MetLife

Request for New York Paid Family Leave *(MET-PFL-1)* - Part A

Metropolitan Life Insurance Company

SECTION 1: Employee information *(to be completed by employee)*

1. Legal first name | Legal middle initial | Legal last name

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

3. Mailing address | City | State | ZIP

Country *(if not U.S.A.)* | 4. Social Security number | ID Number | 5. Date of birth *(mm/dd/yyyy)*

6. Primary phone number | 7. Email address | 8. Gender ☐ Male ☐ Female ☐ Not designated/Other

9. Preferred language

☐ English ☐ Español ☐ Русский ☐ Polski ☐ 中文 ☐ Italiano ☐ Kreyòl ayisyen ☐ 한국어

☐ Other _____

Optional *(for research purposes)*

10. Ethnicity and race: optional, 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

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

13. Last date worked *(actual/anticipated)* prior to start of leave

13a. Estimated PFL start date *(mm/dd/yyyy)* | 13b. Estimated PFL end date *(mm/dd/yyyy)*

Name of employee requesting PFL

First name	Middle initial	Last name	PFL claim number

14. If providing less than 30 days advance notice from the Estimated PFL start date, please explain.

15a. Will PFL be for a continuous period of time and/or periodic? ☐ Continous ☐ Periodic

15b. Identify dates PFL will be taken	15c. Are these dates estimated? ☐ Yes ☐ No

SECTION 2: Employment information *(to be completed by employee)*

16. Business name	17. Date of hire *(mm/dd/yyyy)*	18. Phone number

19. Work location - Street address	City	State	ZIP

Country *(if not U.S.A.)*	20. Average weekly wage *(This data will be requested of both employee and employer)*

Scheduled work week ☐M ☐Tu ☐W ☐Th ☐F ☐Sa ☐Su

Is work week ☐ regular or ☐ variable

21a. Does employee have more than one employer? ☐ Yes ☐ No

21b. If yes, is employee taking PFL from the other employer? ☐ Yes ☐ No

22. 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.

SECTION 3: 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.

Sign Here	Signature of Employee	Date *(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.

Request for New York Paid Family Leave *(MET-PFL-1)* - Part B

Name of employee requesting PFL

First name	Middle initial	Last name	PFL claim number

SECTION 4: Employer information *(to be completed by employer)*

1. Business name

Business mailing address	City	State	ZIP

Country *(if not U.S.A.)*

2. FEIN

Sub-code number *(Sub-division)*/Sub-point number *(Branch)*

Group report number

3. Employer's contact name for questions related to PFL

4. Phone number	5. Email address	6. Employee's date of hire *(mm/dd/yyyy)*

7. Employee's occupation

8. 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			

8a. Last date worked *(actual/anticipated)* prior to start of leave

Scheduled work week ☐M ☐Tu ☐W ☐Th ☐F ☐Sa ☐Su

Is work week ☐ regular or ☐ variable

9. Calculated average gross weekly wage $

10. If employee received or will receive full wages while on PFL, will employer be requesting reimbursement?

☐ Yes ☐ No

If yes, please provide dates

Name of employee requesting PFL

First name	Middle initial	Last name	PFL claim number

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

☐ NY State Disability ☐ PFL ☐ Both NY State Disability and PFL ☐ None

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

NY State Disability: _____ Weeks _____ Days

Please provide specific dates for NY State Disability

From	To

PFL: _____ Weeks _____ Days

Please provide specific dates for PFL

From	To

12. Is the employee taking Family Medical Leave Act (FMLA) concurrently with PFL? ☐ Yes ☐ No

PFL Insurance Carrier

13. PFL insurance carrier's name	Fax number
Metropolitan Life Insurance Company	**1-800-230-9531**

Mailing address	City	State	ZIP
PO Box 14590	**Lexington**	**KY**	**40512**

SECTION 5: 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 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.

Sign Here	Employer's authorized signature	Title	Date *(mm/dd/yyyy)*

☐ 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.

Request for New York Paid Family Leave *(MET-PFL-1)* form instructions

Under New York State Law, qualified employees are entitled to Paid Family Leave (PFL) benefits to:

- Bond with a newborn, a newly adopted or fostered child
- Care for a family member with a serious health condition
- Care for family members as needed due to another family member's active military duty or impending active duty

Read below for instructions on how to request Paid Family Leave (PFL).

