Lincoln Financial Group®

Request For NY Paid Family Leave (LF PFL-1)
Release of Personal Health Information (LF PFL-3)
Health Care Provider Certification For Care Of Family Member With Serious Health Condition (LF PFL-4)

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.

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 Information Under The Paid Family Leave Law (Form LF PFL-3)*** and submit it to their health care provider, along with a copy of the ***Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form LF PFL-4).*** The employee requesting PFL submits both the ***Request For Paid Family Leave (Form LF PFL-1)*** and the ***Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form LF PFL-4)*** 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:

_____
Street Address

_____
City State Zip Code

3. Employee's Social Security number:

_____

4. Employee's date of birth:

_____ /_____ /_____

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. I

-

-

-

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: _____ /_____ /_____

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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 address:

_____
Business Name

_____
Street Address

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

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 employer)

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

Enter the 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.

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
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**

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

10a. Are wages being continued during PFL? ☐ Yes ☐ No

If yes, ☐ Salary Continuance ☐ Sick Pay ☐ Vacation ☐ PTO

Beginning Date: _____ /_____ /_____ Ending Date: _____ /_____ /_____ Weekly Amount Paid _____

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

NOTE: When requested, reimbursement is payable to the employer. Failure to select "Yes" for requesting reimbursement from Lincoln Life & Annuity Company of New York will result in a waiver of the right to reimbursement.

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 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

_____
Title

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LF PFL-3 RELEASE OF PERSONAL HEALTH INFORMATION UNDER THE PAID FAMILY LEAVE LAW

(to be completed by the care recipient or authorized representative)

Before completing and signing, the care recipient or authorized representative must read the ***Release Of Personal Health Information Under The Paid Family Leave Law (Form LF PFL-3)*** in its entirety before signing and dating. 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 LF PFL-4).***

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.

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

Care recipient's (patient's) name: (first name, middle, last name) Date of birth: (MM/DD/YYYY)

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

I, _____, authorize my health care provider listed on this form to release my personal health information to _____ and Lincoln Life & Annuity Company of New York.
Care Recipent's Name
Employee'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 relates 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

Identify the health care provider who is currently providing you with treatment for a condition that is subject to the employee's request for PFL benefits.

1. Health Care Provider's Name:

_____

2. Health Care Provider's Address:

_____
Street Address

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

3. Health Care Provider's Telephone Number:

_____ - _____ - _____

TO BE COMPLETED BY THE EMPLOYEE

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

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

Care Recipient Information

4. Care Recipient's Address:

_____
Street Address

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

5. Care Recipient's Social Security Number:

_____

6. Care Recipient's telephone number:

_____ - _____ - _____

READ AND SIGN BELOW.

I hereby request that the health care provider listed above give a completed ***Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form LF PFL-4)*** to the employee identified on the LF PFL-4 form. I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and any estimation of the amount of care that I require from the employee requesting PFL benefits as a result of my current condition.

_____ _____ /_____ /_____
Care Recipient's Signature Date (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 (MM/DD/YYYY

The employee should retain a copy for his or her own records.

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LF PFL-4 Health Care Provider Certification For Care Of A 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 below)

TO BE COMPLETED BY THE EMPLOYEE

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

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

Last 4 digits of employee's Social Security number (or TIN) _____

Employee's address

_____
Street Address

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

Care recipient's (patient's) name (first name, middle, last name): Patient's Date of Birth (MM/DD/YYYY)

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

As the patient's health care provider, you must complete all applicable requested information unless noted as optional. 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.

1. Does patient require care by the employee requesting Paid Family Leave (PFL)?

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.

☐ Yes ☐ No (If no, skip to "Health Care Provider Information".)

2. Primary ICD-10 Code: _____ 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 _____

TO BE COMPLETED BY THE EMPLOYEE

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

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

Care recipient's (patient's) name: (first name, middle, last name) Date of birth: (MM/DD/YYYY)

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

Health Care Provider Information

8. Health care provider's name

_____

9. Health care provider's mailing address

_____
Mailing Address

_____
City State Zip Code Country (if not USA)

10. Type of health care provider:

- ☐ Medical Doctor (MD)
- ☐ Doctor of Osteopathy (DO)
- ☐ Doctor of Podiatric Medicine (DPM)
- ☐ Doctor of Chiropractic Medicine (DC)
- ☐ Dentist (DDS/DDM)
- ☐ Physician's Assistant (PA)
- ☐ Nurse Practitioner (NP)
- ☐ Licensed Psychologist
- ☐ Licensed Social Worker (LMSWLCSW)
- ☐ Other (specify) _____

10. Health care provider's telephone number (provide area or country code): _____ - _____ - _____

11. Health care provider's fax number (provide area or country code): _____ - _____ - _____

12. Health care provider's email address (if available):_____

13. State or country (if not U.S.A.) in which health care provider is licensed to practice: _____

14. Specialty:_____

15. Health care provider's license number:_____

Certification and Signature

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

My signature attests that the information I have provided in this form is based on my professional assessment within my licensed scope of practice.

_____ _____ /_____ /_____
Health Care Provider's Signature Date Signed (MM/DD/YYYY)