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 TIN**

☐☐☐ - ☐☐ - ☐☐☐☐

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

☐☐ / ☐☐ / ☐☐☐☐

6. **Employee's primary telephone number**

(☐☐☐) ☐☐☐ - ☐☐☐☐

7. **Employee's preferred email address while on PFL** (if available)

8. **Employee's gender**

☐ Male ☐ Female ☐ Not designated/Other

9. **Employee's preferred language**

☐ English ☐ Español ☐ Русский ☐ Polski
☐ 中文 ☐ Italiano ☐ Kreyòl ayisyen ☐ 한국어
☐ Other

Optional (for research purposes)

10. **Employee's ethnicity/race**
For purposes of health demographic only. (U.S. Centers for Disease Control and Prevention (CDC) code set, version 1.0.)

Is employee of Hispanic, Latino/a, or Spanish origin?
(One or more categories may be selected.)

☐ Mexican
☐ Mexican American
☐ Chicano/a
☐ Puerto Rican
☐ Dominican
☐ Cuban
☐ Another Hispanic, Latino/a, or Spanish origin
☐ Not of Hispanic, Latino/a, or Spanish origin
☐ Unknown

What is employee's race?
(One or more categories may be selected.)

☐ American Indian or Alaska Native
☐ Black or African American
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ White
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other race

Paid Family Leave (PFL) Request (to be completed by the employee)

11. **Reason for PFL request:** ☐ Bond with child ☐ Care for family member ☐ Military qualifying event

12. **The family member is employee's:**

☐ Child ☐ Spouse ☐ Domestic partner ☐ Parent ☐ Parent-in-law ☐ Grandparent ☐ Grandchild

Form PFL-1 continued on next page

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

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

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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 __weekly__ 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.

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/2010/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 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

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

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