MAIMONIDES MEDICAL CENTER

CODE: ACDM AFFAIRS 028 (Revised)
Date: November 16 , 2023
ORIGNALLY ISSUED: February 23, 2023

SUBJECT: RESIDENT/FELLOW LEAVE OF ABSENCE

I. POLICY

Maimonides Medical Center provides employees with time off with or without pay for various reasons. This policy establishes Medical Center guidelines for granting and administering leaves of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), New York State Paid Family Leave Law (PFL), and other applicable federal, state and local laws.

This policy details leaves of absences residents or fellows under the Committee on Interns & Residents (CIR) Collective Bargaining Agreement (CBA) are entitled to receive, ensures compliance with ACGME institutional requirements around Medical, Parental and Caregiver Leave and ensures conformance with all other State, City and Federal requirements

This policy applies to all GME programs at Maimonides Medical Center (and is in addition to HR 16.)

Confidentiality

Forms that contain confidential medical information will be considered confidential and be treated as such to the extent required under applicable law.

General Rules

- You may not obtain or apply for other employment or work in any capacity, for any person or entity, start a new company, or become self-employed, while you are on a leave of absence. Acceptance of other employment or work for any entity while on leave may be treated as misconduct or as a voluntary resignation from employment with the Medical Center, and could be grounds for discipline. This rule applies to all employees, whether or not covered by a CBA or other agreement.
- If an employee needs a job accommodation in order to return to work after a leave, that request must also be submitted in writing to Human Resources, Labor Division with a copy to Academic Affairs and the employee's supervisor, with appropriate medical documentation, at least 10 days before the leave is due to expire, or as soon as the employee is aware of the need. Requests for accommodations will be evaluated in accordance with applicable law.

ACGME Leave Requirements

- Residents/Fellows can apply for a minimum of six weeks of approved medical, parental, and caregiver leave(s) of absence for qualifying reasons that are consistent with applicable laws at least once and at any time during an ACGME-accredited program, ACGME leave will be

available to Residents/Fellow upon the commencement of their residency. Accordingly, there is no waiting or accrual period.

- Residents/Fellows will receive 100 percent of their salary for the first six weeks of the first qualifying, approved medical, parental, or caregiver leave(s) of absence either from their vacation, paid sick leave, other paid leave bank, or directly from Maimonides depending on the employee's paid leave balances.
- Residents/Fellows approved for the eligible leave will also be provided with a seventh (7) week of paid time off reserved for use outside of the first six weeks of the first approved medical, parental, or caregiver leave(s) of absence taken if time not have been taken prior to the initiation of the leave.
- Maimonides Medical Center will ensure the continuation of health and disability insurance benefits for residents/fellows and their eligible dependents during any approved medical, parental, or caregiver leave(s) of absence;
- Maimonides Medical Center will ensure this policy is available for review by residents/fellows at all times;
- Maimonides Medical Center will ensure that each of its ACGME-accredited programs provides its residents/fellows with accurate information regarding the impact of an extended leave of absence upon the criteria for satisfactory completion of the program and upon a resident's/fellow's eligibility to participate in examinations by the relevant certifying board(s).
- ACGME leave runs concurrently with Family Medical Leave Act, New York's Paid Family Leave, and/or any other leave provided to Residents/Fellows.
- For any medical, parental or caregiver leave covered by the FMLA or any other leave of absence but not qualifying under the New York Paid Family Leave Law, the Resident/Fellow are required to first use and exhaust any available paid time off provided to them under the CBA or by Maimonides policy - vacation time, sick time, personal days, any other paid time appropriate to the leave. Maimonides is permitted to use resident/fellow's vacation time, sick time, personal days, any other paid time off in order to adhere to ACGME's requirement that an employee receives 100% of their salary while on FMLA or any other leave of absence not qualifying under the New York Paid Family Leave Law.
- For any parental or caregiver leave provided under New York's Paid Family Leave, the Resident/Fellow may elect vacation time, sick time, personal day, owed holiday time not otherwise paid out, to supplement New York Paid Family Leave payments to maintain full pay or if not, Maimonides will supplement the New York Paid Family Leave payments in order for the Resident/Fellow to receive 100% of their salary.
- To the extent, as set forth above, the Resident/Fellow's vacation time, sick time, personal days, any other paid time does not cover the full salary of the Resident/Fellow during the six weeks of fully paid time off for an applicable medical, parental and caregiver leave, Maimonides will maintain the Resident/Fellow full pay and benefits.
- Per ACGME requirements, use of a Resident/Fellow's vacation leave for ACGME Leave will be restricted so that the resident maintains one week of vacation leave in his/her vacation bank.

II. CATEGORIES OF LEAVES

A. Medical Leave

1. Medical Leave (non-work related)

a. A continuous leave for an employee's own serious health condition.

b. Employees under the CIR CBA who are absent (or will be absent) in excess of one (1) calendar week (7 consecutive days from first day out) due to a serious health condition or to give birth must initiate a leave of absence (LOA) claim. If the leave is foreseeable (planned in advance), employees must initiate a leave of absence claim three (3) months prior to the anticipated leave date. If the leave is unexpected, such as unexpected illness or injury, employees must initiate a leave of absence claim as far in advance of the anticipated leave date as practicable. Generally, this should be the same day or the next business day of when the employee becomes aware of the need for the leave.

2. Medical Leave (work-related illness or injury) – Workers' Compensation

a. A continuous leave for an employee's own serious health condition as a result of a work-related illness or injury. Refer to Policy HR-63, *Workers' Compensation – Incident Reporting and Claims*, for details related to incident reporting and initiating leaves of absence claims.

B. Caregiver Leave

1. A continuous leave to care for a child*, spouse (including domestic partner) or parent** with a serious health condition.

   a. A "serious health condition" is an illness, injury, impairment, or physical or mental condition that involves either (a) inpatient care in a hospital, hospice, or residential health care facility; or (b) continuing treatment or continuing supervision by a health care provider.

2. CIR members eligible under FMLA (See "Family Medical Leave Act of 1993 in this policy) who are absent (or will be absent) to care for a qualified family member with a serious health condition for four (4) consecutive days or more must initiate a FMLA leave claim.

***** The term "child" refers to the employee's own dependent child, adopted child, foster child for whom the employee has legal foster care responsibility, stepchild, legal ward, or a child for whom the employee has overall parental responsibility on an established basis and who is living in the household of the employee.

** The term "parent" is defined broadly as the biological, adoptive, step, foster parent, grandparent or in law of an employee or an individual who stood in loco parentis to the employee when the employee was a son or daughter.

C. Parental Leave

1. Leaves related to the birth of a child, to adopt a child, for the foster care placement of a child with the employee, to bond with a newborn child within 12 months of the birth, to bond with an adopted child within 12 months of the adoption or placement for adoption or to bond with a foster child within 12 months of the placement of the child.
   a. Birthing Parent - If the leave is for the purpose of giving birth, parental leave is a personal medical leave of absence.
   b. Bonding- If the Leave is for Bonding with a new child (biological, adopted, step or foster child or a domestic partner's child) within the first 12 months of birth, adoption or placement of a child it is a personal non-medical leave of absence. Employee can initiate a PFL claim through Standard *Security.* Employee may choose to supplement their PFL with accrued vacation time at a rate of 1/3vacation day for each day of PFL for up to six (6) weeks, so that the employee receive full pay during that period.

III. BENEFITS AND JOB RETENTION

A. Committee of Interns and Residents Collective Bargaining Agreement

1. Resident and Fellow's job retention rights are governed by the CIR CBA. Your vacation and holiday time are available for you to be used for leaves at your discretion. Your sick time is also available to be used for leaves related to your own medical needs or those of your dependents.

B. New York State Paid Family Leave (PFL)

New York's Paid Family Leave program provides wage replacement to employees to help them bond with a child, care for a close relative with a serious health condition, or help relieve family pressures when someone is called to active military service. House Staff are eligible to apply for PFL once employment has commenced.

1. PFL eligible employees (employees who regularly work 20 or more hours per week after 26 consecutive weeks of employment or employees who work less than 20 hours per week but have worked 175 days), are entitled to a maximum of twelve (12) workweeks of Paid Family Leave in any 52-week period with a wage benefit of 67 percent of the employee average weekly salary capped at 67 percent of the New York Average Weekly wage. The 52-week clock starts on the first day the employee takes Paid Family Leave.
2. PFL may be granted to eligible employees to provide care to a qualifying family member with a serious health condition, to bond with a child after giving birth, adoption or welcoming a child into foster care, or for military exigency (to attend to family matters if your spouse, domestic partner, child, or parent is on active duty or has been notified of an impending call or to active duty). However, if both spouses work for Maimonides and are eligible for paid family leave under this policy, the spouses will not be granted leave for the same period of time to bond with a newborn or adopted or foster care child within the 12 months following the birth or placement of the child. Spouses will each be entitled to the maximum PFL benefit under the law, even though it cannot be taken at the same time.
3. While on PFL, employees remain subject to all changes that may occur in the CIR health care or other benefit programs and are subject to all other employment-related policies. Health insurance is maintained at the level and under the conditions that coverage would have been provided if the employee had continued in employment continuously for the duration of the approved PFL.
4. Benefits are limited to a total of 26 weeks in a 52-week period for New York Short Term Disability and 12 weeks for PFL.
5. Employees cannot be paid DBL (disability benefits) and PFL at the same time, i.e., receive benefits for both concurrently. They have to be taken in sequence. For example, in the case of pregnancy, an employee may receive disability benefits through 6-8 weeks postpartum and then may receive PFL benefits to further bond with the child.
6. Intermittent PFL is allowed only in full-day increments.

C. Family and Medical Leave Act of 1993 (FMLA)

Eligibility for leave under the Family and Medical Leave Act of 1993 (FMLA) is extended to all Resident/Fellows covered under the CIR CBA when employment commences.

1. FMLA eligible employees are entitled to a maximum of twelve (12) workweeks of leave during any rolling 12-month period. However, if both spouses work for Maimonides and are eligible for leave under this policy, the spouses will be limited to a total of 12

workweeks off between the two of them when the leave is to (a) bond with a newborn or adopted or foster care child within 12 months following the birth or placement of the child ("Bonding Leave").

2. Resident/Fellows are required to use any accrued vacation, paid sick leave, other paid leave available while an employee is exclusively on FMLA
3. In the case of Military Caregiver leave, FMLA eligible employees are entitled a maximum of twenty six (26) workweeks of leave during any rolling 12-month period. However, if both spouses work for Maimonides and are eligible for leave under this policy, the spouses will be limited to a total of 26 workweeks off between the two of them.
4. A 12-month period begins on the date of an employee's first use of FMLA leave. Successive 12-month periods commence on the date of the employee's first use of such leave after the preceding 12-month period has ended.
5. FMLA eligible employees *(See "Family Medical Leave Act of 1993* in this policy) who will be absent for an adoption or foster care placement of a child, or to care for a child within twelve (12) months of birth (bonding) must initiate a family leave claim.
6. The Family and Medical Leave Act makes it unlawful for any employer to interfere with, restrain, or deny the exercise of any right provided under the FMLA. Furthermore, it is unlawful to discharge or discriminate against any person for opposing any practice made unlawful by the FMLA or for involvement in any proceeding under or relating to the FMLA.
7. While on FMLA leaves of absence, employees remain subject to all changes that may occur in the CIR health care or other benefit programs and are subject to all other employment-related policies.
8. Health insurance is maintained at the level and under the conditions that coverage would have been provided if the employee had continued in employment continuously for the duration of the approved FMLA leave.
9. Duration of Personal Medical Leave – Requests for leaves in excess of the maximum twelve weeks allowable as FMLA leave will not be governed by the FMLA, and will be evaluated in accordance with applicable law and Medical Center policy. The Medical Center reserves the right, consistent with its own policy, practice, applicable law and collective bargaining agreements, to deny requests for leaves that are not governed by the FMLA.

IV. LOA PROCEDURES

The procedures below provide detailed information to initiate a leave of absence claim, extend a leave and to return to work.

A. Notify Program Director

1. Notify program director, as soon as possible, on how you would like to address those needs using sick, vacation, personal time, or other available leave time. Should you choose to use your vacation or holiday time, you do not need to initiate a claim for PFL or New York State Disability as per the instructions below. The CIR Leave form is required for any leave time that exceeds vacation time.

B. Initiate a Claim

1. If the leave is foreseeable (planned in advance) employees must inform the Program Director and Academic Affairs three (3) months prior to the anticipated Leave Date. If the leave is unexpected, such as unexpected illness or injury, employees must notify the Program Director and Academic Affairs as far in advance of the anticipated leave date as possible. Generally, this should be the same day or the next business day of when the employee becomes aware of the need for the leave.
2. Employee must request the Standard Security and HR/CIR LOA forms from Academic Affairs Office [Attachment 1].
3. Employee must submit the Standard Security Claim form directly to Standard Security to confirm if the leave is an eligible leave three (3) months prior to commencing the Leave of Absence. If the leave is unexpected, such as unexpected illness or injury, employees must initiate a leave of absence claim as far in advance of the anticipated leave date as possible. Generally, this should be the same day or the next business day of when the employee becomes aware of the need for the leave.

C. Return to Work

1. Employee must notify his or her supervisor five (5) business days prior to the date that they are scheduled to return to work, or as soon as possible prior to the scheduled return to work.
2. An employee on a personal medical leave must be medically cleared before returning to work. Employee must provide a completed *Medical Substantiation to Return From A Medical Leave* form to Human Resources for review and determination.

V. PAY WHILE ON LEAVE OF ABSENCE

Per the ACGME Institutional Requirements, Residents/Fellows will receive one hundred (100) percent of their salary for the first six weeks of the first qualifying, approved medical, parental, or caregiver leave(s) of absence. Thereafter, time away from work will be unpaid, unless the employee is eligible for compensation through PFL, NYDBL, or the use of accrued sick, vacation or holiday time as per the CIR CBA and applicable law.

VI. RESPONSIBILITY

A. Employees are responsible to:

1. Notify program director or designee of their intent to apply for leave of absence and to initiate a leave claim by following the steps outlined in Section IV ("Procedures") of this policy.
2. Notify program director or designee of their anticipated date of return to work within the time frames specified.
3. Notify program director or designee of a leave extension within the time frames specified.
4. Cooperate in obtaining medical documentation from their or family member's health care provider, which is complete and sufficient.
5. If necessary, cooperate with the process of determining any reasonable work accommodations.

B. Program Directors are responsible to:

1. Sign completed LOA request forms following receipt of such from employees.

2. Ensure that each of its ACGME-accredited programs provides its residents/fellows with accurate information regarding the impact of an extended leave of absence upon the criteria for satisfactory completion of the program and upon a resident's/fellow's eligibility to participate in examinations by the relevant certifying board(s).
3. Contact the employee regarding the status of his or her leave if the employee fails to advise the supervisor of his or her status and return to work expectation.

C. Academic Affairs is responsible to:

1. Provide the Standard Security and CIR/HR Leave forms to a resident/fellow requesting a leave of absence [Attachment 1].
2. Complete and remit *Personnel Change Forms* (PCFs) related to employees' leaves and returns to work as noted in Section IV ("Procedures") of this policy

D. Human Resources is responsible to:

1. Complete and remit to the union the employer section of union disability forms and PFL forms received from employees or insurance carriers.
2. Process PCFs received from departments.
3. Complete voluntary disability forms and no-fault forms received from employees.

E. The Graduate Medical Education Committee is responsible to:

1. Provide oversight of ACGME-accredited programs' implementation of institutional policy(ies) for vacation and leaves of absence, including medical, parental, and caregiver leaves of absence, at least annually; (Core) as detailed in Prof-86.

F. The Sponsoring Institution is responsible to provide support services and develop health care delivery systems to minimize residents'/fellows' work that is extraneous to their ACGME-accredited program(s)' educational goals and objectives, and to ensure that residents'/fellows' educational experience is not compromised by excessive reliance on residents/fellows to fulfill non-physician service obligations. These support services and systems must include: (Core):

1. Institutional processes for ensuring the availability of resources to support residents'/fellows' well-being and education by minimizing impact to clinical assignments resulting from leaves of absence. (Core)

II. CONTROL

The DIO in partnership with the GMEC is responsible for overseeing this policy in compliance in ACGME Institutional Requirement I.B.4.a).(5) ACGME-accredited programs' implementation of institutional policy(ies) for vacation and leaves of absence, including medical, parental, and caregiver leaves of absence, at least annually; (Core)

Kenneth Gibbs
President & CEO

Reference(s): The Family and Medical Leave Act of 1993; New York State Paid Family Leave Law; HR 16 Leaves of Absence for Serious Medical Conditions; HR 63: Reasonable Accommodations for Employees and Applicants; CIR CBA 2022-2025

Department Responsible: Academic Affairs

Attachments: Attachment 1: Leave of Absence Request and Standard Security form

☐Return completed supervisor-signed form via email to JHughes@maimonidesmed.org or fax to 718-635-7484.

LEAVE OF ABSENCE (LOA) REQUEST (*COMPLETE THE HIGHLIGHTED SECTIONS*)

MUST BE COMPLETED BY EMPLOYEE IF TOTAL ABSENCE – PAID OR UNPAID – WILL BE IN EXCESS OF 7 CONSECUTIVE CALENDAR DAYS FOR OWN DISABILITY OR IN EXCESS OF 3 CONSECUTIVE DAYS FOR CARE OF A QUALIFIED FAMILY MEMBER (FMLA) OR 1 DAY FOR PAID FAMILY LEAVE (PFL)

For medical/ PFL leaves, you must first call Standard Security at 800-477-0087; then enter your Standard Security Claim Number here:

#

Employee Name:	**Employee ID:**	**( ) Union:**
Department:	**Title:**	**( ) Non-Union**
Home Phone:	**Work Extension:**	**Mobile Phone:**

Initial Application

Extension Request / Amendment

_____

Specify the date of the LOA Request form that is to be amended

☐ **CONTINUOUS LEAVE** ☐ **INTERMITTENT LEAVE**

Reason For Leave of Absence:

	Own Illness		Union Business		Military
	Care for Qualified Family Member Specify Relationship_____		Educational		FMLA
	Work-Incurred Disability		Care of Service Member		
	Maternity*		Reduced Work Schedule		
	Care for Newborn/Placed Child*		Personal (Non Medical)		

*** You must provide medical information to Standard Security within the 15 days following your leave request. Once you initiate your LOA claim, a Standard Security case manager or leave specialist will communicate the needed information.**

Date of Last Day at Work:	**Requested Leave Start Date:**	**Anticipated Return Date:**

Pay Request

- **For your own continuous or intermittent medical leave**, accrued sick, vacation or holiday time can be used.
- **For Paid Family Leave (PFL)**, accrued sick, vacation or holiday time can be used to supplement payments for an eligible LOA. **CIR members must also apply for PFL through Standard Security.**
- **Personal non-medical leaves** must be submitted to your departmental Program director for approval.

Please list the total number of unused days you currently have to use for your LOA as per your department:

_____**Vacation Days** _____**Holiday Days** _____**Sick Days**

( ) I wish to be paid the following accrued time: ____hours **Vacation** ____hours **Holiday**

Employee: I hereby certify that the information given above is true and correct to the best of my knowledge. I understand that any misrepresentation of the reason for leave or any facts supporting the leave will result in denial of the leave and may result in disciplinary action up to and including termination. I also understand that I am required to return to work once the LOA is no longer approved by Standard Security, or in the case of non-medical leaves, by the approved return to work date noted below, unless the leave is extended and a new leave end date is approved in writing. Unless provided an approved accommodation or an extended leave of absence, if I fail to return to work on or before the leave end date, I will have been deemed to have resigned from my position at Maimonides Medical Center. I understand that I will be required to submit medical updates to remain on an approved leave of absence. **Additionally, I have read and understand the following two policies: ACDM AFFAIRS028 and HR Policy #16. If my request is for a non- medical leave, I have read and understand my CBA**

I understand that if I am out of service for more than the board allows, I will have to extend my time in the training program and sign an Off Cycle Contract to complete training and be eligible to sit for my boards. I also understand that it is my responsibility to inform my Chiefs, Coordinator, and the Academic Affairs office the day I go out on leave, and the day I return from my leave.

Please Note- You will be evaluated by the Program Director and PEC to assess where you are in the program and ensure all requirements are met for graduation. This will determine if you need to make any educational time up after your Leave.

Employee Signature:_____ **Date:** _____

Program Director: I acknowledge receipt of my employee's leave of absence request.

Program Director's Signature:_____ **Date of Acknowledgement:** _____

Please remember to remit a PCF to HR at HR_LOA (with the employee's requested accrued time pay.)

FOR NON-MEDICAL LEAVES ONLY (PERSONAL, EDUCATIONAL, MILITARY)

PROGRAM DIRECTOR – PLEASE COMPLETE THIS SECTION WITHIN 2 DAYS OF RECEIPT FROM EMPLOYEE

( ) Requested leave is approved	**Leave to begin on:** _____	**Expected return to work is:**_____
( ) Requested leave is denied	**Reason for denial**	

Program Director's Name & Signature	**Date**	**Program Director's Telephone Number**
Department Head's Name & Signature	**Date**	

STANDARD SECURITY
LIFE INSURANCE COMPANY

If you are pre-filing your PFL claim and are still working, your employer should ***not*** complete their section of the claim form (PFL-1B).

TYPE OF LEAVE / Who is filing	FORMS TO BE COMPLETED AND FILED WITH CARRIER	CERTIFICATION REQUIRED **IN ADDITION TO CLAIM FORMS*
BONDING WITH CHILD **Birth mother filing**	PFL 1 (REQUEST FOR PAID FAMILY LEAVE) A. EMPLOYEE COMPLETES B. EMPLOYER COMPLETES PFL 2 (BONDING CERTIFICATION) EMPLOYEE COMPLETES	(1) INFANT'S BIRTH CERTIFICATE; OR (2) IF A BIRTH CERTIFICATE IS UNAVAILABLE, DOCUMENTATION OF PREGNANCY OR BIRTH FROM A HEALTH CARE PROVIDER THAT INCLUDES THE MOTHER'S NAME AND THE CHILD'S DUE OR BIRTH DATE.
BONDING WITH CHILD **Other parent filing**	PFL 1 (REQUEST FOR PAID FAMILY LEAVE) A. EMPLOYEE COMPLETES B. EMPLOYER COMPLETES PFL 2 (BONDING CERTIFICATION) EMPLOYEE COMPLETES	(1) IF AVAILABLE, A BIRTH CERTIFICATE THAT NAMES THE PARENT REQUESTING LEAVE; (2) IF PARENT IS NOT NAMED ON THE BIRTH CERTIFICATE, A VOLUNTARY ACKNOWLEDGMENT OF PATERNITY OR COURT ORDER OF FILIATION; (3) IF THE DOCUMENTS IN (1) OR (2) ARE NOT AVAILABLE, THEN THE EMPLOYEE MUST PROVIDE (A) A COPY OF DOCUMENTATION OF PREGNANCY OR BIRTH FROM A HEALTH CARE PROVIDER THAT INCLUDES THE MOTHER'S NAME AND THE CHILD'S DUE OR BIRTH DATE, AND (B) A SECOND DOCUMENT VERIFYING THE PARENT'S RELATIONSHIP WITH THE BIRTH MOTHER (I.E., MARRIAGE CERTIFICATE, CIVIL UNION DOCUMENTS, OR DOMESTIC PARTNER DOCUMENTS). (4) IF THE DOCUMENTS IN (B) ARE NOT AVAILABLE, A PARENT MAY SUBMIT OTHER DOCUMENTARY EVIDENCE OF PARENTAL RELATIONSHIP FOR EVALUATION ON A CASE-BY-CASE BASIS.
BONDING WITH CHILD **Foster parent filing**	PFL 1 (REQUEST FOR PAID FAMILY LEAVE) A. EMPLOYEE COMPLETES B. EMPLOYER COMPLETES PFL 2 (BONDING CERTIFICATION) EMPLOYEE COMPLETES	(1) LETTER OF FOSTER CARE PLACEMENT ISSUED BY COUNTY OR CITY DEPARTMENT OF SOCIAL SERVICES OR LOCAL VOLUNTEER AGENCY. (2) IF THE EMPLOYEE IS NOT NAMED IN THE PLACEMENT DOCUMENT, THE EMPLOYEE SHOULD SUBMIT: (A) A COPY OF THE DOCUMENT DEMONSTRATING PLACEMENT, AND (B) A SECOND DOCUMENT VERIFYING THE RELATIONSHIP TO THE PARENT NAMED IN THE DOCUMENT (I.E., MARRIAGE CERTIFICATE, CIVIL UNION DOCUMENTS, OR DOMESTIC PARTNERSHIP DOCUMENTS).
BONDING WITH CHILD **Adoptive parent filing**	PFL 1 (REQUEST FOR PAID FAMILY LEAVE) A. EMPLOYEE COMPLETES B. EMPLOYER COMPLETES PFL 2 (BONDING CERTIFICATION) EMPLOYEE COMPLETES	(1) COURT DOCUMENT INDICATING THAT ADOPTION IS IN PROCESS OR IS BEING FINALIZED, OR (2) FOR LEAVE TAKEN PRIOR TO ADOPTION, A DOCUMENT DEMONSTRATING THAT THE ADOPTION PROCESS IS UNDERWAY, INCLUDING BUT NOT LIMITED TO, A SIGNED STATEMENT FROM AN ATTORNEY, ADOPTION AGENCY, OR ADOPTION RELATED SOCIAL SERVICE PROVIDER THAT THE EMPLOYEE IS IN THE PROCESS OF ADOPTING A CHILD. (3) IF THE SECOND PARENT IS NOT NAMED IN THE DOCUMENTS REFERENCED IN (1) AND (2) ABOVE, THE EMPLOYEE MUST PROVIDE: (A) A COPY OF THE DOCUMENT DEMONSTRATING ADOPTION, AND (B) A SECOND DOCUMENT VERIFYING THE RELATIONSHIP TO THE PARENT NAMED IN THE DOCUMENT (I.E. MARRIAGE CERTIFICATE, CIVIL UNION DOCUMENTS, OR DOMESTIC PARTNERSHIP DOCUMENTS).

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. The employee then provides the form to the employer to complete Part B.
- The employer completes Part B of the *Request For Paid Family Leave (Form PFL-1)* and returns it to the employee within three days.
- Additional forms are required depending on the type of leave being requested. The employee requesting leave is responsible for the completion of these forms.
- **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)

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
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)*.

Form PFL-1 Instructions continued on next page

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

Form PFL-1 Instructions continued from prior page

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/2010/soc_alph.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 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.

NEW YORK STATE | Paid Family Leave

Standard Security Life Insurance Company
P.O. Box 25339, Farmington, NY 14425
Phone: 800-477-0087 | Fax: 585-398-2854
Email: claims@sslicny.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 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

Standard Security Life Insurance Company P.O. Box 25339, Farmington, NY 14425
Phone: 800-477-0087 | Fax: 585-398-2854 | Email: claims@sslicny.com

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

22. Do you want a 10% Federal Tax Deduction taken from your PFL benefit? ☐ Yes ☐ No **If you choose no, you will receive the total gross benefit.**

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.

Standard Security Life Insurance Company P.O. Box 25339, Farmington, NY 14425
Phone: 800-477-0087 | Fax: 585-398-2854 | Email: claims@sslicny.com

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 (☐☐☐) ☐☐☐ - ☐☐☐☐

5a. Employer's contact fax number (☐☐☐) ☐☐☐ - ☐☐☐☐

6. Employer's contact email address _____

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

7a. Last day employee worked: (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

8. Employee's occupation Codes are available at: www.bls.gov/soc/2010/soc_alph.htm ☐☐ - ☐☐☐☐

8a. Indicate occupation (code MUST be provided also): _____

8b. Indicate the employee's normal work days ☐ Mon. ☐ Tues. ☐ Wed. ☐ Th. ☐ Fri. ☐ Sat. ☐ Sun.

8c. Is the employee considered Full time (Normal work schedule is 20 hours or more a week) **or Part time** (Normal work schedule is less than 20 hours per week)? ☐ FT ☐ PT

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

10a. If yes, what time period are you requesting reimbursement for? From _____ **To:** _____

Form PFL-1 continued on next page

Standard Security Life Insurance Company P.O. Box 25339, Farmington, NY 14425
Phone: 800-477-0087 | Fax: 585-398-2854 | Email: claims@sslicny.com

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 / 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: **Standard Security Life Insurance Company**

Mailing address: **P.O. Box 25339**

City, State: **Farmington, NY** | Zip code: **14425** | Country (if not U.S.A.)

14. PFL insurance carrier's telephone number (8 0 0) 4 7 7 - 0 0 8 7

14a. PFL insurance carrier's fax number (5 8 5) 3 9 8 - 2 8 5 4 **14b. Email:** claims@sslicny.com

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) Instructions

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/Certification	Description
Health care provider certification of pregnancy	An **original** letter obtained from the birth mother's health care provider that certifies pregnancy. It should include the mother's name and the expected due date.
Health care provider certification of birth	An **original** letter obtained from the birth mother's health care provider that includes the mother's name and child's date of birth.
Birth Certificate	A **copy** of the certificate issued by the city or county office in which the child is born.
Voluntary Acknowledgment of Paternity (Form LDSS-4418)	A **copy** of the form that establishes legal fatherhood when the parents are unmarried. Completed by both mother and father. For more information, see childsupport.ny.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.

