New York City District Council of Carpenters
# BENEFIT FUNDS

Re: COVID-19 Disability and/or Paid Family Leave Application

Dear Participant:

At your request, the New York City District Council of Carpenters ("NYCDCC") Welfare Fund (the "Fund") is providing you with the enclosed **COVID-19 Disability and/or Paid Family Leave ("COVID-19 DB/PFL") application.** This application consists of three forms:

**a.** Request for COVID-19 Quarantine DB/PFL-Self (Form SCOVID19)
**b.** Request for Paid Family Leave (Form PFL-1)
**c.** NYS COVID-19 Paid Leave Employer Attestation Form.

It should be noted that the COVID-19 DB/PFL benefit offered by the Fund is a self-insured product that is **administered by Amalgamated Employee Benefits Administrators, Inc**. To initiate a COVID-19 DB/PFL claim you will need to take the following steps:

1. Review, sign, and complete Sections 1-2 of the Request for COVID-19 Quarantine DB/PFL-Self (Form SCOVID19).
2. Have your employer complete and return to you:
   - Section 3 of the Request for COVID-19 Quarantine DB/PFL-Self (Form SCOVID19).
   - NYS COVID-19 Paid Leave Employer Attestation Form.
3. Review, complete and sign Part A – Employee Information on the Request for Paid Family Leave (Form PFL-1).
   - Leave questions 11 and 12 on this form BLANK.
   - Do not have your employer complete Part B – Employer Information. (This MUST be completed by the Fund Office, see No. 5 below).
4. Gather your last eight (8) weeks of pay stubs.
5. Send Parts A & B of the Request for Paid Family Leave (Form PFL-1), along with your eight weeks of paystubs to the Fund, at the address below. (*Please note*: In the event there is a discrepancy in your work history, the Fund may require you to submit additional paystubs (up to 26 weeks) to validate your eligibility for the COVID-19 DB/PFL benefit).

**NYCDCC Welfare Fund 395**
**Hudson Street**
**New York, NY 10014 Att:**
**PFL Unit**
**Or by Fax at (212) 366-3301**
**Email: welfare@nyccbf.org**

6. Once your eligibility has been confirmed, the Fund will complete Part B and return the completed Request for Paid Family Leave (Form PFL-1) to you.

7. Once you receive: (a) the completed Request for COVID-19 Quarantine DB/PFL-Self (Form SCOVID19) and NYS COVID-19 Paid Leave Employer Attestation Form)back from your employer; and (b) the completed Request for Paid Family Leave (Form PFL-1) back from the Fund, submit these completed forms, as well as your mandatory or precautionary order of quarantine or isolation, as well as any other supporting documentation to **Amalgamated Employee Benefits Administrators, Inc.:**

**Amalgamated Employee Benefits Administrators**
**P.O. Box 5453 White**
**Plains, NY 10602**
**Fax: (914) 367-4114**
**Email: SubmitClaimForms@amalgamtedbenefits.com**

**Failure to complete and/or provide the necessary supporting documentation will result in a denial of the claim. As such, it's important that you complete the application in its entirety and provide *all necessary* documentation.**

If you have any questions regarding this matter, please contact the Fund at (800) 529-3863 and we will be happy to assist you.

Sincerely,
NYCDCC Welfare Fund

Amalgamated Employee Benefits Administrators
Delivering High Quality, Customized TPA Services

NEW YORK STATE | Paid Family Leave

New York City District Council of Carpenters
**BENEFIT FUNDS**

**Request for COVID-19 Quarantine DB/PFL – Self** (Form SCOVID19)

New York City District Council of Carpenters Benefit Funds
Amalgamated Employee Benefits Administrators
P.O. Box 5453
White Plains, NY 10602
Toll Free 833-941-1057
Email: SubmitClaimForms@amalgamatedbenefits.com
Fax: 914-367-4114

# Instructions for taking Disability and/or Paid Family Leave for yourself due to COVID-19 Quarantine/Isolation

1. Complete Sections 1 – 2 of this form and Part A of the ***Request for Paid Family Leave (Form PFL-1)***. Leave Questions 11 and 12 blank on *Form PFL-1* and instead complete Section 1 below.
2. Notify and submit application to your employer to answer Section 3 of this form and sign the Attestation Form
3. Part B is submitted to NYCDCC Benefit Funds to complete and return to employee within 3 business days.
4. Attach mandatory or precautionary order of quarantine or isolation.
5. Submit all completed forms and order of quarantine/isolation to Amalgamated Employee Benefits Administrators.

For further guidance, visit the PFL website at **PaidFamilyLeave.ny.gov**.

## SECTION 1 - PAID FAMILY LEAVE (PFL) REQUEST (to be completed by the employee)

You may be eligible to take BOTH disability benefits and Paid Family Leave benefits up to a maximum disability benefit of $2,043.92 and up to a maximum Paid Family Leave benefit of $840.70, for a TOTAL of $2,884.62 per week.

Reason for PFL request: ☐ Disability and/or Paid Family Leave benefits due to COVID-19 Quarantine/Isolation

## SECTION 2 - EMPLOYEE ATTESTATION (to be completed by the employee)

My signature affirms that I have exhausted any paid sick leave and that I am not physically able to perform work for my employer through remote access or similar means during a mandatory or precautionary order of quarantine or isolation.

