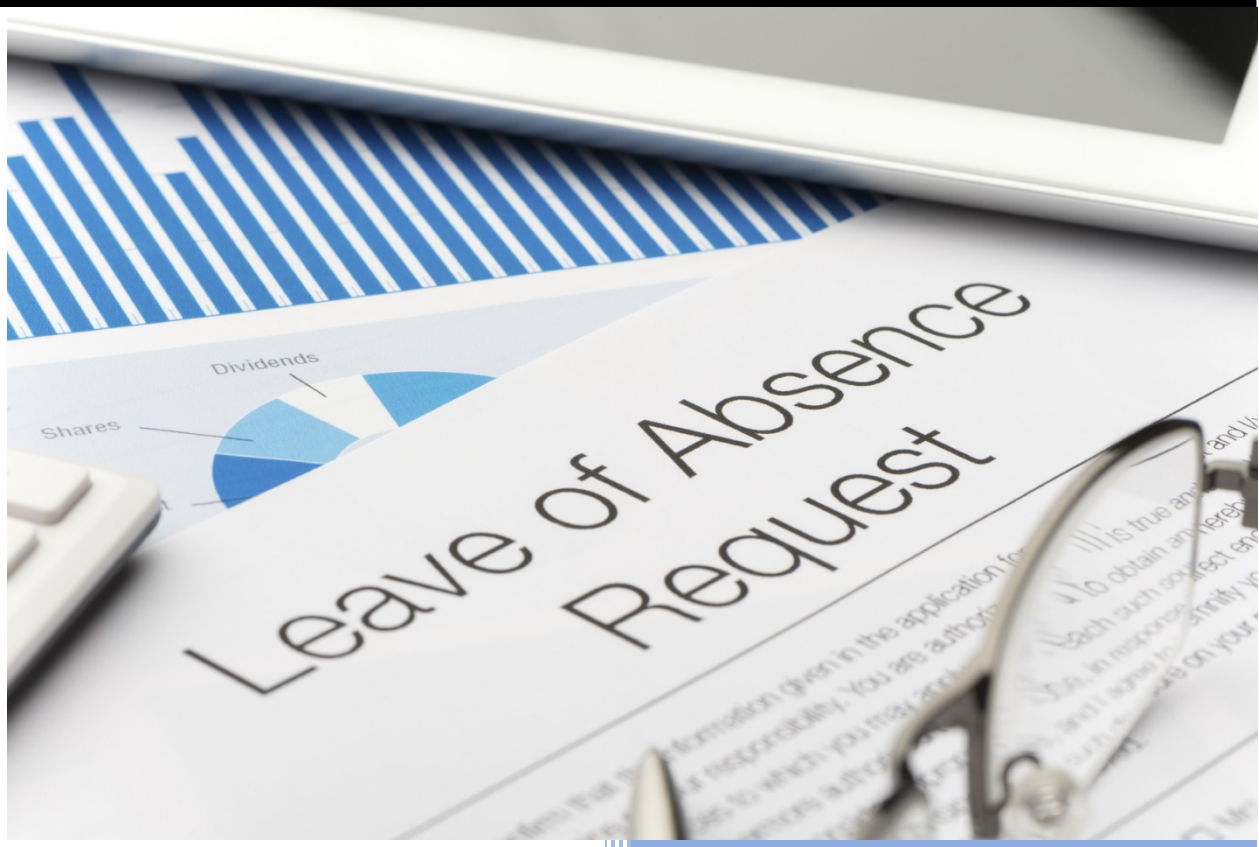
FY 2019

A&S Leave Management Toolkit

For Administrative Employees



Columbia University

EVP HR Team

FY 2019

A&S LEAVE MANAGEMENT TOOLKIT

Appendix

FORMS

Purpose Statement

The Office of the Executive Vice President Human Resources team (EVP-HR) is committed to supporting Arts & Sciences' (A&S) departments, centers, institutes, and programs with their Leave Management needs. To meet the needs of this diverse population, EVP-HR has created customizable tools and resources to help educate the A&S population and provide guidance, consultation, and a clear process.

The A&S Leave Management Toolkit was created to foster communication between managers and employees on all aspects of an upcoming leave of absence. It provides administrators with clear steps in the process for planning, managing and recording various types of leaves. Serving as a roadmap for employees, administrators and managers, this toolkit provides initial guidance on the steps necessary to manage leaves of absence for administrative employees.

The EVP-HR team will continue to assist with University policy interpretation and ensuring compliance with local, state and federal regulations. We are available to provide managers and employees with the guidance and information necessary to complete each step of the leave management process successfully. This Toolkit is designed to be a reference tool but as always, ***"When in Doubt, Reach Out!"***

Sincerely,
EVP-HR Team

A&S Leave of Absence Process (Medical)

Overview

The Arts & Sciences (A&S) leave of absence process for medical leaves outlines the steps necessary to manage leaves of absence effectively for administrative staff– within Arts & Sciences. Included are forms, templates, and information in an easy-to-follow format to guide departmental administrators and managers through the leave management process.

Responsible Office/Contacts

Contact the EVP-HR Team with any questions about this process or the leave management process: Patrice Turner (pct2113@columbia.edu), Tanique Dunkley (td2432@columbia.edu), Davima Broadbelt (db2115@columbia.edu), or Roje Thomas (rt2736@columbia.edu).

Process Steps

1) As soon as an employee is aware of the need for a medical leave, the employee contacts their Director of Academic Administration and Finance (DAAF) or supervisor. If no supervisor is available, or if the employee prefers, s/he contacts the EVP-HR team directly.

   Note: If an employee has been absent for more than 5 business days, the DAAF/supervisor will contact the employee to request appropriate documentation to record the absence and determine if a leave of absence is applicable.

2) Once the employee has notified their DAAF/supervisor:
   a. The department, center, institute or program informs EVP-HR of the upcoming leave via email
   b. The EVP-HR team contacts the employee and/or supervisor, within 1 week of notification, to set up a meeting and discuss the upcoming leave and options. (See appendix for list of forms and links.)
      i. At the conclusion of the meeting, the *Leave & Payroll Timeline* is completed by the department/supervisor, confirmed by the employee, and sent to EVP-HR to schedule payroll adjustments, etc.

3) To initiate a disability claim with Cigna, the employee must call Cigna at 800-362-4462 (or 866-562-8421 español) on or 3 days before leave begins. (If applicable, the employee indicates the desire for Paid Family Leave (PFL) during call.) Once the claim is initiated and the DB450 form is received by Cigna, Cigna will:
   a. Alert Columbia University's central office of Leave Management (LMO) of the new claim and LMO will begin tracking the leave

b. Email EVP-HR with a 'Questionnaire' to verify dates and details of the leave.
    i. EVP-HR will complete the 'Questionnaire' (and the PFL information form and complete the employer section of the PFL application form if applicable), confirm the information with the supervisor, and return the questionnaire to Cigna.
    ii. The employee and department revises the *Leave & Payroll Timeline*, if necessary and returns it to EVP-HR
    iii. If the employee wishes to take Paid Family Leave, they may complete the applicable sections of the appropriate PFL Application forms (see table in appendix) and send them to EVP-HR

4) Cigna will certify the leave, contacting the employee and/or physician for any outstanding information.

5) ***__The employee must notify the department and Cigna of date of birth/adoption__***

6) Once Cigna reviews the Short Term Disability (STD) claim, Cigna will send communications to EVP-HR (via secure email) and the employee (via Postal Mail):
    a. If **approved** by Cigna: EVP-HR will confirm PAF codes (on *Leave & Payroll Timeline*) with supervisor and then submit PAF to CUHR to place the employee on a leave of absence in PAC.
    b. If **rejected** by Cigna (or if there are any issues): EVP-HR will escalate the claim to Leave Management for resolution

7) When EVP-HR receives the approval notice from Cigna, EVP-HR will inform the department and/or employee.
    a. The department will complete the PAF, using codes on the *Leave & Payroll Timeline*, and submit it to EVP-HR.
    b. EVP-HR will submit the PAF to Central HR to update the leave status in PAC.
    c. EVP-HR will submit all PFL paperwork to Cigna if applicable.

8) Depending on the nature of the leave, the EVP-HR office will schedule regular check-in communications with the employee (or supervisor) in order to stay abreast of a return to work date.

