



Applying for Minnesota Family and Medical Insurance (MN PFML)

This packet contains the necessary information to initiate a request for Minnesota PFML (Equivalent Plan) and contains the certification materials required for each leave type. The below checklists provide guidance for what specific information needs to be completed and returned for each type of leave. Employees must notify their employer of their need for this leave before submitting their request.

To Use Minnesota Family and Medical Insurance To:

Care for yourself while experiencing a serious health condition:

- ☐ Complete Part A (Employee Statement)
- ☐ Have your Health Care Provider complete Part B (Employee's Serious Health Condition Certification)
- ☐ Send completed forms and any other attachments to New York Life Group Benefit Solutions

Bond with a new child (new birth, foster or adoption):

- ☐ Complete Part A (Employee Statement)
- ☐ Complete Part C (Bonding certification)
- ☐ Send completed forms and any other attachments to New York Life Group Benefit Solutions

Care for a family member with a serious health condition:

- ☐ Complete Part A (Employee Statement)
- ☐ Have your family member's Health Care Provider complete Part D (Care of Family Member Health Certification)
- ☐ Send completed forms and any other attachments to New York Life Group Benefit Solutions

Qualifying Military Exigency Leave for a family member:

- ☐ Complete Part A (Employee Statement) and Part E (Military Exigency Leave Attestation Form)
- ☐ Send completed forms and any other attachments to New York Life Group Benefit Solutions

Take Safe Leave for you or a family member:

- ☐ Complete Part A (Employee Statement)
- ☐ Send completed forms and any other attachments to New York Life Group Benefit Solutions



NYL GBS Leave Solutions Request for Paid Family Leave

Part A: Employee Statement (to be Completed by the Employee Requesting Leave)

1. **Employee's Legal Name** (First Name, Middle Initial, Last Name)

2. **Employee's Mailing Address** (Street Address including Apartment/Floor Number)

City

State

Zip Code

3. **Employee's Social Security Number or TIN**

4. **Employee's Date of Birth**

5. **Employee's Gender** ☐ Male ☐ Female ☐ Not designated/Other

6. **Employee's Contact Phone Number** (Includes Area Code)

7. **Employee's Contact Email Address**

8. **Reason for Minnesota PFML request** (choose one option)

- ☐ Medical leave due to **my own** serious health condition ☐ Bond with my new child
☐ Care for my Family Member with a serious health condition ☐ Safe Leave ☐ Qualifying Military Exigency Leave

9. **The family member's relationship* to the Employee (Claimant) is:**

* "Relationship" includes biological, foster, adoptive, step, and in loco parentis relationships and the same relationships to the employee's spouse or domestic partner, if applicable.

- | | |
|--|--|
| ☐ Self | ☐ Grandparent or Spouse's Grandparent |
| ☐ Spouse | ☐ Grandchild |
| ☐ Domestic Partner | ☐ Sibling or Spouse's Sibling |
| ☐ Parent | ☐ Spouse's Parent |
| ☐ Child (Provide Child's Age Below) | ☐ Child's Spouse |
| Child's Age (years) _____ | ☐ Son-in-law or Daughter-in-law |
| ☐ Other individual who has an expectation and reliance of care. This relationship type is one where there is a significant bond similar to a family relationship. (affirm & provide detail in a. and b. below) | |

a. I hereby assert that a family-like relationship exists between

and

_____ (your name)

_____ (name of person you have a family-like bond with)

b. Describe how this individual relies on you for care.

Employee Name: _____ Employee Social Security Number: _____
Employee Address: _____

Part A: Employee Statement - Continued from previous page

10. Give the name and details of your recent employer(s).

If you had more than one employer in the past 12 months, name all employers. Wage amount should include all total gross pay earned in Minnesota employment. To calculate the average weekly wage, determine your highest quarter of wages earned through employment in Minnesota during your Base Period, and divide by 13. Base Period means the four most recent completed calendar quarters, or all available quarters if fewer than 4 have been completed prior to leave.

