Amalgamated Employee Benefits Administrators
Delivering High Quality, Customized TPA Services

New York City District Council of Carpenters
BENEFIT FUNDS

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
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HOW TO REQUEST PAID FAMILY LEAVE

to care for a family member with a serious health condition

BEFORE YOU APPLY FOR PAID FAMILY LEAVE

- ☐ **Check the eligibility requirements.** See next page or visit **PaidFamilyLeave.ny.gov/eligibility**.
- ☐ **Plan your leave.** Leave can be taken all at once or intermittently, but must be taken in full-day increments.
- ☐ **Notify your employer at least 30 days in advance**, if foreseeable, or as soon as possible.

COMPLETE YOUR FORMS AND ATTACH REQUIRED DOCUMENTATION

☐ **Complete the *Request for Paid Family Leave (Form PFL-1).***

Note: This form has sections that need to be completed by you and by your employer.

- ☐ Fill out your section, make a copy, and give the form to the NYCDCC Benefit Funds to fill out ***Part B***.
- ☐ NYCDCC Benefit Funds is required to return ***Form PFL-1*** to you within three business days. If there is a delay, you do not have to wait to proceed. Send the ***Form PFL-1*** that you have filled out, along with the rest of your request package, directly to Amalgamated Employee Benefits Administrators.

☐ **Complete the *Release of Personal Health Information Under the Paid Family Leave Law (Form PFL-3).***

- ☐ Your family member (the care recipient) completes Form PFL-3 and submits the form to their health care provider to keep on file.
  This form authorizes a health care provider to release information regarding your family member's serious health condition to you and Amalgamated Employee Benefits Administrators
  Do not send this form to the insurance carrier.

☐ **Complete the *Health Care Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4).***

Note: This form has sections that need to be completed by the health care provider.

- ☐ Fill out your section, make a copy, and give the form to your family member's health care provider.
- ☐ Ask the provider to complete their portion of the form and return it to you in a timely manner.

SUBMIT TO NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS BENEFIT FUNDS

☐ **You must submit your completed request package to your employer's insurance carrier within 30 days after the start of your leave to avoid losing benefits.**

Keep a copy of all forms and documentation for your records.

To complete the employer sections and sign off of eligibility, please mail forms to **395 Hudson Street, New York, NY 10014** or fax to **(212) 366-3301**.

You **MUST** include your last 8 weeks pay stubs that were immediately prior to your first leave date.

You can call the NYCDCC Benefit Finds for assistance at **(800) 529-3863**.

Mail or fax your From PFL-1, PFL-3 and Form PFL-4 and the required documentation to Amalgamated Employee Benefits Administartors after the PFL-1 has been signed off from the NYCDCC Benefit Funds Office.

Please DO NOT submit your request package to the NYS Workers' Compensation Board.

It is YOUR responsibility to submit the forms to Amalgamated Employee Benefits Administrators. It is NOT your employer's responsibility.

Important to know

- In most cases, the insurance carrier must pay or deny benefits within 18 days of receiving your completed request or your first day of leave, whichever is later. Your request cannot be considered incomplete solely because NYCDCC Benefit Funds did not fill out **Part B** of ***Form PFL-1*** within three business days.
- If the carrier denies or fails to timely pay your benefits, or you have any other claim-related dispute, you may request to have the carrier's actions reviewed. More information can be found at **nyspfla.namadr.com**.
- Complaints about employer discrimination or retaliation are resolved by a Workers' Compensation Board Law Judge after a hearing. If you believe that your employer has discriminated or retaliated against you for taking or requesting Paid Family Leave, visit **PaidFamilyLeave.ny.gov/protections** or contact **(844) 337-6303**.

Eligibility

- Most employees who work for private employers in New York State are covered under Paid Family Leave.
  - **Full-time employees:** If you work a regular schedule of 20 or more hours per week, you are eligible after 26 consecutive weeks of employment with your employer.
  - **Part-time employees:** If you work a regular schedule of less than 20 hours per week, you are eligible after working for your employer for 175 days, which do not need to be consecutive.
- Non-represented public employees may be covered if their employer has voluntarily opted in to provide the benefit. Union-represented public employees may be covered if the benefit has been negotiated through collective bargaining.
- Citizenship and/or immigration status is not a factor in employee eligibility.
- If you believe you are eligible, you can apply for Paid Family Leave and the insurance carrier will make a determination.
- If you have questions about eligibility rules, call the **NYCDCC Benefit Funds Member Services** at **(800) 529-3863** or the **PFL Helpline** at **(844) 337-6303** (Monday - Friday, 8:30 a.m. to 4:30 p.m.).

FAMILY MEMBERS YOU CAN CARE FOR:
Spouse/domestic partner
Child/stepchild
Parent/stepparent/parent-in-law
Grandparent
Grandchild
Sibling (New in 2023!) Check with your employer's insurance carrier for details on when this goes into effect for their policy.