    EVP-HR will initiate communication with the employee at least two weeks before their scheduled return to work date to:
    a. Confirm return to work date
    b. Confirm if accommodation is requested
    c. Inform employee that a doctor's note – stating that the employee is cleared to return to work – is required.

9) Employee will send the above referenced note to their DAAF or supervisor on, or before, their actual return to work date.

10) DAAF/supervisor will forward the return to work note and PAF to EVP-HR to end the leave in PAC.

IF AN EXTENSION IS REQUESTED: EVP-HR will confirm the new end date(s) with the employee and/or supervisor and contact Cigna. Cigna will review the extension request. If approved, Cigna will send a new approval notice to EVP-HR and the employee. If denied, EVP-HR will contact the department and/or the employee to discuss next steps.

****Any changes to the leave timeline MUST be communicated to EVP-HR and Cigna ASAP****

A&S LEAVE MANAGEMENT PROCESS

Start

Notification | Submission | Review & Approval | PAC Update(s)

Employee

As soon as employee is aware of the need for a leave of absence, the employee will contact their DAAF or supervisor to discuss upcoming leave *(If no supervisor available, employee contacts EVP-HR directly)*

A. Employee returns completed *Leave & Payroll Timeline* (and PFL application – with employee section completed, if applicable) to EVP-HR & supervisor
B. Employee calls Cigna at 800.362.4462 or 866.562.8421 (Español)(on the first day out – but no more than 6 days before leave begins) to initiate Short-term Disability (STD) claim (s); sends forms to Cigna & Leave Management (LMO);
C. Indicates desire for Paid Family Leave (PFL) if applicable

When in Doubt, Reach Out!

EVPHR Team
Patrice Turner (pct2113@columbia.edu)
Tanique Dunkley (td2432@columbia.edu)
Davima Broadbelt (dbb2115@columbia.edu)
Rojè Thomas (rt2736@columbia.edu)

A. Employee (or physician) returns requested forms and documents if required
B. Employee notifies Dept., EVP-HR, & Cigna of date of birth/ adoption

Employee (or department) contacts EVP-HR to confirm return to work on 1st day back in office
IF EXTENSION IS REQUESTED: EVP-HR will confirm the new end date(s) with the employee/dept. and update Cigna

Department/ Supervisor

Department informs EVP-HR of upcoming leave

Confirms Cigna STD questionnaire details (completes PFL info form, and employer section of PFL application, if applicable); returns to EVP-HR
Re-send *Leave & Payroll Timeline* for confirmation

Within 2 days

2 days

2 days

Dept. submits PAF to EVP-HR to update leave status in PAC; Contact employee to confirm return from leave (RFL) 2 weeks before scheduled return**

EVP-HR Team

EVP-HR contacts employee to meet and discuss leave process and provide forms, contacts, and important information

2 day waiting period

EVP-HR completes Cigna STD questionnaire (& PFL info form if applicable), sends to supervisor for confirmation

Returns STD questionnaire to Cigna

3 days waiting period

Upon receipt of approval notice(s), EVP-HR informs dept; EVP-HR submits completed PFL paperwork to Cigna, if applicable and confirm submission with dept./employee

Upon notification from dept., EVP-HR will submit PAF to Central HR to record end of leave in PAC

Cigna

Cigna sends STD questionnaire to EVP-HR (University's central office of Leave Management [LMO] begins tracking the leave)

2 days

2 days

Cigna contacts employee to request any outstanding documents; contacts physician to certify disability

Cigna reviews claim and certifies leave

5-18 days waiting period

APPROVED:
Sends approval notice to employee & EVP-HR office
If rejected, EVP-HR will escalate the issue to LMO

End

IF THERE ARE ANY ISSUES OR IF THE LEAVE IS NOT APPROVED WITHIN 5 BUSINESS DAYS, EVP-HR WILL ESCALATE THE MATTER TO LEAVE MANAGEMENT

Appendix

DESCRIPTION OF FORMS

Cigna NYSDBL Intake Brochure - The employee must file the New York State Disability (NYSDBL) claim: By Phone: 888-842-4462, 8 a.m. - 8 p.m. EST, Monday through Friday; or Online: www.Cigna.com/customer-forms (link is external) (no username/password)

Leave & Payroll Timelines – Use the appropriate tab to create a Leave & Payroll Timeline for each leave case

FMLA form (WH-380-E) – Must be completed by the employee and their healthcare provider; then returned to the Cigna by an indicated deadline. The purpose of this form is to certify an employee's eligibility for a leave of absence under the Family and Medical Leave Act.

NYS Disability form (DB-450) – Must be completed by the employee and their healthcare provider and then returned to the Cigna by the indicated deadline. The purpose of this form is to validate the request of leave with the appropriate medical professionals.

Paid Family Leave (PFL) Information form – If applicable, this form must be completed by the department and/or EVP-HR.

Paid Family Leave (PFL) Application forms:

Type of Paid Family Leave	Reason	Required Form(s)
PFL Bonding Leave	Bond with a newborn, a newly adopted or fostered child	PFL-1 PFL-2
PFL Family Care Leave	Care for a family member with serious health condition	PFL-1 PFL-3 PFL-4
PFL Military-Related Leave	Assist family members due to another family member's active military duty or impending active duty abroad	PFL-1 PFL-5

Paid Family Leave (PFL) Statement of Rights – This is a reference documents for employee's eligible for Paid Family Leave

INFORMATIONAL LINKS

Family and Medical Leave Act of 1993 (FMLA)

http://hr.columbia.edu/policy/family-and-medical-leave-act-fmla

Medical Leave of Absence Policy for Full-Time Officers

http://hr.columbia.edu/policy/medical-leave-absence-full-time-officers-administration

Medical Leave of Absence (Non-Union Support Staff)

http://hr.columbia.edu/policy/medical-leave-absence-non-union-support-staff

Disability Insurance/Salary Continuation Plan for Full-Time Officers

http://hr.columbia.edu/find-out-about/benefits/officers-health-welfare/officers-2017-disability-insurance

Parental Care Leave

http://hr.columbia.edu/policy/parental-care-leave

New York State Paid Family Leave

http://policylibrary.columbia.edu/new-york-state-paid-family-leave

https://paidfamilyleave.ny.gov/paid-family-leave-information-employees

HOW TO REPORT A DISABILITY CLAIM

under Columbia University New York State Disability

When do I report a claim?

- Contact your manager on or before your first day out of work. Tell them when and for how long you plan to be absent.
  - Submit a medical note to your department after five (5) days absence.
  - Complete and return any applicable Family Medical Leave Act (FMLA) paperwork to the Columbia University Human Resources Leave Management Office.
- If you know you'll be out for more than one week, call Cigna at **800.362.4462**. Make sure you call us before your seventh day out of work so we can begin reviewing your claim.

How do I report a disability claim?

Simply do one of the following:

- Call toll-free **800.362.4462** or **866.562.8421** (Español). A representative will walk you through the process.
- Fill out a claim form online at Cigna.com/customer-forms using the following steps:
  - Click 'Select Disability/Accident/Life/Critical Illness Forms'
  - Click 'Submit a Disability Claim'
  - This will bring you to the disclosure notice page
  - Review and click 'Continue' at the bottom of the page
  - Click 'Submit a Disability Claim Online' to begin

If you need immediate medical attention, please call 911

What information do I need?

Before you call or get online, please have this information handy:

- Your name, uni, address, phone number, birth date, Social Security number and email address.
- Employment information, such as date hired and job title.
- Reason for your claim – illness, injury or pregnancy.
- Description of your illness, symptoms, and/or diagnosis. Include the date your symptoms started and if you have had these symptoms before.
- Workers' compensation claims you've filed or plan to file.
- Details about doctor, hospital or clinic visits, including dates and contact information.

continued on the next page

Cut and carry for easy reference

How to report a disability claim:
800.362.4462 or 866.562.8421 (Español)
Visit: Cigna.com/customer-forms

Please have this Information handy:

- Your name, uni, address, phone number, birth date, date of hire, Social Security number and your employer's name, address and phone number.
- Date of your claim and when you plan to return to work. If you're pregnant, give your expected delivery date.
- Name, address and phone number of each doctor you are seeing for this absence.

Together, all the way.®

Cigna®

What happens next?

