



Request For NY Paid Family Leave (LF PFL-1)  
 Release of Personal Health Information (LF PFL-3)  
 Health Care Provider Certification For Care Of Family  
 Member With Serious Health Condition (LF PFL-4)

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 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 LF 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 LF PFL-4)**. The employee requesting PFL submits both the **Request For Paid Family Leave (Form LF PFL-1)** and the **Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form LF PFL-4)** 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: \_\_\_\_\_ 3. Employee's Social Security number: \_\_\_\_\_

Street Address

4. Employee's date of birth: \_\_\_\_\_

City State Zip Code

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](http://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: \_\_\_\_/\_\_\_\_/\_\_\_\_



Request For NY Paid Family Leave (LF PFL-1)  
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 Member With Serious Heath Condition (LF PFL-4)

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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 Country (if not U.S.A.)

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](http://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)**

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.

<b>Disability:</b>	Weeks:	Please provide specific dates for Disability:
	Days:	

<b>PFL:</b>	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-3 RELEASE OF PERSONAL HEALTH INFORMATION UNDER THE PAID FAMILY LEAVE LAW**  
 (to be completed by the care recipient or authorized representative)

Before completing and signing, the care recipient or authorized representative must read the **Release Of Personal Health Information Under The Paid Family Leave Law (Form LF PFL-3)** in its entirety before signing and dating. 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 LF PFL-4)**.

**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.

Employee's name: (first, middle, last) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Care recipient's (patient's) name: (first name, middle, last name) \_\_\_\_\_ Date of birth: (MM/DD/YYYY) \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 First Middle Last

I, \_\_\_\_\_, authorize my health care provider listed on this form to  
 Care Recipient's Name  
 release my personal health information to \_\_\_\_\_ and  
 Employee's Name  
 Lincoln Life & Annuity Company of New York.

**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 relates 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**

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. Heath Care Provider's Name:  
 \_\_\_\_\_

2. Heath Care Provider's Address:  
 \_\_\_\_\_  
 Street Address  
 \_\_\_\_\_  
 City State Zip Code Country (if not U.S.A.)

3. Heath Care Provider's Telephone Number:  
 \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**TO BE COMPLETED BY THE EMPLOYEE**

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

Date of birth: (MM/DD/YYYY)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
First Middle Last

**Care Recipient Information**

4. Care Recipient's Address:

\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City State Zip Code Country (if not U.S.A.)

5. Care Recipient's Social Security Number:

6. Care Recipient's telephone number:

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

**READ AND SIGN BELOW.**

I hereby request that the health care provider listed above give a completed **Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form LF PFL-4)** to the employee identified on the LF 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 (MM/DD/YYYY)

**Authorized Representative**

I, \_\_\_\_\_, represent the care recipient in this matter as authorized by:  
Print Name

- Parental Right     Power of Attorney (attach copy)     Court Order (attach copy)     Health Care Proxy (attach copy)

\_\_\_\_\_  
Authorized Representative Signature Date (MM/DD/YYYY)

**The employee should retain a copy for his or her own records.**





**TO BE COMPLETED BY THE EMPLOYEE**

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

Date of birth: (MM/DD/YYYY)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
First Middle Last

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

Date of birth: (MM/DD/YYYY)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
First Middle Last

**Health Care Provider Information**

8. Health care provider's name

\_\_\_\_\_

9. Health care provider's mailing address

\_\_\_\_\_ Mailing Address

\_\_\_\_\_ City State Zip Code Country (if not USA)

10. 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 telephone number (provide area or country code): \_\_\_\_\_

11. Health care provider's fax number (provide area or country code): \_\_\_\_\_

12. Health care provider's email address (if available): \_\_\_\_\_

13. State or country (if not U.S.A.) in which health care provider is licensed to practice: \_\_\_\_\_

14. Specialty: \_\_\_\_\_

15. 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)