HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

APPLICATION FOR NEW YORK PAID FAMILY LEAVE BENEFITS

This application package is divided into three sections, as follows:

PFL 1, Part A **Employee Information -** to be completed by the **employee** who is applying for Paid Family Leave benefits.

PFL 1, Part B **Employer Information –** to be completed by the **employer's** authorized representative.

PFL 5 **Military Qualifying Event –** to be completed by the **employee** and attached to the applicable supporting documentation.

PFL 5-T **Military Qualifying Event (Form PFL-5-T) -** To be completed by the **employee** and attached to the applicable supporting documentation, if qualifying event is to meet with a third party.

Submit completed application along with the required supporting documentation to:

The Hartford
P.O.Box 14306
Lexington, KY 40512-4306
Fax Number: (866) 411-5613
E-mail: PFL@thehartford.com

The Hartford
P.O.Box 14306
Lexington, KY 40512-4306
Fax Number: (866) 411-5613
E-mail: PFL@thehartford.com

Clear Form

Request For NY Paid Family Leave
(Form PFL-1)

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

1. Legal name (first name, middle initial, last name)

2. Other last names, if any, under which you have worked

3. Mailing address

4. Social Security Number

5. Date of birth (MM/DD/YYYY)

6. Primary telephone number
( )

7. Preferred email address while on PFL (if available)

8. Gender
☐ Male ☐ Female ☐ Not designated/Other

9. Preferred language
☐ English ☐ Español ☐ Русский ☐ Polski ☐ 中文 ☐ Italiano ☐ Kreyòl ayisyen ☐ 한국어 ☐ Other: _____

10. Race/Ethnicity - 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

11. Reason for PFL Request:

☐ Bond with Child ☐ Care for Family Member ☐ Military Qualifying Event

12. The Family Member is your:

☐ Child ☐ Spouse ☐ Domestic Partner ☐ Parent ☐ Parent-in-law ☐ Grandparent ☐ Grandchild

13. Will PFL be for a Continuous period of time and/or Periodic?:

(Note: If dates are "Continuous", you 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".)

PFL start date (MM/DD/YYYY) **PFL end date (MM/DD/YYYY)**

☐ **Continuous** _____ _____ ☐ **Dates are estimated**

Identify dates periodic PFL will be taken:

☐ **Periodic** _____ ☐ **Dates are estimated**

14. When submitting a request for PFL, 30 days advance notice is required. If providing less than 30 day's advance notice, please explain:

(Note: If the explanation will not fit in the space provided on the form, enter "See Attached" and add an attachment with the explanation.)

If you need assistance, please call (800) 549-6514
www.ny.gov/PaidFamilyLeave

PFL-1 11-17

Employment Information (to be completed by the employee)

15. Business name

16. Date of Hire (MM/DD/YYYY) (Note: Enter the date of hire to the best of your recollection. If it has been more than a year since your date of hire, entering the year in which employment started is sufficient.):

17. Work location (Street address):

18. Your average gross weekly wage during the last eight weeks prior to the start of PFL: $ _____

(Note: Enter the best estimate of average gross weekly wage as this will also be confirmed with your employer. 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.

19. Employer's telephone number for contact regarding this request: ( )

20a. Do you have more than one employer? ☐ Yes ☐ No

20b. If yes, are you taking PFL from the other employer? ☐ Yes ☐ No

21. Are you currently receiving Workers' Compensation Lost Wage Benefits? ☐ Yes ☐ No

22. Your PFL benefit is 100% taxable. The federal government and State of New York allow us to withhold 10% of your benefit for Federal Income Tax (FIT) and 2.5% for State Income Tax (SIT) with your permission.

22a. Would you like us to withhold FIT? ☐ Yes ☐ No

22b. Would you like us to withhold SIT? ☐ 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 of my leave start date. I understand The Hartford will contact me to advise how to submit any required missing information.