During the call, Cigna will ask for your permission to get your medical information. Here's how it works:

- After you give Cigna your claim information, you'll be transferred to a recorded message.
- Listen to the recording and answer "Yes" or "No" to the questions.
- At the end of the recording, say "Yes" if you give permission or "No" if you do not.
- You can cancel your permission at any time by calling your Cigna claims manager.

After the call, Cigna will send you a letter. It'll include a copy of the recorded message for your records. It'll also include a form that gives Cigna permission to get other information we may need to finish processing your claim. Please sign and return that form. Check with your doctor to see if there are any other forms you need to sign.

A Cigna claim manager will call you and your employer (HR Departmental Contact) for a list of your job requirements, last day worked and sick time used. The claim manager will also call your doctor for your medical records. This information will help Cigna figure out how long you may be out of work, and the benefits you may be able to receive.

What happens if my claim is approved?

- Cigna will send you an approval letter that gives you an explanation of your benefits. You may also get a recorded call from Cigna with this information.
- Cigna will coordinate payment of your benefits as soon as possible.
- Cigna will tell your employer that your claim has been approved, and the date you plan to return to work.

What happens if my claim is denied?

- Cigna will send you a letter that explains why. The letter will also tell you how you can appeal the decision.
- Cigna will let your employer know the claim is denied.
- You should call your HR Departmental Contact/ Manager when you get the letter to discuss next steps.

What can I expect while I'm out?

Your Cigna claim manager will stay in touch to help you return to work quickly and safely. The Cigna claim manager may work with you, your doctor and your employer to talk about different work options. This may include an adjustment to your job or work schedule. Your employer may also call you to check on your progress and offer support.

What if I can't return to work on the date my disability benefits end?

Call your Cigna claim manager to talk about the situation and learn about your options.

- Any request for extension of a leave must be submitted prior to the expected return to work date to the Columbia University Human Resources Leave Management Office.

What should I do when it's time to return to work?

Call your Cigna claim manager to confirm the date you'll be returning to work. Call your manager to let them know your return-to-work date.

Prior to returning to work, medical certification from a physician should be submitted to both Cigna and the Columbia University Human Resources Leave Management Office.

Questions?

- Call **800.362.4462**. A Cigna representative is available to help you between 8:00 am and 8:00 pm EST.
- Columbia University Human Resources
  Leave Management Office
  615 West 131st Street, MC 8703
  Studebaker 4th Floor
  New York, NY 10027
  Telephone: (212) 851-7000
  Fax: (212) 851-7069
  Email: leavemanagement@columbia.edu

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached:

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____Yes. If so, explain:

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Print Form

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. USE THIS FORM IF YOU BECOME SICK OR DISABLED **WHILE EMPLOYED** OR IF YOU BECOME SICK OR DISABLED **WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT**. USE CLAIM FORM **DB-300** IF YOU **BECOME SICK OR DISABLED AFTER HAVING BEEN UNEMPLOYED MORE THAN FOUR (4) WEEKS**.
2. YOU MUST COMPLETE ALL ITEMS OF PART A - THE **"CLAIMANT'S STATEMENT"**. BE ACCURATE. CHECK ALL DATES.
3. BE SURE TO DATE AND SIGN YOUR CLAIM (SEE ITEM 12). IF YOU CANNOT SIGN THIS CLAIM FORM, YOUR REPRESENTATIVE MAY SIGN IT IN YOUR BEHALF. IN THAT EVENT, THE NAME, ADDRESS AND REPRESENTATIVE'S RELATIONSHIP TO YOU SHOULD BE NOTED UNDER THE SIGNATURE.
4. **DO NOT MAIL THIS CLAIM UNLESS YOUR HEALTH CARE PROVIDER COMPLETES AND SIGNS PART B - THE "HEALTH CARE PROVIDER'S STATEMENT."**
5. YOUR COMPLETED CLAIM SHOULD BE MAILED **WITHIN THIRTY (30) DAYS AFTER YOU BECOME SICK OR DISABLED TO YOUR LAST EMPLOYER OR YOUR LAST EMPLOYER'S INSURANCE COMPANY.**
6. MAKE A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS BEFORE YOU SUBMIT IT.

PART A - CLAIMANT'S STATEMENT (Please Print or Type) ANSWER ALL QUESTIONS

Social Security Number

1. My name is..... (First / Middle / Last)
2. Address..... (Number / Street / City or Town / State / Zip Code / Apt. No.)
3. Tel. No. . . . 4. Date of Birth . . . 5. Married (Check one) ❑Yes ❑No
6. My disability is (if injury, also state how, when and where it occurred) .....

.....

7. I became disabled on ..... (Month / Day / Year) a. I worked on that day ❑ Yes ❑No

   b. I have since worked for wages or profit. ❑ Yes ❑ No If "Yes", give dates .....

8. Give name of last employer. If more than one employer during the last eight (8) weeks, name all employers.

EMPLOYER'S			DATES OF EMPLOYMENT						AVERAGE WEEKLY WAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM			THROUGH			
			Mo.	Day	Yr.	Mo.	Day	Yr.	
Columbia University in the City of New York									

9. My job is or was ..... (Occupation) ..... (Name of Union and Local Number, If Member)
10. For the period of disability covered by this claim
    a. Are you receiving wages, salary or separation pay: ..... ❑ Yes ❑ No
    b. Are you receiving or claiming:
       (1) Workers' compensation for work-connected disability..... ❑ Yes ❑ No
       (2) Unemployment Insurance Benefits..... ❑ Yes ❑ No
       (3) Damages for personal injury ..... ❑ Yes ❑ No
       (4) Benefits under the Federal Social Security Act for long-term disability ..... ❑ Yes ❑ No

    IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 10a OR 10b, COMPLETE THE FOLLOWING:
    I have ❑ received ❑ claimed from ..... for the period ..... (Date) to..... (Date)
11. I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began ..... ❑ Yes ❑ No
    If "Yes", fill in the following: I have been paid by .....From ..... (Date) To ..... (Date)
12. I have read the instructions above. I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled; and that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Claim signed on ..... (Date) ..... (Claimant's Signature)

If signed by other than claimant, print below: name, address, and relationship of representative.

.....

Disclosure of Information: The Board will not disclose any information about your case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized party, you must file with the Board an original signed Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records, or an original signed, notarized authorization letter. You may telephone your local WCB office to have Form OC-110A sent to you, or you may download it from our web page, www.wcb.state.ny.us. It can be found under the heading Common Forms Online. Mail the completed authorization form or letter to the address given below.

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NYS WORKERS' COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

SI TIENE DUDAS RELACIONADAS CON LA RECLAMACIÓN DE BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA DE NUEVA YORK, O ESCRIBA A: WORKER'S COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY- MENANDS, ALBANY, NY 12241-0005

DB-450 (2-04) **HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE**

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

IMPORTANT: USE THIS FORM ONLY WHEN THE CLAIMANT BECOMES SICK OR DISABLED **WHILE EMPLOYED OR** BECOMES SICK OR DISABLED **WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT**. OTHERWISE USE CLAIM FORM DB-300.

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY AND THE FORM MAILED TO THE INSURANCE CARRIER OR SELF-INSURED EMPLOYER, OR RETURNED TO THE CLAIMANT WITHIN SEVEN DAYS OF THE RECEIPT OF THE FORM. For item 7d, give approximate date. Make some estimate. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks".

1. Claimant's Name ..... 2. Date of Birth ..... 3. Sex ❑ Male ❑ Female

4. Diagnosis/Analysis ..... Diagnosis Code.....
   a. Claimant's Symptoms .....
   .....
   .....
   b. Objective Findings .....
   .....

5. Claimant Hospitalized? ❑ Yes ❑ No From ..... To .....
6. Operation Indicated? ❑ Yes ❑ No a. Type ..... b. Date .....
7. Enter Dates for the Following:

	Month	Day	Year
a. Date of your first treatment for this disability			
b. Date of your most recent treatment for this disability			
c. Date claimant was unable to work because of this disability			
d. Date claimant will be able to perform usual work			

   (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)
8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? ❑ Yes ❑ No
   If yes, has form C-4 been filed with the Workers' Compensation Board? ❑ Yes ❑ No
   Remarks (attach additional sheet, if necessary) .....
   (If disability is pregnancy related, please enter estimated delivery

I affirm that I am a	❑ Chiropractor ❑ Dentist	❑ Physician ❑ Podiatrist	❑ Psychologist ❑ Nurse-Midwife	Licensed in the State of	License Number

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Health Care Provider's Signature ..... Date .....
Health Care Provider's Name (Please Print) ..... Tel.No. .....
Office Address .....
Number Street City or Town State Zip

HIPAA NOTICE - In order to adjudicate a workers' compensation claim, WCL13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

Mail this form to:

Columbia University HR Disability Services
Studebaker, 4th Floor
615 West 131st Street
New York, NY 10027

fax: 212-851-7069
email: hrdisability@columbia.edu

Instructions to complete the Leave & Payroll Timeline

1 Enter Employee's Name

2 Select Employee's Department Name

3 Enter Leave Begin Date

This entry will automatically populate the leave dates in rows and columns N8 through O39.

