Lincoln Financial Group®

Request For NY Paid Family Leave (LF PFL-1) Bonding (LF PFL-2)

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.

The employee submits the completed **Request For Paid Family Leave (Form LF PFL-1)** with the completed **Bonding Certification (Form LF PFL-2** attached) 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 records.

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 NY 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 mailing 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 the 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 the 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 (MM/DD/YYYY

_____
Title

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LF PFL-2 BONDING CERTIFICATION (to be completed by the employee)

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:

_____ /_____ /_____

Child's Name: (first, middle, last) _____ /_____ /_____

1. Child's date of birth: _____ /_____ /_____
2. Child's gender: ☐ Male ☐ Female ☐ Not designated / Other
3. Child is employee's: ☐ Biological child ☐ Step child ☐ Foster child ☐ Adopted child ☐ Legal ward
   ☐ Spouse/Domestic partner's child ☐ In Loco Parentis
4. Select one of the following and attach the document as required as evidence of the relationship:

PLEASE DO NOT SEND ORIGINALS

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

5. Date of foster care or adoption placement, if applicable (MM/DD/YYYY) : _____ /_____ /_____

TO BE COMPLETED BY THE EMPLOYEE

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

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

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 NY Workers' Compensation Law. My signature affirms that the infromation I am providing is true and accurate to the best of my knowledge and belief.

_____ _____ /_____ /_____
Employee's Signature Date Signed (MM/DD/YYYY)