NOTICE OF TOTAL OR PARTIAL DENIAL OF REQUEST/CLAIM FOR PAID FAMILY LEAVE BENEFITS

Your request/claim for Paid Family Leave has been denied. The reason for denial is listed in the below check box and in the Explanation (Box 13). Important information is attached to this form, including what you should do if you disagree with the denial (Instructions for Disputing the Denial of a Request/Claim).

Employee	Date of this Notice	Social Security No. (Last 4 Digits)
Employee's Address	First Day of Leave	Carrier No. (Claim/File)	Date Request Received (by Carrier)
	Type of Leave	☐ Bonding ☐ Family Care - Serious Health Condition ☐ Military Exigency
Employer	Employer's Address	
Policy Holder or Union (if different from Employer)		

You are hereby notified that your request/claim for Paid Family Leave benefits is denied for the reason(s) checked below:

☐ 1. You failed to furnish the information necessary to process your request and did not provide the requested missing claim information within 30 days of beginning leave on: _____

☐ 2. Your record of employment is not sufficient to establish your eligibility for Paid Family Leave benefits.

☐ 3. You are not a covered employee of this employer.

☐ 4. Your employer is not a covered employer.

☐ 5. We are not your employer's Paid Family Leave Benefits Insurance carrier. Your request/claim has been returned and a copy of this notice has been sent to the Workers' Compensation Board. We suggest you contact the Paid Family Leave toll-free Helpline at (844) 337-6303.

☐ 6. Family member's health condition does not qualify as a serious health condition.

☐ 7. Person requiring care is not a qualifying family member.

☐ 8. Another employee of the same employer is taking Paid Family Leave during the same period to bond/care for the same family member.

☐ 9. You have received the maximum benefits payable during a period of 52 consecutive weeks for Paid Family Leave and/or disability benefits.

- ☐ a. No benefits payable.
- ☐ b. Partial denial. Benefits are payable from _____ to _____

☐ 10. The request for Paid Family Leave and required documentation was not furnished within 30 days of when the period of Paid Family Leave began (see dates above).

- ☐ a. No benefits payable.
- ☐ b. Partial denial. Payments are being made beginning two weeks prior to the date your request/claim was received. Benefits are payable from _____ to _____

☐ 11. The employer was not given notice of a foreseeable reason for Paid Family Leave at least 30 days in advance.

- ☐ a. No benefits payable.
- ☐ b. Partial denial. Payments are being made beginning 30 days after notice was given. Benefits are payable from _____ to _____

☐ 12. Other.

13. Explanation:

Signature _____ Name and Title _____ Telephone Number and Extension _____

Email Address _____

EMPLOYEE INSTRUCTIONS

INSTRUCTIONS FOR WHEN AN INSURANCE CARRIER INDICATES THEY ARE NOT YOUR EMPLOYER'S CURRENT CARRIER

If Box #5 is checked on the previous page, it means that the insurance carrier you submitted your request/claim to is not providing Paid Family Leave coverage to your employer. Call the Paid Family Leave toll-free Helpline at (844) 337-6303 to determine the proper insurance carrier:

1. If another insurance carrier provides coverage for your employer, re-file the request/claim with that carrier
2. If your employer does not have Paid Family Leave coverage, you may file your request/claim with the Board. Call (844) 337-6303, or visit www.ny.gov/PaidFamilyLeave for more information on filing an uninsured employer claim.
3. If the Board's records indicate that the carrier with whom the request/claim was originally filed does provide coverage to your employer, follow the directions below to request an arbitrator review the denial.

INSTRUCTIONS FOR DISPUTING THE DENIAL OF A REQUEST/CLAIM

If you disagree with the insurance carrier or self-insured employer's reason for the full or partial denial of your request/claim for Paid Family Leave, you have the right to request that a neutral arbitrator review your request/claim within six months of it being denied. Instructions are below. For more information, call National Arbitration and Mediation at (516) 941-3250 or visit www.nyspfla.com.

You may request arbitration by mail or online:

By Mail:

1. Complete the included *Request for Arbitration* form (PFL-ARBN) and attach:
   - a copy of this notice of total or partial denial of Paid Family Leave request/claim,
   - a copy of your request for Paid Family Leave and any supporting documentation submitted to the carrier or self-insured employer, and
   - any other evidence to support why your request should be granted.
2. Include a money order or credit card authorization form to pay a $25 filing fee. You will be reimbursed if your request/claim is found to be valid.
3. Send the request to:
   National Arbitration and Mediation
   990 Stewart Avenue, 1st Floor
   Garden City, NY 11530
   Attn.: PFL Arbitrations
4. Send a copy of the Request for Arbitration and supporting documentation to the insurance carrier's and employer's addresses on the first page of the notice of denial.

Online:

1. Go to www.nyspfla.com
2. Complete a *Request for Arbitration* on the website. You will need to upload:
   - a copy of this notice of total or partial denial of Paid Family Leave request/claim,
   - a copy of your request for Paid Family Leave and any supporting documentation submitted to the carrier or self-insured employer, and
   - any other evidence to support why your request should be granted.
3. Pay a $25 filing fee online. You will be reimbursed if your request/claim is found to be valid.
4. Send a copy of the Request for Arbitration and supporting documentation to the insurance carrier's and employer's addresses on the first page of the notice of denial.