4 Enter Projected Leave End Date

5 Enter dates under each Applicable leave section

6 Choose appropriate PAF codes and effective dates next to each of the corresponding leave sections

Guidance on PAF codes can be found in the PFL approval notices from Leave Management and on the HR Website:

PAC Action Reason Codes Link: https://humanresources.columbia.edu/content/action-reason-codes

HR Manager Toolkit Link: https://humanresources.columbia.edu/toolkit

Scroll down to the "Managing Leaves of Absence" tab

7 Add dates to complete the Leave Summary section (above the "Important Information" section)

8 Add dates for the 1st day back in the office/active and the 1st pay date on CU payroll after leave

Examples*

1 An Officer who is going out on a pregnancy-related disability leave, beginning 1/14/19, will use 6 weeks of short-term disability and then use 10 weeks of Paid Family Leave. She will return to work after the PFL has concluded. Here is the estimated leave summary for this situation:

Leave Type	Effective Date	PAF Action	PAF Reason	Date PAF must be sent to HRPC to avoid a negative impact on payroll
Salary Continuation	1/14/2019	PLA	NOC	**12/28/2018** for a 1/15/19 paycheck
Paid Family Leave	2/25/2019	LOA	PFF	**2/15/2019** for a 2/28/19 paycheck
Return to work	5/6/2019	RFL	LOA	**5/1/2019** for a 5/15/19 paycheck

1/14/19-2/24/19	N/A	2/25/19-5/5/19	5/6/2019
Salary Continuation - Disability	**Time Off**	**Paid Family Leave**	**Return from Leave**

2 A Local 2110 union employee who is going out on a pregnancy-related disability leave, beginning 1/14/19, will use 6 weeks of short-term disability (using 15 sick days & 5 vacation days) and then 10 weeks of Paid Family Leave. She will return to work after the PFL has concluded. Here is the estimated leave summary for this situation:

Leave Type	Effective Date	PAF Action	PAF Reason	Date PAF must be sent to HRPC to avoid a negative impact on payroll
Accrued Time Off - Paid Leave during STD	1/14/2019	PLA	NOC	**1/11/19** for a 1/25/19 paycheck
Short-term Disability* - Unpaid Leave	2/11/2019	LOA	FNO	**2/25/19** for a 3/8/19 paycheck
**STD dates are certified by a physician. In this case the employee is using accrued time off to receive full pay during short-term disability.*				
Paid Family Leave	2/25/2019	LOA	PFF	**2/25/19** for a 3/8/19 paycheck
Return to work	5/6/2019	RFL	LOA	**5/6/19** for a 5/17/19 paycheck

1/14/18-2/24/18	1/14/19-2/17/19	2/25/19-5/5/19	5/6/2019
Short-term Disability	**Accrued Time Off**	**Paid Family Leave**	**Return from Leave**

**These examples assume timely submission of required paperwork. Late paperwork & communication may delay payrolls.*

Commonly Used PAF Codes for Leaves

Type or Payroll Action Type	Action	Reason
Columbia University Salary Continuation (CUSC)	PLA	NOC
Paid Family Leave (PFL)	PFL/PFF	NOC
Personal Leave of Absence (PER)	LOA	PER/FPL/FPR
Accrued Time Off (TO)	PLA	NOC

For Intermittent Leaves, consult EVP-HR and Leave Management to avoid payroll issues and ensure leave is recorded properly in PAC.

Frequently Asked Questions

Leaves of Absence

1 Will all regular payroll deductions (i.e. medical/dental premiums, transit, retirement contributions, CU matching contributions, etc…) continue while I am on leave?

· Yes, all regular deductions will be taken out of an employee's paycheck *while they are on paid leave* (on the University's payroll).

· No deductions will be taken while the employee is on an unpaid leave as they will not receive a paycheck from the University. The employee will be responsible for paying the medical/dental contributions while on an unpaid leave. The will be the same amount that is normally deducted from the employee's paycheck. (For unpaid leaves beyond 6 months, the medical/dental contribution will be at higher, COBRA, rates.)

2 How are time off accruals handled during leaves of absence?

· Employees on a *paid leave of absence* will accrue sick, personal, and vacation days as normal.

· Employees on an *unpaid leave of absence* will not accrue any paid time off.

3 Which employees are eligible for Paid Family Leave?

Covered employees become eligible to take Paid Family Leave for a qualifying event once they have met the minimum time-worked requirements:

Full-time employees: Employees who work a regular schedule of 20 or more hours per week are eligible after 26 consecutive weeks of employment.

Part-time employees: Employees who work a regular schedule of less than 20 hours per week are eligible after working 175 days, which do not need to be consecutive. Employees with irregular schedules should look at their average schedule to determine if they work, on average, fewer than 20 hours per week.

The use of scheduled vacation time; the use of personal, sick or other time away from work that has been approved by the University; or other periods where the employee is away from work but is still considered to be an employee of the University, shall be counted as consecutive weeks or consecutive work weeks, or days worked, as long as the contributions to the cost of family leave benefits have been paid for such periods of time.

4 Is Paid Family Leave (PFL) only eligible to New York State residents?

No, PFL is available to all employees who work in New York State (subject to eligibility criteria).

5 When and how can an employee apply for Paid Family Leave?

Paid Family Leave should be applied for on the first day out of the office (or no more than 6 days in advance) & after Short-term disability concludes (if applicable), the employee must contact Cigna to apply for Paid Family Leave. EVP-HR will provide salary and leave info for PFL approved application and return it to the employee within 3 days. Once the employee completes the PFL application, they must submit it to Cigna.

6 If a continuous leave begins in 2018, and it extends into 2019, is the employee eligible for the benefits at the 2019 rate and an extra two weeks?

The employee gets the benefit rate and number of weeks in effect on the first day of your leave.

7 If an employee starts an intermittent leave in 2018, and it extends into 2019, is the employee eligible for the benefits at the 2019 rate and an extra two weeks?

The employee gets the benefit rate and number of weeks in effect on the first day of a period of leave. When more than three months passes between days of Paid Family Leave, the employee's next day or period of Paid Family Leave is considered a new claim under the law. This means that the employee will need to file a new Request for Paid Family Leave and that the employee may be eligible for the increased benefits available should this day or period of Paid Family Leave begin in 2019.

8 An employee used all eight weeks of PFL in 2018. Can the same employee take more PFL in 2019 if they experience another qualifying event?

If the employee experiences another qualifying event in 2019, they may be eligible for up to two weeks of additional leave. The maximum amount of leave in 2019 is 10 weeks in a 52 week period. If the employee took eight weeks of PFL in the last

52 weeks, and has another qualifying event in 2019, they may be limited to two weeks at the new rate, since it is a rolling calendar. When it has been 52 weeks from the employee's 2018 leave dates, they will accrue a new week of available PFL up to another eight weeks.

9 How can we set up direct deposit for Short-Term Disability and Paid Family Leave payments?

During the initial call with Cigna, employees must indicate the need for Direct Deposit. The claim specialist will work with the employee to complete this request**.

**This only pertains to payments disbursed via Cigna. Payments made through the University (i.e. salary continuation for officers, short-term disability/Paid Family Leave payments used in conjunction with accrued paid time off that enables employees to recieve full pay during the leave) are not eligible fo direct deposit through Cigna.

10 If the Department/Center/Institute approves a leave of absence (disability or PFL) for an employee who is not eligible for FMLA and has no unused, accrued sick, vacation, or personal days available for use, and Cigna rejects/deines the claim, what are the employee's options?

