NEW YORK LIFE GROUP BENEFIT SOLUTIONS

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 • P.O. Box 81077 • Cleveland, OH 44181 • Fax: 866.472.3221 • Phone: 888.842.4462

Notification #: _____ Absence #: _____

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CLEAR FORM

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
☐ Care for my Family Member with a serious health condition
☐ Bond with my new child
☐ 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
☐ Spouse
☐ Domestic Partner
☐ Parent
☐ Child (Provide Child's Age Below)
Child's Age (years) ____
☐ Grandparent or Spouse's Grandparent
☐ Grandchild
☐ Sibling or Spouse's Sibling
☐ Spouse's Parent
☐ Child's Spouse
☐ 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

_____ (your name) and _____ (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 _____ – Leave End Date _____

Enter the first date you are requesting continuous leave from work. — *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 _____ – Leave End Date _____

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

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

NYL GBS Leave Solutions
Certification of Health Care Provider for Employee's Serious Health Condition

Part B: For Completion by the Health Care Provider

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave. Answer, fully and completely, all applicable parts. 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 employee is seeking leave. 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: _____
2. Address: _____ Email: _____

   Type of practice / Medical specialty: _____

   Certification License Number or NPI number: _____

Please complete the following:

3. Approximate date condition commenced: _____ Probable duration of condition: _____
4. Date(s) you treated the patient for condition in the past 12 months:

   _____
5. 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: _____
6. Will the patient need treatment visits at least twice per year due to the condition? ☐ No ☐ Yes
7. Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes
8. Is the medical condition pregnancy? ☐ No ☐ Yes If yes, expected delivery date: _____
9. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ No ☐ Yes If yes, explain:

   _____
10. Is the employee unable to perform any of his/her job functions due to the condition based on the employee's own description of his/her job? ☐ No ☐ Yes

    If yes, identify the job functions the employee is unable to perform:

    _____
11. 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).

    _____

Subsection 2: Must be completed for all continuous leaves:

1. Will the employee 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: _____

(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)

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

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