Reset

TheStandard®

The Standard Life Insurance Company of New York
800.368.2859 Tel 866.752.4037 Fax
PO Box 4160 Portland OR 97208

Applying For Paid Family Leave (PFL)

To Use Paid Family Leave To:

Bond with a newborn, a newly adopted or fostered child

Complete Form PFL-1
- ☐ Complete PFL-1, Part A
- ☐ Provide PFL-1 to employer
- ☐ Employer completes PFL-1, Part B and returns to you within 3 days

Complete Form PFL-2
- ☐ Complete PFL-2 and collect required documentation

Send forms and documents
- ☐ Send completed forms and required documentation to The Standard
- ☐ The Standard accepts or denies claim within 18 days

Care for a family member with a serious health condition

Complete Form PFL-1
- ☐ Complete PFL-1, Part A
- ☐ Provide PFL-1 to employer
- ☐ Employer completes PFL-1, Part B and returns to you within 3 days

Complete Form PFL-3
- ☐ Care recipient completes PFL-3 and provides to health care provider
- ☐ Care recipient's health care provider keeps PFL-3

Complete Form PFL-4
- ☐ Complete "Employee" information at the top of PFL-4
- ☐ Provide PFL-4 to care recipient's health care provider
- ☐ Care recipient's health care provider completes PFL-4 and returns to you

Send forms and documents
- ☐ Send completed forms and required documentation to The Standard
- ☐ The Standard accepts or denies claim within 18 days

Assist family members due to another family member's active military duty or impending active duty abroad

Complete Form PFL-1
- ☐ Complete PFL-1, Part A
- ☐ Provide PFL-1 to employer
- ☐ Employer completes PFL-1, Part B and returns to you within 3 days

Complete Form PFL-5
- ☐ Complete PFL-5 and collect required documentation

Send forms and documents
- ☐ Send completed forms and required documentation to The Standard
- ☐ The Standard accepts or denies claim within 18 days

Please keep a copy of all pages for your records.

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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 Standard 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.

Question 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 Standard 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.

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

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).

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
Average Weekly Wage	$525
Prorated Weekly Bonus	+ $50
Average Weekly Wage (including bonus) =	**$575**

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 Standard, 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 Standard 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 Standard has 18 days to pay or deny the claim.**

If The Standard does not permit pre-submitting, The Standard 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.

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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/home.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 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 10a: 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 11b.

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.

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Request For Paid Family Leave (Form PFL-1)

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	City	State	Zip Code	Country (if not USA)
4. Employee's 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 ☐ X		

9. Employee's preferred language

☐ English ☐ Español ☐ Russian ☐ Polski ☐ Chinese ☐ Italiano ☐ Haitian ☐ 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 ☐ Sibling ☐ Spouse ☐ Domestic partner ☐ Parent ☐ Parent-in-law ☐ Grandparent ☐ Grandchild

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Request For Paid Family Leave (Form PFL-1)

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)

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

☐ Continuous _____ /_____ /_____ _____ /_____ /_____ ☐ Dates are estimated

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

Identify dates periodic PFL will be taken:

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

22. Is employee receiving full pay from employer while on PFL leave?

☐ 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 (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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Request For Paid Family Leave (Form PFL-1)

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			
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: https://www.bls.gov/soc/home.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	Check Days Normally Worked
1				☐ Monday
2				☐ Tuesday
3				☐ Wednesday
4				☐ Thursday
5				☐ Friday
6				☐ Saturday
7				☐ Sunday
8				
Calculated average gross weekly wage:				

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

10b. Through what date will the employee receive full wages? _____
(MM/DD/YYYY)

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Request For Paid Family Leave (Form PFL-1)

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)

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 _____ Days _____ Please provide specific dates for Disability: _____

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

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
The Standard Life Insurance Company of New York

Mailing address
PO Box 4160

City	State	Zip code	Country (if not U.S.A.)
Portland	**OR**	**97208**	

14. PFL insurance carrier's telephone number	15. PFL policy number
(800) 368-2859	

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

Sign Up for Digital Payments

Have you signed up for digital payments yet? If so, you can disregard this notice.

Get your claim payment faster with digital payments with The Standard Life Insurance Company of New York. If your claim is approved, you can choose to have benefits paid to you via Zelle or direct deposit.[1]

How do digital payments work?

1. Your digital payment eligible claim is approved.[2]
2. You'll receive an email or text notification with a link to choose your payment preference.[3]
3. Follow the link to complete digital payment setup.

To sign up for digital payments,[4] choose one of the following options:

1. **Fastest Option:** Call or text "HELLO" to 888.937.4783 and follow the prompts to choose your payment preference and to provide employee and employer information.
2. **Additional Option:** Complete and submit this form below:
   - Fax to: 888.878.3686
   - Mail to: The Standard Life Insurance Company of New York
     Administrative Office: P.O. Box 2800, Portland, OR 97208

Digital Payment Sign Up Form

Employee First Name _____ Employee Last Name _____

Employee DOB (MM/DD/YY) _____ Employee Zip Code _____

Employer Name _____

Check "✓" to choose your preferred payment method.

Digital payment (Zelle or direct deposit) ☐ Payment by check ☐

Your contact details

Enter the mobile number or email address where you will receive notifications. This information is required for Zelle or direct deposit.

Mobile: _____ Email: _____

Email notifications will come from notification@thepaychoice.com. Text messages will come from 26489 or 21239.

The payment method you choose can be saved for any recurring payment you may receive. **If you don't choose a notification method, we may use the method we have on file or mail a check.**

1 By electing to receive claim payments digitally, we're not guaranteeing approval of your claim.
2 Not all benefits are eligible for digital claim payments.
3 If your claim is approved and you do not respond to the text or email notification with your preferred payment option within (3) calendar days, The Standard‡ will automatically send a paper check.
4 If you elect to receive claim payments digitally, you authorize use of the information you provide to access your bank account information for the purpose of facilitating payment transactions.

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‡ The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products in New York are offered by, and the sole responsibility of, The Standard Life Insurance Company of New York of White Plains, New York. The Standard Life Insurance Company of New York is licensed to solicit insurance business in only the state of New York.

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Release Of Personal Health Information Under The Paid Family Leave Law (PFL) (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 legal name, and care recipient's (patient's) legal name and date of birth at the top of each page.

The PFL insurance carrier legal 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.

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Release Of Personal Health Information Under The Paid Family Leave Law (PFL) (Form PFL-3)

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first name, middle initial, last name)	
Care recipient's (patient's) legal 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, _____ , authorize my health care provider listed on this form to
Care recipient's (patient's) legal name

release my personal health information to _____ and their
Employee's legal name

employer's PFL insurance carrier The Standard Life Insurance Company of New York.

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)
( )

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Release Of Personal Health Information Under The Paid Family Leave Law (PFL) (Form PFL-3)

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first name, middle initial, last name)	
Care recipient's (patient's) legal 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)

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

4. Care recipient's mailing address Mailing address			
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, _____ , represent the care recipient in this matter as authorized by:
Print legal name

☐ 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.

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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 legal 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) legal name and date of birth at the top of page 1.
- Employee enters their legal name and date of birth, and care recipient's (patient's) legal 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 required 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.

The Standard Life Insurance Company of New York

800.368.2859 Tel 866.752.4037 Fax
PO Box 4160 Portland OR 97208

Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal 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) legal 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)

GINA Disclaimer: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information is defined to include an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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 Days/month
8. Health care provider's name	

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TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)
Care recipient's (patient's) legal 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)

9. 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 (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)

Print