EQUITABLE

Equitable Financial Life Insurance Company

Applying For Paid Family Leave

To Use Paid Family Leave To:

NEW YORK STATE | Paid Family Leave

Bond with a newborn, a newly adopted or fostered child

Complete Form PFL-1

- Complete PFL-1, Part A

Complete Form PFL-2

- Complete PFL-2 and collect supporting documentation

Send forms and documents

- Send completed forms and supporting documentation to insurance carrier
- Insurance carrier accepts or denies claim within 18 days

Care for a family member with a serious health condition

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

Please keep a copy of all pages for your records.

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.

- 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 the employer's PFL insurance carrier 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, foste , 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 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

Form PFL-1 Instructions continued on next page

If you need assistance, please call (844) 337-6303
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

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)*.

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 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 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.

Fax, email 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
Email:
claimsubmission@groupclaims.com

Request For Paid Family Leave
(Form PFL-1)

NEW YORK STATE | Paid Family Leave

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**
   ☐ M ☐ F ☐ X

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

If you need assistance, please call (844) 337-6303
www.ny.gov/PaidFamilyLeave

PFL-1 11-17

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) - 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.

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 (844) 337-6303
www.ny.gov/PaidFamilyLeave

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) Cod** ☐☐☐☐

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/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 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

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) - 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

Mailing address

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

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

15. 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

Bonding Certification (Form PFL-2) Instruction

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/Certificatio	Description
Health care provider certification of pregnanc	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 bor
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 (844) 337-6303
www.ny.gov/PaidFamilyLeave

DO NOT SCAN

EQUITABLE

Equitable Financial Life Insurance Company

Request For Paid Family Leave

Bonding Certification (Form PFL-2)

NEW YORK STATE | Paid Family Leave

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 - -

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** ☐ M ☐ F ☐ X
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

If you need assistance, please call (844) 337-6303
www.ny.gov/PaidFamilyLeave

PFL-2 11-17

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 (MM/DD/YYYY)

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
claimsubmission@groupclaims.com

Paid Family Leave
STATEMENT OF RIGHTS

NEW YORK STATE | Paid Family Leave

If you need to take time off from work to care for a family member, you may be entitled to Paid Family Leave benefits.

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

- **BOND** with a newly born, adopted or fostered child;
- **CARE** for a family member with a serious health condition (see **paidfamilyleave.ny.gov** for eligible family members); or
- **ASSIST** loved ones when a spouse, domestic partner, child or parent is deployed abroad on active military service.

Paid Family Leave may also be available for use in situations when you or your minor dependent child are under an order of quarantine or isolation due to COVID-19. See **PaidFamilyLeave.ny.gov/COVID19** for full details.

Eligibility:

- If you have a regular work schedule of 20 or more hours per week, you are eligible after 26 consecutive weeks of employment with your employer.
- If you have a regular work schedule of less than 20 hours per week, you are eligible after working for your employer for 175 days, which do not need to be consecutive.

Citizenship or immigration status is not a factor in your eligibility.

Benefits:

You can take up to 12 weeks of Paid Family Leave and receive 67% of your average weekly wage, capped at 67% of the New York State Average Weekly Wage. Generally, your average weekly wage is the average of your last eight weeks of pay prior to starting Paid Family Leave. Leave can be taken all at once or intermittently, but must be in full-day increments.

Rights and Protections:

- **Job protection**: Return to the same or comparable job after you take leave.
- You keep your **health insurance** while on leave (you may have to continue paying your portion of the premium costs, if any).
- Your employer is **prohibited from discriminating or retaliating** against you for requesting or taking Paid Family Leave.

Disputes:

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

Discrimination Complaints:

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

1. Complete the ***Formal Request for Reinstatement Regarding Paid Family Leave (Form PFL-DC-119)***.
2. Send your completed form to your employer and a copy of the completed form to: Paid Family Leave, P.O. Box 9030, Endicott, NY 13761-9030
3. If your employer does not reinstate you or take other corrective action within 30 days, you may file a discrimination complaint with the Workers' Compensation Board using the ***Paid Family Leave Discrimination/Retaliation Complaint (Form PFL-DC-120)***. The Workers' Compensation Board will assemble your case and schedule a hearing.
4. There are other state and federal laws that protect employees from discrimination. Additional information is available at **PaidFamilyLeave.ny.gov**.

Paid Family Leave Request Process:

1. Notify your employer at least 30 days in advance, if foreseeable, or as soon as possible.
2. Complete and submit the ***Request for Paid Family Leave (Form PFL-1)*** to your employer.
3. You must submit your completed request package to your employer's insurance carrier within 30 days after the start of your leave to avoid losing benefits.
4. In most cases, the insurance carrier must pay or deny benefits within 18 calendar days of receiving your completed request or your first day of leave, whichever is later.

You may obtain all forms from your employer, their insurance carrier listed below, or online at **PaidFamilyLeave.ny.gov/Forms**.

For more information, forms and instructions, visit PaidFamilyLeave.ny.gov or call the PFL Helpline (844)-337-6303

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law. Your employer's Paid Family Leave benefits insurance carrier is: EQUITABLE FINANCIAL LIFE INSURANCE COMPANY
HOME OFFICE:1345 Avenue of the Americas, New York, NY 10105 Phone: (888) 292-4636

PRESCRIBED BY THE CHAIR,
WORKERS' COMPENSATION BOARD
NYS Paid Family Leave
PO Box 9030, Endicott NY 13761

PFL-271S (9/22) LC-7796 LC-7728-4 GRP-52 (12/22)

Clear Form

NY PFL Tax Withholding and Electronic Funds Transfer (EFT) Request Form

EQUITABLE

Tax Withholding:

Your PFL benefit is 100% taxable. The federal government allows us to withhold 10% of your benefit for Federal Income Tax (FIT) with your permission.

Would you like us to withhold FIT? ☐ Yes ☐ No

EFT Instructions:

1. Read the Terms and Conditions listed below.

2. Enter your name, address, home telephone number and Employee ID.

3. Complete the bank and account information for your Electronic Funds Transfer request.

4. You and all other parties to the account specified must sign this form.

5. Return the completed form to the Group Claims Department.

Note: Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the EFT Program.

Name: _____

Address: _____

Telephone Number: ( ) - _____

Employee ID: _____

Name of Bank: _____

Bank Address: _____

Bank Telephone Number: ( ) - _____

Type of Account (select one):

Checking: **Saving:**

Account Number: _____ Account Number: _____

Bank Routing Number: _____

Attach a voided blank personal check.

Indicate any other names on the account selected:

_____

AUTHORIZATION

I / We authorize Equitable Financial Life Insurance Company, hereinafter called "The Insurance Company", and/or its Third Party Administrator, hereinafter called "TPA", and affiliated companies, to initiate credit entries (and to initiate, if necessary, debit entries and adjustments for credit entries made in error) to my (our) account indicated above and the Depository named above, hereinafter called Depository, to credit and/or debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until The Insurance Company and /or its TPA has received written notice from me (us) of its termination in such time and in such manner as to afford The Insurance Company and /or its TPA and Depository a reasonable opportunity to act on it.

_____ _____

Signature(s): **Date:**

_____ _____

TERMS AND CONDITIONS

Receiving benefits by direct deposit or electronic funds transfer is voluntary. If at any time during your leave you wish to revoke this EFT request, you can do so by contacting our office.

The Insurance Company and /or its TPA will not be responsible for any banking fees charged for direct deposit or electronic funds transfer; however, The Insurance Company and /or its TPA will not charge you any fees for depositing your benefits into this account.

I understand that this agreement may be terminated by me upon written notice to The Insurance Company and /or its TPA

The cancellation will be processed for the time period following receipt of the notice.

I understand that a change in the title of this account which alters the interest of any party terminates this authorization and that a new authorization must then be submitted to continue direct deposit/EFT.

I understand that it is my responsibility to inform The Insurance Company and /or its TPA of any address changes immediately.

I further understand that any benefit payment forwarded to the financial institution covering a period of time after my death will be refunded to The Insurance Company and /or its TPA. I agree that the financial institution shall have the right of offset for such a refund.

I authorize the financial institution specified in this authorization to provide The Insurance Company and /or its TPA with my home address and the names of any joint account holders for the account specified herein.

I understand that I am responsible for verifying the accuracy of my account data and for promptly notifying The Insurance Company and /or its TPA of any errors or changes including termination of my EFT request.

SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

As a party to this account, I understand that I am personally liable, both individually and as a member of the group of parties to this account, for the full amount of all benefit payments covering any period after the death of the disability benefit recipient. This is a liability to The Insurance Company and /or its TPA. If I am entitled to any benefit as the beneficiary of the disability benefit recipient, the amount of my liability may be deducted from the amount payable to me. I agree that the financial institution shall have the right of offset for such a refund, and I authorize the financial institution to provide The Insurance Company and /or its TPA with my home address.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to The Insurance Company and /or its TPA or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so. The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately notify The Insurance Company and /or its TPA if the authorization is cancelled by the financial institution. The financial institution can not cancel the authorization by advice to The Insurance Company and /or its TPA.

Signature: _____ Date: _____

I certify that I have read and understand the Terms and Conditions of this EFT Agreement, including the SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

Signature(s) of Other Persons on Account: _____ Date _____

_____ Date: _____