐ Periodic — Identify dates periodic PFL will be taken: — ☐ 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.

Guardian Specific Information	Normal work schedule:	MON	TUES	WED	THURS	FRI	SAT	SUN	_____HOURS/DAY _____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.

If you need assistance, please call (800) 268-2525 Fax (610) 807-2950
Paid_Family_Leave@glic.com www.ny.gov/PaidFamilyLeave

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)

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. Employee's occupation Codes are available at: www.bls.gov/soc/2010/soc_alph.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			
Calculated average gross weekly wage:			

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

If you need assistance, please call (800) 268-2525 Fax (610) 807-2950
Paid_Family_Leave@glic.com www.ny.gov/PaidFamilyLeave

Plan #

TO BE COMPLETED BY THE EMPLOYEE

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

Employee's social security # _____

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:

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

Guardian Specific Information	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

If you need assistance, please call (800) 268-2525 Fax (610) 807-2950
Paid_Family_Leave@glic.com www.ny.gov/PaidFamilyLeave

Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

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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 **original** 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 **original** 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 **copy** of the certificate issued by the city or county office in which the child is born.
Voluntary Acknowledgment of Paternity (Form LDSS-4418)	A **copy** of the form that establishes legal fatherhood when the parents are unmarried. Completed by both mother and father. For more information, see childsupport.ny.gov/dcse/aop_howto.html
Court Order of Filiation	A **copy** of the order from the family court that names the father of a child. Establishes legal fatherhood when the parents are unmarried. Completed by both mother and father. For more information, visit childsupport.ny.gov/dcse/aop_howto.html
Marriage Certificate	A **copy** of the official statement issued by the town or city clerk from which the marriage certificate was issued.
Civil union/domestic partner's documentation	A **copy** of the certificate of civil union or domestic partnership.
Foster care placement letter	A **copy** of the letter of foster care placement issued by the county or city department of social services or authorized voluntary foster care agency.
Court documents of adoption	A **copy** of the court document finalizing adoption or documentation in furtherance or court order finalizing adoption.
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.

If you need assistance, please call (800) 268-2525
www.ny.gov/PaidFamilyLeave

DO NOT SCAN

GUARDIAN® NEW YORK STATE | 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)

1. **Child's date of birth** (MM/DD/YYYY) / /
2. **Child's gender** ☐ Male ☐ Female ☐ Not designated/Other
3. **Does child live with the employee requesting PFL?** ☐ Yes ☐ No
4. **Child is employee's:**
   ☐ Biological child ☐ Stepchild ☐ Foster child ☐ Adopted child ☐ Legal ward ☐ Spouse/Domestic partner's child ☐ Loco parentis
5. **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

6. **Date of foster care or adoption placement, if applicable** (MM/DD/YYYY) / /

Form PFL-2 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)

__ __ / __ __ / __ __ __ __

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)

__ __ / __ __ / __ __ __ __

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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.

If you need assistance, please call (800) 268-2525
www.ny.gov/PaidFamilyLeave

DO NOT SCAN

GUARDIAN® NEW YORK STATE | 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 #

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) - 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.

If you need assistance, please call (800) 268-2525
www.ny.gov/PaidFamilyLeave

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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.

If you need assistance, please call (800) 268-2525
www.ny.gov/PaidFamilyLeave

DO NOT SCAN

GUARDIAN® NEW YORK STATE 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)

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 (optional)**

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

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

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)

/ /

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) - continued from prior page

Form PFL-4 continued from prior page

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 (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)

/ /

Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

If you need assistance, please call (800) 268-2525 Fax (610) 807-2950
Paid_Family_Leave@glic.com www.ny.gov/PaidFamilyLeave

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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.

If you need assistance, please call (800) 268-2525
www.ny.gov/PaidFamilyLeave

DO NOT SCAN

GUARDIAN® NEW YORK STATE 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
☐ Arranging for parental care
☐ Counseling
☐ Making financial arrangements
☐ Making legal arrangements
☐ Acting as military member's representative before a federal, state, or local agency for purpose of obtaining, arranging, or appealing military service benefits
☐ Attending any event sponsored by the military or military service organizations
☐ Other

Form PFL-5 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)

__ __ / __ __ / __ __ __ __

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)

__ __ / __ __ / __ __ __ __

Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

If you need assistance, please call (800) 268-2525 Fax (610) 807-2950
Paid_Family_Leave@glic.com www.ny.gov/PaidFamilyLeave

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.)

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: