

Lincoln Life & Annuity Company of New York
Service Office Address: PO Box 2609, Omaha, NE 68103-2609
Home Office: Syracuse, NY
Toll free (800) 423-2765 Fax (877) 843-3950
www.LincolnFinancial.com
disabilityclaims@lfg.com

LF PFL-1 PART A - EMPLOYEE INFORMATION (to be completed by employee)

The employee requesting leave is responsible for the completion of these forms.

The employee requesting PFL must complete Part A of the **Request for Paid Family Leave (Form LF 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 employee submits the completed **Request For Paid Family Leave (Form LF PFL-1)** with the completed **Bonding Certification (Form LF PFL-2)** attached to Lincoln Life & Annuity Company of New York using the address; fax number, or email address above. The employee should retain a copy of each submitted form for their records.

1. Employee's legal name: (first, middle, last) _____ / _____ / _____

2. Employee's address:

3. Employee's Social Security number:

Street Address

4. Employee's date of birth:

City

State

Zip Code

5. Employee's primary telephone number: _____ - _____ - _____

6. Employee's email address: _____

7. Employee's gender: Male Female Not designated / Other

8. Employee's preferred language: English Español Polski Italiano Kreyòl ayisyen
 Русский 中文 한국어 Other _____

9a. Reason for PFL request: Newborn Bonding Adoption Bonding Foster Care Bonding
 Military Leave Family Care

9b. The family member is the employee's: Child Spouse Domestic Partner Parent
 Parent-in-law Grandparent Grandchild

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

Continuous Dates are estimated

PFL start date (MM/DD/YYYY) ____ / ____ / ____ PFL end date (MM/DD/YYYY) ____ / ____ / ____

Intermittent Dates are estimated

Identify dates Intermittent PFL will be taken: _____

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

TO BE COMPLETED BY THE EMPLOYEE

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

Date of birth: (MM/DD/YYYY)

_____/_____/_____
First Middle Last

12. Business Name: _____

13. Employee's date of hire: ____/____/____

14. Employee's work location:

Street Address

City

State

Zip Code

15a. Does employee have more than one employer? Yes No

15b. If yes, is employee taking PFL from the other employer? Yes No

16. 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 NY 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)

Payment Method

If your claim is approved, payments will be sent in the form of a check, or you may choose to receive your payment through Direct Deposit (electronic funds transfer). This will eliminate mail delays and ensure your payment is deposited directly into your bank account on the date it is due each month. You may not be charged any fees for services that are necessary to access your benefits in full.

You also may elect Direct Deposit at any time by calling (800) 423-2765, or by going to our website, www.Lincoln4Benefits.com.

Please indicate your preferred method of payment for your benefits:

Check Direct Deposit

For Payment Method Direct Deposit

Financial Institution's name : _____

Type of Account Checking Savings

Bank Routing Number: _____

Account Number: _____

Signature: _____ Date: ____/____/____

Lincoln Life & Annuity Company of New York
Service Office Address: PO Box 2609, Omaha, NE 68103-2609
Home Office: Syracuse, NY
Toll free (800) 423-2765 Fax (877) 843-3950
www.LincolnFinancial.com
disabilityclaims@lfg.com

LF PFL-1 PART B - EMPLOYER INFORMATION (to be completed by the employer)

The employer of the employee requesting PFL must complete all information in Part B. Employer signs and dates, and then returns to the employee requesting PFL within three business days.

Employee's name: (first name, middle name, last name) Date of birth: (MM/DD/YYYY)
_____/_____/_____/_____/_____/_____
First Middle Last

1. Business's full legal name and mailing address:

Business Name

Street Address

City

State

Zip Code

NY Statutory Disability/Paid Family Leave Policy Number: _____

Claim Location Number: _____

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 https://www.bls.gov/oes/current/oes_stru.htm _____

TO BE COMPLETED BY THE EMPLOYEE

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

Date of birth: (MM/DD/YYYY)

_____/_____/_____/_____/_____/_____
First Middle Last

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

11a. In the preceding 52 weeks has the employee taken leave for:

- NY Statutory Disability PFL Both NY Statutory Disability and PFL None

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

NOTE: The maximum number of weeks available for NY 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 NY Statutory Disability and PFL during the preceding 52 weeks.

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

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

12. Is the employee taking leave under the federal Family Medical Leave Act (FMLA) concurrently with PFL? Yes No

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

LF PFL-2 BONDING CERTIFICATION (to be completed by the employee)

1. Employee's legal name: (first, middle, last) _____ / _____ / _____

2. Employee's address:

3. Employee's Social Security number:

Street Address

4. Employee's date of birth:

City State Zip Code

____ / ____ / ____

Child's Name: (first, middle, last) _____ / _____ / _____

1. Child's date of birth: ____ / ____ / ____

2. Child's gender: Male Female Not designated / Other

3. Child is employee's: Biological child Step child Foster child Adopted child Legal ward
 Spouse/Domestic partner's child In Loco Parentis

4. Select one of the following and attach the document as required as evidence of the relationship:

PLEASE DO NOT SEND ORIGINALS

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

5. Date of foster care or adoption placement, if applicable (MM/DD/YYYY) : ____ / ____ / ____

TO BE COMPLETED BY THE EMPLOYEE

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

Date of birth: (MM/DD/YYYY)

_____/_____/_____/_____/_____/_____
First Middle Last

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 NY 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)