



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 | <input type="checkbox"/> | <input type="checkbox"/> | _____ - _____ | |
| b. Worker's Compensation | <input type="checkbox"/> | <input type="checkbox"/> | _____ - _____ | |
| c. MN PFML | <input type="checkbox"/> | <input type="checkbox"/> | _____ - _____ | |
| d. Other (Specify other employer provided leave) | <input type="checkbox"/> | <input type="checkbox"/> | _____ - _____ | |
| 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 Certification for Health Care Provider for Family Member's Serious Health Condition

Part D: For Completion by the Health Care Provider

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine PFML coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Employee Name: _____

Subsection 1: Must be completed for all types of leaves:

1. Provider's name: _____ Phone: _____ Fax: _____
Address: _____
Type of practice / Medical specialty: _____
Certification License Number or NPI number: _____

Please complete the following:

2. Approximate date condition commenced: _____ Expected Duration: _____
3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
 No Yes
If yes, dates of admission in the past 12 months: _____

4. Date(s) you treated the patient for condition in the past 12 months:

5. Will the patient need treatment visits at least twice per year due to the condition? No Yes

6. Was medication, other than over-the-counter medication, prescribed? No Yes

7. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? No Yes If yes, state the nature of such treatments and expected duration of treatment:

8. Is the medical condition pregnancy? No Yes If yes, expected delivery date: _____

continued >

Subsection 1: Must be completed for all types of leaves: (continued)

9. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, including x-rays or diagnostic testing, or any regimen of continuing treatment such as the use of specialized equipment) If this leave is to care for a child 18 years of age or older, please provide specific Activities of Daily Living the child may need assistance in performing (i.e., bathing, cooking, hygiene, taking public transportation, etc.).

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10. Is the patient's serious health condition expected to last at least seven (7) days? No Yes

AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

Subsection 2: Must be completed for all continuous leaves:

1. Will the patient be incapacitated for a **single continuous period of time** due to his/her medical condition, including any time for treatment and recovery? No Yes

If yes, estimate the beginning and ending dates for the period of incapacity:

Start date: _____ End date: _____

During this time, will the patient need care? No Yes

If yes, explain the care needed by the patient and why such care is medically necessary:

(Form is considered incomplete/insufficient if not provided for a continuous leave)

Subsection 3: Must be completed for all intermittent leaves:

1. Will the employee need intermittent time off? No Yes

If yes, estimate the beginning and ending dates for the period the patient needs to be out of work:

Start date: _____ End date: _____

2. OFFICE VISITS/TREATMENTS:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the maximum frequency of follow-up treatments/office visits that employee would need off work for related incapacity that the employee may experience over the next 6 months.

(e.g. Duration: 3 hours per visit/treatment

Frequency: 3 times per 1 week(s) / month(s) (check one)

Duration: _____ hours per visit/treatment

Frequency: _____ times per _____ week(s) / month(s) (check one)

3. INCAPACITY:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the maximum frequency of incapacity that employee would need off work over the next 6 months.

(e.g. Duration: 3 hours per day or 2 days per episode

Frequency: 3 times per 1 week(s) / month(s) (check one)

Duration: _____ hours per day or _____ days per episode

Frequency: _____ times per _____ week(s) / month(s) (check one)

During this time, will the patient need care? No Yes

If yes, explain the care needed by the patient and why such care is medically necessary:

(Form is considered incomplete if not provided the number of hours missed per week)

Subsection 4: Must be completed for reduced work schedule leaves:

1. Will the employee need to work reduced work schedule due to his/her medical condition, including any time for treatment and recovery? No Yes

If yes, estimate the beginning and ending dates for the period of incapacity:

Start date: _____ End date: _____

(Form is considered incomplete/insufficient if not provided)

ADDITIONAL INFORMATION

Signature of Health Care Provider

Date:

*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 #: _____