OFFICERS OF ADMINISTRATION:

A. The Department/Center/Institute can advance Paid Time Off (PTO) for use. This time must be planned and approved in advance.
B. Employee can take an unpaid leave of absence - pending EVP-HR & CUHR approval.
C. The Department/Center/Institute can deny the leave of absence.

UNION & NON-UNION SUPPORT STAFF:

A. Employees who have successfully passed the probationary period can take an unpaid leave of absence - pending EVP-HR & CUHR approval.
B. The Department/Center/Institute can deny the leave of absence.

Medical Leave of Absence & Payroll Timeline for

Officers of Administration

Employee Name	
Department	
1st day out of office	1/1/2019
Expected Return to Work	

Notes:

Columbia University Salary Continuation (CUSC)

Columbia University benefit for eligible employees on Short-term Disability

Payroll Information	Paid via CU
Amount Due to Employee	Full Salary (*up to 6 months)
Salary Continuation Begins	________
Salary Continuation Ends	________

Accrued Time Off (TO)

Accrued vacation, personal, and sick days used to receive full pay

Payroll Information	Paid via CU
Amount Due to Employee	Full Salary
Vacation Days	# of days: From: / / To: / /
Personal Days	# of days: From: / / To: / /

Paid Family Leave (PFL)

NYS Paid Family Leave cannot be taken during short-term disability

Payroll Information	Paid via Cigna
Amount Due to Employee	55% of weekly salary (up to $746.41/week) for 10 weeks
PFL Begins	________
PFL Ends	________

Columbia University Parental Care Leave (PCL)

Unpaid Leave of Absence

Payroll Information	Unpaid
Amount Due to Employee	$0/week
PCL Begins	________
PCL Ends	________

Return from Leave (RFL)

1st day back in the office

Return to Work	________

PAF Codes

Effective Date	Action	Reason
________	________	________
________	________	________
________	________	________
________	________	________
________	________	________

	Week begins	Week Ends	
1	1/1/19	1/7/19	First day of approved disability
2	1/8/19	1/14/19	
3	1/15/19	1/21/19	
4	1/22/19	1/28/19	
5	1/29/19	2/4/19	
6	2/5/19	2/11/19	Average end of disability after standard births
7	2/12/19	2/18/19	
8	2/19/19	2/25/19	Average end of disability after c-section births
9	2/26/19	3/4/19	
10	3/5/19	3/11/19	
11	3/12/19	3/18/19	
12	3/19/19	3/25/19	
13	3/26/19	4/1/19	
14	4/2/19	4/8/19	
15	4/9/19	4/15/19	
16	4/16/19	4/22/19	
17	4/23/19	4/29/19	
18	4/30/19	5/6/19	
19	5/7/19	5/13/19	
20	5/14/19	5/20/19	
21	5/21/19	5/27/19	
22	5/28/19	6/3/19	
23	6/4/19	6/10/19	
24	6/11/19	6/17/19	
25	6/18/19	6/24/19	
26	6/25/19	7/1/19	Salary Continuation Exhaustion Date for Officers

________ **1st pay date on CU Payroll after leave**

________ **1st day back in the office/Active**

LEAVE SUMMARY

Columbia University Salary Continuation -Short-term Disability	Paid Family Leave	Accrued Time Off	Return from Leave

Important Information

Family Medical Leave Act (FMLA)	FMLA is a benefit mandated by New York state that provides unpaid job protection for eligible employees; maximum 12 weeks/year. Employees who have worked at CU for 12 months or more are eligible for FMLA. FMLA leaves can be taken due to the following circumstances: The birth or adoption of a child or the foster care placement of a child (FMLA leave must be concluded within 12 months of the birth, adoption or placement of the child; To care for the employee's spouse, child or parent who has a serious health condition; A serious health condition of the employee that makes the employee unable to perform the functions of employee's job.
Columbia University Salary Continuation (CUSC)	Salary Continuation is a university benefit that provides full pay to Officers of Administration, who are on short-term disability (certified by a physician), up to 6 months
Columbia University Parental Care Leave (PCL)	PCL begins automatically after the medical disability period ends (for those employees eligible for payment under a pregnancy-related disability) or adoption/fostering of a child. This benefit can be used once within a 12-month period, up to a maximum of 6 months.
Paid Family Leave (PFL)	PFL is a benefit provided by New York state for employees to: **Bond** with a newly born, adopted or fostered child within the first 12 months of birth or placement. **Care** for a spouse, domestic partner, child/stepchild, parent/stepparent, parent-in-law, grandparent, or grandchild with a serious health condition. **Assist** a spouse, domestic partner, child/stepchild, parent/stepparent or parent-in-law when they are deployed abroad on active military service. This benefit can be used up to 12 months after the qualifying event. (For those eligible for payment under a pregnancy-related disability, Paid Family Leave begins after the medical disability period ends.)

Medical Leave of Absence & Payroll Timeline for

Non-Union Support Staff (NUSS)

Employee Name	
Department	
1st day out of office	1/1/2019
Expected Return to Work	

Notes:

Short-term Disability (STD)
Payments from NYS while employee is certified disabled by a physician

Payroll Information	Paid via Cigna
Amount Due to Employee	$170/week
STD Begins	
STD Ends	

Accrued Time Off (TO)
Accrued vacation, personal, and sick days used to receive full pay

Payroll Information	Paid via CU
Amount Due to Employee	Full Salary
Vacation Days	# of days: From: / / To: / /
Personal Days	# of days: From: / / To: / /
Sick Days	# of days: From: / / To: / /

Paid Family Leave (PFL)
NYS Paid Family Leave cannot be taken during short-term disability

Payroll Information	Paid via Cigna
Amount Due to Employee	55% of weekly salary (up to $746.41/week) for 10 weeks
PFL Begins	
PFL Ends	

Columbia University Parental Care Leave (PCL)
Unpaid Leave of Absence

Payroll Information	Unpaid
Amount Due to Employee	$0/week
PCL Begins	
PCL Ends	

Return from Leave (RFL)
1st day back in the office

Return to Work	

PAF Codes

Effective Date	Action	Reason

	Week begins	Week Ends	
1	1/1/19	1/7/19	First day of approved disability
2	1/8/19	1/14/19	
3	1/15/19	1/21/19	
4	1/22/19	1/28/19	
5	1/29/19	2/4/19	
6	2/5/19	2/11/19	Average end of disability for standard births
7	2/12/19	2/18/19	
8	2/19/19	2/25/19	Average end of disability for c-section births
9	2/26/19	3/4/19	
10	3/5/19	3/11/19	
11	3/12/19	3/18/19	
12	3/19/19	3/25/19	
13	3/26/19	4/1/19	
14	4/2/19	4/8/19	
15	4/9/19	4/15/19	
16	4/16/19	4/22/19	
17	4/23/19	4/29/19	
18	4/30/19	5/6/19	
19	5/7/19	5/13/19	
20	5/14/19	5/20/19	
21	5/21/19	5/27/19	
22	5/28/19	6/3/19	
23	6/4/19	6/10/19	
24	6/11/19	6/17/19	
25	6/18/19	6/24/19	
26	6/25/19	7/1/19	

1st pay date on CU Payroll after leave

1st day back in the office/Active

LEAVE SUMMARY

Short-term Disability	**Paid Family Leave**	**Accrued Time Off**	**Return from Leave**

Important Information

Family Medical Leave Act (FMLA)

FMLA is a benefit mandated by New York state that provides unpaid job protection for eligible employees; maximum 12 weeks/year. Employees who have worked at CU for 12 months or more are eligible for FMLA. FMLA leaves can be taken due to the following circumstances: The birth or adoption of a child or the foster care placement of a child (FMLA leave must be concluded within 12 months of the birth, adoption or placement of the child; To care for the employee's spouse, child or parent who has a serious health condition; A serious health condition of the employee that makes the employee unable to perform the functions of employee's job.

Paid Family Leave (PFL)

PFL is a benefit provided by New York state for employees to: **Bond** with a newly born, adopted or fostered child within the first 12 months of birth or placement. **Care** for a spouse, domestic partner, child/stepchild, parent/stepparent, parent-in-law, grandparent, or grandchild with a serious health condition. **Assist** a spouse, domestic partner, child/stepchild, parent/stepparent or parent-in-law when they are deployed abroad on active military service. This benefit can be used up to 12 months after the qualifying event. (For those eligible for payment under a pregnancy-related disability, Paid Family Leave begins after the medical disability period ends.)

