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**