Employee name: **Employee Date of Birth:**

PART B - EMPLOYER INFORMATION (to be completed by the employer)

1. **Business's full legal name and mailing address**

2. **Employer's contact name for questions related to PFL:**

3. **Employer's contact telephone number:** ( )

4. **Employer's contact email address:**

5. **Employee's date of hire**

6. **PFL coverage effective date**

7. **Employee's Work Location:**

8. **Employee's occupation** Codes are available at: www.bls.gov/soc/2010/soc_alph.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			
		Total:	
		Calculated average gross <u>weekly</u> wage:	

10. **Actual days worked in the week prior to the start of the leave:** (Check all days that apply)

Sunday: ☐ **Monday:** ☐ **Tuesday:** ☐ **Wednesday:** ☐ **Thursday:** ☐ **Friday:** ☐ **Saturday:** ☐

11. **If employee received or will receive full wages while on PFL, will employer be requesting reimbursement?** ☐ Yes ☐ No
If Yes, please provide date range of reimbursement: From: _____ **Through:** _____

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

13. **PFL policy number:**

14. **Has this employee received NY disability benefits or PFL benefits within the 52 weeks prior to the start of this leave request that were not administered by The Hartford?:**

☐ Yes ☐ No ☐ Unknown as employment began within the last 52 weeks

If yes, fill in the following:

Paid by (Carrier Name/State):

Dates Paid:

Employee name: **Employee Date of Birth:**

PART B - EMPLOYER INFORMATION (to be completed by the employer)

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

The Hartford
P.O.Box 14306
Lexington, KY 40512-4306
Fax Number: (866) 411-5613
E-mail: PFL@thehartford.com

Request For NY Paid Family Leave
Military Qualifying Event (Form PFL-5)

Clear Form

TO BE COMPLETED BY THE EMPLOYEE	
Legal name (first name, middle initial, last name)	**Other last names, if any, under which you have worked**
Mailing address	
Social Security Number	**Date of birth** (MM/DD/YYYY)

MILITARY QUALIFYING EVENT (to be completed by the employee)

1. **Name of military member on covered active duty or impending call to covered active duty status (international deployment)** (first name, middle initial, last name)

   _____

2. **Military member's date of birth** (MM/DD/YYYY) _____

3. **Military member's gender** ☐ Male ☐ Female ☐ Not designated/Other

4. **Military member's mailing address**

   _____

5. **The above-named military member is employee's:** ☐ Spouse ☐ Domestic partner ☐ Child ☐ Parent

6. **Period of military member's covered active duty** (MM/DD/YYYY)

   _____ to _____

7. **Please select one of the following and attach the indicated document to support that the military member is on covered active duty or impending call or order to covered active duty status. Please blacken out the location of the active millitary member prior to submitting to us. Note: this certification along with the required documentation listed below must be returned to The Hartford in order for us to process your request for PFL.**

   ☐ Covered active duty orders
   ☐ Letter of impending call or order to covered duty
   ☐ Documentation of military leave signed by the approving authority for military member's Rest and Recuperation

Qualifying Reason For Leave (to be completed by the employee)

What is the reason employee is requesting PFL? (One or more reasons may be selected. If other is selected, please provide an explanation of the need for leave. For example: "My spouse was just called on short notice to covered active duty status, and will be deployed to in five days. I need to take PFL to be with them and make arrangements for while they are away on active duty." 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 your full name, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, and mailing address at the top of the attachment.)

☐ Arranging for child care
☐ Arranging for parental care
☐ Counseling
☐ Making financial arrangements
☐ Making legal arrangements
☐ Acting as military member's representative before a federal, state, or local agency for purpose of obtaining, arranging, or appealing military service benefits
☐ Attending any event sponsored by the military or military service organizations
☐ Other _____

TO BE COMPLETED BY THE EMPLOYEE

Legal name (first name, middle initial, last name) _____

Date of birth (MM/DD/YYYY) _____

MILITARY QUALIFYING EVENT (to be completed by the employee) - continued from prior page

9. Written documentation supporting this request for leave is available and attached?

☐ Yes ☐ No ☐ None Available

Note: A complete and sufficient certification to support a request for PFL leave due to a qualifying event includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. If leave is requested to meet with a third party, the employee must provide the supporting documentation of the meeting that includes the name, address, appropriate contact information of the individual or entity with whom you are meeting (i.e., either telephone number, fax number, or email address of the individual or entity), or the PFL -5-T.