Columbia University Parental Care Leave (PCL)

PCL begins automatically after the medical disability period ends (for those employees eligible for payment under a pregnancy-related disability) or adoption/fostering of a child. This benefit can be used once within a 12-month period, up to a maximum of 6 months.

Medical Leave of Absence & Payroll Timeline for

Local 2110 Union Support Staff

Employee Name	
Department	
1st day out of office	1/1/2019
Expected Return to Work	

Notes:

Short-term Disability (STD)

Payments from NYS while employee is certified disabled by a physician

Payroll Information	Paid via Cigna
Amount Due to Employee	$170/week
STD Begins	
STD Ends	

Accrued Time Off (TO)

Accrued vacation, personal, and sick days used to receive full pay

Payroll Information	Paid via CU				
Amount Due to Employee	Full Salary				
Vacation Days	# of days:	From:	/ /	To:	/ /
Personal Days	# of days:	From:	/ /	To:	/ /
Sick Days	# of days:	From:	/ /	To:	/ /

Paid Family Leave (PFL)

NYS Paid Family Leave cannot be taken during short-term disability

Payroll Information	Paid via Cigna
Amount Due to Employee	55% of weekly salary (up to $746.41/week) for 10 weeks
PFL Begins	
PFL Ends	

Return from Leave (RFL)

1st day back in the office

Return to Work	

PAF Codes

Effective Date	Action	Reason

	Week begins	Week Ends	
1	1/1/19	1/7/19	First day of approved disability
2	1/8/19	1/14/19	
3	1/15/19	1/21/19	
4	1/22/19	1/28/19	
5	1/29/19	2/4/19	
6	2/5/19	2/11/19	Average end of disability for standard births
7	2/12/19	2/18/19	
8	2/19/19	2/25/19	Average end of disability for c-section births
9	2/26/19	3/4/19	
10	3/5/19	3/11/19	
11	3/12/19	3/18/19	
12	3/19/19	3/25/19	
13	3/26/19	4/1/19	
14	4/2/19	4/8/19	
15	4/9/19	4/15/19	
16	4/16/19	4/22/19	
17	4/23/19	4/29/19	
18	4/30/19	5/6/19	
19	5/7/19	5/13/19	
20	5/14/19	5/20/19	

1st pay date on CU Payroll after leave

1st day back in the office/Active

LEAVE SUMMARY

Short-term Disability	Accrued Time Off	Paid Family Leave	Return from Leave

Family Medical Leave Act (FMLA)

Paid Family Leave (PFL)

Important Information

FMLA is a benefit mandated by New York state that provides unpaid job protection for eligible employees; maximum 12 weeks/year. Employees who have worked at CU for 12 months or more are eligible for FMLA. FMLA leaves can be taken due to the following circumstances: The birth or adoption of a child or the foster care placement of a child (FMLA leave must be concluded within 12 months of the birth, adoption or placement of the child; To care for the employee's spouse, child or parent who has a serious health condition; A serious health condition of the employee that makes the employee unable to perform the functions of employee's job.

PFL is a benefit provided by New York state for employees to: **Bond** with a newly born, adopted or fostered child within the first 12 months of birth or placement. **Care** for a spouse, domestic partner, child/stepchild, parent/stepparent, parent-in-law, grandparent, or grandchild with a serious health condition. **Assist** a spouse, domestic partner, child/stepchild, parent/stepparent or parent-in-law when they are deployed abroad on active military service. This benefit can be used up to 12 months after the qualifying event. (For those eligible for payment under a pregnancy-related disability, Paid Family Leave begins after the medical disability period ends.)

Personal Leave of Absence & Payroll Timeline for

Officers of Administration & Non-Union Support Staff (NUSS)

Employee Name	
Department	
1st day out of office	1/1/2019
Expected Return to Work	

Notes:

Accrued Time Off (TO)

Accrued vacation, personal, and sick days used to receive full pay

Payroll Information		Paid via CU			
Amount Due to Employee		Full Salary			
Vacation Days	# of days:	From: / /	To:	/ /	
Personal Days	# of days:	From: / /	To:	/ /	
Sick Days	# of days:	From: / /	To:	/ /	

Personal Leave of Absence (PER)

Unpaid Leave of absence

Payroll Information	Unpaid
Amount Due to Employee	$0/week
Leave Begins	
Leave Ends	

Return from Leave (RFL)

1st day back in the office

Return to Work	

PAF Codes

Effective Date	Action	Reason

	Week begins	Week Ends	
1	1/1/19	1/7/19	First day of approved leave
2	1/8/19	1/14/19	
3	1/15/19	1/21/19	
4	1/22/19	1/28/19	
5	1/29/19	2/4/19	
6	2/5/19	2/11/19	
7	2/12/19	2/18/19	
8	2/19/19	2/25/19	
9	2/26/19	3/4/19	
10	3/5/19	3/11/19	
11	3/12/19	3/18/19	
12	3/19/19	3/25/19	
13	3/26/19	4/1/19	
14	4/2/19	4/8/19	
15	4/9/19	4/15/19	
16	4/16/19	4/22/19	
17	4/23/19	4/29/19	
18	4/30/19	5/6/19	
19	5/7/19	5/13/19	
20	5/14/19	5/20/19	

LEAVE SUMMARY

Accrued Time Off	**Personal Leave of Absence**	**Return from Leave**

1st Paycheck on CU Payroll after leave: _____

1st day back in the office/Active: _____

Personal Leave of Absence (PERS)

Important Information

A personal leave of absence is available to full-time Officers of Administration, benefits-eligible part-time Officers of Administration and Non-Union Support Staff employees who have completed 12 months of service. This unpaid leave of absence may be granted for personal reasons and must not exceed six months.

New York State Paid Family Leave (PFL) Information Form

Employee Name:

Reason for Leave (to take care of a family member/bonding/military):

Is employee eligible for PFL? Yes ☐ No ☐
If yes, please provide # of average hours worked in the last 8 weeks:
If employee works less than 20 hours per week, please also provide # of days worked since hire:
Is the employee taking Family Medical Leave Act concurrently with PFL? Yes ☐ No ☐

Last Day Worked:
Date PFL will begin:
Date PFL will end (8 weeks maximum in 2018):
If end date is unknown or leave is intermittent or reduced schedule, please explain:

Will the employee receive paid NYC sick time? If yes, please provide dates:
Will the employee receive vacation pay? If yes, please provide dates:
Will the employee use personal days? If yes, please provide dates:

Employee Wage Information:
NOTE: Only complete this portion if the leave has begun. For future leaves, a separate request for the employee's wage information will be sent to the department once the leave has begun.

Please provide the last 8 weeks wage information (gross earnings including overtime and add comp)

	Pay Period	Number of Days Worked	Gross Earnings
Week 1			
Week 2			
Week 3			
Week 4			
Week 5			
Week 6			
Week 7			
Week 8			

Reminders:

- Officers of Research and Libraries should coordinate with the Provost Office consistent with all of other leaves
- If applicable, remember to provide FMLA forms to employees

Information provided by:
Email:
Department:
Date:

** Please Return Completed Questionnaire to Leave Management **

Columbia University
Leave Management Office
615 W. 131st Street, 4th Floor
New York, New York 10027
Fax: 212-851-7069

If you have, any questions and/or concerns please contact**:**
212-851-0698 or via email at leavemanagement@columbia.edu

NEW YORK STATE | Paid Family Leave

HOW TO APPLY FOR PAID FAMILY LEAVE

STEP 1: 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.

STEP 2: COLLECT SUPPORTING DOCUMENTATION

BOND

TO BOND WITH A NEWLY BORN, ADOPTED, OR FOSTERED CHILD

Complete Form PFL-2

- ❑ Complete PFL-2 and collect supporting documentation.

OR

CARE

TO CARE FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION

Complete Form PFL-3

- ❑ Care recipient completes PFL-3 and provides to health care provider. Care recipient's health care provider keeps PFL-3 on file.

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.

OR

ASSIST

TO ASSIST FAMILY MEMBERS DUE TO ANOTHER FAMILY MEMBER'S ACTIVE MILITARY DUTY OR IMPENDING ACTIVE DUTY ABROAD

Complete Form PFL-5

- ❑ Complete PFL-5 and collect supporting documentation.

