Paid Famil

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

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

Question 3: Enter the employerûs Standard Industrial Classiýcation (SIC) Code. Contact your carrier if you donût 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 employeeûs 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 ñYesò for requesting reimbursement from the insurance carrier, will result in a waiver of the right to reimbursement.

Question 11a: ódisabilityô refers to NYS statutory required disability. If the answer is ñnone,ò enter a ñ0ò 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:

NEW
YORK
Leave

Form PFL-1 continued from prior page

Employment Information (to be completed by the employee)

15. Business name

16. Employee's date of hire

17.

TO BE COMPLETED BY THE EMPLOYEE

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

Employee's date of birth

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: ☐ ☐ PFL ☐ Both Disability and PFL ☐

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

Disability:

Please provide specific dates for Disability:

PFL:

Please provide specific dates for PFL:

12. Is the employee taking Family Medical Leave Act (FMLA) concurrently with PFL? ☐ ☐

13. PFL insurance carrier's name and mailing address

PFL insurance carrier's name

Country (if not U.S.A.)

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

15. PFL policy number

Declaration and signature

☐ **I afýrm 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

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.

/ /