



# Applying For Paid Family Leave To Use Paid Family Leave To:



## Paid Family Leave

### **Bond with a newborn, a newly adopted or fostered child**

#### **Complete Form PFL-1**

- Complete PFL-1, Part A

#### **Complete Form PFL-2**

- Complete PFL-2 and collect supporting documentation

#### **Send forms and documents**

- Send completed forms and supporting documentation to insurance carrier
- Insurance carrier accepts or denies claim within 18 days

Care for a family member with a serious health condition

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

Please keep a copy of all pages for your records.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including underwriting companies Hartford Life and Accident Insurance Company and Hartford Fire Insurance Company. Home Office is Hartford, CT. The Hartford is the administrator for certain group benefits business written by Aetna Life Insurance Company and Talcott Resolution Life Insurance Company (formerly known as Hartford Life Insurance Company). The Hartford also provides administrative and claim services for employer leave of absence programs and self-funded disability benefit plans.

# 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.
- Additional forms are required depending on the type of leave being requested. The employee requesting leave is responsible for the completion of these forms.
- **The employee submits the completed *Request For Paid Family Leave (Form PFL-1)* with the required additional form to the employer's PFL insurance carrier listed on Part B of *Request For Paid Family Leave (Form PFL-1)*. The employee should retain a copy of each submitted form for their records.**

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

The employee requesting PFL must complete all required information.

### Paid Family Leave (PFL) Request (to be completed by the employee)

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

**Questions 13:** If dates are "Continuous", the employee must provide the start and end dates of the requested PFL. These dates should be the actual dates that the PFL will begin and end. If uncertain, estimate the start and end dates and indicate "Dates are estimated". If dates are "Periodic", enter the dates PFL will be taken. Please be as specific as possible. If the dates are unknown or estimated,

indicate "Dates are estimated".

If dates are estimated, the PFL carrier may require you to submit a request for payment **after** the PFL day is taken. Payment for approved claims will be due as soon as possible but in no event more than 18 days from the date of the completed request.

**Question 14:** If the employee is submitting the PFL request to their employer with less than 30 days' advance notice from the start date of the PFL, the employee must explain why 30 days' notice could not be given. If the explanation will not fit in the space provided on the form enter "See Attached" and add an attachment with the explanation. Be sure to include the employee's full name and their date of birth at the top of the attachment.

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

**Question 16:** Enter the date of hire to the best of the employee's recollection. If it has been more than a year since the date of hire, entering the year in which employment started is sufficient

**Question 18:** Enter the best estimate of average gross weekly wage. Include only the wages earned from the employer listed on this request form. **The gross weekly wage is the total weekly pay - including overtime, tips, bonuses and commissions - before any deductions are made by the employer**, such as federal and state taxes. If the employer is not able to supply this information, the employee can calculate their gross weekly wage as follows:

**Step 1:** Add all gross wages received (before any deductions) over the last eight weeks prior to the start of PFL, including overtime and tips earned. (See Step 3 for instructions for calculating bonuses and/or commissions.)

**Step 2:** Divide the gross wages calculated in step one by eight (or the number of weeks worked if less than eight) to calculate the average weekly wage.

**Step 3:** If the employee received bonuses and/or commissions during the 52 weeks preceding PFL, add

the prorated weekly amount to the average weekly wage. To determine the prorated weekly amount, add all bonuses/commissions earned in the preceding 52 weeks and then divide by 52.

Example of a gross weekly wage calculation:

Week 1 - Gross wage including overtime	\$550
Week 2 - Gross wage	\$500
Week 3 - Gross wage	\$500
Week 4 - Gross wage	\$500
Week 5 - Gross wage	\$500
Week 6 - Gross wage	\$500
Week 7 - Gross wage, including overtime	\$600
Week 8 - Gross wage, including overtime	+ \$550
Total =	\$4,200
Divide by 8	÷ 8
Average Weekly Wage =	\$525
Bonus earned in preceding 52 weeks	\$2,600
Divide by 52	÷ 52
Prorated Weekly Bonus =	\$50

*Form PFL-1 Instructions continued on next page*

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

*Form PFL-1 Instructions continued from prior page*

Average Weekly Wage	\$525	
Prorated Weekly Bonus	+	\$50
<b>Average Weekly Wage (including bonus) =</b>		<b>\$575</b>

Please note that the employer is also required to provide this information in Part B of the *Request For Paid Family Leave (Form PFL-1)*.

**If you are pre-submitting form:** Indicate if the employee is pre-submitting their PFL request. Pre-submitting is defined as submitting the application in advance of an upcoming qualifying event, with certain required information missing due to the information being unknown at the time of the submitting. If pre-submitting is permitted by the carrier

or self-insured employer, the missing information must be supplied as soon as it is known. Benefits cannot be determined until all of the required information is provided.

The PFL insurance carrier or self-insured employer will provide the employee a notice within five days which 1) states the claim is pending; 2) identifies what information is missing; 3) instructs how to submit the missing information.

**Once all information is supplied, the PFL insurance carrier or self-insured employer has 18 days to pay or deny the claim.**

If the carrier or self-insured employer does not permit pre-submitting, the carrier or self-insured employer must return the Request for Paid Family Leave within five days to the employee with an explanation that the claim should be re-submitted when all information is available.

**Employee signs and dates, before giving this form to their employer to complete Part B.**

**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.

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



**Paid Family  
Leave**

INSTRUCTIONS INCLUDED WITH FORM

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

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

\_\_\_\_\_

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

\_\_\_\_\_

3. **Employee's mailing address**

Street address  
\_\_\_\_\_

City, State  
\_\_\_\_\_

Zip code  
\_\_\_\_\_

Country (if not U.S.A.)  
\_\_\_\_\_

4. **Employee's Social Security Number or TIN**

□□□□ - □□□ - □□□□□□

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

□□ / □□ / □□□□□□

6. **Employee's primary telephone number**

( □□□□ ) □□□□ - □□□□□□

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

\_\_\_\_\_

8. **Employee's gender**

Male  Female  Not designated/Other

9. **Employee's preferred language**

English  Español  Русский  Polski  
 中文  Italiano  Kreyòl ayisyen  한국어  
 Other  
\_\_\_\_\_

### Optional (for research purposes)

10. **Employee's ethnicity/race**

For purposes of health demographic only. (U.S. Centers for Disease Control and Prevention (CDC) code set, version 1.0.)

**Is employee of Hispanic, Latino/a, or Spanish origin?**  
(One or more categories may be selected.)

- Mexican  
 Mexican American  
 Chicano/a  
 Puerto Rican  
 Dominican  
 Cuban  
 Another Hispanic, Latino/a, or Spanish origin  
 Not of Hispanic, Latino/a, or Spanish origin  
 Unknown

**What is employee's race?**

(One or more categories may be selected.)

- American Indian or Alaska Native  
 Black or African American  
 Asian Indian  
 Chinese  
 Filipino  
 Japanese  
 Korean  
 Vietnamese  
 Other Asian  
 White  
 Native Hawaiian  
 Guamanian or Chamorro  
 Samoan  
 Other Pacific Islander  
 Other race

## Paid Family Leave (PFL) Request (to be completed by the employee)

11. **Reason for PFL request:**  Bond with child  Care for family member  Military qualifying event

12. **The family member is employee's:**

Child  Spouse  Domestic partner  Parent  Parent-in-law  Grandparent  Grandchild

Form PFL-1 continued on next page



**TO BE COMPLETED BY THE EMPLOYEE**

**Employee's name** (first name, middle initial, last name) \_\_\_\_\_

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

**PART A - EMPLOYEE INFORMATION** (to be completed by the employee) - continued from 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 dates periodic PFL will be taken:   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?**  Yes  No

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

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

**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.

# Bonding Certification (Form PFL-2) Instruction

If the employee is requesting PFL to bond with a newborn, an adopted child or a foster child, the employee must submit the *Bonding Certification (Form PFL-2)* with the *Request For Paid Family Leave (Form PFL-1)*.

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

The employee requesting PFL must complete all applicable requested information.  
Send completed forms and supporting documentation to insurance carrier.

If this form is being submitted in advance (pre-submitting) and some information is unknown, the insurance carrier will contact the employee and explain how to provide the required additional information.

**Questions 1 & 2:** If the form is submitted to the PFL insurance carrier prior to the birth of a child, this is considered pre-submitting. The employee is then required to provide the required documentation of the child's birth to the PFL insurance carrier. The PFL carrier will tell the employee how to provide the required additional documentation.

There may be instances where PFL can be taken before the adoption or foster care is finalized. For example, the employee may be required to appear in court or travel to another country as part of the adoption or foster care process. The employee should include documentation to show that the PFL is necessary to further the adoption or foster care.

**Question 5:** See chart below for documentation details. Unless specified, do not send the original documents

Bonding Form/Certificatio	Description
Health care provider certification of pregnanc	An <b>original</b> letter obtained from the birth mother's health care provider that certifies pregnancy. It should include the mother's name and the expected due date.
Health care provider certification of birt	An <b>original</b> letter obtained from the birth mother's health care provider that includes the mother's name and child's date of birth.
Birth Certificat	A <b>copy</b> of the certificate issued by the city or county office in which the child is bor
Voluntary Acknowledgment of Paternity (Form LDSS-4418)	A <b>copy</b> of the form that establishes legal fatherhood when the parents are unmarried. Completed by both mother and father. For more information, see <a href="http://childsupport.ny.gov/dcse/aop_howto.html">childsupport.ny.gov/dcse/aop_howto.html</a>
Court Order of Filiation	A <b>copy</b> of the order from the family court that names the father of a child. Establishes legal fatherhood when the parents are unmarried. Completed by both mother and father. For more information, visit <a href="http://childsupport.ny.gov/dcse/aop_howto.html">childsupport.ny.gov/dcse/aop_howto.html</a>
Marriage Certificate	A <b>copy</b> of the official statement issued by the town or city clerk from which the marriage certificate was issued
Civil union/domestic partner's documentation	A <b>copy</b> of the certificate of civil union or domestic partnership
Foster care placement letter	A <b>copy</b> of the letter of foster care placement issued by the county or city department of social services or authorized voluntary foster care agency.
Court documents of adoption	A <b>copy</b> of the court document finalizing adoption or documentation in furtherance or court order finalizing adoption
Other documentation	Other documentation of parental relationship may be accepted if none of the others listed apply.

### 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.



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



## Paid Family Leave

INSTRUCTIONS INCLUDED WITH FORM

### TO BE COMPLETED BY THE EMPLOYEE

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

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

□□ / □□ / □□□□

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

Employee's Social Security Number or TIN

□□□□ - □□ - □□□□

### Employee's mailing address

Mailing address

City, State

Zip code

Country (if not U.S.A.)

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

1. Child's date of birth (MM/DD/YYYY) □□ / □□ / □□□□

2. Child's gender  Male  Female  Not designated/Other

3. Does child live with the employee requesting PFL?  Yes  No

#### 4. Child is employee's:

Biological child  Stepchild  Foster child  Adopted child  Legal ward  Spouse/Domestic partner's child  Loco parentis

#### 5. Select one of the following and attach the document as required as evidence of the relationship.

##### Parent of newborn child:

###### Birth mother:

Health care provider certification of pregnancy (include expected due date AND mother's name); OR

Health care provider certification of birth (include date of birth of child AND mother's name); OR

Child's birth certificate

###### Other parent:

Copy of birth certificate naming second parent; OR

Voluntary acknowledgment of paternity; OR

Court order of filiation; OR

Birth mother documents (see above) PLUS one of the following:

Marriage certificate; OR

Certificate of civil union; OR

Evidence of domestic partnership

OR; Other documentation of parental relationship

##### Foster parent:

Letter of foster care placement or anticipated placement issued by county or city department of Social Services or authorized voluntary foster care agency

##### Adoptive parent:

Court document finalizing adoption

Documentation in furtherance of adoption

6. Date of foster care or adoption placement, if applicable (MM/DD/YYYY) □□ / □□ / □□□□

Form PFL-2 continued on next page



**TO BE COMPLETED BY THE EMPLOYEE**

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

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

/   /

**BONDING CERTIFICATION** (to be completed by the employee) - continued from prior page

*Form PFL-2 continued from prior page*

**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)

/   /

**Fax or mail completed form to:**

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



# 2021 STATEMENT OF RIGHTS



## 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 spouse, domestic partner, child or parent is called to active military service abroad.

Paid Family Leave may also be available for use in situations when you or your minor dependent child are under an order of quarantine or isolation due to COVID-19. See [PaidFamilyLeave.ny.gov/COVID19](https://www.PaidFamilyLeave.ny.gov/COVID19) for full details.

### 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. Citizenship or immigration status is not a factor in your eligibility.

### Benefits:

In 2021, you can take up to 12 weeks of Paid Family Leave and receive 67% of your average weekly wage, capped at 67% 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 within 30 days of starting your leave, to avoid losing benefits.
4. In most cases, the insurance carrier must pay or deny benefits within 18 calendar days of receiving your completed request or your first day of leave, whichever is later.

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

### 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 requesting or taking 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 or take other corrective action within 30 days, you may file a discrimination complaint with the Workers' Compensation Board using the *Paid Family Leave Discrimination/Retaliation Complaint (Form PFL-DC-120)*. The Workers' Compensation Board will assemble your case and schedule a hearing.
4. There are other state and federal laws that protect employees from discrimination. Additional information is available at [PaidFamilyLeave.ny.gov](https://www.PaidFamilyLeave.ny.gov).

For more information, forms and instructions, visit [PaidFamilyLeave.ny.gov](https://www.PaidFamilyLeave.ny.gov) or call the PFL Helpline (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  
Email: [PFL@thehartford.com](mailto:PFL@thehartford.com)

PRESCRIBED BY THE CHAIR,  
WORKERS' COMPENSATION BOARD

NYS Paid Family Leave  
PO Box 9030, Endicott NY 13761

### Si necesita tomarse tiempo libre del trabajo para cuidar a un familiar, quizás tenga derecho a beneficios de Permiso Familiar Pagado

**El Permiso Familiar Pagado (Paid Family Leave, PFL) es un seguro financiado por el empleado que brinda tiempo libre pago con el empleo protegido para:**

- **FORTALECER** el vínculo con un recién nacido, un hijo adoptado o de cuidado temporal;
- **CUIDAR** de un familiar con una condición médica grave; o
- **AYUDAR** a sus seres queridos cuando un cónyuge, una pareja doméstica, un hijo o un padre es llamado al servicio militar activo en el exterior.

El Permiso Familiar Pagado también podría estar disponible para su uso en situaciones en las que usted o su hijo menor de edad dependiente se encuentran bajo una orden de cuarentena o aislamiento debido al COVID-19. Para ver detalles completos, visite [PaidFamilyLeave.ny.gov/COVID19](https://PaidFamilyLeave.ny.gov/COVID19).

#### Elegibilidad:

- Los empleados con un cronograma de trabajo regular de 20 horas o más por semana son elegibles después de 26 semanas consecutivas de empleo.
- Los empleados con un cronograma de trabajo regular de menos de 20 horas por semana son elegibles después de 175 días trabajados.

El estatus migratorio o ciudadanía no es un factor en su elegibilidad.

#### Beneficios:

En 2021, puede pedir hasta 12 semanas de Permiso Familiar Pagado y recibir el 67% de su salario semanal promedio, limitado al 67% del Salario Semanal Promedio del Estado de Nueva York. En general, su salario semanal promedio es el promedio de las últimas ocho semanas de su paga antes de comenzar el Permiso Familiar Pagado.

#### Derechos y protecciones:

- **Protección del puesto de empleo:** Regrese al mismo puesto de empleo, o un puesto comparable, después de tomarse la licencia.
- Usted conserva su **seguro médico** mientras está de licencia (quizás deba seguir pagando su parte de la prima, si la hubiera).
- Su empleador tiene **prohibido discriminarlo o tomar represalias** contra usted por solicitar o tomar Permiso Familiar Pagado.
- No está obligado a agotar su licencia por enfermedad o tiempo de vacaciones acumulado antes de usar el Permiso Familiar Pagado.

#### Proceso de solicitud de un Permiso Familiar Pagado:

1. Notifique a su empleador al menos 30 días por adelantado, si la necesidad de tomarse licencia es previsible, o lo antes posible de lo contrario.
2. Complete y presente la **Solicitud del Permiso Familiar Pagado (Formulario PFL-1)** a su empleador.
3. Complete y adjunte los formularios adicionales según sea necesario y envíelos a la compañía de seguros que figura a continuación dentro de los 30 días siguientes a haber comenzado su licencia, para evitar perder los beneficios.
4. En la mayoría de los casos, la compañía de seguros debe pagar o denegar los beneficios dentro de los 18 días calendario posteriores a la recepción de su solicitud completada o en su primer día de licencia; lo que ocurra después.

Puede obtener todos los formularios de su empleador, su compañía de seguros que se indica más adelante, o por internet ingresando a [PaidFamilyLeave.ny.gov/Forms](https://PaidFamilyLeave.ny.gov/Forms).

#### Disputas:

Si su solicitud de Permiso Familiar Pagado es rechazado, puede solicitar que un árbitro neutral revise el rechazo. La compañía de seguros que se indica más adelante le brindará información sobre cómo solicitar el arbitraje.

#### Quejas por discriminación:

Si su empleador lo despide, reduce su paga o sus beneficios, o lo sanciona de cualquier manera como resultado de su solicitud o toma de un Permiso Familiar Pagado, puede solicitar su reincorporación siguiendo estos pasos:

1. Complete la **Solicitud formal de reincorporación con respecto al Permiso Familiar Pagado (Formulario PFL-DC-119)**.
2. Envíe su formulario completado a su empleador y una copia del formulario completado a:  
Paid Family Leave, P.O. Box 9030, Endicott, NY 13761-9030
3. Si su empleador no lo reincorpora o toma otras acciones correctivas dentro de los 30 días, puede presentar una queja por discriminación ante la Junta de Compensación Obrera (Workers' Compensation Board) usando el formulario de **Queja por Discriminación/Represalias por Permiso Familiar Pagado (Formulario PFL-DC-120)**. La Junta de Compensación Obrera armará su caso y programará una audiencia.
4. Hay otras leyes federales y estatales que protegen a los empleados contra la discriminación. Encontrará más información disponible en [PaidFamilyLeave.ny.gov](https://PaidFamilyLeave.ny.gov).

Para más información, formularios e instrucciones, visite [PaidFamilyLeave.ny.gov](https://PaidFamilyLeave.ny.gov) o llame a la Línea de Ayuda de PFL al (844)-337-6303

Esta información es una presentación simplificada de sus derechos según lo requiere el Artículo 229 de la Ley de beneficios de Permiso Familiar Pagado y Discapacidad. La compañía de seguros de beneficios Permiso Familiar Pagado de su empleador es:

The Hartford P.O. Box 14306 Lexington, KY 40512-4306  
Fax Number: (866) 411-5613 Phone Number: (800) 549-6514  
Email: [PFL@thehartford.com](mailto:PFL@thehartford.com)

ORDENADO POR LA PRESIDENTA,  
LA JUNTA DE COMPENSACIÓN OBRERA  
NYS Paid Family Leave  
PO Box 9030, Endicott NY 13761

# NY PFL Tax Withholding and Electronic Funds Transfer (EFT) Request Form



## Tax Withholding:

Your PFL benefit is 100% taxable. The federal government allows us to withhold 10% of your benefit for Federal Income Tax (FIT) with your permission.

Would you like us to withhold FIT?  Yes  No

## EFT 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.

\_\_\_\_\_  
**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: \_\_\_\_\_