To Use Paid Family Leave To:

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 14358, Lexington, KY 40511 Fax: 610- 807-2950
Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

Guardian

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)

Question 12: A child is defined as a biological, adopted, or foster son or daughter, a stepson or stepdaughter, a legal ward, a son or daughter of a domestic partner, or the person to whom the employee stands in loco parentis. A parent is defined as a biological, foster, or adoptive parent, parent-in-law, a stepparent, a legal guardian, or other person who stood in loco parentis to the employee when the employee was a child.

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 orestimated, indicate "Dates are estimated".

If dates are estimated, the PFL carrier may require youto 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/2018/major_groups.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 Member ID /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
☐ 中文 ☐ 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 ☐ Sibling

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 <u>weekly</u> 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 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)

1. Business's full legal name and mailing address

Business name
County of Dutchess

Mailing address
22 Market Street

City, State	Zip code	Country (if not U.S.A.)
Poughkeepsie, NY	12601	

2. Employer's FEIN 14-6002566

3. Employer's Standard Industrial Classification (SIC) Code 9199

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

Risk Management

5. Employer's contact telephone number 845-486-2169

6. Employer's contact email address

riskmanagement@dutchessny.gov

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

8. Employee's occupation Codes are available at: www.bls.gov/soc/2018/major_groups.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 <u>weekly</u> wage:			$0.00

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 14358

City, State
Lexington, KY

Zip code
40511

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

Guardian

Guardian Insurance Paid Leave Claims
P.O. Box 14358
Lexington, KY 40511
1-800-268-2525 Fax 1-610-807-2950
Paid_Family_Leave@glic.com

New York PFL – Leave Time Tracking Sheet

Insured Name:	
Plan Number:	
Claim Number:	

The following information is needed to continue our handling of your Paid Leave claim.

It is your responsibility to track and report any missed work due to an approved Leave of Absence. Please follow the instructions below for reporting this time to Guardian.

1. Save a copy of this form for use in reporting future Leave Time.
2. Record dates work was **missed** each week**.** Only full day absences related to your approved Leave can be reported.
3. Please indicate "Relationship to Employee" for which leave is being taken.
4. Sign and date the form.
5. Have your Employer complete and sign their portion of the form verifying the dates for which Leave was taken.
6. Submit the completed form weekly by one of the following methods: 1) Fax**: (610)-807-2950** 2) Email: **Paid_Family_leave@glic.com**

EMPLOYEE SECTION:

Complete the below chart if using Intermittent Leave:

Date Leave Time Used	Full Day Used (Yes /No)	Leave Reason	Details of Leave	Relationship to Employee
Sample – 1/21/2021	Y	Care of Spouse	Doctors Appointment	Spouse – John Smith

Complete the below if using Continuous (uninterrupted) Leave:

Leave Begin Date	Leave End Date	Leave Reason	Details of Leave	Relationship to Employee
Sample – 1/21/2021	2/15/2021	Bonding	Care of Newborn	Son – John Smith Jr.

Employee Certification and Signature

1) Please indicate your typical work schedule prior to taking your requested Paid Family Leave.

☐ MO ☐ TU ☐ WE ☐ TH ☐ FR ☐ SA ☐ SU

By signing below, you attest that the information you have provided above is accurate.

Employee Signature	Date	Phone #	Email

IMPORTANT: Please have your employer complete the following to confirm your reported Leave. Delay in processing of you claim could result if this form is submitted without the below employer confirmation.

Insured Name:	
Plan Number:	
Claim Number:	

EMPLOYER SECTION:

1) Are you paying the employee **100% of their full wages** while they are on Leave? ☐ Yes ☐ No

   a. If 'YES' please provide dates: through

   b. If full wages paid, are you requesting reimbursement? ☐ Yes ☐ No

2) Please confirm the employment status of the Employee: ☐ Active ☐ Laid Off/Furloughed – Effective Date:_____

By signing below, you are confirming the accuracy of the Leave dates supplied by the above employee.

Print Name: _____

Employer Signature	Date		Phone #	Email

Guardian

Direct Pay Enrollment and Authorization

If you are unable to provide a handwritten signature due to technical limitations resulting from the COVID-19 pandemic, Guardian will accept a typewritten name in lieu of your signature on an interim basis. You must check the box below each signature line certifying that you understand that your typewritten name has the same force and effect as your signature.

For **faster** service please:
1. Complete this form on-line
2. Print, sign and scan it or use interim accommodation of typing your name in the signature line
3. Save the completed form to your computer
4. Return to Claim Submission page
5. Click Secure Channel Claim Submission button and follow prompts

To mail this form:
Guardian NY Paid Family Leave
PO Box 14358,Lexington, KY 40511
To fax the form:
(610)-807-2950
Customer Service:
1-800-268-2525

For direct deposit of your Paid Family Leave (PFL) benefit payments to your checking or savings account, please include all of the information requested. Please allow up to 10 business days for processing, upon receipt of completed documentation. If you have any questions about completing this form, please contact us at (800) 268-2525.
** **Please be advised that not all PFL plans are subject to direct deposit availability** **

1. Claim Information:

Claim Number (if known): _____ Claimant Name: _____ Group #: _____

2. REQUIRED: Provide a voided check, deposit slip or letter from your financial institution with routing and account numbers and attach to this authorization request. See example.

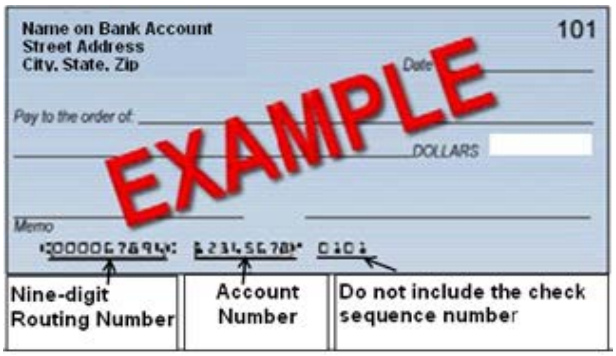
Account Type: (Choose One)

☐ Checking Account or ☐ Savings Account

Bank Name: _____

Bank Routing Number (ABA#): _____

Bank Account Number: _____



3. Sign and date this authorization:

I authorize Guardian Life Insurance Company of America ("Company") to deposit any benefits I am eligible to receive directly into the account and bank I have indicated above or to such other account as the bank or any successor bank designates as my account. I also authorize the Company to debit my account for any deposits made in error. I also understand that the direct deposit service will stay in effect until I notify the Company in writing of cancellation or until I am no longer eligible for or due payments, whichever comes first. **This request will also stay in effect should my STD claim transition into an approved LTD claim, if applicable**. I understand that I have the opportunity to view my EOBs and payment history via registration on GuardianAnytime.com.

☐ Check this box to discontinue receiving paper EOBs.

_____ _____
Claimant Signature Date

☐ I am unable to provide a signature due to the COVID-19 pandemic. I understand that my typewritten name has the same force and effect as my signature.

4. Joint Account Holder Agreement (Please check here if you are the sole account holder) ☐

I understand and agree that any funds deposited after the date of death of the Claimant that are not otherwise payable under the plan are to be immediately returned to Guardian Life Insurance Company of America.

_____ _____
Joint Account Holder Signature Date

☐ I am unable to provide a signature due to the COVID-19 pandemic. I understand that my typewritten name has the same force and effect as my signature.

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 name (first name, middle initial, last name)

Employee's social security #

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)

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: