EQUITABLE

Equitable Financial Life Insurance Company
For Assistance Call (866) 274-9887

How to Request Paid Family Leave to care for a family member with a serious health condition

BEFORE YOU APPLY FOR PAID FAMILY LEAVE

- ☐ **Check the eligibility requirements**. See next page or visit PaidFamilyLeave.ny.gov/eligibility.
- ☐ **Plan your leave**. Leave can be taken all at once or intermittently, but must be taken in full-day increments.
- ☐ **Notify your employer at least 30 days in advance**, if foreseeable, or as soon as possible.

COMPLETE YOUR FORMS AND ATTACH REQUIRED DOCUMENTATION

- ☐ **Complete the Request for Paid Family Leave (Form PFL-1).**
  Note: This form has sections that need to be completed by you and by your employer.
  - ☐ Fill out your section, make a copy, and give the form to your employer to fill out **Part B**.
  - ☐ Your employer is required to return **Form PFL-1** to you within three business days. If there is a delay, you do not have to wait to proceed. Send the **Form PFL-1** that you have filled out, along with the rest of your request package, directly to Equitable.
- ☐ **Complete the Release of Personal Health Information Under the Paid Family Leave Law (Form PFL-3).**
  - ☐ Your family member (the care recipient) completes Form PFL-3 and submits the form to their health care provider to keep on file.
    This form authorizes a health care provider to release information regarding your family member's serious health condition to you and your employer's insurance carrier.
    Do not send this form to the insurance carrier.
- ☐ **Complete the Health Care Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4).**
  Note: This form has sections that need to be completed by the health care provider.
  - ☐ Fill out your section, make a copy, and give the form to your family member's health care provider.
  - ☐ Ask the provider to complete their portion of the form and return it to you in a timely manner.

SUBMIT TO EQUITABLE

- ☐ **You must submit your completed request package to Equitable within 30 days after the start of your leave to avoid losing benefits.**
  Keep a copy of all forms and documentation for your records.

Mail or fax your ***Form PFL-1, Form-PFL-3*** and ***Form PFL-4***, and required documentation to Equitable.

Send completed forms to: Equitable, EB Claims, 8501 IBM Dr, Suite 150-C Charlotte, NC 28262
Fax Number: (315) 477-2499
ebclaims@equitable.com

If you need assistance please call Equitable at (866) 274-9887, Customer Service is available Monday - Friday, 8:00 a.m. to 8:00 p.m.

Please do NOT submit your request package to the NYS Workers' Compensation Board.

How to Request Paid Family Leave to care for a family member with a serious health condition (continued)

Important to know

- In most cases, the insurance carrier must pay or deny benefits within 18 days of receiving your completed request or your first day of leave, whichever is later. Your request cannot be considered incomplete solely because your employer did not fill out **Part B** of ***Form PFL-1*** within three business days.
- If the carrier denies or fails to timely pay your benefits, or you have any other claim-related dispute, you may request to have the carrier's actions reviewed. More information can be found at nyspfla.namadr.com.
- Complaints about employer discrimination or retaliation are resolved by a Workers' Compensation Board Law Judge after a hearing. If you believe that your employer has discriminated or retaliated against you for taking or requesting Paid Family Leave, visit PaidFamilyLeave.ny.gov/protections or contact (844) 337-6303.

Eligibility

- Most employees who work for private employers in New York State are covered under Paid Family Leave.
  - **Full-time employees:** If you work a regular schedule of 20 or more hours per week, you are eligible after 26 consecutive weeks of employment with your employer.
  - **Part-time employees:** If you work a regular 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.
- Non-represented public employees may be covered if their employer has voluntarily opted in to provide the benefit. Union-represented public employees may be covered if the benefit has been negotiated through collective bargaining.
- Citizenship and/or immigration status is not a factor in employee eligibility.
- If you believe you are eligible, you can apply for Paid Family Leave and Equitable will make a determination.
- If you have questions about eligibility rules, call the Equitable Helpline at (866) 274-9887 (Monday - Friday, 8:00 a.m. to 8:00 p.m).

FAMILY MEMBERS YOU CAN CARE FOR:
Spouse/domestic partner
Child/stepchild
Parent/stepparent/parent-in-law
Grandparent
Grandchild
Sibling (New in 2023!) Check with your employer's insurance carrier for details on when this goes into effect for their policy.

CARE CAN INCLUDE PROVIDING:
Necessary physical care
Emotional support
Visitation
Assistance in treatment
Transportation
Help arranging for a change in care
Assistance with essential daily activities
Personal attendant services

Remember: It is YOUR responsibility to submit the forms to Equitable It is NOT your employer's responsibility.

EQUITABLE

Equitable Financial Life Insurance Company
For Assistance Call (866) 274-9887

FORM PFL-1 INSTRUCTIONS

Request for Paid Family Leave (Form PFL-1)

- To request Paid Family Leave (PFL), the employee (hereafter, "you") 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. You will then provide the form to your employer to complete Part B.
- Your employer completes Part B of the ***Request for Paid Family Leave (Form PFL-1)*** and returns it to you within three business days.
- Additional forms are required depending on the type of leave being requested. **You are responsible** for the completion of these forms.
- **Submit** the completed ***Request for Paid Family Leave (Form PFL-1)*** with the required **additional form(s)** to **Equitable Financial Life Insurance Company**, your employer's PFL insurance carrier.

Send completed forms to: Equitable, EB Claims, 8501 IBM Dr, Suite 150-C, Charlotte, NC 28262
Fax Number: (315) 477-2499
ebclaims@equitable.com

Remember to keep a copy of forms you submit for your records.

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

You must complete all required information.

PFL Request (to be completed by the employee)

Question 12: A child includes a biological, adopted, or fostered child, a stepchild, a legal ward, a child of a domestic partner, or the person to whom you stand 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 you when you were a child.

Question 13: If dates are "Continuous," you 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, Equitable 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 you are submitting the PFL request to your employer with less than 30 days' advance notice from the start date of the PFL, you 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 your full name and date of birth at the top of the attachment.

Form PFL-1 Instructions continued on next page

If you need assistance please call (866) 274-9887
ebclaims@equitable.com

DO NOT SCAN

FORM PFL-1 INSTRUCTIONS - CONTINUED FROM PRIOR PAGE

PART A - EMPLOYEE INFORMATION (to be completed by the employee) - continued from prior page

Employment Information (to be completed by the employee)

Question 16: Enter the date of hire to the best of your 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, you can calculate your 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 you 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 (866) 274-9887
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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)*.

When pre-submitting form: Indicate if you are pre-submitting your 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 submission. If pre-submitting is permitted, the missing information must be supplied as soon as it is known.

Benefits cannot be determined until all of the required information is provided.

Equitable will provide you with 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, Equitable has 18 days to pay or deny the claim.**

If Equitable does not permit pre-submitting, Equitable must return the ***Request for Paid Paid Family Leave (Form PFL-1)*** to you explaining that the claim should be re-submitted when all information is available.

SIGN and DATE this form BEFORE giving it to your 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. Employers should contact their carrier if they don't know their 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 dividing the total 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 11b.

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.

Questions 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.

Form PFL-1 Instructions continued on next page

If you need assistance please call (866) 274-9887
ebclaims@equitable.com

DO NOT SCAN

FORM PFL-1 INSTRUCTIONS - CONTINUED FROM PRIOR PAGE

Be sure to complete the appropriate additional PFL form(s) based on the type of 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 Taxpayer 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 Taxpayer 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 forms to:

Equitable Financial Life Insurance Company
Attn: Equitable, EB Claims
8501 IBM Dr.
Suite 150-C
Charlotte, NC 28262
Fax Number: (315) 477-2499
ebclaims@equitable.com

If you need assistance please call (866) 274-9887
ebclaims@equitable.com

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NEW YORK STATE | Paid Family Leave

Send completed form to:
Equitable, EB Claims, 8501 IBM Dr, Suite 150-C Charlotte, NC 28262
Fax Number: (315) 477-2499
ebclaims@equitable.com

Request for Paid Family Leave
(Form PFL-1)

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 Taxpayer Identification Number**
   ☐☐☐ - ☐☐ - ☐☐☐☐

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
☐ 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 _____

Form PFL-1 continued on next page

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ebclaims@equitable.com

FORM PFL-1 - CONTINUED FROM PRIOR PAGE

PART A - EMPLOYEE INFORMATION (to be completed by the employee) - continued from prior page

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

TO BE COMPLETED BY THE EMPLOYEE

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

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

☐☐/ ☐☐/ ☐☐☐☐

13. Will PFL be for a continuous period of time and/or intermittent?

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

☐ Intermittent Identify dates intermittent PFL will be taken: ☐ Dates are estimated

14. If providing less than 30 days' advance notice to the employer, please explain:

Form PFL-1 continued on next page

If you need assistance please call (866) 274-9887
ebclaims@equitable.com

FORM PFL-1 - CONTINUED FROM PRIOR PAGE

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.

I consent to receiving ☐ cell phone ☐ email communications from the insurance company related to my claim(s) at the email address and/or cell phone number provided above.

Form PFL-1 continued on next page

If you need assistance please call (866) 274-9887
ebclaims@equitable.com

FORM PFL-1 - 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** ☐☐ - ☐☐☐☐☐☐☐

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/2018/major_groups.htm

☐☐ - ☐☐☐☐

Form PFL-1 continued on next page

If you need assistance please call (866) 274-9887
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FORM PFL-1 - CONTINUED FROM PRIOR PAGE

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:			

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 (866) 274-9887
ebclaims@equitable.com

FORM PFL-1 - CONTINUED FROM PRIOR PAGE

TO BE COMPLETED BY THE EMPLOYEE

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

Employee's date of birth

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
Equitable Financial Life Insurance Company

Mailing address
8501 IBM Dr, Suite 150-C

City, State	Zip code	Country (if not U.S.A.)
Charlotte, NC	**28262**	

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

15. PFL policy number

Form PFL-1 continued on next page

If you need assistance please call (866) 274-9887
ebclaims@equitable.com

FORM PFL-1 - CONTINUED FROM PRIOR PAGE

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 (866) 274-9887
ebclaims@equitable.com

EQUITABLE

Equitable Financial Life Insurance Company
For Assistance Call (866) 274-9887

FORM PFL-3 INSTRUCTIONS

Release of Personal Health Information Under the Paid Family Leave Law (Form PFL-3)

- If an employee (hereafter, "you") request Paid Family Leave (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 you so you can seek 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.
- You submit 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 Equitable Financial Life Insurance Company (your employer's PFL insurance carrier) for PFL benefit determination.

