

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY



**APPLICATION FOR NEW YORK PAID FAMILY LEAVE BENEFITS**

This application package is divided into three sections, as follows:

- PFL 1, Part A Employee Information** - to be completed by the **employee** who is applying for Paid Family Leave benefits.
- PFL 1, Part B Employer Information** – to be completed by the **employer's** authorized representative.
- PFL 2 Bonding Certification** – to be completed by the **employee** and attached to the applicable supporting documentation.

Submit completed application along with the required supporting documentation to:

The Hartford  
P.O.Box 14306  
Lexington, KY 40512-4306  
Fax Number: (866) 411-5613  
E-mail: [PFL@thehartford.com](mailto:PFL@thehartford.com)



The Hartford  
P.O.Box 14306  
Lexington, KY 40512-4306  
Fax Number: (866) 411-5613  
E-mail: PFL@thehartford.com

# Request For NY Paid Family Leave (Form PFL-1)

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

<b>1. Legal name</b> (first name, middle initial, last name)		<b>2. Other last names, if any, under which you have worked</b>									
<b>3. Mailing address</b>											
<b>4. Social Security Number</b>	<b>5. Date of birth</b> (MM/DD/YYYY)	<b>6. Primary telephone number</b> (      )									
<b>7. Preferred email address while on PFL</b> (if available)		<b>8. Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not designated/Other									
<b>9. Preferred language</b> <input type="checkbox"/> English <input type="checkbox"/> Español <input type="checkbox"/> Русский <input type="checkbox"/> Polski <input type="checkbox"/> 中文 <input type="checkbox"/> Italiano <input type="checkbox"/> Kreyòl ayisyen <input type="checkbox"/> 한국어 <input type="checkbox"/> Other: _____											
<b>10. Race/Ethnicity - Optional (For purposes of health demographic only.) (U.S. Centers for Disease Control and Prevention (CDC) code set, version 1.0.):</b> <b>Is employee of Hispanic, Latino/a, or Spanish origin? (One or more categories may be selected.)</b> <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Dominican <input type="checkbox"/> Cuban <input type="checkbox"/> Another Hispanic, Latino/a, or Spanish origin <input type="checkbox"/> Not of Hispanic, Latino/a, or Spanish origin <input type="checkbox"/> Unknown <b>What is employee's race? (One or more categories may be selected.)</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other											
<b>11. Reason for PFL Request:</b> <input type="checkbox"/> Bond with Child <input type="checkbox"/> Care for Family Member <input type="checkbox"/> Military Qualifying Event											
<b>12. The Family Member is your:</b> <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Parent <input type="checkbox"/> Parent-in-law <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild											
<b>13. Will PFL be for a Continuous period of time and/or Periodic?:</b> <small>(Note: If dates are "Continuous", you 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".)</small>  <table style="width:100%; border: none;"> <tr> <td style="width: 30%;"><input type="checkbox"/> <b>Continuous</b></td> <td style="width: 30%; text-align: center;">PFL start date (MM/DD/YYYY) _____</td> <td style="width: 30%; text-align: center;">PFL end date (MM/DD/YYYY) _____</td> <td style="width: 10%;"><input type="checkbox"/> <b>Dates are estimated</b></td> </tr> <tr> <td><input type="checkbox"/> <b>Periodic</b></td> <td colspan="2" style="text-align: center;">Identify dates periodic PFL will be taken: _____</td> <td><input type="checkbox"/> <b>Dates are estimated</b></td> </tr> </table>				<input type="checkbox"/> <b>Continuous</b>	PFL start date (MM/DD/YYYY) _____	PFL end date (MM/DD/YYYY) _____	<input type="checkbox"/> <b>Dates are estimated</b>	<input type="checkbox"/> <b>Periodic</b>	Identify dates periodic PFL will be taken: _____		<input type="checkbox"/> <b>Dates are estimated</b>
<input type="checkbox"/> <b>Continuous</b>	PFL start date (MM/DD/YYYY) _____	PFL end date (MM/DD/YYYY) _____	<input type="checkbox"/> <b>Dates are estimated</b>								
<input type="checkbox"/> <b>Periodic</b>	Identify dates periodic PFL will be taken: _____		<input type="checkbox"/> <b>Dates are estimated</b>								
<b>14. When submitting a request for PFL, 30 days advance notice is required. If providing less than 30 day's advance notice, please explain:</b> <small>(Note: If the explanation will not fit in the space provided on the form, enter "See Attached" and add an attachment with the explanation.)</small>											



**Employment Information (to be completed by the employee)**

15. **Business name**

16. **Date of Hire (MM/DD/YYYY)** (Note: Enter the date of hire to the best of your recollection. If it has been more than a year since your date of hire, entering the year in which employment started is sufficient.):

17. **Work location (Street address):**

18. **Your average gross weekly wage during the last eight weeks prior to the start of PFL: \$ \_\_\_\_\_**

(Note: Enter the best estimate of average gross weekly wage as this will also be confirmed with your employer. 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.

19. **Employer's telephone number for contact regarding this request: ( \_\_\_\_\_ ) \_\_\_\_\_**

20a. **Do you have more than one employer?**  Yes  No

20b. **If yes, are you taking PFL from the other employer?**  Yes  No

21. **Are you currently receiving Workers' Compensation Lost Wage Benefits?**  Yes  No

22. **Your PFL benefit is 100% taxable. The federal government and State of New York allow us to withhold 10% of your benefit for Federal Income Tax (FIT) and 2.5% for State Income Tax (SIT) with your permission.**

22a. **Would you like us to withhold FIT?**  Yes  No

22b. **Would you like us to withhold SIT?**  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 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 of my leave start date. I understand The Hartford will contact me to advise how to submit any required missing information.

Employee name:

Employee Date of Birth:

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

1. Business's full legal name and mailing address

\_\_\_\_\_

2. Employer's contact name for questions related to PFL:

\_\_\_\_\_

3. Employer's contact telephone number:

( ) \_\_\_\_\_

4. Employer's contact email address:

\_\_\_\_\_

5. Employee's date of hire

\_\_\_\_\_

6. PFL coverage effective date

\_\_\_\_\_

7. Employee's Work Location:

\_\_\_\_\_

8. Employee's occupation Codes are available at: [www.bls.gov/soc/2010/soc\\_alpha.htm](http://www.bls.gov/soc/2010/soc_alpha.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			
<b>Total:</b>			
<b>Calculated average gross <u>weekly</u> wage:</b>			

10. Actual days worked in the week prior to the start of the leave: (Check all days that apply)

Sunday:  Monday:  Tuesday:  Wednesday:  Thursday:  Friday:  Saturday:

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

If Yes, please provide date range of reimbursement: From: \_\_\_\_\_ Through: \_\_\_\_\_

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

13. PFL policy number:

14. Has this employee received NY disability benefits or PFL benefits within the 52 weeks prior to the start of this leave request that were not administered by The Hartford?:

Yes  No  Unknown as employment began within the last 52 weeks

If yes, fill in the following:

Paid by (Carrier Name/State): \_\_\_\_\_

Dates Paid: \_\_\_\_\_

Employee name:

Employee Date of Birth:

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

**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



The Hartford  
 P.O.Box 14306  
 Lexington, KY 40512-4306  
 Fax Number: (866) 411-5613  
 E-mail: PFL@thehartford.com

# Request For NY Paid Family Leave Bonding Certification (Form PFL-2)

<b>TO BE COMPLETED BY THE EMPLOYEE</b>	
<b>Legal name</b> (first name, middle initial, last name)	<b>Other last names, if any, under which you have worked</b>
<b>Mailing address</b>	
<b>Social Security Number</b>	<b>Date of birth</b> (MM/DD/YYYY)

## BONDING CERTIFICATION (to be completed by the employee)

<b>1. Child's name:</b>	<b>2. Child's date of birth:</b> (MM/DD/YYYY):
<b>3. Does child live with the employee requesting PFL?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please provide mailing address for child:	
<b>4. Child's Social Security Number:</b>	<b>5. Child's gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not designated/Other
<b>5. Child is employee's:</b> <input type="checkbox"/> Biological child <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster child <input type="checkbox"/> Adopted child <input type="checkbox"/> Legal ward <input type="checkbox"/> Spouse/Domestic partner's child <input type="checkbox"/> In loco parentis	
<b>6. Select one of the following and attach the document as required as evidence of the relationship.</b> Note: this certification along with the required documentation listed below must be returned to The Hartford in order for us to process your request for PFL. <b>Parent of newborn child:</b> <input type="checkbox"/> Child's birth certificate; OR <input type="checkbox"/> Voluntary acknowledgment of paternity (Form LDSS-4418); OR <input type="checkbox"/> Court order of filiation; OR <input type="checkbox"/> Healthcare provider certification of pregnancy or birth; OR <input type="checkbox"/> Other documentation of parental relationship <b>Foster parent:</b> <input type="checkbox"/> Letter of foster care placement or anticipated placement issued by county or city department of Social Services or authorized voluntary foster care agency <b>Adoptive parent:</b> <input type="checkbox"/> Court document finalizing adoption; OR <input type="checkbox"/> Documentation in furtherance of adoption	
<b>7. Date of foster care or adoption placement, if applicable</b> (MM/DD/YYYY): _____	

## BONDING CERTIFICATION (to be completed by the employee)

**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)





# NY PFL Electronic Funds Transfer (EFT) Request Form

**Instructions:**

1. Read the Terms and Conditions listed below.

2. Enter your name, address, home telephone number and Employee ID.

3. Complete the bank and account information for your Electronic Funds Transfer request.

4. You and all other parties to the account specified must sign this form.

5. Return the completed form to The Hartford Claims Office.

**Note:** Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the EFT Program.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: (     ) - \_\_\_\_\_

Employee ID: \_\_\_\_\_

Name of Bank: \_\_\_\_\_

Bank Address: \_\_\_\_\_

Bank Telephone Number: (     ) - \_\_\_\_\_

**Type of Account (select one):**

**Checking:**

**Saving:**

Account Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

Bank Routing Number: \_\_\_\_\_

Attach a voided blank personal check.

Indicate any other names on the account selected:

\_\_\_\_\_

**AUTHORIZATION**

I / We authorize ( \_\_\_\_\_ ) and affiliated companies (herein after called The Hartford), to initiate credit entries (and to initiate, if necessary, debit entries and adjustments for credit entries made in error) to my (our) account indicated above and the Depository named above, hereinafter called Depository, to credit and/or debit the same to such account. I (we) acknowledge that the origination of A C H transactions to my (our) account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until The Hartford has received written notice from me (us) of its termination in such time and in such manner as to afford The Hartford and Depository a reasonable opportunity to act on it. I (we) understand I (we) should allow at least (# \_\_\_\_\_) days for the first CREDIT to occur.

Signature(s): \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_

**TERMS AND CONDITIONS**

Receiving benefits by direct deposit or electronic funds transfer is voluntary. If at any time during your leave you wish to revoke this EFT request, you can do so by contacting our office.

The Hartford will not be responsible for any banking fees charged for direct deposit or electronic funds transfer; however, The Hartford will not charge you any fees for depositing your benefits into this account.

I understand that this agreement may be terminated by me upon written notice to The Hartford.

The cancellation will be processed for the time period following receipt of the notice.

I understand that a change in the title of this account which alters the interest of any party terminates this authorization and that a new authorization must then be submitted to continue direct deposit/EFT.

I understand that it is my responsibility to inform The Hartford of any address changes immediately.

I further understand that any benefit payment forwarded to the financial institution covering a period of time after my death will be refunded to The Hartford. I agree that the financial institution shall have the right of offset for such a refund.

I authorize the financial institution specified in this authorization to provide The Hartford with my home address and the names of any joint account holders for the account specified herein.

I understand that I am responsible for verifying the accuracy of my account data and for promptly notifying The Hartford of any errors or changes including termination of my EFT request.

**SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.**

As a party to this account, I understand that I am personally liable, both individually and as a member of the group of parties to this account, for the full amount of all benefit payments covering any period after the death of the disability benefit recipient. This is a liability to The Hartford. If I am entitled to any benefit as the beneficiary of the disability benefit recipient, the amount of my liability may be deducted from the amount payable to me. I agree that the financial institution shall have the right of offset for such a refund, and I authorize the financial institution to provide The Hartford with my home address.

**CANCELLATION**

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to The Hartford or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so. The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately notify The Hartford if the authorization is cancelled by the financial institution. The financial institution can not cancel the authorization by advice to The Hartford.



\_\_\_\_\_  
Signature:

\_\_\_\_\_  
Date:

I certify that I have read and understand the Terms and Conditions of this EFT Agreement, including the SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

\_\_\_\_\_  
Signature(s) of Other Persons on Account:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date:

<sup>1</sup> The Hartford<sup>®</sup> is The Hartford Financial Services Group, Inc. and its subsidiaries.





# Paid Family Leave

# STATEMENT OF RIGHTS FOR PAID FAMILY LEAVE

## IF YOU NEED TO TAKE TIME OFF FROM WORK TO CARE FOR A FAMILY MEMBER, YOU MAY BE ENTITLED TO PAID FAMILY LEAVE BENEFITS

**Paid Family Leave is employee funded insurance that provides job-protected, paid time off to:**

- Bond with a newly born, adopted or fostered child;
- Care for a family member with a serious health condition; or
- Assist loved ones when a family member is called to active military service abroad.

### Eligibility:

- Employees with a regular work schedule of **20 or more hours per week** are eligible after **26 consecutive weeks** of employment.
- Employees with a regular work schedule of **less than 20 hours per week** are eligible after **175 days worked**.

You are eligible regardless of your citizenship or immigration status.

**Benefits:** In 2018, you can take up to eight weeks of Paid Family Leave and receive 50% of your average weekly wage, capped at 50% of the New York State average weekly wage. Generally, your average weekly wage is the average of your last eight weeks of pay prior to starting Paid Family Leave.

### Rights and Protections

- **Job Protection:** Return to the same or comparable job after you take leave.
- You keep your **health insurance** while on leave (you may have to continue paying your portion of the premium costs, if any).
- Your **employer is prohibited from discriminating or retaliating** against you for requesting or taking Paid Family Leave.
- You **do not have to exhaust sick leave or vacation** accruals before using Paid Family Leave.

### Paid Family Leave Request Process

1. Notify your employer at least 30 days in advance, if foreseeable, or as soon as possible.
2. Complete and submit the Request for Paid Family Leave (Form PFL-1) to your employer.
3. Complete and attach the additional forms as required and submit to the insurance carrier listed below.
4. The insurance carrier must pay or deny your request within 18 days of receiving your completed request.

You may obtain all forms from your employer, their insurance carrier listed below or online at [www.ny.gov/PaidFamilyLeave](http://www.ny.gov/PaidFamilyLeave).

### Disputes

If your Paid Family Leave claim is denied, you may request to have the denial reviewed by a neutral arbitrator. The insurance carrier listed below will provide you with information about requesting arbitration.

### Discrimination Complaints

If your employer terminates your employment, reduces your pay and/or benefits, or disciplines you in any way as a result of you taking or asking about Paid Family Leave, you may request to be reinstated by taking these steps:

1. Complete the Formal Request for Reinstatement Regarding Paid Family Leave form (PFL-DC-119)
2. Send your completed form to your employer and a copy of the completed form to: Paid Family Leave, P.O. Box 9030, Endicott, NY 13761-9030
3. If your employer does not reinstate you within 30 days, you may file a discrimination complaint with the Worker's Compensation Board using form PFL-DC-120, available at <http://www.ny.gov/PaidFamilyLeave>. The Worker's Compensation Board will assemble your case and schedule a hearing.

**For more information, forms, and instructions,  
visit [www.ny.gov/PaidFamilyLeave](http://www.ny.gov/PaidFamilyLeave) or call (844)-337-6303.**

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law. Your employer's paid family leave benefits insurance carrier is:

The Hartford  
P.O.Box 14306  
Lexington, KY 40512-4306  
Fax Number: (866) 411-5613  
Phone Number: (800) 549-6514

**PRESCRIBED BY THE CHAIR,  
WORKERS' COMPENSATION BOARD**