Guardian® | NEW YORK STATE Paid Family Leave

Request For Paid Family Leave
(Form PFL-1)

Plan # _____

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 Member ID /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

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

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For assistance, please call (800) 268-2525   Fax (610) 807-2950
Paid_Family_Leave@glic.com   www.ny.gov/PaidFamilyLeave

Plan # _____

TO BE COMPLETED BY THE EMPLOYEE

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

_____

Employee's social security # _____

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

☐☐ / ☐☐ / ☐☐☐☐

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

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

☐ Continuous

PFL start date (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

PFL end date (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

☐ Dates are estimated

☐ Periodic

☐ Dates are estimated

Identify dates periodic PFL will be taken:

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

Employment Information (to be completed by the employee)

15. Business name

_____

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

17. Employee's work location

Street address

City, State

Zip code

Country (if not U.S.A.)

18. Employee's average gross _weekly_ wage (This data will be requested of both employee and employer) _____

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

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

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

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

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

| Guardian Specific Information | Normal work schedule: | MON ☐ | TUES ☐ | WED ☐ | THURS ☐ | FRI ☐ | SAT ☐ | SUN ☐ | _____ HOURS/DAY _____ HOURS/WEEK |

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.

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Plan #

TO BE COMPLETED BY THE EMPLOYEE

Employee's social security # _____

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

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

_____   ☐☐ / ☐☐ / ☐☐☐☐

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

1. Business's full legal name and mailing address

Business name

Mailing address

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

2. Employer's FEIN ☐☐ - ☐☐☐☐☐☐☐

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

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

_____

5. Employer's contact telephone number (☐☐☐) ☐☐☐ - ☐☐☐☐

6. Employer's contact email address

_____

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

8. Employee's occupation Codes are available at: www.bls.gov/soc/2018/major_groups.htm ☐☐ - ☐☐☐☐

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

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

10. If employee received or will receive full wages while on PFL, will employer be requesting reimbursement? ☐YES ☐NO

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TO BE COMPLETED BY THE EMPLOYEE

Employee's social security # _____

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

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

_____

☐☐ / ☐☐ / ☐☐☐☐

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

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

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

Disability:

Weeks	Please provide specific dates for Disability:
Days	

PFL:

Weeks	Please provide specific dates for PFL:
Days	

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
Guardian Life Insurance

Mailing address
PO Box 981576

City, State	Zip code	Country (if not U.S.A.)
El Paso, TX	79998-1576	

14. PFL insurance carrier's telephone number (8 0 0) 2 6 8 - 2 5 2 5

15. PFL policy number _____

Guardian Specific Information	If employee received or will receive full wages while on PFL and employer is requesting reimbursement, please indicate the dates employee is paid from_____ through_____.

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

_____

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