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LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

New York Paid Family Leave
Initial Statement of Claim

## HOW TO FILE A CLAIM

Please follow the instructions listed below to avoid unnecessary delays in processing your claim. This form must be fully completed for each disability claim. If the claim form is not fully completed, the processing of the claim may be delayed.

NEW YORK STATE

**Paid Family Leave**

Reliance Standard Life insurance Company
P.O. Box 7749
Philadelphia, PA 19101-7749
(800) 351-7500 or
You May Fax to: (267) 256-3519
claimsintake@rsli.com

## 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
☐ 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 (CCDC) code set, Version 1.0).
**Is employee of Hispanic, Latino/a or Spanish origin?**

(One of 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 the 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

CONTINUED FROM PRIOR PAGE

TO BE COMPLETED BY THE EMPLOYEE

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

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

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

**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 the 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.

**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.

Employee's signature _____ Date signed _____

CONTINUED FROM PRIOR PAGE

TO BE COMPLETED BY THE EMPLOYEE

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 _____ STD Policy No. _____**

**PFL/DBL Policy No. _____**

**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/2020/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 weekly wage | | | |

**10a. If employee received or will receive full wages while on PFL, will employer be requesting reimbursement?**
☐ **Yes** ☐ **No**

**10b. Date Began _____ Date Ended _____**

**11a. In the preceding 52 weeks has the employee taken leave for:**
☐ **NYS Disability** ☐ **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.**

**Weeks: _____ Please provide specific dates to Disability _____**
**Disability:**
**Days: _____**

**Weeks: _____ Please provide specific dates to Disability _____**

**PFL:**

**Days: _____**

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

**12. Is the employee taking family Leave Act (FMLA) concurrently with PFL? ☐ Yes ☐ No**

**13. 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) _____

**14. PFL insurance carrier's telephone number (_____)_____**

**15. PFL policy number _____**

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**Declaration and signature**

☐ **I affirm the employee regularly works 20 or more hours per weeks and has been in employment for at least 26 consecutive weeks OR the employees 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.**

**Employer signature** **Date signed**

_____ _____

**Title**

_____

I authorize FRSL to send my disability payments to Bank designated below for electronic deposit in my Account.
I understand that I may terminate this arrangement at any time by writing to FRSL address above.

☐ Yes Set-up Direct Deposit

Name of Bank (Print) _____

Address of Bank _____

City _____ State _____ Zip_____

Choose Type of Account

☐ Checking ☐ Savings

Bank Transit/Routing Number (9 Digits) _____

Personal Account Number _____
Or Attached a Voided Check imprinted with you name.

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

Employee's Signature Telephone Number Date

_____ (_____)_____ _____

| | |
|---|---|
| IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS CONTACT THE NEAREST OFFICE OF THE NYS WORKERS' COMPENSATION BOARD, OR WRITE TO WORKER'S COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY- MENANDS, ALBANY, NY 12241-0005 | SI TIENE DUDAD REPLACIONADAS CON LA RECLMACION DE BENEFICOS POR INCAPACIDAD, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA DE NUEVA YORK O ESCRIBA A: WORKER'S COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY- MENANDS, ALBANY, NY 12241-0005 |

TO BE COMPLETED BY THE EMPLOYEE

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

_____

**Paid Family Leave**

# Request for Paid Family Leave
Bonding Certification (form PFL-2)

**INSTRUCTIONS INCLUDED WITH FORM**

TO BE COMPLETED BY THE EMPLOYEE

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 _____

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 acknowledgement 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 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 of adoption placement, if applicable** (MM/DD/YYYY) _____

## Bonding Certification (Form PFL-2) Instructions

If an 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.gove/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.gove/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 personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.