Current Minnesota Employer Business' name, address, and phone	Average number of hours worked per week	Average number of days worked per week	Average weekly wage (\$)
Prior Minnesota Employer(s) during past 12 months (if applicable) Business' name, address, and phone	Average number of hours worked per week	Average number of days worked per week	Average weekly wage (\$)

11. Will Leave be utilized Continuously or Intermittently? Provide Details Below.

Any changes to your leave plans and/or estimated dates, must be communicated/confirmed as soon as possible to us and your employer.

Continuous Leave:

Continuous uninterrupted period of leave for a single qualifying reason.

(Format date as MM/DD/YYYY)

Leave Start Date

Enter the first date you are requesting continuous leave from work.

Leave End Date

Enter the last date you are requesting continuous leave through.

Intermittent Leave:

Leave in separate, non-consecutive time periods rather than a single span of time for a single qualifying reason.

(Format date as MM/DD/YYYY)

Leave Start Date

Enter the first date you are requesting continuous leave from work.

Leave End Date

Enter the last date you are requesting continuous leave through. If unknown, please enter a date one year from start date

Episodic time off Dates/hour(s) requested: _____

12. Have you Received or Claimed any of the Following Benefits in the Preceding 52 weeks?

Provide Details Below including Dates (From/To) and Amounts Paid.

Benefit Type	Received	Claimed	Dates	Amount(s)
a. Unemployment Benefits	☐	☐	_____ - _____	_____
b. Worker's Compensation	☐	☐	_____ - _____	_____
c. MN PFML	☐	☐	_____ - _____	_____
d. Other (Specify other employer provided leave)	☐	☐	_____ - _____	_____
Specify other employer provided leave _____				

Declaration and Signature

NOTICE: Any person who includes any false or misleading information on an application for an insurance policy, may be guilty of fraud and may be subject to civil or criminal penalties if intentional and material to the risk assumed. I further certify that if benefits are paid in excess of the amount to which I am entitled, I will return to the payor of such benefits, the amount that was overpaid, and I acknowledge that failure to do so may result in the accrual of interest and other penalties.

I am hereby making a request for benefits for Minnesota Family and Medical Leave Insurance under my employer's equivalent plan. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Signature

Date



NYL GBS Leave Solutions Documentation of Bonding

Part C: Bonding Certification

Please note that it is also acceptable to send in supporting documentation in place of this form.

Section 1: Complete for Bonding	
This Section To Be Completed by the Employee	
Employee Name: _____	
Employer Name: _____	
Reason for my leave request for federal, state, and/or a company leave: _____	
Name and Age of Child _____	or Expected* / Actual Date of Birth: _____
<i>*If expected date is provided, please contact New York Life Group Benefit Solutions to confirm the actual delivery date.</i>	
By signing below, I certify the above information is true and correct. I understand that failure to promptly return to work at the end of my leave may be treated as a resignation unless an extension has been approved in writing by my employer.	
_____ Employee Signature	_____ Date

Section 2: Complete for Adoption	
This Section To Be Completed by the Adoption Administrator	
Verify that the employee's absence is due to the adoption of a child and the date of the adoption: _____	
Signature of Adoption Program Administrator: _____	Date: _____
Printed Name of Administrator: _____	
Organization Name: _____	
Address: _____	Phone Number (with area code): _____

Section 3: Complete for Foster Placement	
This Section To Be Completed by the Foster Placement Administrator	
Verify that the employee's absence will occur on: _____	
Foster Care Placement Date: _____	
Signature of Foster Care Program Administrator: _____	Date: _____
Printed Name of Administrator: _____	
Organization Name: _____	
Address: _____	Phone Number (with area code): _____

*PLEASE BE SURE TO RETURN ALL PAGES

Return completed certification form to:

NYL GBS Leave Solutions
Email: AbsenceManagement@newyorklife.com
Fax: 866.472.3221
P.O. Box 81077 Cleveland, OH 44181

NYL GBS Leave Solutions • P.O. Box 81077 • Cleveland, OH 44181 • Fax: 866.472.3221 • Phone: 888.842.4462

Notification #: _____ Absence #: _____