Request For Paid Family Leave *(MET-PFL-1)*

To request PFL, the employee requesting PFL completes all items in Part A of the Request For Paid Family Leave *(MET-PFL-1)*. All items on the form are required unless noted as optional. The employee then provides the form and instructions to the employer to complete Part B.

Additional forms are required depending on the type of PFL leave being requested. The employee requesting leave is responsible for the completion of these forms.

Reason for Paid Family Leave	Required Additional Form
Bond with a newborn, a newly adopted child or a foster child	Bonding Certification *(MET-PFL-2)*
*Care for a family member with a serious health condition	Health Care Provider Certification For Care Of Family Member With Serious Health Condition *(MET-PFL-4)*
Time off due to a family member's active military duty or impending active duty	Military Qualifying Event *(MET-PFL-5)*

* If the employee is taking PFL to care for a family member with a serious health condition, the care recipient completes the Release Of Personal Health Information Under The Paid Family Leave Law *(MET-PFL-3)*. This form must be provided to the care recipient's health care provider along with the Health Care Provider Certification For Care Of Family Member With Serious Health Condition *(MET-PFL-4)*. The health care provider completes the Health Care Provider Certification For Care Of Family Member With Serious Health Condition *(MET-PFL-4)* and returns it to the employee requesting PFL.

The employee submits the completed Request For Paid Family Leave *(MET-PFL-1)*, with the required additional form(s) by fax to MetLife Disability at 1-800-230-9531 or by mail to MetLife Disability, P.O. Box 14590, Lexington, KY 40512. The employee should retain a copy of each submitted form for his or her records.

SECTION 1: Employee information *(to be completed by employee)*

The employee requesting PFL must complete all required information.

Question 2: Indicate if employee has used another last name, either professionally or personally, in the past year.

Question 4: Social Security number or TIN: An employee who has a Taxpayer Identification Number (TIN) should enter his or her TIN.

Paid Family Leave request

Questions 11 & 12: Indicate the reason for the PFL request and the employee's relationship to the family member.

Questions 13a & 13b: 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.

Question 14: If the employee is submitting the PFL request to his or her 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 claim number *(if available)* at the top of the attachment.

Question 15b: Enter the dates PFL will be taken. Please be as specific as possible. If the dates are unknown or estimated, MetLife may require you to submit a request for payment **after** the PFL day is taken. Payment will be due as soon as possible but in no event more than 18 days from the date of the request for payment.
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 claim number *(if available)* at the top of the attachment.

Indicate if the employee is pre-submitting his or her 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 filing. The employee must provide the missing information as soon as it is known. Benefits cannot be determined until all of the required information is provided.

MetLife 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, MetLife has 18 days to pay or deny the claim.

SECTION 2: Employment information

Question 16: Enter the employer's business name.

Question 19: Enter the address of the employee's work location.

Question 20: Enter the best estimate of the employee's average gross weekly wage, include only the wages earned from the employer listed on this request form. The gross weekly wage is the employee's 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 his or her 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

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 *(MET-PFL-1)*.

Question 21b: If the employee has more than one employer, indicate whether the employee is taking PFL from the other employer.

Employee enters name and claim number *(if available)* at the top of each page in the fields provided. Employee signs and dates, before giving this form to his or her employer to complete Sections 4 and 5.

SECTION 4: Employer information *(to be completed by the employee's employer)*

The employer of the employee requesting PFL must complete all information in Sections 4 and 5.

Question 1: Enter the business' full legal name and address.

Question 2: If a Social Security number is used for the Federal Employer Identification Number (FEIN), enter the Social Security number.

Question 3, 4 & 5: Enter the name, phone number and email address of a contact person at the employer who can answer questions regarding this form.

Question 7: The employee occupation code can be found at: **http://www.bls.gov/soc/**

Question 8: 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 20 on page 2 of these instructions.)

Question 9: Calculate the gross average weekly wage by adding up the gross amounts paid, listed in Question 8, and then divide by eight (or number of weeks worked if less than eight).

Question 11b: The maximum number of weeks available for NY State 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 State Disability and PFL during the preceding 52 weeks. If the answer is "none," enter a "0" for total weeks and days.

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.

Employer signs and dates, and then returns to the employee requesting PFL within three business days.
See page 1 of these instructions for required forms relevant to the type of PFL leave being requested.

