firstreliancestandard
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Reset

New York Paid Family Leave
Initial Statement of Claim

HOW TO FILE A CLAIM

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

NEW YORK STATE

Paid Family Leave

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

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

1. **Employee's legal name (first name, middle initial, last name)**
_____

2. **Other last names, if any, under which employee has worked**
_____

3. **Employee's mailing address**
Street address_____
City, State _____
Zip code _____ Country *(if not U.S.A)* _____

4. **Employee's Social Security Number or TIN**
_____

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

6. **Employee's primary telephone number**
(___ ___)_____

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

8. **Employee's gender**
☐ Male ☐ Female ☐ Not designated/Other

9. **Employee's preferred language**
☐ English ☐ Español ☐ Русский ☐ Polski
☐ 中文 ☐ Italiano ☐ Kreyòl ayisyen ☐ 한국어
☐ Other

Optional (for research purposes)

10. Employee's ethnicity/race
For purposes of health demographic only. (U.S. Centers for Disease Control and Prevention (CCDC) code set, Version 1.0).
Is employee of Hispanic, Latino/a or Spanish origin?

(One of more categories may be selected)

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

What is employee's race?

(One or more categories may be selected

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

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

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

12. The family member is employee's:

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

CONTINUED FROM PRIOR PAGE

TO BE COMPLETED BY THE EMPLOYEE

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

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

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

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

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

☐ Periodic: Identify dates periodic PFL will be taken _____ ☐ Dates are estimated

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

_____

_____

Employment Information (to be completed by the employee)

15. Business name

_____

16. Employee's date of hire _____ (MM/DD/YYYY)

17. Employee's work location

Street address_____

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

18. Employee's average gross <u>weekly</u> wage (This data will be requested of both employee and employer) _____

19. Employer's telephone number for contact regarding this request (_____)_____

20a. Does the employee have more than one employer? ☐ **Yes** ☐ **No**

20b. If yes, is employee taking PFL from the other employer? ☐ **Yes** ☐ **No**

21. Is employee currently receiving Workers' Compensation Lost Wage Benefits? ☐ **Yes** ☐ **No**

Disclosure statement: Information regarding PFL benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Declaration and signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for Insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, Information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employee's signature _____ Date signed _____

CONTINUED FROM PRIOR PAGE

TO BE COMPLETED BY THE EMPLOYEE

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

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

PART B – EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address

Business name _____

Mailing address _____

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

2. Employer's FEIN _____ **STD Policy No.** _____

PFL/DBL Policy No. _____

3. Employer's Standard Industrial Classification (SIC) Code _____

4. Employer's contact name for questions related to PFL _____

5. Employer's contact telephone number (_____) _____

6. Employer's contact email address _____

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

8. Employee's occupation _____

Codes are available at: www.bls.gov/soc/2020/soc_alph.htm _____

9. Enter the last 8 weeks of gross wages for the employee and calculate the average gross weekly wage

Week no.	Week ending date (MM/DD/YYYY)	Number of days worked	Gross amount paid
1			
2			
3			
4			
5			
6			
7			
8			
Calculated average weekly wage			

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

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

11a. In the preceding 52 weeks has the employee taken leave for:
☐ **NYS Disability** ☐ **Both Disability and PFL** ☐ **None**

11b. Enter the total number of weeks and days taken for both Disability and PFL in the last 52 weeks.

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

Weeks: _____ Please provide specific dates to Disability _____

PFL:

Days: _____

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

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

13. PFL Insurance carrier's name and mailing address:

PFL insurance carrier's name: _____

Mailing address_____

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

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

15. PFL policy number _____

Declaration and signature

☐ **I affirm the employee regularly works 20 or more hours per weeks and has been in employment for at least 26 consecutive weeks OR the employees regularly works less than 20 hours per week and has worked at least 175 days.**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for Insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, Information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employer signature **Date signed**

_____ _____

Title

_____

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

☐ Yes Set-up Direct Deposit

Name of Bank (Print) _____

Address of Bank _____

City _____ State _____ Zip_____

Choose Type of Account

☐ Checking ☐ Savings

Bank Transit/Routing Number (9 Digits) _____

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

Any person who knowingly and with intent to defraud any insurance company or other person files an application for Insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, Information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation

Employee's Signature	Telephone Number	Date
_____	(___)_____	_____

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

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

- If an employee is requesting 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 Infor*mation *Under The Paid Family Leave Law (Form PFL-3)* and submit it to their health 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 the employee seeking 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.

- The employee requesting PFL submits 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 their employer's PFL insurance carrier, or to their employer if the employer is self-insured, for PFL determination.

  NOTE: This form will be retained by the health care provider. The employee should make a copy for their 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).

Employee enters their name, and care recipient's (patient's) name and date of birth at the top of each page.

The PFL insurance carrier name requested at the top of the form is the same as the PFL insurance carrier 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 tax identification number, is derived from the Board's administrative authority under Workers' Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

Paid Family Leave

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 initial, last name) Care recipient's (patient's) date of birth

_____ _____
(MM/DD/YYYY)

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, _____, authorize my health care provider listed on this form to release my personal
Care recipient's (patient's) name

Information to _____ and their employer's PFL insurance
Employee's name

Carrier _____.
PFL Insurance Carrier's name

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 this 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*

3. Health care provider's telephone number (*provide area or country code)*

_____

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

_____ _____
(MM/DD/YYYY)

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.

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 results of my current condition.*

Care recipient's signature Date signed (MM/DD/YYYY)

_____ _____

Authorized representative

I, _____ represent the care recipient in this matter as authorized by:
Print Name

☐ Parental right ☐ Power of attorney *(attach copy)* ☐ Court order *(attach copy*) ☐ Health care proxy *(attach copy*)

Authorized representative signature Date signed (MM/DD/YYYY)

_____ _____

The employee should retain a copy for their own records

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

The employees requesting 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:

- Employee enters their name, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, mailing address, and care recipient's (patient's) name and date of birth at the top of page 1.
- Employee enters their name and date of birth, and care recipient's (patient's) name and date of birth at the top of page 2.
- Employee gives 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 A FAMILY MEMBER WITH A 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.

Patient information / 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)*

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.

Employee:

- When you receive the completed *Health Care Provider Cerfication for Care of Family Member with Serious Health Condition (form PFL-4)* form from the health care provider, send the completed forms and supporting documentation to the insurance carrier.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 o(5 USC 552a)

The Workers' Compensation Board's (Board's) authority to request that employees provide personal information, including their social security 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.

Paid Family Leave

Request for Paid Family Leave
Health Care Provider Certification For Care of Family Member With Serious Health Condition (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 _____

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 A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

Patient information / 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)*

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 requires care _____Days/week OR _____Days/month**

Health Care Provider Information (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

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

_____

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 A FAMILY MEMBER WITH A 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) ☐ Dentist (DDS/DDM) ☐ Licensed Social Worker (LMSW/:CSW)

☐ Doctor of Oseopathy (DO) ☐ Physician's Assistant (PA) ☐ Other (specify) _____

☐ Doctor of Podiatric Medicine (DPM ☐ Nurse Practioner (NP)

☐ Doctor of Chiropractic Medicine (DPC) ☐ Licensed Psychologist

10. Health care provider's mailing address

_____
Mailing address

_____ _____ _____
City, State *Zip* *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 knowlingly 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 thate 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 with my licensed scope of practice.

Heath care provider's signature _____ Date signed _____