Amalgamated Employee Benefits Administrators
Delivering High Quality, Customized TPA Services

1199SEIU Benefit Funds

1199SEIU National Benefit Fund
c/o AEBA, Inc.
Email: 1199PFL@AmalgamatedBenefits.com
Toll Free: (888) 447-9055
Fax: (914) 367-5374

Paid Family Leave Form

Bond with a newborn, a newly adopted or fostered child

☑ **Complete Form PFL-1**
- Employee completes PFL-1, Part A.
- Employee provides PFL-1 to employer.
- Employer completes PFL-1, Part B.

☑ **Complete Form PFL-2**
- Employee completes PFL-2 and collects supporting documentation.

☑ **Send forms and documents**
- Employee sends completed forms and supporting documentation to employer.
- Employer sends completed forms and supporting documentation to Plan Administrator within three days by electronic mail to 1199PFL@AmalgamatedBenefits.com or by facsimile to (914) 367-5374.
- Plan Administrator accepts or denies claim within 18 days.

Care for a family member with a serious health condition

☑ **Complete Form PFL-1**
- Employee completes PFL-1, Part A.
- Employee provides PFL-1 to employer.
- Employer completes PFL-1, Part B.

☑ **Complete Form PFL-3**
- Care recipient or authorized representative completes PFL-3 and provides to care recipient's healthcare provider.
- Care recipient's healthcare provider keeps PFL-3.

☑ **Complete Form PFL-4**
- Employee completes "Employee" information at the top of PFL-4.
- Employee provides PFL-4 to care recipient's healthcare provider.
- Care recipient's healthcare provider completes PFL-4 and returns to employee.

☑ **Send forms and documents**
- Employee sends completed forms and supporting documentation to employer.
- Employer sends completed forms and supporting documentation to Plan Administrator within three days by electronic mail to 1199PFL@AmalgamatedBenefits.com or by facsimile to (914) 367-5374.
- Plan Administrator 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**
- Employee completes PFL-1, Part A.
- Employee provides PFL-1 to employer.
- Employer completes PFL-1, Part B.

☑ **Complete Form PFL-5**
- Employee completes PFL-5 and collects supporting documentation.

☑ **Send forms and documents**
- Employee sends completed forms and supporting documentation to employer.
- Employer sends completed forms and supporting documentation to Plan Administrator within three days by electronic mail to 1199PFL@AmalgamatedBenefits.com or by facsimile to (914) 367-5374.
- Plan Administrator accepts or denies claim within 18 days.

Please keep a copy of all pages for your records.

If you need assistance, please call (646) 473-9200.

DO NOT SCAN

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 Plan Administrator 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 and supporting documentation to the employer. The employee should retain a copy of each submitted form and supporting document for his or her 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 adopted 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 Plan Administrator may require you to submit a request for payment after the PFL day is taken. Payment for approval 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 his or her 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 his or her 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 his or her 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 1 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 calculated in Step 2. 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
Average Weekly Wage	$525
Plus 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)*.

Form PFL-1 Instructions continued on next page

If you need assistance, please call (646) 473-9200.

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

The 1199SEIU National Benefit Fund does not accept pre-submission of claims. 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. The Plan Administrator will return pre-submitted Requests for Paid Family Leave within five days to the employee with an explanation that the claim should be resubmitted when all information is available.

Employee signs and dates before giving this form to his or her 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 Plan Administrator 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 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: "NYS Disability" refers to NYS statutory-required disability. If the answer to this question is "None," then enter a "0" for total numbers of "Weeks" and "Days" in Question 10a.

Question 10a: 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.

Questions 12 & 13: Enter the Paid Family Leave or Disability/PFL Plan Administrator's name, address and PFL telephone 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 must have been in employment for at least 26 consecutive weeks.

Employer signs and dates. Submit completed forms and supporting documentation to the Plan Administrator within three days by electronic mail to 1199PFL@AmalgamatedBenefits.com or by facsimile to (914) 367-5374.

Be sure to complete the appropriate additional PFL form(s) based on the type of PFL 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 taxpayer 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 taxpayer 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 (646) 473-9200.

DO NOT SCAN

Amalgamated Employee Benefits Administrators
Delivering High Quality, Customized TPA Services

1199SEIU Benefit Funds

Request for Paid Family Leave (Form PFL-1)

INSTRUCTIONS INCLUDED WITH FORM

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

1. Employee's legal name (first name, middle initial, last name)

2. Other last names, if any, under which employee has worked

3. Employee's mailing address

STREET ADDRESS

CITY STATE

ZIP CODE COUNTRY (IF NOT U.S.A.)

4a. Employee's Social Security Number or Taxpayer Identification Number (TIN)

4b. Employee's 1199SEIU Health Benefits ID card number

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

6. Employee's primary telephone number

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

8. Employee's gender

☐ Male ☐ Female ☐ Not designated/Other

9. Employee's preferred language

☐ English ☐ Español ☐ Polski ☐ русский
☐ 한국어 ☐ 中文 ☐ Italiano ☐ Kreyòl Ayisyen
☑ Other (specify):

Optional (for research purposes)

10. Employee's ethnicity/race

For purposes of health demographics 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

Form PFL-1 continued on next page

If you need assistance, please call (646) 473-9200.

PFL-1 10-17

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 prior page

Form PFL-1 continued from prior page

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

☐ **Continuous** PFL start date (MM/DD/YYYY) _____ PFL end date (MM/DD/YYYY) _____ ☐ **Dates are estimated**

☐ **Periodic** Identify start and end date that periodic PFL will be taken _____ ☐ **Dates are estimated**

14. If providing less than 30 days' 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 _____

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

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

20b. Is employee currently receiving Workers' Compensation Lost Wage Benefits? ☐ Yes ☐ No

20c. Name and address of other employer (if applicable)

_____

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)

If you need assistance, please call (646) 473-9200.

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' full legal name and mailing address

BUSINESS NAME

STREET ADDRESS

CITY STATE ZIP CODE COUNTRY (IF NOT U.S.A.)

2. Employer's Federal Employer Identification Number (FEIN) _____

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

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

5. Employer's contact telephone number _____

6. Employer's contact email address _____

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

8. Employee's occupation (Codes are available at www.BLS.gov/SOC/2018/Major_Groups.htm.) _____

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

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

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

Form PFL-1 continued on next page

If you need assistance, please call (646) 473-9200.

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

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

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

Disability: Please provide specific dates for Disability:

Weeks _____

Days _____

PFL: Please provide specific dates for PFL:

Weeks _____

Days _____

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

13. PFL Plan Administrator's name and mailing address

1199SEIU National Benefit Fund for Health and Human Service Employees

PFL PLAN ADMINISTRATOR'S NAME

498 Seventh Avenue

STREET ADDRESS

New York	**NY**	**10018-0009**	
CITY	STATE	ZIP CODE	COUNTRY (IF NOT U.S.A.)

14. PFL Plan Administrator's telephone number (646) 473-9200

15. PFL policy number _____

Declaration and signature

☐ **I affirm the employee is a Wage Class I, II or III employee who is enrolled in the 1199SEIU National Benefit Fund and has been in employment for at least 26 consecutive weeks.**

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 Paid Family Leave benefits under the NYS Workers' Compensation Law. 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

If you need assistance, please call (646) 473-9200.

Release of Personal Health Information under the Paid Family Leave Law (Form PFL-3) Instructions

- If an employee is requesting Paid Family Leave (PFL) to care for a family member with a serious health condition, the care recipient or an authorized patient representative must complete a *Release of Personal Health Information under the Paid Family Leave Law (Form PFL-3)* and submit it to the care recipient's healthcare provider, along with a copy of the *Healthcare 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 healthcare provider to complete the *Healthcare 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 *Healthcare Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4)* to his or her employer, for PFL benefit determination.

  NOTE: This form will be retained by the healthcare provider. The employee should make a copy for his or her records before giving it to the healthcare provide

Care recipient or authorized representative signs and dates.

This form is given to the care recipient's healthcare provider along with the *Healthcare Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4).*

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTHCARE 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 healthcare provider with Form PFL-4)

Employee enters his or her name and care recipient's (patient's) name and date of birth at the top of each page.

The PFL Plan Administrator name requested at the top of the form is the same as the PFL Plan Administrator identified in *Request for Paid Family Leave (Form PFL -1)* Part B line 12.

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 healthcare proxy or power of attorney, permitting the representative to sign on behalf of the care recipient. The healthcare 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 taxpayer 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 taxpayer 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 (646) 473-9200.

DO NOT SCAN

Amalgamated Employee Benefits Administrators
Delivering High Quality, Customized TPA Services

1199SEIU Benefit Funds

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)	**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)

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTHCARE 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 healthcare provider with Form PFL-4)

I, _____, authorize my healthcare provider listed on this form to
CARE RECIPIENT'S (PATIENT'S) NAME

release my personal health information to _____
EMPLOYEE'S NAME

and their employer's PFL Plan Administrator _____
PFL PLAN ADMINISTRATOR'S NAME

Records Subject to Release: This form gives the healthcare provider listed permission to include information from your healthcare records on the attached medical certification. This form gives your healthcare provider permission to release only the information in your healthcare 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 healthcare provider listed on this form.

This form does NOT allow your healthcare provider to release the following types of information, unless you specifically permit such release. Put an "X" next to any information your healthcare provider MAY release:

☐ HIV/AIDS information ☐ Mental health information ☐ Alcohol/drug treatment ☐ Psychotherapy notes

Healthcare Provider Information (to be completed by the care recipient or authorized representative

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

1. Healthcare provider's name

_____

2. Healthcare provider's mailing address

_____
STREET ADDRESS

_____
CITY STATE ZIP CODE COUNTRY (IF NOT U.S.A.)

3. Healthcare provider's telephone number (provide area or country code)

_____

If you need assistance, please call (646) 473-9200.

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)

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTHCARE 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 healthcare 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

STREET ADDRESS

CITY | STATE | ZIP CODE | COUNTRY (IF NOT U.S.A.)

5. Care recipient's Social Security Number _____

6. Care recipient's telephone number (provide area or country code)_____

READ AND SIGN BELOW

I hereby request that the healthcare provider listed give a completed *Healthcare 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 NAME

☐ Parental right ☐ Power of attorney (attach copy) ☐ Court order (attach copy) ☐ Healthcare proxy (attach copy)

AUTHORIZED REPRESENTATIVE'S SIGNATURE | DATE SIGNED (MM/DD/YYYY)

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

Healthcare Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4) Instructions

The employee requesting Paid Family Leave (PFL) to care for a family member with a serious health condition must submit the *Healthcare 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 his or her name, date of birth, other last names, if any, under which he or she has worked, Social Security Number or Taxpayer Identification Number (TIN), mailing address, and care recipient's (patient's) name and date of birth at the top of page 1.
- Employee enters his or her 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 *Healthcare Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4)* to the care recipient's healthcare provider.

HEALTHCARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION (to be completed by the healthcare provider for the care recipient (patient) and returned to the employee identified above)

The patient's healthcare provider must complete all applicable requested information unless noted as optional.

Question 2: Providing the optional ICD-10 code is recommended.

The patient's healthcare provider must complete the Patient Information and Healthcare Provider sections of the *Healthcare Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4).*

Healthcare 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 *Healthcare Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4)* form from the healthcare provider, send the completed forms and supporting documentation to your employer.

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 taxpayer 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 taxpayer 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 (646) 473-9200.

DO NOT SCAN

Amalgamated Employee Benefits Administrators
Delivering High Quality, Customized TPA Services

1199SEIU Benefit Funds

Request for Paid Family Leave

Healthcare 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 Taxpayer Identification Number (TIN)

Employee's mailing address

STREET 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)

HEALTHCARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION (to be completed by the healthcare provider for the care recipient (patient) and returned to the employee identified above)

Care recipient (patient) information (to be completed by the healthcare provider)

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

☐ Yes ☐ No (If "No," skip to "Healthcare Provider Information" below .)

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

Healthcare provider information (to be completed by the healthcare provider)

8. Healthcare provider's name

If you need assistance, please call (646) 473-9200.

PFL-1 10-17

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)

HEALTHCARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION (to be completed by the healthcare provider for the care recipient (patient) and returned to the employee identified above) - continued from prior page

9. Type of healthcare provider:

- ☐ Medical Doctor (MD)
- ☐ Doctor of Osteopathy (DO)
- ☐ Doctor of Podiatric Medicine (DPM)
- ☐ Doctor of Chiropractic Medicine (DC)
- ☐ Dentist (DDS/DMD)
- ☐ Physician Assistant (PA)
- ☐ Nurse Practitioner (NP)
- ☐ Licensed Psychologist
- ☐ Licensed Social Worker (LMSW/LCSW)
- ☐ Other (specify): _____

10. Healthcare provider's mailing address

STREET ADDRESS

CITY | STATE | ZIP CODE | COUNTRY (IF NOT U.S.A.)

11. Healthcare provider's telephone number (provide area or country code)

12. Healthcare provider's fax number (provide area or country code)

13. Healthcare provider's email address (if available)

14. State or country (if not U.S.A.) in which healthcare provider is licensed to practice

15. Specialty

16. Healthcare provider's license number

Healthcare provider information (to be completed by the healthcare provider)

8. Healthcare provider's name

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.

HEALTHCARE PROVIDER'S SIGNATURE | DATE SIGNED (MM/DD/YYYY)

If you need assistance, please call (646) 473-9200.