Employee Signature:_____ Date:_____

Print Employee Name: _____

## SECTION 3 - EMPLOYER ATTESTATION (to be completed by the employer)

My signature affirms that this employee has exhausted any paid sick leave and that he or she is not physically able to perform their work through remote access or similar means during a mandatory or precautionary order of quarantine or isolation.

Employer Signature:_____ Date:_____

Print Employer Name/Entity: _____

Amalgamated Employee Benefits Administrators must pay or deny benefits within 18 calendar days of receiving your completed request. Your request cannot be considered incomplete solely because your employer failed to fill out Section 3 above or Part B of *Form PFL-1*.

If you disagree with Amalgamated Employee Benefits Administrators decision, or if payment is untimely, you may request arbitration with NAM (National Arbitration and Mediation) at nyspfla.com.

CCOVID19 3-20

# 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 NYCDCC Benefit Funds to complete Part B.
- The NYCDCC Benefit Funds 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 supporting documentation listed on Part B of *Request For Paid Family Leave (Form PFL-1)* to Amalgamated Employee Benefits Administrators. 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*



**If you need assistance, please call (844) 337-6303**
www.ny.gov/PaidFamilyLeave

**DO NOT SCAN**

## 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 NYCDCC Benefit Funds 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.

**The NYCDCC Benefit Funds must sign and date Part B before giving this form to the employee.**

## PART B EMPLOYER INFORMATION (to be completed by the NYCDCC Benefit Funds

**The NYCDCC Benefit Funds Office on behalf of 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.

**NYCDCC Benefit Funds 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*



If you need assistance, please call (844) 337-6303
www.ny.gov/PaidFamilyLeave

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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 Amalgamated Employee Benefits Administrators 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 NYCDCC Benefit Funds)

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*



If you need assistance, please call (844) 337-6303
www.ny.gov/PaidFamilyLeave

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 NYCDCC Benefit Funds) 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



If you need assistance, please call (844) 337-6303
www.ny.gov/PaidFamilyLeave

# NYS COVID-19 PAID LEAVE
# EMPLOYER ATTESTATION FORM

**Company Name:** _____

**Tax ID No.:** _____

**Address:** _____

**City, State, Zip:** _____

**Contact Name:** _____

**Phone Number:** _____ **Email:** _____

**Signature:** _____

**Print Name:** _____

**Date:** _____

**Employer Category:**
Please select one of the following:

- ☐ 10 or fewer employees as of 1/1/2020, with 2019 net income of less than $1 million
- ☐ 10 or fewer employees as of 1/1/2020, with 2019 net income greater than $1 million
- ☐ 11-99 employees as of 1/1/2020
- ☐ 100 or more employees as of 1/1/2020

***Employers may be required, upon request by the Welfare Fund, to provide documentation substantiating their response to this question.***

**Please return this attestation to Amalgamated Employee Benefits Administrators, at the address below. Please also remind the employee that their completed SCOVID and PFL1 forms must be returned to Amalgamated Employee Benefits Administrators, at the below address:**

**Amalgamated Employee Benefits Administrators**
**P.O. Box 5453**
**White Plains, NY 10602**
**SubmitClaimForms@amalgamatedbenefits.com**
**Fax: 914-367-4114**

***Due to the varying State and Federal regulations regarding eligibility there is no guarantee of payment.***

# NYS COVID-19 PAID LEAVE EMPLOYER ATTESTATION FORM

**Employee Name:** _____
**Date of Hire:** _____
**Wage Rate:** _____
**Last Day of Work:** _____
**Dates of Leave Requested:** _____
**Employee's Scheduled Hours Per Week:** _____

## Reason(s) for Leave:

Is the employee subject to a mandatory or precautionary order of isolation or quarantine due to COVID-19 infection or exposure?

____ Yes ____ No

If Yes, please direct the employee to submit a copy of their mandatory or precautionary order of quarantine or isolation (which can be obtained by the employee contacting their local health department).[1]

## Extension of Benefits Previously Provided under the federal Families First Coronavirus Response Act

Through March 31, 2021, an employer may provide employees with certain paid sick leave and expanded family and medical leave benefits (which were previously provided under the federal Families First Coronavirus Response Act) and seek reimbursement for such paid leave in the form of tax credits. *See* https://www.dol.gov/agencies/whd/pandemic/ffcra-questions#104

Is your company providing these extended benefits to this employee?

____ Yes ____ No

If Yes: Identify the dates the employee is receiving these extended benefits: _____

[1] If the local health department is unable to immediately provide the employee with the order of quarantine or isolation, the employee should submit documentation from a licensed medical provider that has treated the employee, attesting that the employee qualifies for the order, and should then follow up with their local health department and submit the order from their local health department as soon as it is available. Local health departments must provide the requested orders within 30 days.

# NYS COVID-19 PAID LEAVE
# EMPLOYER ATTESTATION FORM

Please return this attestation to Amalgamated Employee Benefits Administrators, at the address below. Please also remind the employee that their completed SCOVID and PFL1 forms must be returned to Amalgamated Employee Benefits Administrators, at the below address:

**Amalgamated Employee Benefits Administrators**
**P.O. Box 5453**
**White Plains, NY 10602**
SubmitClaimForms@amalgamatedbenefits.com
**Fax: 914-367-4114**

**Due to the varying State and Federal regulations regarding eligibility there is no guarantee of payment.**

***Please note that all information provided on this form is subject to audit by the Welfare Fund. Employers must respond truthfully and accurately in all communications with the Welfare Fund.***