Lincoln Financial Group®

Request For NY Paid Family Leave (LF PFL-1)
Military Qualifying Event (LF PFL-5)

Lincoln Life & Annuity Company of New York
Service Office Address: PO Box 2609, Omaha, NE 68103-2609
Home Office: Syracuse, NY
Toll free (800) 423-2765 Fax (877) 843-3950
www.LincolnFinancial.com
disabilityclaims@lfg.com

LF PFL-1 PART A - EMPLOYEE INFORMATION (to be completed by employee)

The employee requesting leave is responsible for the completion of these forms.

The employee requesting PFL must complete Part A of the **Request for Paid Family Leave (Form LF 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.

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 (LF PFL-5)** with the **Request For Paid Family Leave (LF PFL-1)** to Lincoln Life & Annuity Company of New York using the address, fax number, or email address above. The employee should retain a copy of each submitted form for their record.

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.

1. Employee's legal name: (first, middle, last) _____ /_____ /_____

2. Employee's address:

_____
Street Address

_____
City State Zip Code

3. Employee's Social Security number:

_____

4. Employee's date of birth:

_____ /_____ /_____

5. Employee's primary telephone number: _____ - _____ - _____

6. Employee's email address: _____

7. Employee's gender: ☐ Male ☐ Female ☐ Not designated / Other

8. Employee's preferred language: ☐ English ☐ Español ☐ Polski ☐ Italiano ☐ Kreyòl ayisyen
☐ Русский ☐ 中文 ☐ 한국어 ☐ Other _____

9. Reason for PFL request: ☐ Newborn Bonding ☐ Adoption Bonding ☐ Foster Care Bonding
☐ Military Leave ☐ Family Care

10. Will PFL be for a continuous period of time and/or intermittent?

☐ Continuous ☐ Dates are estimated

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

☐ Intermittent ☐ Dates are estimated

Identify dates Intermittent PFL will be taken: _____

11. If providing less than 30 days advance notice to the employer, please explain:

_____

_____

_____

_____

TO BE COMPLETED BY THE EMPLOYEE

Employee's name: (first name, middle name, last name) Date of birth: (MM/DD/YYYY)

_____ /_____ /_____ _____ /_____ /_____

First Middle Last

12. Business Name: _____ 13. Employee's date of hire:_____ /_____ /_____

14. Employee's work location:

_____

Street Address

_____

City State Zip Code

15a. Does employee have more than one employer? ☐ Yes ☐ No

15b. If yes, is employee taking PFL from the other employer? ☐ Yes ☐ No

16. 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)

Payment Method

If your claim is approved, payments will be sent in the form of a check, or you may choose to receive your payment through Direct Deposit (electronic funds transfer). This will eliminate mail delays and ensure your payment is deposited directly into your bank account on the date it is due each month. You may not be charged any fees for services that are necessary to access your benefits in full.

You also may elect Direct Deposit at any time by calling (800) 423-2765, or by going to our website, www.Lincoln4Benefits.com.

Please indicate your preferred method of payment for your benefits.

☐ Check ☐ Direct Deposit

For Payment Method Direct Deposit:

Financial Institution's name : _____

Type of Account: ☐ Checking ☐ Savings

Bank Routing Number: _____

Account Number: _____

Signature: _____ Date: _____ /_____ /_____

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LF PFL-1 PART B - EMPLOYER INFORMATION (to be completed by the employer)

The employer of the employee requesting PFL must complete all information in Part B. Employer signs and dates, and then returns to the employee requesting PFL within three business days.

Employee's name: (first name, middle name, last name) Date of birth: (MM/DD/YYYY)

_____ /_____ /_____ _____ /_____ /_____
First Middle Last

1. Business's full legal name and address:

_____
Business Name

_____
Street Address

_____
City State Zip Code

NY Statutory Disability/Paid Family Leave Policy Number: _____

Claim Location Number: _____

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/soc2010/soc.alph.htm: _____

TO BE COMPLETED BY THE EMPLOYEE

Employee's name: (first name, middle name, last name) Date of birth: (MM/DD/YYYY)

_____ /_____ /_____ _____ /_____ /_____

First Middle Last

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

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

Enter the 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.

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
Average Weekly Wage =	$525
Bonus earned in preceding 52 weeks	$2,600
Divide by 52	- 52
Prorated Weekly Bonus =	$50
Average Weekly Wage	$525
Prorated Weekly Bonus	+ $50
Average Weekly Wage (including bonus) =	**$575**

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

10a. Are wages being continued during PFL? ☐ Yes ☐ No

If yes, ☐ Salary Continuance ☐ Sick Pay ☐ Vacation ☐ PTO

Beginning Date: _____ Ending Date: _____ Weekly Amount Paid _____

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

NOTE: When requested, reimbursement is payable to the employer. Failure to select "Yes" for requesting reimbursement from Lincoln Life & Annuity Company of New York will result in a waiver of the right to reimbursement.

TO BE COMPLETED BY THE EMPLOYEE

Employee's name: (first name, middle name, last name) Date of birth: (MM/DD/YYYY)

_____ /_____ /_____ _____ /_____ /_____

First Middle Last

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

11a. In the preceding 52 weeks has the employee taken leave for:

☐ NY Statutory Disability ☐ PFL ☐ Both NY Statutory Disability and PFL ☐ None

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

NOTE: The maximum number of weeks available for NY 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 NY Statutory Disability and PFL during the preceding 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 leave under the federal Family Medical Leave Act (FMLA) concurrently with PFL? ☐ Yes ☐ No

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

_____

Title

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LF PFL - 5 MILITARY QUALIFYING EVENT CERTIFICATION (to be completed by the employee)

Employee's legal name: (first, middle, last) _____ /_____ /_____

Employee's date of birth: _____ /_____ /_____ Employee's Social Security Number or TIN: _____

Employee's address:

_____
Street Address

_____
City State Zip Code

1. Name of Military Member on covered active duty or impending call to covered active duty status:

_____ /_____ /_____
First Middle Last

2. Military Member Date of Birth (MM/DD/YYYY): _____ /_____ /_____

3. Military Member Gender: ☐ Male ☐ Female ☐ Not designated / Other

4. Military Member Mailing Address:

_____
Street 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 on 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

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 organization
☐ Other _____

TO BE COMPLETED BY THE EMPLOYEE

Employee's name: (first name, middle name, last name) Date of birth: (MM/DD/YYYY)

_____ /_____ /_____ _____ /_____ /_____
First Middle Last

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)