NOTE: This form will be retained by the health care provider. You should ***make a copy*** for you records ***before*** giving it to the health care provider.

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)

You (the Employee) enter your name, and care recipient's (patient's) name and date of birth at the top of each page. **Equitable Financial Life Insurance Company** is the PFL insurance carrier at the top of Form PFL-4 and 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 Taxpayer 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 Taxpayer 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 (866) 274-9887
ebclaims@equitable.com

DO NOT SCAN

NEW YORK STATE | Paid Family Leave

Send completed form to:
Equitable, EB Claims, 8501 IBM Dr, Suite 150-C Charlotte, NC 28262
Fax Number: (315) 477-2499
ebclaims@equitable.com

Request for Paid Family Leave

Release of Personal Health Information Under the Paid Family Leave Law (Form PFL-3)

INSTRUCTIONS INCLUDED WITH FORM

TO BE COMPLETED BY THE EMPLOYEE

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

Care recipient's (patient's) name (first name, middle

Care recipient's (patient's) date of birth

__ __ / __ __ __ __ __ __ __ __

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 **Equitable Financial Life Insurance Company.**

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

If you need assistance please call (866) 274-9887
ebclaims@equitable.com

FORM PFL-3 - CONTINUED FROM PRIOR PAGE

TO BE COMPLETED BY THE EMPLOYEE

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

__ __ / __ __ / __ __ __ __

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

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 (866) 274-9887
ebclaims@equitable.com

EQUITABLE

Equitable Financial Life Insurance Company
For Assistance Call (866) 274-9887

FORM PFL-4 INSTRUCTIONS

Health Care Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4)

The employee (hereafter, "you") requesting Paid Family Leave (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 (you):

- Enter your name, date of birth, other last names, if any, under which you have worked, Social Security number or Taxpayer Identification Number (TIN), mailing address, and care recipient's (patient's) name and date of birth at the top of page 1.
- Enter your name and date of birth, and care recipient's (patient's) name and date of birth at the top of page 2.
- You give 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.

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.

- When you receive the completed ***Health Care Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4)*** from the health care provider -

Send **completed forms** and **supporting documentation** to:

Equitable Financial Life Insurance Company
EB Claims,8501 IBM Dr, Suite 150-C, Charlotte, NC 28262
Fax Number: (315) 477-2499 or **ebclaims@equitable.com**

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 Taxpayer 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 Taxpayer 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 (866) 274-9887
ebclaims@equitable.com

DO NOT SCAN

NEW YORK STATE | Paid Family Leave

Send completed forms to:
Equitable, EB Claims, 8501 IBM Dr, Suite 150-C Charlotte, NC 28262
Fax Number: (315) 477-2499
ebclaims@equitable.com

Request for Paid Family Leave
(Form PFL-4)
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.)

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)

Care Recipient (Patient) Information (to be completed by the health care provider)

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** Days/week **OR** Days/month

Health Care Provider Information (to be completed by the health care provider)

8. **Health care provider's name**

Form PFL-4 continued on next page

If you need assistance please call (866) 274-9887
ebclaims@equitable.com

FORM PFL-4 - 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)

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

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 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)

If you need assistance please call (866) 274-9887
ebclaims@equitable.com

Paid Family Leave

STATEMENT OF RIGHTS

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.

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. Equitable, 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. You must submit your completed request package to Equitable, your employer's insurance carrier, within 30 days after the start of your leave to avoid losing benefits.
3. 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 Equitable (the insurance carrier listed below), your employer, or online at PaidFamilyLeave.ny.gov/Forms.

For more information, forms and instructions, write to ebclaims@equitable.com or call the Equitable Helpline (866)-274-9887

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

Send completed forms to:
Equitable, EB Claims
8501 IBM Dr, Suite 150-C
Charlotte, NC 28262
Fax Number: (315) 477-2499
ebclaims@equitable.com

Questions? Call us at: (866) 274-9887

*Equitable is the brand name of the retirement and protection subsidiaries of Equitable Holdings, Inc., including Equitable Financial Life Insurance Company (NY, NY); Equitable Financial Life Insurance Company of America, an AZ stock company with an administrative office located in Charlotte, NC; and Equitable Distributors, LLC.

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

Clear Form

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

EQUITABLE

Equitable Financial Life Insurance Company
For Assistance Call (866) 274-9887

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: Account Number: _____

☐ Saving: 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(s):

_____ _____

_____ _____

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 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:

Signature:_____ Date:_____

Signature:_____ Date:_____