CARE CAN INCLUDE PROVIDING:
Necessary physical care
Emotional support
Visitation
Assistance in treatment
Transportation
Help arranging for a change in care
Assistance with essential daily activities
Personal attendant services

REMEMBER: Submit the completed forms to Amalgamated Employee Benefits Administrators it is not the NYCDCC Benefit Funds responsibility.

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New York City District Council of Carpenters
BENEFIT FUNDS

Request for Paid Family Leave (Form PFL-1) Instructions

- To request Paid Family Leave (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 business 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)* along 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.

PFL Request (to be completed by the employee)

Question 12: A child includes a biological, adopted, or fostered child, a stepchild, a legal ward, a child 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.

Question 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	+ $500
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

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 employer is also required to provide this information in Part B of the *Request for Paid Family Leave (Form PFL-1)*.

When 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 submission. 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* to the employee within five days explaining that the claim should be re-submitted when all information is available.

NYCDCC Benefits Funds Office must sign and date Part B before returning it to the employee.

PART B - EMPLOYER INFORMATION (to be completed by the NYCDCC Benefits 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. Employers should contact their carrier if they don't know their 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 dividing the total 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.

Questions 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 Benefits 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 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 Taxpayer 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 Taxpayer 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.

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New York City District Council of Carpenters
BENEFIT FUNDS

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 Taxpayer Identification Number**

___ - ___ - ____

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**

☐ M ☐ F ☐ X

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
☐ Another 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 ☐ Sibling

Form PFL-1 continued on next page

PFL-1 12-22

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 intermittent?

☐ Continuous — PFL start date (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐ — PFL end date (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐ — ☐ Dates are estimated

☐ Intermittent — Identify dates intermittent PFL will be taken: — ☐ Dates are estimated

14. If providing less than 30 days' 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 weekly 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 the insurance carrier 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 employer)

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

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 employer) - 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

Release of Personal Health Information Under the Paid Family Leave Law (Form PFL-3) Instructions

- If an employee is requesting Paid Family Leave (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 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 PFL-4)*.
- The *Release of Personal Health Information Under the Paid Family Leave Law (Form PFL-3)* enables the health care provider to complete *Health Care Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4)* and release it to the employee seeking PFL benefits.
- Before completing and signing, the care recipient must read the *Release of Personal Health Information Under the Paid Family Leave Law (Form PFL-3)* in its entirety.
- The employee requesting PFL submits both the *Request for Paid Family Leave (Form PFL-1)* and the *Health Care Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4)* to their employer's PFL insurance carrier, or to their employer if the employer is self-insured, for PFL benefit determination.

  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.

Care recipient or authorized representative signs and dates.

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 PFL-4)*.

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form PFL-4)

Employee enters their name, and care recipient's (patient's) name and date of birth at the top of each page.

The PFL insurance carrier name requested at the top of the form is the same as the PFL insurance carrier identified in *Request for Paid Family Leave (Form PFL-1)* Part B line 13.

Care recipient or authorized representative must complete all applicable requested information.

If a care recipient is unable to fill out this form, an authorized representative must attach a copy of legal documentation, such as a health care proxy or power of attorney, permitting the representative to sign on behalf of the care recipient. The health care provider will require this documentation of authorization unless the authorized representative is a parent signing on behalf of a minor child.

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 Taxpayer 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 Taxpayer 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.

DO NOT SCAN

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New York City District Council of Carpenters
BENEFIT FUNDS

Request for Paid Family Leave
Release of Personal Health Information Under the Paid Family Leave Law (Form PFL-3)

INSTRUCTIONS INCLUDED WITH FORM

TO BE COMPLETED BY THE EMPLOYEE

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

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

Care recipient's (patient's) date of birth (MM/DD/YYYY)

__ __ / __ __ / __ __ __ __

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form PFL-4)

I, Care recipient's (patient's) name **, authorize my health care provider listed on this form to release my personal health information to** Employee's name **and their employer's PFL insurance carrier** PFL insurance carrier's name Amalgamated Employee Benefits Administrators **.**

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 relate 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 (to be completed by the care recipient or authorized representative)

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. **Health care provider's name**

2. **Health care provider's mailing address**

Mailing address

City, State | Zip code | Country (if not U.S.A.)

3. **Health care provider's telephone number** (provide area or country code)

Form PFL-3 continued on next page

TO BE COMPLETED BY THE EMPLOYEE

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

Care recipient's (patient's) name (first name, middle initial, last name) **Care recipient's (patient's) date of birth** (MM/DD/YYYY)

__ __ / __ __ / __ __ __ __

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form PFL-4) - continued from prior page

Form PFL-1 continued from prior page

Care Recipient Information (to be completed by the care recipient or authorized representative)

4. Care recipient's mailing address

Mailing address

City, State | Zip code | Country (if not U.S.A.)

