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

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

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

Name of employee requesting PFL

First name	Middle initial	Last name	PFL claim number

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			

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

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

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

Name of employee requesting PFL

First name	Middle initial	Last name	PFL claim number

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

Bonding Certification *(MET-PFL-2)*.

The employee requesting PFL must complete all applicable requested information.

Name of employee requesting PFL

First name	Middle initial	Last name	PFL claim number

SECTION 1: Bonding certification *(to be completed by the employee)*

1. Child's Date of birth *(mm/dd/yyyy)*

2. Child's gender
☐ Male ☐ Female ☐ Not designated/Other

3. Does the child live with the employee requesting PFL? ☐ Yes ☐ No

4. Child is employee's:
☐ Biological child ☐ Stepchild ☐ Foster child ☐ Adopted child ☐ Legal ward
☐ Spouse/domestic partner's child

5. Select one of the following and attach a copy of the document required as evidence of the relationship.

Parent of newborn infant:

Birth mother:

- ☐ Health care provider certification of pregnancy *(include expected due date AND mother's name)*; OR
- ☐ Health care provider certification of birth *(include date of birth of infant AND mother's name)*; OR
- ☐ Child's birth certificate

Other parent:

- ☐ Voluntary acknowledgment of paternity; OR
- ☐ Copy of birth certificate naming second parent; OR
- ☐ Court order of filiation; OR
- ☐ Birth mother documents (see above) PLUS one of the following:
  - ☐ Marriage certificate; OR
  - ☐ Certificate of civil union; OR
  - ☐ Certificate of domestic partnership
- ☐ OR; Other documentation of parental relationship

Foster parent:

☐ Letter of foster care placement or anticipated placement issued by county or city department of Social Services or authorized voluntary foster care agency

Date of foster care or adoption placement if applicable *(mm/dd/yyyy)* _____

Adoptive parent: ☐ Court document finalizing adoption ☐ Documentation in furtherance of adoption

Name of employee requesting PFL

First name	Middle initial	Last name	PFL claim number

SECTION 2: 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)* _____

Request for Paid Family Leave: Bonding Certification *(MET-PFL-2)* form instructions

If the employee is requesting PFL to bond with a newborn, a newly adopted child or a foster child, the employee must submit the Bonding Certification *(MET-PFL-2)* with the Request For Paid Family Leave *(MET-PFL-1)*.

Employee enters name and claim number *(if available)* at the top of each page in the fields provided.

Questions 1-4: Enter the child's information, and indicate the child's relationship to the employee.

If the form is submitted to MetLife prior to the birth of a child, this is considered pre-submitting. The employee is then required to contact MetLife and provide the required documentation of the child's birth. MetLife will advise the employee how and when to provide the required additional documentation.

There may be instances where PFL can be taken before the adoption is finalized. For example, the employee may be required to appear in court or travel to another country as part of the adoption process. The employee should include documentation to show that the PFL is necessary to further the adoption.

Question 5: See chart below for documentation details. Unless specified, do not send the original documents.

Bonding Form/Certification	**Description**
Health care provider certification of pregnancy	An original letter obtained from the birth mother's health care provider that certifies pregnancy. It should include the mother's name and the expected due date.
Health care provider certification of birth	An original letter obtained from the birth mother's health care provider that includes the mother's name and child's date of birth.
Birth Certificate	A copy of the certificate issued by the city or county office in which the infant is born.
Voluntary Acknowledgment of Paternity *(Form LDSS-4418)*	A copy of the form that establishes legal fatherhood when the parents are unmarried. Completed by both mother and father. For more information, see childsupport.ny.gov/dcse/aop_howto.html
Court Order of Filiation	A copy of the order from the family court that names the father of a child. Establishes legal fatherhood when the parents are unmarried. Completed by both mother and father. For more information, visit childsupport.ny.gov/dcse/aop_howto.html
Marriage Certificate	A copy of the official statement issued by the town or city clerk from which the marriage certificate was issued.
Civil union/domestic partner's documentation	A copy of the certificate of civil union or domestic partnership.
Foster care placement letter	A copy of the letter of foster care placement issued by the county or city department of social services or authorized voluntary foster care agency.
Court documents of adoption	A copy of the court document finalizing adoption or documentation in furtherance or court order finalizing adoption.
Other documentation	Other documentation of parental relationship may be accepted if none of the others listed apply.

