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).
   a. Leave Questions 11 and 12 blank on Form PFL-1 and instead complete Section 1 below.

2. Give completed forms to your employer.
   a. Employer completes Section 3 of this form and Part B of Form PFL-1, within 3 business days.

3. Attach mandatory or precautionary order of quarantine or isolation.

4. Submit all forms and order of quarantine/isolation to your employer’s PFL insurance carrier listed on Part B of Form PFL-1.

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: ____________________________

The insurance carrier 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 the insurance carrier’s decision, or if payment is untimely, you may request arbitration with NAM (National Arbitration and Mediation) at nyspfla.com.
Part B - Employer Information (to be completed by the employer) - 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:

<table>
<thead>
<tr>
<th>Disability:</th>
<th>Weeks</th>
<th>Please provide specific dates for Disability:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>PFL:</th>
<th>Weeks</th>
<th>Please provide specific dates for PFL:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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