5. Care recipient's Social Security number ___ - __ - ____

6. Care recipient's telephone number (provide area or country code)

READ AND SIGN BELOW

I hereby request that the health care provider listed give a completed *Health Care Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4)* to the employee identified on the 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 signed (MM/DD/YYYY)

__ __ / __ __ / __ __ __ __

Authorized representative

I, Print name **, represent the care recipient in this matter as authorized by:**

☐ Parental right ☐ Power of attorney (attach copy) ☐ Court order (attach copy) ☐ Health care proxy (attach copy)

Authorized representative's signature

Date signed (MM/DD/YYYY

__ __ / __ __ / __ __ __ __

The employee should retain a copy for their own records

Health Care Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4) Instructions

The employee requesting Paid Family Leave (PFL) to care for a family member with a serious health condition must submit the *Health Care Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4)* with the *Request for Paid Family Leave (Form PFL-1)*.

Employee:

- Employee enters their name, date of birth, other last names, if any, under which they have worked, Social Security number or Taxpayer Identification Number (TIN), mailing address, and care recipient's (patient's) name and date of birth at the top of page 1.
- Employee enters their name and date of birth, and care recipient's (patient's) name and date of birth at the top of page 2.
- Employee gives the *Health Care Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4)* to the health care provider.

HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION
(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

The patient's health care provider must complete all applicable requested information unless noted as optional.

Question 2: Providing the optional ICD-10 code is recommended.

The patient's health care provider must complete the Patient Information and Health Care Provider sections of the *Health Care Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4)*.

Health care provider signs and dates, and then returns the form to the employee requesting PFL.

If you believe the patient is the victim of abuse or neglect caused by the employee requesting PFL, you may decline to provide this certification.

Employee:

- When you receive the completed *Health Care Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4)* from the health care provider, send the completed forms and supporting documentation to the insurance carrier.

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 Taxpayer 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 Taxpayer 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.

DO NOT SCAN

Amalgamated Employee Benefits Administrators
Delivering High Quality, Customized TPA Services

New York City District Council of Carpenters
BENEFIT FUNDS

Request for Paid Family Leave

Health Care Provider Certification for Care of Family Member with Serious Health Condition (Form PFL-4)

INSTRUCTIONS INCLUDED WITH FORM

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name) **Employee's date of birth** (MM/DD/YYYY)

_____ ☐☐ / ☐☐ / ☐☐☐☐

Other last names, if any, under which employee has worked

_____

Employee's Social Security number or TIN

☐☐☐ - ☐☐ - ☐☐☐☐

Employee's mailing address

Mailing address

City, State | Zip code | Country (if not U.S.A.)

Care recipient's (patient's) name (first name, middle initial, last name) **Care recipient's (patient's) date of birth** (MM/DD/YYYY)

_____ ☐☐ / ☐☐ / ☐☐☐☐

HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION

(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

Care Recipient (Patient) Information (to be completed by the health care provider)

1. **Does patient require care by the employee requesting Paid Family Leave (PFL)?**

   ☐ Yes ☐ No (If no, skip to "Health Care Provider Information.")

   Note: For the purposes of this section, "providing care" may include necessary physical care, emotional support, visitation, assistance in treatment, transportation, arranging for a change in care, assistance with essential daily living matters, and personal attendant services.

2. **Primary ICD-10 code (optional)** ☐☐☐☐☐☐☐☐

3. **Diagnosis**

   _____

4. **Date patient's condition commenced** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

5. **First date care for patient is needed** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

6. **Expected date patient will no longer require care** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

7. **Estimated number of days per week OR days per month patient requires care** Days/week **OR** Days/month

Health Care Provider Information (to be completed by the health care provider)

8. **Health care provider's name**

   _____

Form PFL-4 continued on next page

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name) **Employee's date of birth** (MM/DD/YYYY)

_____ ☐☐ / ☐☐ / ☐☐☐☐

Care recipient's (patient's) name (first name, middle initial, last name) **Care recipient's (patient's) date of birth** (MM/DD/YYYY)

_____ ☐☐ / ☐☐ / ☐☐☐☐

HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION

(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above) - continued from prior page

Form PFL-4 continued from prior page

9. Type of health care provider:

☐ Medical Doctor (MD)	☐ Dentist (DDS/DDM)	☐ Licensed Social Worker (LMSW/LCSW)
☐ Doctor of Osteopathy (DO)	☐ Physician's Assistant (PA)	☐ Other (specify)
☐ Doctor of Podiatric Medicine (DPM)	☐ Nurse Practitioner (NP)	
☐ Doctor of Chiropractic Medicine (DC)	☐ Licensed Psychologis	

10. Health care provider's mailing address

Mailing address

City, State | Zip code | Country (if not U.S.A.)

11. Health care provider's telephone number (provide area or country code) _____

12. Health care provider's fax number (provide area or country code) _____

13. Health care provider's email address (if available) _____

14. State or country (if not U.S.A.) in which health care provider is licensed to practice _____

15. Specialty _____

16. 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 ☐☐ / ☐☐ / ☐☐☐☐