STEP 3: SEND FORMS AND DOCUMENTS

- ❑ Send completed forms and supporting documentation to insurance carrier at the address provided in the *PFL-1 Form* Part B, Question 13 (the section your employer completed), or directly to your employer if they are self-insured.
- ❑ Insurance carrier accepts or denies claim within 18 days.
- ❑ You do not need to wait for this decision to start your leave.

Please keep a copy of all pages for your records.

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

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

- To request PFL, the employee requesting PFL must complete Part A of the *Request For Paid Family Leave (Form PFL-1)*. All items on the form are required unless noted as optional. The employee then provides the form to the employer to complete Part B.
- The employer completes Part B of the *Request For Paid Family Leave (Form PFL-1)* and returns it to the employee within three days.
- Additional forms are required depending on the type of leave being requested. The employee requesting leave is responsible for the completion of these forms.
- **The employee submits the completed *Request For Paid Family Leave (Form PFL-1)* with the required additional form to the employer's PFL insurance carrier listed on Part B of *Request For Paid Family Leave (Form PFL-1)*. The employee should retain a copy of each submitted form for their records.**

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

The employee requesting PFL must complete all required information.

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

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

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

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

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

Employment Information (to be completed by the employee)

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

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

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

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

Step 3: If the employee received bonuses and/or commissions during the 52 weeks preceding PFL, add the prorated weekly amount to the average weekly wage. To determine the prorated weekly amount, add all bonuses/commissions earned in the preceding 52 weeks and then divide by 52.

Example of a gross weekly wage calculation:

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

Form PFL-1 Instructions continued on next page

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

Form PFL-1 Instructions continued from prior page

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

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

If you are pre-submitting form: Indicate if the employee is pre-submitting their PFL request. Pre-submitting is defined as submitting the application in advance of an upcoming qualifying event, with certain required information missing due to the information being unknown at the time of the submitting. If pre-submitting is permitted by the carrier or self-insured employer, the missing information must be supplied as soon as it is known. Benefits cannot be determined until all of the required information is provided.

The PFL insurance carrier or self-insured employer will provide the employee a notice within five days which 1) states the claim is pending; 2) identifies what information is missing; 3) instructs how to submit the missing information. **Once all information is supplied, the PFL insurance carrier or self-insured employer has 18 days to pay or deny the claim.**

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

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

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

The employer of the employee requesting PFL must complete all information in Part B.

Question 2: If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number.

Question 3: Enter the employer's Standard Industrial Classification (SIC) Code. Contact your carrier if you don't know your SIC code.

Question 8: The employee occupation code can be found at: www.bls.gov/soc/2018/major_groups.htm

Question 9: Enter the wages earned by the employee during the last eight weeks preceding the PFL start date. The gross amount paid is the employee's gross weekly pay, including any overtime and tips earned for that week, plus the weekly prorated amount of any bonus or commission received during the preceding 52 weeks. (For detailed steps, see Question 18 starting on page 1 of the instructions.) Calculate the gross average weekly wage by adding up the gross amounts paid, and then divide by eight (or number of weeks worked if less than eight).

Question 10: Failure to select "Yes" for requesting reimbursement from the insurance carrier, will result in a waiver of the right to reimbursement.

Question 11a: 'Disability' refers to NYS statutory required disability. If the answer is "none," enter a "0" for total weeks and days in Question 12b.

Question 11b: The maximum number of weeks available for NYS statutory disability and PFL in any 52 week period is 26 weeks. Specify the total number of weeks, as well as the number of additional days if the leave includes a partial week, taken for NYS statutory disability and PFL during the preceding 52 weeks.

Question 13, 14 & 15: Enter the Paid Family Leave or Disability/PFL insurance carrier's name, address and PFL policy number. If this employer is self-insured, enter the name and address of where the PFL request should be submitted for processing.

Affirmation employee is eligible for PFL: An employee who regularly works 20 hours or more per week must have been in employment for at least 26 consecutive weeks. An employee who regularly works less than 20 hours per week must have worked 175 days.

Employer signs and dates, and then returns to the employee requesting PFL within three business days.

Be sure to complete the appropriate additional PFL form(s) based on the type of PFL leave being requested.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).

The Workers' Compensation Board's (Board's) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board's administrative authority under Workers' Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

NEW YORK STATE | Paid Family Leave

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.)

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 <u>weekly</u> 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.

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: 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 worked	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

TO BE COMPLETED BY THE EMPLOYEE

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

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

PART B - EMPLOYER INFORMATION (to be completed by the employer) - continued from prior page

Form PFL-1 continued from prior page

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

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

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

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

13. PFL insurance carrier's name and mailing address

PFL insurance carrier's name

Mailing address

City, State | Zip code | Country (if not U.S.A.)

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

15. PFL policy number

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

Bonding Certification (Form PFL-2) Instructions

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/Certification	Description
Health care provider certification of pregnancy	An **original** 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 birth	An **original** letter obtained from the birth mother's health care provider that includes the mother's name and child's date of birth.
Birth Certificate	A **copy** of the certificate issued by the city or county office in which the child is born.
Voluntary Acknowledgment of Paternity (Form LDSS-4418)	A **copy** of the form that establishes legal fatherhood when the parents are unmarried. Completed by both mother and father. For more information, see childsupport.ny.gov/dcse/aop_howto.html
Court Order of Filiation	A **copy** 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 childsupport.ny.gov/dcse/aop_howto.html
Marriage Certificate	A **copy** 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 **copy** of the certificate of civil union or domestic partnership.
Foster care placement letter	A **copy** 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 **copy** 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.

NEW YORK STATE | Paid Family Leave

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

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)

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

- If an employee is requesting PFL to care for a family member with a serious health condition, the care recipient or an authorized representative must complete a *Release Of Personal Health Information Under The Paid Family Leave Law (Form PFL-3)* and submit it to their health care provider, along with a copy of the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)*.
- The *Release Of Personal Health Information Under The Paid Family Leave Law (Form PFL-3)* enables the health care provider to complete *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* and release it to the employee seeking PFL benefits.
- Before completing and signing, the care recipient must read the *Release Of Personal Health Information Under The Paid Family Leave Law (Form PFL-3)* in its entirety.
- The employee requesting PFL submits both the *Request For Paid Family Leave (Form PFL-1)* and the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* to their employer's PFL insurance carrier, or to their employer if the employer is self-insured, for PFL benefit determination.

  NOTE: This form will be retained by the health care provider. The employee should make a copy for their records before giving it to the health care provider.

Care recipient or authorized representative signs and dates.

This form is given to the care recipient's health care provider along with the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4).*

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form PFL-4)

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

The PFL insurance carrier name requested at the top of the form is the same as the PFL insurance carrier identified in *Request For Paid Family Leave (Form PFL -1)* Part B line 13.

Care recipient or authorized representative must complete all applicable requested information.

If a care recipient is unable to fill out this form, an authorized representative must attach a copy of legal documentation, such as a health care proxy or power of attorney, permitting the representative to sign on behalf of the care recipient. The health care provider will require this documentation of authorization unless the authorized representative is a parent signing on behalf of a minor child.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).

The Workers' Compensation Board's (Board's) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board's administrative authority under Workers' Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

NEW YORK STATE | Paid Family Leave

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

INSTRUCTIONS INCLUDED WITH FORM

TO BE COMPLETED BY THE EMPLOYEE

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

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

Care recipient's (patient's) date of birth (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form PFL-4)

I, Care recipient's (patient's) name **, authorize my health care provider listed on this form to release my personal health information to** Employee's name **and their employer's PFL insurance carrier** PFL insurance carrier's name **.**

Records Subject to Release: This form gives the health care provider listed permission to include information from your health care records on the attached medical certification. This form gives your health care provider permission to release only the information in your health care records that relate to your current condition, which is the subject of the employee's request for Paid Family Leave benefits.

Duration of Revocable Release: This authorization ends after one year, or when you revoke the release. You can cancel this release at any time. To cancel, send a letter to the health care provider listed on this form.

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

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

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

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

1. **Health care provider's name**

2. **Health care provider's mailing address**

Mailing address

City, State | Zip code | Country (if not U.S.A.)

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

Form PFL-3 continued on next page

TO BE COMPLETED BY THE EMPLOYEE

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

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

Care recipient's (patient's) date of birth (MM/DD/YYYY)

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form PFL-4) - continued from prior page

Form PFL-3 continued from prior page

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

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

Mailing address

City, State | Zip code | Country (if not U.S.A.)