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.

MetLife

Request for New York Paid Family Leave

Military Qualifying Event *(MET-PFL-5)*

Name of employee requesting PFL

First name	Middle initial	Last name	PFL claim number

SECTION 1: Military qualifying event *(to be completed by employee)*

Name of military member on covered active duty or call to covered active duty status

1. First name	Middle initial	Last name

Military member's 2. Mailing address	City	State	ZIP

Country *(if not U.S.A.)*	3. Date of birth *(mm/dd/yyyy)*	4. Gender
		☐ Male ☐ Female ☐ Not designated/Other

5. Period of military member's covered active duty

From date *(mm/dd/yyyy)*	To date *(mm/dd/yyyy)*

6. The above-named military member is employee's

☐ Spouse ☐ Domestic partner ☐ Child ☐ Parent

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 to covered active duty status:

☐ Covered active duty orders

☐ Letter of impending call to covered duty

☐ Documentation of military leave signed by the approving authority for military member's Rest and Recuperation

Qualifying reason for leave

8. Describe the reason employee is requesting PFL due to a qualifying event

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

☐ Yes ☐ No ☐ None available

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.

Name of employee requesting PFL

First name	Middle initial	Last name	PFL claim number

Leave for meetings *(if applicable)*

If leave is requested to meet with a third party, the employee 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.

Name of individual with whom employee is meeting

10. First name	Middle initial	Last name

11. Title	12. Organization

13. Mailing address	City	State	ZIP

Country *(if not U.S.A.)*	14. Phone number *(provide area or country code)*

15. Fax number *(provide area or country code)*	16. Email address

17. Describe nature of meeting:

18. Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time *(e.g., one deployment-related meeting every month)*

If the PFL request is to meet with a third party *(such as to arrange child care or parental care, attend counseling, etc.)*, enter the meeting information, including the meeting's purpose, with whom it will take place, and contact information. Attach supporting documentation for each meeting.

SECTION 2: 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)*

Military Qualifying Event *(Form MET-PFL-5)* Form Instructions

If an employee is requesting PFL because of a family member's active military duty or impending active duty, the employee must submit the Military Qualifying Event *(MET-PFL-5)* with the Request For Paid Family Leave *(MET-PFL-1)*.

The employee must identify the family member called to service, provide a copy of the member's active or impending duty orders, and describe the reason leave is being requested.

Military Qualifying Event *(to be completed by the employee)*

The employee requesting PFL must complete all applicable requested information.

Employee enters name and full SSN and claim number.

Enter the military member's information, and indicate the military member's relationship to the employee.

Question 5: Enter dates of expected military covered active duty.

Question 7: Documentation that shows that the military member is on covered active duty or is on impending call to covered active duty is required and must be attached to this form. Select the type of documentation that is attached from the list below.

Required documentation includes one of the following:

- Covered active duty orders; OR
- Letter of impending call to covered duty; OR
- Documentation of military leave signed by the approving authority for military member's Rest and Recuperation.

Qualifying Reason for Leave

Question 8: Explain the need for PFL because of the Military Qualifying Event. For example: "My spouse was just called on short notice to covered active duty status, and will be deployed to *(country)* 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 the employee's full name and claim number at the top of the attachment.

Question 9: Include one or more of the qualifying supporting documents:

- Meeting announcement for informational briefing sponsored by the military; or
- Document(s) confirming an appointment with a school official, doctor, attorney or financial advisor; or
- Copy of a bill for services for the handling of legal or financial affairs.

Leave for Meetings *(if applicable)*

If the PFL request is to meet with a third party (such as to arrange child care or parental care, attend counseling, etc.), enter the meeting information, including the meeting's purpose, with whom it will take place, and contact information. Attach supporting documentation for each meeting.