NEW YORK STATE | Paid Family Leave

Standard Security Life Insurance Company
P.O. Box 25339, Farmington, NY 14425
Phone: 800-477-0087 | Fax: 585-398-2854
Email: claims@sslicny.com

Request For Paid Family Leave
Bonding Certification (Form PFL-2)

INSTRUCTIONS INCLUDED WITH FORM

TO BE COMPLETED BY THE EMPLOYEE

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

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

Other last names, if any, under which employee has worked

Employee's Social Security Number or TIN - -

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** ☐ Male ☐ Female ☐ Not designated/Other
3. **Does child live with the employee requesting PFL?** ☐ Yes ☐ No
4. **Child is employee's:** ☐ Biological child ☐ Stepchild ☐ Foster child ☐ Adopted child ☐ Legal ward ☐ Spouse/Domestic partner's child
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

Standard Security Life Insurance Company P.O. Box 25339, Farmington, NY 14425
Phone: 800-477-0087 | Fax: 585-398-2854 | Email: claims@sslicny.com

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)

__ __ / __ __ / __ __ __ __

STANDARD SECURITY
LIFE INSURANCE COMPANY

CLAIMANT: READ THESE INSTRUCTIONS CAREFULLY

PLEASE NOTE: Do not date and file this form prior to your first date of disability. In order for your claim to be processed, Parts A, B and C must be completed.

1. If you are using this form because you became disabled **while employed** or you became disabled **within four (4) weeks after termination of employment**, your completed claim should be mailed **within thirty (30) days of your first date of disability to your employer or your last employer's insurance carrier.** You may find your employer's disability insurance carrier on the Workers' Compensation Board's website, www.wcb.ny.gov, using Employer Coverage Search.

2. If you are using this form because you became **disabled after having been unemployed for more than four (4) weeks**, your completed claim MUST be mailed to: **Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029.** If you answered "Yes" to question 13.B.3, please complete and attach Form DB-450.1.

If you do not receive a response from us within 45 days or if you have questions about your disability benefits claim, please call our office at (800) 477-0087. For general information about disability benefits, please visit www.wcb.ny.gov or call the Board's Disability Benefits Bureau at (877) 632-4996.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a). The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 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 claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. 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

HIPAA NOTICE - In order to adjudicate a workers' compensation claim or disability benefits claim, WCL 13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the insurance carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

Disclosure of Information: The Board will not disclose any information about your case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized part, you must file with the Board an original signed Form OC-110A "Claimants Authorization to Disclose Workers' Compensation Records." This form is available on the WCB website (www.wcb.ny.gov) and can be accessed by clicking the "Forms" link. If you do not have access to the internet please call (877) 632-4996 or visit our nearest Customer Service Center to obtain a copy of the form. In lieu of Form OC-110A, you may also submit an original signed, notarized authorization letter.

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

STANDARD SECURITY
LIFE INSURANCE COMPANY
P.O. Box 25339
Farmington, NY 14425
phone 800-477-0087
claims@sslicny.com

New York State
NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

You must answer all questions in Part A and questions 1 through 3 in Part B. Health care providers must complete Part B on page 2. Employer must complete part C.

PART A - CLAIMANT'S INFORMATION (**Please Print or Type**)

1. First Name: _____ Last Name: _____ MI: ___
2. Mailing Address (Street & Apt. #): _____
   City: _____ State: _____ Zip: _____
3. Daytime Phone #: _____ Email Address: _____
4. Social Security #: ___ / ___ / _____ 5. Date of Birth: ___ / ___ / _____ 6. Gender: ☐ M ☐ F ☐ X
7. Describe your disability (if injury, also state how, when, and where it occurred): _____
   _____
8. Date you became disabled: ___ / ___ / _____ Did you work on that day?: ☐ Yes ☐ No
   Have you recovered from this disability?: ☐ Yes ☐ No If Yes, date you were able to return to work: ___ / ___ / _____
   Have you since worked for wages or profit?: ☐ Yes ☐ No If Yes, list dates: _____
9. Name of last employer prior to disability. If more than one employer in previous eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in last eight (8) weeks worked.

LAST EMPLOYER PRIOR TO DISABILITY			PERIOD OF EMPLOYMENT		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
OTHER EMPLOYER (during last eight (8) weeks)			**PERIOD OF EMPLOYMENT**		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
			Mo. Day Yr.	Mo. Day Yr.	

10. My job is or was: _____ (Occupation) 11. Union Member: ☐ Yes ☐ No If "Yes": _____ (Name of Union or Local Number)
12. Were you claiming or receiving unemployment prior to this disability? ☐ Yes ☐ No
    If you did **not** claim or if you claimed but did **not** receive unemployment insurance benefits *after* LAST DAY WORKED, explain reasons fully: _____
    _____
    If you did receive unemployment benefits, provide all periods collected: _____
    _____
13. For the period of disability covered by this claim:
    A. Are you receiving wages, salary or separation pay? ☐ Yes ☐ No
    B. Are you receiving or claiming:
    1. Unemployment Benefits ☐ Yes ☐ No 2. Paid Family Leave? ☐ Yes ☐ No
    3. Workers' compensation for work-connected disability? ☐ Yes ☐ No
    4. No-Fault motor vehicle accident? ☐ Yes ☐ No **or** personal injury involving third party? ☐ Yes ☐ No
    5. Long-term disability benefits under the Federal Social Security Act for ***this*** disability: ☐ Yes ☐ No

    IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 13, COMPLETE THE FOLLOWING:
    I have: ☐ received ☐ claimed from _____ for the period: ___ / ___ / _____ to: ___ / ___ / _____
14. In the year (52 weeks) before your disability began, have you received disability benefits for other periods of disability? ☐ Yes ☐ No
    If yes, Paid by: _____ from: ___ / ___ / _____ to: ___ / ___ / _____
15. In the year (52 weeks) before your disability began, have you received Paid Family Leave? ☐ Yes ☐ No
    If yes, Paid by: _____ from: ___ / ___ / _____ to: ___ / ___ / _____
16. If you became disabled while employed or within four weeks of your last day worked, did your employer provide you with your rights under Disability Law within 5 days of your notice or request for disability forms? ☐ Yes ☐ No

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. The foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

_____ **Claimant's Signature** _____ **Date**

An individual may sign on behalf of the claimant only if he or she is legally authorized to do so and the claimant is a minor, mentally incompetent or incapacitated. If signed by other than claimant, print information below and complete and submit Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records.

_____ **On behalf of Claimant** _____ **Address** _____ **Relationship to Claimant**

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY. THE ATTENDING HEALTH CARE PROVIDER SHALL COMPLETE AND RETURN TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF RECEIPT OF THIS FORM. For item 7-d, you must give estimated date. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 9. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS**.

1. Last Name: _____ First Name: _____ MI: __

2. Gender: ☐ M ☐ F ☐ X 3. Date of Birth: ___ / ___ / _____

4. Diagnosis/Analysis: _____ Diagnosis Code: _____

a. Claimant's symptoms: _____

b. Objective findings: _____

5. Claimant hospitalized?: ☐ Yes ☐ No From: ____ / ____ / _____ To: ____ / ____ / _____

6. Operation indicated?: ☐ Yes ☐ No a. Type _____ b. Date ____ / ____ / _____

7. ENTER DATES FOR THE FOLLOWING	MONTH	DAY	YEAR
a. Date of your first treatment for this disability			
b. Date of your most recent treatment for this disability			
c. Date Claimant was unable to work because of this disability			
d. Date Claimant will again be able to perform work (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)			
e. If pregnancy related, please check box and enter the date ☐ estimated delivery date OR ☐ actual delivery date			

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease?:
☐ Yes ☐ No If "Yes", has Form C-4 been filed with the Board? ☐ Yes ☐ No

I certify that I am a:

_____ _____ _____
(Physician, Chiropractor, Dentist, Podiatrist, Psychologist, Nurse-Midwife) **Licensed or Certified in the State of** **License Number**

_____ _____ _____
Health Care Provider's Printed Name **Health Care Provider's Signature** **Date**

_____ _____
Health Care Provider's Address **Phone #**

Part C - EMPLOYER'S STATEMENT

1. Employee's Name: _____ **2.** Soc. Sec. #: ☐☐☐ ☐☐ ☐☐☐☐

3. Employee's Address: _____
Number Street Apartment Number City / Town State Zip Code

4. Employee's Occupation: _____ **5.** Date of Hire: _____ **6.** Status: ☐ Full Time ☐ Part Time

7. Is the Claimant an: ☐ Employee ☐ Owner ☐ High School Student **7a.** Date of Birth _____

8. Indicate the employee's normal work schedule: ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

9. If the employee is no longer in your employ, explain why: ☐ Quit ☐ Fired ☐ Laid Off ☐ Other (explain) _____

10. Date Employee last worked: _____ **10a.** Do you expect to rehire him/her? ☐ YES ☐ NO

11. Date Employee returned to work: _____

12. Are you paying wages or sick time: ..... ☐ YES ☐ NO

a. If **YES,** time period paid: _____

b. Are you requesting reimbursement for this time period? ..... ☐ YES ☐ NO

13. Is Employee receiving or claiming Unemployment Ins? ..... ☐ YES ☐ NO

14. Is Employee receiving or claiming Workers' Comp. Ins? ..... ☐ YES ☐ NO

15. Did this Disability occur as a result of employment? ..... ☐ YES ☐ NO

16. Is Employee in a Union proving **MONETARY DISABILITY BENEFITS?** ..... ☐ YES ☐ NO

17. Are you aware of other employment claimant may have? ..... ☐ YES ☐ NO

18. Has the employee received DBL or PFL benefits within the past 52 weeks? ☐ YES ☐ NO

19. TAXABLE PERCENTAGE _____ % (If blank or not a %, we will tax at 100%)

POLICY NUMBER: _____

Weekly Wages 8 Weeks prior to Last Day Worked Before Disability
(include value of Board, Lodging, and Tips if any)

	Week Ending Month Day Year	No. of Days Worked	GROSS WEEKLY WAGES
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
		TOTAL	

EMPLOYER INFORMATION:

Employer Name: _____ Employer Address: _____

Phone: _____ Fax: _____ E-mail: _____

Print Name: _____ Sign: _____ Title: _____ Date: _____

After Parts A, B, & C are COMPLETED, Do one of the following: SSLICNY Phone: 800-477-0087 or 585-398-2340

Mail to: SSLICNY, P.O. Box 25339 Farmington, NY 14425 or Fax to: 585-398-2854 or E-mail to: claims@sslicny.com