MetLife

Request for New York Paid Family Leave

Release Of Personal Health Information (PHI)
Under The Paid Family Leave Law *(MET-PFL-3)*

Things to know before you begin

- This form will be retained by the health care provider. The employee should make a copy for his or her records before giving it to the health care provider.
- The employee should retain a copy for his or her own records.

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

SECTION 1: To permit the release of personal health information by the health care provider for a family member with a serious health condition *(to be signed by the health care recipient)*

I, _____ *(Care recipient's name)*, authorize my health care provider listed on this form to release my personal health information to _____ *(Employee's name)* and MetLife.

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. Your health care provider may not, however, discuss your health care information with anyone.

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
- ☐ Alcohol/drug treatment
- ☐ Mental health information
- ☐ 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.

Health care provider's name

Mailing address	City	State	ZIP

Country *(if not U.S.A.)*	Phone number *(provide area or country code)*

Care recipient information

Care recipient - Mailing address	City	State	ZIP

Country *(if not U.S.A.)*

Social Security number *(if applicable)*	Phone number *(provide area or country code)*

Name of employee requesting PFL

First name	Middle initial	Last name	PFL claim number

SECTION 2: Signature

Read and sign below. I hereby request that the health care provider listed above give a completed MET-PFL-4 form to the person identified above. 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.

Sign Here Signature of Care recipient _____ Date *(mm/dd/yyyy)* _____

Authorized representative *(if applicable)*

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)*

Sign Here Signature of Authorized representative _____ Date *(mm/dd/yyyy)* _____

Release of Personal Health Information (PHI) under the Paid Family Leave Law *(MET-PFL-3)* form instructions

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 *(MET-PFL-3)* and submit it to his or her health care provider, along with a copy of the Health Care Provider Certification For Care Of Family Member With Serious Health Condition *(MET-PFL-4)*.

The Release Of Personal Health Information Under The Paid Family Leave Law *(MET-PFL-3)* enables the health care provider to complete Health Care Provider Certification For Care Of Family Member With Serious Health Condition *(MET-PFL-4)* and release it to the employee seeking PFL benefits. The employee requesting PFL then submits both the MET-PFL-1 and the Health Care Provider Certification For Care Of Family Member With Serious Health Condition *(MET-PFL-4)* to MetLife Disability, P.O. Box 14590, Lexington, KY 40512, or by fax at 1-800-230-9531, for PFL benefit determination.

Before completing and signing, the care recipient must read the Release Of Personal Health Information Under The Paid Family Leave Law *(MET-PFL-3)* in its entirety.

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.

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 *(MET-PFL-4)*.

MetLife

Request for New York Paid Family Leave

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

Things to know before you begin

- If you believe the care recipient is the victim of abuse or neglect caused by the employee requesting PFL, you may decline to provide this certification.
- The employee requesting 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 *(MET-PFL-4)* with the Request For Paid Family Leave *(MET-PFL-1)*.

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

To be completed by the Employee

Employee's first name	Middle initial	Last name

Employee's mailing address	City	State	ZIP

Country *(if not U.S.A.)*	Social Security number	PFL claim number

SECTION 1: Health care provider certification for care of family member with serious health condition *(to be completed by the health care provider and returned to the aboved named employee)*

Patient information *(family member with serious health condition)*

First name	Middle initial	Last name

Date of birth *(mm/dd/yyyy)*

_____

Does patient require care by the employee requesting Paid Family Leave (PFL)?
(If no, skip to "Health Care Provider Information".) ☐ Yes ☐ No

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.

Primary ICD-10 code *(optional)*	Date patient's condition commenced *(mm/dd/yyyy)*

Diagnosis

First date care for patient is needed *(mm/dd/yyyy)*	Expected date patient will no longer require care *(mm/dd/yyyy)*

Estimated number of days per week OR days per month patient requires care

_____ Days/week OR _____ Days/month

Name of employee requesting PFL

First name	Middle initial	Last name	PFL claim number

Health care provider information

First name	Middle initial	Last name

Type of health care provider:

- ☐ Doctor of Osteopathy (DO)
- ☐ Medical Doctor (MD)
- ☐ 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)*

Mailing address	City	State	ZIP

Country *(if not U.S.A.)*	Phone number *(provide area or country code)*

Fax number	Email address *(if available)*	Specialty

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

SECTION 2: 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.

Sign Here	Signature of Health care provider	Date *(mm/dd/yyyy)*

Health Care Provider signs and dates, and then returns the form to the employee requesting PFL.