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)

The Hartford
P.O.Box 14306
Lexington, KY 40512-4306
Fax Number: (866) 411-5613
E-mail: PFL@thehartford.com

Request For NY Paid Family Leave
Military Qualifying Event (Form PFL-5-T)

Directions for you: If leave is requested to meet with a third party, you must provide supporting documentation of the meeting that includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone number, fax number or email address of the individual or entity). The reason for a meeting can include: arranging for child or parental care, counseling, making financial or legal arrangements, acting as the military member's representative before a federal, state or local agency for purposes of obtaining, arranging or appealing military service benefits, or attending any event sponsored by the military or military service organizations. This for is only required if the qualifying event is a meeting with a thrid party.

TO BE COMPLETED BY THE EMPLOYEE

Legal name (first name, middle initial, last name)	**Other last names, if any, under which you have worked**

Mailing address

Social Security Number	**Date of birth** (MM/DD/YYYY)

QUALIFYING REASON FOR LEAVE - DOCUMENTATION

Please submit this documentation for each required meeting/event.

Name of individual with whom employee is meeting _____

Title _____

Organization _____

Telephone number (provide area or country code) ( ) _____

Fax number (provide area or country code) ( ) _____

Email address _____

Mailing address _____

Describe nature of meeting. Include dates, if known:

Clear Form

THE HARTFORD

NY PFL Electronic Funds Transfer (EFT) Request Form

Instructions:

1. Read the Terms and Conditions listed below.

2. Enter your name, address, home telephone number and Employee ID.

3. Complete the bank and account information for your Electronic Funds Transfer request.

4. You and all other parties to the account specified must sign this form.

5. Return the completed form to The Hartford Claims Office.

Note: Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the EFT Program.

Name: _____

Address: _____

Telephone Number: ( ) - _____

Employee ID: _____

Name of Bank: _____

Bank Address: _____

Bank Telephone Number: ( ) - _____

Type of Account (select one):

Checking: **Saving:**

Account Number: _____ Account Number: _____

Bank Routing Number: _____

Attach a voided blank personal check.

Indicate any other names on the account selected:

_____

AUTHORIZATION

I / We authorize (_____)
and affiliated companies (herein after called The Hartford), to initiate credit entries (and to initiate, if necessary, debit entries and adjustments for credit entries made in error) to my (our) account indicated above and the Depository named above, hereinafter called Depository, to credit and/or debit the same to such account. I (we) acknowledge that the origination of A C H transactions to my (our) account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until The Hartford has received written notice from me (us) of its termination in such time and in such manner as to afford The Hartford and Depository a reasonable opportunity to act on it. I (we) understand I (we) should allow at least (#) days for the first CREDIT to occur.

_____ _____

Signature(s): **Date:**

_____ _____

12/2017

TERMS AND CONDITIONS

Receiving benefits by direct deposit or electronic funds transfer is voluntary. If at any time during your leave you wish to revoke this EFT request, you can do so by contacting our office.

The Hartford will not be responsible for any banking fees charged for direct deposit or electronic funds transfer; however, The Hartford will not charge you any fees for depositing your benefits into this account.

I understand that this agreement may be terminated by me upon written notice to The Hartford.

The cancellation will be processed for the time period following receipt of the notice.

I understand that a change in the title of this account which alters the interest of any party terminates this authorization and that a new authorization must then be submitted to continue direct deposit/EFT.

I understand that it is my responsibility to inform The Hartford of any address changes immediately.

I further understand that any benefit payment forwarded to the financial institution covering a period of time after my death will be refunded to The Hartford. I agree that the financial institution shall have the right of offset for such a refund.

I authorize the financial institution specified in this authorization to provide The Hartford with my home address and the names of any joint account holders for the account specified herein.

I understand that I am responsible for verifying the accuracy of my account data and for promptly notifying The Hartford of any errors or changes including termination of my EFT request.

SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

As a party to this account, I understand that I am personally liable, both individually and as a member of the group of parties to this account, for the full amount of all benefit payments covering any period after the death of the disability benefit recipient. This is a liability to The Hartford. If I am entitled to any benefit as the beneficiary of the disability benefit recipient, the amount of my liability may be deducted from the amount payable to me. I agree that the financial institution shall have the right of offset for such a refund, and I authorize the financial institution to provide The Hartford with my home address.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to The Hartford or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so. The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately notify The Hartford if the authorization is cancelled by the financial institution. The financial institution can not cancel the authorization by advice to The Hartford.

_____ _____

Signature: Date:

I certify that I have read and understand the Terms and Conditions of this EFT Agreement, including the SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

_____ _____

Signature(s) of Other Persons on Account: Date

_____ _____

Date:

[1] The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

NEW YORK STATE | Paid Family Leave

STATEMENT OF RIGHTS FOR PAID FAMILY LEAVE

IF YOU NEED TO TAKE TIME OFF FROM WORK TO CARE FOR A FAMILY MEMBER, YOU MAY BE ENTITLED TO PAID FAMILY LEAVE BENEFITS

Paid Family Leave is employee funded insurance that provides job-protected, paid time off to:

- Bond with a newly born, adopted or fostered child;
- Care for a family member with a serious health condition; or
- Assist loved ones when a family member is called to active military service abroad.

Eligibility:

- Employees with a regular work schedule of **20 or more hours per week** are eligible after **26 consecutive weeks** of employment.
- Employees with a regular work schedule of **less than 20 hours per week** are eligible after **175 days worked**.

You are eligible regardless of your citizenship or immigration status.

Benefits: In 2018, you can take up to eight weeks of Paid Family Leave and receive 50% of your average weekly wage, capped at 50% of the New York State average weekly wage. Generally, your average weekly wage is the average of your last eight weeks of pay prior to starting Paid Family Leave.

Rights and Protections

- **Job Protection**: Return to the same or comparable job after you take leave.
- You keep your **health insurance** while on leave (you may have to continue paying your portion of the premium costs, if any).
- Your **employer is prohibited from discriminating or retaliating** against you for requesting or taking Paid Family Leave.
- You **do not have to exhaust sick leave or vacation** accruals before using Paid Family Leave.

Paid Family Leave Request Process

1. Notify your employer at least 30 days in advance, if foreseeable, or as soon as possible.
2. Complete and submit the Request for Paid Family Leave (Form PFL-1) to your employer.
3. Complete and attach the additional forms as required and submit to the insurance carrier listed below.
4. The insurance carrier must pay or deny your request within 18 days of receiving your completed request.

You may obtain all forms from your employer, their insurance carrier listed below or online at www.ny.gov/PaidFamilyLeave.

Disputes

If your Paid Family Leave claim is denied, you may request to have the denial reviewed by a neutral arbitrator. The insurance carrier listed below will provide you with information about requesting arbitration.

Discrimination Complaints

If your employer terminates your employment, reduces your pay and/or benefits, or disciplines you in any way as a result of you taking or asking about Paid Family Leave, you may request to be reinstated by taking these steps:

1. Complete the Formal Request for Reinstatement Regarding Paid Family Leave form (PFL-DC-119)
2. Send your completed form to your employer and a copy of the completed form to: Paid Family Leave, P.O. Box 9030, Endicott, NY 13761-9030
3. If your employer does not reinstate you within 30 days, you may file a discrimination complaint with the Worker's Compensation Board using form PFL-DC-120, available at http://www.ny.gov/PaidFamilyLeave. The Worker's Compensation Board will assemble your case and schedule a hearing.

For more information, forms, and instructions, visit www.ny.gov/PaidFamilyLeave or call (844)-337-6303.

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law. Your employer's paid family leave benefits insurance carrier is:

The Hartford
P.O.Box 14306
Lexington, KY 40512-4306
Fax Number: (866) 411-5613
Phone Number: (800) 549-6514

PRESCRIBED BY THE CHAIR, WORKERS' COMPENSATION BOARD