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

- 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.

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

The employer of the employee requesting PFL must complete all information in Part B.

Question 3: If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number.

Question 4: Enter the employer's Standard Industrial Classification (SIC) Code. Contact your carrier if you don't know your SIC code.

Question 9: 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 starting 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 11: Failure to select "Yes" for requesting reimbursement from the insurance carrier, will result in a waiver of the right to reimbursement.

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

Question 12b: 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 14, 15 & 16: 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.

Equitable is the brand name of Equitable Holdings, Inc. and its family of companies, including Equitable Financial Life Insurance Company (Equitable Financial) (NY, NY), Equitable Financial Life Insurance Company of America (AZ stock corp., admin. office: Jersey City, NJ), and Equitable Distributors, LLC.

Fax or mail completed form to:
Group Claims Department
P.O. Box 14294
Lexington, KY 40512-4294
Fax 1-855-864-0530
Phone Number: (866) 274-9887

Request For Paid Family Leave
(Form PFL-1)

INSTRUCTIONS INCLUDED WITH FORM

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

1. **9a d`cmYYBg`bUa Y** Çã• ó∤ æ{ ^Ê{ ãåå|^Á§ ãæ|Ê∤æ• ó∤ æ{ ^D ________________ **Employee's date of birth** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

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

   Business name ________________

   Mailing address ________________

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

3. **Employer's FEIN** ☐☐ - ☐☐☐☐☐☐☐

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

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

6. **Employer's contact telephone number** (☐☐☐) ☐☐☐ - ☐☐☐☐

7. **Employer's contact email address**
____

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

9. **Employee's occupation** Codes are available at: www.bls.gov/soc/2018/major_groups.htm ☐☐ - ☐☐☐☐

10. **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:			

11. 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

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

Form PFL-1 continued from prior page

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

12b. Enter the total number of weeks and days taken for both Disability and PFL in the last 52 weeks:

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

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

14. PFL insurance carrier's name and mailing address

PFL insurance carrier's name

Mailing address

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

15. PFL insurance carrier's telephone number ( ) -

16. PFL policy number

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

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