SHELTERPOINT
ShelterPoint Life Insurance Company

Request for Paid Family Leave (PFL)

Checklist for Requesting Paid Family Leave (PFL)

BEFORE YOU APPLY:

☐ Check eligibility requirements for Paid Family Leave. https://paidfamilyleave.ny.gov/eligibility

- Full time employees (regularly working 20+ hours/week) are eligible after **26** consecutive working weeks with your current covered employer.
- Part-Time employees (regularly work less than 20 hours/week) are eligible after **175** working days with your employer.
- Time on DBL does not count towards weeks worked for PFL eligibility purposes.
- Eligibility does not transfer over from one employer to another. If you separate from employment, eligibility for benefits ends with that employer.

☐ Plan your leave. Leave can be taken continuously or intermittently, in increments as small as 1 full day. Partial-day or hourly PFL is not permissible.

☐ Notify your employer at least 30 days before the start of leave (if it is foreseeable); otherwise notify your employer as soon as possible. You do not need to give ShelterPoint advance notice.

COMPLETE FORMS & ATTACH REQUIRED DOCUMENTATION:

☐ Complete PFL-1A, Claimant Statement, in full. **Please PRINT clearly.** Make a copy, and give the claim package to your employer to complete Part B.

☐ Your employer completes PFL-1B, Employer Statement, in full, makes a copy for their files, and returns the completed form to you (within 3 business days).

☐ Complete the certification for your leave type, and attach supporting documentation. Your claim is not complete without valid proof documentation & certifications to support the leave request.

Family Care	Bonding	Military Exigency
☐ your family member needs to complete the HIPAA Authorization form (PFL-3) and provide it to their doctor, allowing medical information to be shared with you and ShelterPoint.	☐ complete the entire PFL-2 Bonding Certification form.	☐ complete the entire Military Exigency form (PFL-5)
☐ Complete the top portion of the Family Care form (PFL-4), providing information on yourself and your qualifying family member requiring care. ☐ Your family member's provider completes the remainder of the Medical Certification form (PFL-4), and returns to you in a timely fashion.	☐ attach proof document(s) supporting the leave. Proof document options are listed on the form.	☐ attach proof document(s) supporting the leave

SUBMIT TO SHELTERPOINT or your employer's current PFL carrier:

Do not file claims with ShelterPoint if we are not your employer's PFL provider for the leave requested.

Completed PFL claims for ShelterPoint policyholders can be submitted to us by any of the below listed methods (choose one- do not submit by multiple methods). **Do not** include instruction pages with your submission.

Email: claimforms@shelterpoint.com (*size of email & attachments cannot exceed 10MB*)
Fax: 516-504-6414
Mail: ShelterPoint Life, 1225 Franklin Ave-Ste 475, Garden City NY 11530

Web address: www.shelterpoint.com Phone #: 1-800-365-4999

Important Notes: Claims filing is the responsibility of the **employee.** It is not the employer's responsibility to submit claims. Claims must be submitted **within 30 days** after the first day of leave, to avoid possibly losing benefits. Pre-filing claims in advance of the leave is not required. It is the employee's responsibility to provide any requested missing information to the Carrier. The employer is required to provide the completed employers' statement; **claim determinations and verification of eligibility for benefits will be made by the Carrier.** If benefits are paid to you in excess of the amount to which you are entitled, you must return the amount overpaid to the payor of such benefits.

If you do not know who your employer's PFL Carrier is you can: look for the Paid Family Leave poster in your workplace; ask your employer; use the employer coverage search application on wcb.ny.gov to look up your employer's PFL carrier; or you may contact the Paid Leave helpline at (844)337-6303 M-F 8:30am-4:30pm EST.

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)

Question 12: A child is defined as a biological, adopted, or foster son or daughter, a stepson or stepdaughter, a legal ward, a son or daughter of a domestic partner, or the person to whom the employee stands in loco parentis. A parent is defined as a biological, foster, or adoptive parent, parent-in-law, a stepparent, a legal guardian, or other person who stood in loco parentis to the employee when the employee was a child.

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

Form PFL-1 Instructions continued on next page

If you need assistance, please call (844) 337-6303
www.ny.gov/PaidFamilyLeave

DO NOT SCAN

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

Form PFL-1 Instructions continued from prior page

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)*.

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/2018/major_groups.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 starting 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.

ShelterPoint Life Insurance Company

Request for Paid Family Leave (Form PFL-1)

Claim number _____

PART A: Employee Information (to be completed by the employee requesting leave)

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 -including apt/fl #, City, State, Zip code)

Street address

City, State

Zip code | *Country (If not USA)*

4. Employee's Social Security Number or I-TIN (required for tax reporting)

___ - ___ - ____

5. Employee's Date of Birth (mm/dd/yyyy)

__ / __ / ____

6. Employee's primary telephone number

(___) ___ - ____

area code

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

8. Employee's gender

☐ M ☐ F ☐ X

9. Employee's preferred language

☐ English ☐ Español (Spanish) ☐ Русский (Russian) ☐ Polski (Polish)

☐ 中文 (Chinese) ☐ Italiano (Italian) ☐ Kreyol ayisyen (Haitian creole) ☐ 한국인 (Korean)

☐ 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 ☐ Sibling*

*(*NEW-for leaves on/after 1/1/23)*

Form PFL-1 continued on next 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) - Continued from previous page

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

*SPL Note to claimant: Leave dates **must be** included with your claim. Dates cannot overlap other claims (e.g pregnancy DBL and bonding PFL). Gaps in between leave dates may not exceed 3 months. Any changes to leave plans must be communicated to Us and your Employer, when known.*

☐ Continuous PFL Start Date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐ - PFL end date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐ ☐ Dates estimated

☐ Periodic Identify periodic dates to be taken: ☐ Dates 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

SAINT DOMINIC'S FAMILY SERVICES

16. Employee's date of hire (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

17. Employee's work location

Street Address

City, State Zip Code

18. Employee's average gross weekly wage (this data will be requested of both employee and employer).

19. Employer's phone number for contact regarding this request

(☐☐☐) 3 5 9 - 3 4 0 0

area code

20a. Does employee have more than 1 employer? ☐ Yes ☐ No

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

21. Is the 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.

Benefit Payment Preference for eligible ShelterPoint Claims

Please choose your preference for receiving benefit payments. Certain options may not be available depending on the leave pattern or benefit recipient. If your claim does not qualify for ACH/direct deposit, your benefit payments will automatically be issued via paper check. A completed enrollment form is required to participate in direct deposit.

☐ Paper Check

☐ Direct Deposit (ACH)

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

Signature **Date** (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.

End of Part A.

Claim Number _____

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: SAINT DOMINIC'S FAMILY SERVICES

Mailing address: 500 WESTERN HIGHWAY

City, State: BLAUVELT, NY

Zip code: 10913

Country (if not U.S.A.):

2. Employer's FEIN 13 - 1740399

3. Employer's Standard Industrial Classification (SIC) Code 8322

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

LAKISHA TURNER

5. Employer's contact telephone number ( ) 359 - 3400

6. Employer's contact email address

lturner@sdfs.org

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

8. Employee's occupation (description or code)_____ . Codes are available at:www.bls.gov/soc/2018/major_groups.htm

9. Enter employee's last 8 weeks of gross wages prior to the leave start date and calculate the average gross weekly wage

Quick tip: For bi-weekly or semi-monthly payrolls, enter the gross wages for the last 4 pay periods.
See instructions for detail on what is included in wages, and for how to calculate for self-employed persons.

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:			

9a. Select the days of the week the employee usually works:

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

9b. Select whether the employee is **full-time** (regularly works 20+ hours per week) or **part-time** (regularly works less than 20 hours per week)

☐ **Full Time**
☐ **Part Time**

10. Will the employee continue to receive full wages from the employer while on paid family leave? ☐ Yes *(provide detail in question 10a)* ☐ No

10a. If you answered **YES** to the question above, provide the date(s) that the employee received/will receive **full wages** from the employer as a result of using **full days** of accrued sick/vacation/paid time off, or through an emplyer offered salary continuance program.

From: **Through:** Is the employer requesting reimbursement for this period? ☐ Yes ☐ No

Claim Number _____

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	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: **ShelterPoint Life Insurance Company**

Mailing address: **1225 Franklin Avenue, Suite 475**

City, State: **Garden City, NY** | Zip Code: **11530** | Country (if not U.S.A.):

14. PFL insurance carrier's telephone number (800) 365 - 4999

15. PFL policy number DBL602033

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: BENEFITS SPECIALIST

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 Information Under The Paid Family Leave Law (Form 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 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 benefit 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 all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

If you need assistance, please call (844) 337-6303
www.ny.gov/PaidFamilyLeave

DO NOT SCAN

NEW YORK STATE | 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, Care recipient's (patient's) name **, authorize my health care provider listed on this form to release my personal health information to** Employee's name **and their employer's PFL insurance carrier** PFL insurance carrier's name **SHELTERPOINT LIFE INSURANCE COMPANY** .

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 that 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 code | Country (if not U.S.A.)

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

Form PFL-3 continued on next page

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

Form PFL-3 continued from prior page

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

4. **Care recipient's mailing address**

Mailing address (including apartment #)

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 result of my current condition.

Care recipient's signature

Date signed (MM/DD/YYYY)

Authorized representative

I, Print name **, represent the care recipient in this matter as authorized by:**

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

Authorized representative's 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 employee 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 CARE OF 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)

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 Certification 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 (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.

If you need assistance, please call (844) 337-6303
www.ny.gov/PaidFamilyLeave

DO NOT SCAN

SHELTERPOINT
ShelterPoint Life Insurance Company

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 - -

Employee's mailing address

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 CARE OF 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)

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 CARE OF 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) - continued from prior page

Form PFL-4 continued from prior page

9. Type of health care provider:

- [x] 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 (LMSW/LCSW)
- [ ] Other (specify)

10. Health care provider's mailing address

Mailing address

City, State | Zip code | 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 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)

Direct Deposit Enrollment and Authorization Form for New York Disability Benefits Law ("DBL") and Paid Family Leave ("PFL") Claims Payments

INSTRUCTIONS

PLEASE PRINT ALL INFORMATION LEGIBLY. This form must be fully completed, signed, and dated to be valid. Incomplete or ineligible submissions are unable to be processed and will not be accepted.

Eligibility for Direct Deposit: ShelterPoint Life Insurance Company ("Company") offers Direct Deposit Payments for continuous DBL and PFL claims where benefit payments are being issued directly to the claimant/employee.

Direct deposit is not currently available for non-NY coverages, in situations where leave is being claimed intermittently, or where the Company is reimbursing your Employer due to continued payment of wages. As a result, direct deposit will not be implemented in these situations, and direct deposit payments will stop if your claim converts from continuous leave to intermittent leave and any future benefit payments due under the claim will be issued via check. In the event that a direct deposit payment is rejected due to inaccurate banking information, the rejected payment and any future benefit payments due under the claim will be issued via check until the bank information is corrected and an updated Enrollment and Authorization Form is submitted.

Required information: you must supply all requested information on this form. Fully completed, signed and dated forms may be sent to ShelterPoint Life by any one of the below listed methods:

- Submit electronically through our claimant portal
- Email to: claimforms@shelterpoint.com
- Fax to: 516-504-6414
- Mail to: ShelterPoint Life, 1225 Franklin Avenue-Ste 475, Garden City NY 11530

If you have any questions regarding this form, please contact our Customer Service Department at 1-800-365-4999 during normal business hours. **Please allow up to 10 business days for set up of your direct deposit request.**

REQUIRED INFORMATION (please print all information LEGIBLY)

1. Claimant Name (First name, Last name)

2. Social Security Number or I-TIN (9 digits)

			-		-				

3. ShelterPoint Life Claim Number(s)

4. Account Type

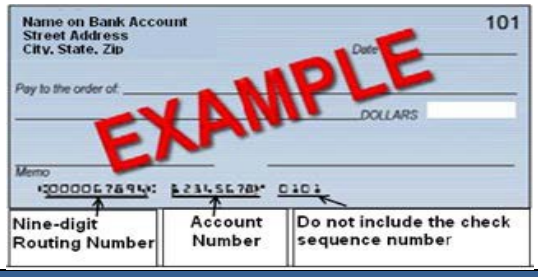
☐ Checking Account ☐ Savings Account

5. Banking Information

Bank Name: _____

Bank Routing Number (ABA#):_____

Bank Account Number:_____



AUTHORIZATION AND SIGNATURE

I authorize ShelterPoint Life Insurance Company ("Company") to deposit any benefits I am eligible to receive directly into the bank account I have indicated above or to such other account as the bank or any successor bank designates as my account. I also authorize the Company to debit my account for any deposits made in error, or the Company reserves the right to request the return of such funds through other mechanisms.I also understand that the direct deposit service will stay in effect until I notify the Company in writing of cancellation or until I am no longer eligible for or due payments, whichever comes first. I acknowledge that if I am also covered under another ShelterPoint Disability / Paid Leave policy, this request will also apply to any other current open claim(s) that are eligible for direct deposit, if approved by the Company. I understand that I have the opportunity to view my EOBs and payment history via claims portal registration on shelterpoint.com.

☐ Check this box if you **do not** want to receive paper EOBs in the mail if your direct deposit request is approved.

Claimant Signature	**Date (mm/dd/yyyy)**