5. **Care recipient's Social Security Number** ___ - ___ - ____

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

READ AND SIGN BELOW

I hereby request that the health care provider listed give a completed *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* to the employee identified on the PFL-4 form. I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and any estimation of the amount of care that I require from the employee requesting PFL benefits as a result of my current condition.

Care recipient's signature

Date signed (MM/DD/YYYY)

Authorized representative

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

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

Authorized representative's signature

Date signed (MM/DD/YYYY)

The employee should retain a copy for their own records.

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

The employee requesting PFL to care for a family member with a serious health condition must submit the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* with the *Request For Paid Family Leave (Form PFL-1)*.

Employee:

- Employee enters their name, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, mailing address, and care recipient's (patient's) name and date of birth at the top of page 1.
- Employee enters their name and date of birth, and care recipient's (patient's) name and date of birth at the top of page 2.
- Employee gives the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* to the health care provider.

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

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

Patient Information / family member with serious health condition (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

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

The patient's health care provider must complete the Patient Information and Health Care Provider sections of the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)*.

Health care provider signs and dates, and then returns the form to the employee requesting PFL.

If you believe the patient is the victim of abuse or neglect caused by the employee requesting PFL, you may decline to provide this certification.

Employee:

- When you receive the completed *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* form from the health care provider, send the completed forms and supporting documentation to the insurance carrier.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).

The Workers' Compensation Board's (Board's) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board's administrative authority under Workers' Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

NEW YORK STATE | Paid Family Leave

Request For Paid Family Leave

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

INSTRUCTIONS INCLUDED WITH FORM

TO BE COMPLETED BY THE EMPLOYEE

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

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

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

Employee's Social Security Number or TIN - -

Employee's mailing address

Mailing address

City, State | Zip code | Country (if not U.S.A.)

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

Care recipient's (patient's) date of birth (MM/DD/YYYY) / /

HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION

(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

Patient Information / family member with serious health condition (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

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

   ☐ Yes ☐ No (If no, skip to "Health Care Provider Information".)

   Note: For the purposes of this section, "providing care" may include necessary physical care, emotional support, visitation, assistance in treatment, transportation, arranging for a change in care, assistance with essential daily living matters, and personal attendant services.

2. **Primary ICD-10 code (optional)**

3. **Diagnosis**

4. **Date patient's condition commenced** (MM/DD/YYYY) / /

5. **First date care for patient is needed** (MM/DD/YYYY) / /

6. **Expected date patient will no longer require care** (MM/DD/YYYY) / /

7. **Estimated number of days per week OR days per month patient requires care** Days/week **OR** Days/month

Health Care Provider Information (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

8. **Health care provider's name**

Form PFL-4 continued from prior page

TO BE COMPLETED BY THE EMPLOYEE

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

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

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

Care recipient's (patient's) date of birth (MM/DD/YYYY)

HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION

(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above) - continued from prior page

Form PFL-4 continued from prior page

9. Type of health care provider:

- ☐ 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)

Military Qualifying Event (Form PFL-5) Instructions

If an employee is requesting PFL because of a family member's covered active military duty or impending covered active duty, the employee must submit the *Military Qualifying Event (Form PFL-5)* with the *Request For Paid Family Leave (Form PFL-1)*.

The employee must identify the family member, provide a copy of the member's covered active duty orders or impending active duty orders, and describe the reason leave is being requested.

MILITARY QUALIFYING EVENT (to be completed by the employee)

The employee requesting PFL must complete all applicable requested information.

Employee enters their name, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, and mailing address at the top of page 1.

Employee enters their name and date of birth at the top of page 2.

Questions 1-5: Enter the military member's information, and indicate the military member's relationship to the employee.

Question 5: 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 6: Enter dates of expected military covered active duty.

Question 7: Documentation that shows that the military member is on covered active duty or has been notified of an impending call or order to covered active duty is required and must be attached to this form. Select the type of documentation that is attached from the list below.

Required documentation includes one of the following:

- Covered active duty orders; OR
- Letter from the military unit documenting impending call or order to covered duty; OR
- Documentation of military leave signed by the approving authority for military member's Rest and Recuperation.

Qualifying Reason for Leave (to be completed by the employee)

Question 8: Explain the need for PFL because of the Military Qualifying Event. For example: "My spouse was just called on short notice to covered active duty status, and will be deployed to (country) in five days. I need to take PFL to be with them and make arrangements for while they are away on active duty." 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, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, and mailing address at the top of the attachment.

Question 9: Include one or more of the qualifying supporting documents:

- Meeting announcement for informational briefing sponsored by the military; or
- Document(s) confirming an appointment with a school official, doctor, attorney or financial advisor; or
- Copy of a bill for services for the handling of legal or financial affairs.

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.

NEW YORK STATE | Paid Family Leave

Request For Paid Family Leave
Military Qualifying Event (Form PFL-5)

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.)

MILITARY QUALIFYING EVENT (to be completed by the employee)

1. **Name of military member on covered active duty or impending call to covered active duty status (international deployment)** (first name, middle initial, last name)

2. **Military member's date of birth** (MM/DD/YYYY) / /

3. **Military member's gender** ☐ Male ☐ Female ☐ Not designated/Other

4. **Military member's mailing address**

Mailing address

City, State | Zip code | Country (if not U.S.A.)

5. **The above-named military member is employee's:** ☐ Spouse ☐ Domestic partner ☐ Child ☐ Parent

6. **Period of military member's covered active duty** (MM/DD/YYYY) / / to / /

7. **Please select one of the following and attach the indicated document to support that the military member is on covered active duty or impending call or order to covered active duty status:**

☐ Covered active duty orders ☐ Letter of impending call or order to covered duty ☐ Documentation of military leave signed by the approving authority for military member's Rest and Recuperation

Qualifying Reason For Leave (to be completed by the employee)

8. **What is the reason employee is requesting PFL?** (One or more reasons may be selected.)

☐ Arranging for child care
☐ Arranging for parental care
☐ Counseling
☐ Making financial arrangements
☐ Making legal arrangements
☐ Acting as military member's representative before a federal, state, or local agency for purpose of obtaining, arranging, or appealing military service benefits
☐ Attending any event sponsored by the military or military service organizations
☐ Other

Form PFL-5 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)

MILITARY QUALIFYING EVENT (to be completed by the employee) - continued from prior page

Form PFL-5 continued from prior page

9. Written documentation supporting this request for leave is available and attached?

☐ Yes ☐ No ☐ None Available

Note: A complete and sufficient certification to support a request for PFL leave due to a qualifying event includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. If leave is requested to meet with a third party, the employee must provide the supporting documentation of the meeting that includes the name, address, appropriate contact information of the individual or entity with whom you are meeting (i.e., either telephone number, fax number, or email address of the individual or entity).

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)

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.)

QUALIFYING REASON FOR LEAVE - DOCUMENTATION

If leave is requested to meet with a third party, the employee must provide supporting documentation of the meeting that includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone number, fax number or email address of the individual or entity). The reason for a meeting can include: arranging for child or parental care, counseling, making financial or legal arrangements, acting as the military member's representative before a federal, state or local agency for purposes of obtaining, arranging or appealing military service benefits, or attending any event sponsored by the military or military service organizations.

Please submit this documentation for each required meeting/event.

Name of individual with whom employee is meeting

Title

Organization

Telephone number (provide area or country code)

Fax number (provide area or country code)

Email address

Mailing address

Mailing address		
City, State	Zip code	Country (if not U.S.A.)

Describe nature of meeting. Include dates, if known:

NEW YORK STATE | Paid Family Leave

STATEMENT OF RIGHTS FOR PAID FAMILY LEAVE

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

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

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

Eligibility:

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

You are eligible regardless of your citizenship or immigration status.

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

Rights and Protections

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

Paid Family Leave Request Process

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

You may obtain all forms from your employer, their insurance carrier listed below or online at www.ny.gov/PaidFamilyLeave.

Disputes

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

Discrimination Complaints

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

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

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

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

Cigna
PO Box 29221
Phoenix, AZ 85038-9221
Phone: 1-888-842-4462
Fax: (800) 642-8553

PRESCRIBED BY THE CHAIR, WORKERS' COMPENSATION BOARD