

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19176
Tel: 877-367-7781 Fax: 877-889-4885
www.prudential.com/mybenefits

Instructions Included with Form

Request for NY Paid Family Leave (PFL) (Based on Form PFL-1)

TO BE COMPLETED BY THE EMPLOYEE Employee's name (first name, middle initial, last name)						Prudential Claim Number Employee's Social Security Number or TIN			
PAF	RT B - E	EMPLOYER INFOR	MATION (to be	completed by	the emp	oloyer)			
1a. Business's full legal name and mailing address					1b. Con		-	oloyer's	
	Business name				Nun	nber Bran	ich FEII	N -	
	Mailing address				3. Em	ployer's Standard Inc	lustrial Classific	cation (SIC) Code	
	City, state, zip code, country (if not U.S.A.)								
4.	Employer's contact name for questions related to PFL					5. Employer's contact telephone number			
7.	Employee's date of hire (MM/DD/YYYY)				6. Employer's contact email address				
	If employee does not work Monday through Friday, check days worked: Varies Explain:			Friday,	Employee's occupation Codes are available at:				
	\square Mond	day 🗆 Tuesday 🗆 Wed			<u>http</u>	s://www.bls.gov/soc	/2018/major_gr	oups.htm	
		sday □ Friday □ Satu							
9.	Week no.	week ending date (MM/DD/YYYY)	SS wages for the	Gross amount paid	Week no.	Week ending date (MM/DD/YYYY)	Number of days worked	Gross amount paid	
	1		-	\$	5		-	\$	
	2			\$	6			\$	
	3			\$	7			\$	
	4			\$	8			\$	
	Calcula	ted average gross <u>w</u>	eekly wage: \$						
10a.	If emplo	oyee received or will r	eceive full wage	s while on PFL,	will emp	loyer be requesting re	eimbursement?	☐ Yes ☐ No	
10b.	-	oyee received or will r ting reimbursement?		full wages, but	: an amoเ	int at least equal to th	ne PFL benefits,	will employer be	
10c.	Dates r	equesting reimburser	ment: From (MM/I	DD/YYYY)	/	To (MM/DD/Y	YYY) /	1	
11a.	In the p	receding 52 weeks ha	s the employee	taken leave for:	□NYS	Disability PFL	☐ Both Disability a	and PFL None	
11b.	Enter t	he total number of w	eeks and days t	aken for both D	Disability	and PFL in the last	52 weeks:		
	Disabi	Weeks Days		specific dates for D					
	PFL:	Weeks Days	Please provide	specific dates for F	PFL:				
12.	Is the e	mployee taking Famil	y Medical Leave	Act (FMLA) cor	ncurrenti	y with PFL? ☐ Yes	□No		



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TO BE COMPLETED BY THE EMPLOYEE	P	rudential Claim Number		
Employee's name (first name, middle initial, last name)		Employee's Social Security Number or TIN		
PART B - EMPLOYER INFORMATION (to	be completed by the employer)			
13. PFL insurance carrier's name and maili	_	B. PFL insurance carrier's telephone number		
The Prudential Insurance Company PFL insurance carrier's name	of America	8 7 7 - 3 6 7 - 7 7 8 1		
Disability Management Services, PC Mailing address	D Box 13480 15	i. PFL policy number		
Philadelphia, PA 19176 City, state, zip code, country (if not U.S.A.)				
Declaration and signature				
☐ I affirm the employee regularly works 20 or more hor regularly works less than 20 hours per week and has		ent for at least 26 consecutive weeks OR the employee		
Any person who knowingly and with intent to defraud an containing any materially false information, or conceals f fraudulent insurance act, which is a crime, and shall also claim for each such violation.	for the purpose of misleading, informatio	n concerning any fact material thereto, commits a		
I am the person authorized to sign as the employer of th the information I have provided is true and accurate.	e employee requesting PFL. My signatu	re affirms that to the best of my knowledge and belief,		
Employer's authorized signature	Title	Date signed (MM/DD/YYYY)		

INSTRUCTIONS

The employer of the employee requesting PFL must complete all information in Part B, sign and date the form and return to the employee or Prudential within 3 business days.

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

Question 3: Enter the employer's Standard Industrial Classification (SIC) Code. Contact your carrier if you don't know your SIC code.

Question 8: The employee occupation code can be found at: www.bls.gov/soc/2010/soc_alph.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. Calculate the gross average weekly wage by adding up the gross amounts paid, and then divide by eight (or number of weeks worked if less than eight).

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
Divide by 0.	•	<u> </u>
Average Weekly Wage =	•	\$525
•	•	
Average Weekly Wage = Bonus earned in preceding 52 weeks: \$2,600	•	
Average Weekly Wage = Bonus earned in preceding 52 weeks: \$2,600 Divide by 52: \$52	•	
Average Weekly Wage = Bonus earned in preceding 52 weeks: \$2,600 Divide by 52: \$52 Prorated Weekly Bonus = \$50	+	\$525



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FORM PFL-1 INSTRUCTIONS, Continued

Question 10a & 10b: 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 11b.

Question 11b: The maximum number of weeks available for NYS statutory disability and PFL in any 52 week period is 26 weeks. Specify the total number of weeks, as well as the number of additional days if the leave includes a partial week, taken for NYS statutory disability and PFL during the preceding 52 weeks.

Question 15: Enter the Paid Family Leave policy number.

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.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).

The Workers' Compensation Board's (Board's) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board's administrative authority under Workers' Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

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