INSTRUCTIONS FOR SELF-INSURED EMPLOYER OR INSURANCE CARRIER:

Do not send to employee

An insurance carrier or self-insured employer will put its name, address, and any other contact information in the blank at the top of the page, including the address for services of arbitration requests. Acceptable reasons for denial of a request/ claim for Paid Family Leave are described below and are found in 12 NYCRR 380-5.4. Attach to the Total or Partial Denial of Request/Claim the employee instructions.

BOX 1: You should check this box if the request/claim for Paid Family Leave was denied without prejudice and the employee failed to furnish the missing information within 30 days from beginning of leave.

BOX 2: Please check this box as a denial reason if the employee requesting Paid Family Leave has not worked for the employer long enough to establish eligibility. In order to be eligible under 12 NYCRR 380-2.5, the employee:

- Regularly works less than 20 hours per week and has worked 175 days for the covered employer, OR
- Regularly works 20 or more hours per week and has been in employment for at least 26 consecutive weeks with the covered employer.

BOX 3: This box should be checked if the employee is not an employee or in employment of the covered employer. The employee may not work for the employer as they claimed, or has filed a waiver, or is not required to be and is not covered voluntarily by the employer's policy. Examples of this include but are not limited to ministers, teachers or professional employees of religious, charitable or educational institutions, golf caddies, farm laborers - complete list found in the Workers' Compensation Law (WCL) section 201.

BOX 4: If the employer is not a covered employer according to the definition in the WCL section 202, please mark this box as a denial reason.

BOX 5: This box should be checked if the carrier receiving the request for Paid Family Leave is not the covered employer's Paid Family Leave insurance carrier. Mail completed form to **NYS Paid Family Leave, PO Box 9030, Endicott, NY 13761.**

BOX 6: Mark here if the family member's health condition does not fit the definition of serious health condition contained in 12 NYCRR 355.9(16). Some examples include the common cold or flu without complications, cosmetic treatments, or routine dental or orthodontia work.

BOX 7: Check this as a denial reason if the person listed in the request for Paid Family Leave as requiring the employee's care is not a qualifying family member under WCL section 201. WCL section 201 defines family member as a child, parent, grandparent, grandchild, spouse or domestic partner of the employee.

BOX 8: This box should be marked if multiple employees from the same covered employer request to take paid family leave during the same period to care for the same family member and the employer has not permitted this. Section 206 (5) of the Workers' Compensation Law states that “a covered employer is not required to permit more than one employee to use the same period of family leave to care for the same family member.”

BOX 9: Check this box as a denial reason if the employee has used their maximum benefit for Paid Family Leave in a 52-week period and/or the maximum disability benefit. The maximum combined disability and paid family leave benefit may not exceed 26 weeks in a 52 week period under section 205 of the WCL. If the employee has not exhausted their benefits, benefits are payable up to the maximum and a partial denial may be issued.

BOX 10: If the employee's request for Paid Family Leave was not timely made within 30 days of the beginning of leave, mark this box. Section 217 of the WCL allows a partial denial for up to two weeks prior to when the proof was furnished.

BOX 11: This box should be checked if the employer was not given notice for foreseeable leave at least 30 days in advance. Partial denials may be issued for up to 30 days from when notice was given if not 30 days in advance (12 NYCRR 380-3.5).

BOX 12: Only check this box if the reason(s) for denial do not fit into one of the categories listed.

BOX 13: Write a **detailed** explanation of why the request for paid family leave is denied, including a list of any missing information if the denial is based on Box 1. Include one of the denial reasons below:

1a. Claim incomplete - Claim form incomplete, missing item number:
1b. Claim incomplete - No certification submitted, the missing certification is:
1c. Claim incomplete - Certification incomplete, missing item number:
1d. Claim incomplete - Certification submitted but missing birth certificate or medical pregnancy documentation
1e. Claim incomplete - Certification submitted but missing evidence of employee's relationship with mother
1f. Claim incomplete - Certification submitted but missing documentation of adoption or foster care
1g. Claim incomplete - Certification submitted but no documentation of family member's military deployment
1h. Claim incomplete - Certification submitted but no information provided concerning reason for military leave
2. Employee not eligible due to length of employment. The employee was employed:
3a. Employee not required to be covered because:
3b. Employee not required to be covered - Not an employee of the employer
3c. Employee not required to be covered - Independent contractor
3d. Employee not required to be covered - Employee filed waiver for working less than 175 days a year
3e. Employee not required to be covered - Employee filed waiver for Social Security eligibility
3f. Employee not required to be covered - Out of state employee
3g. Employee not required to be covered - Domestic worker who works less than 40 hours a week
3h. Employee not required to be covered - Farm laborer
3i. Employee not required to be covered - Minister, teacher, or professional employee of non-profit
4. Employer not required to have coverage - Public or other exempt employer type without voluntary coverage
5a. Incorrect carrier - Carrier not the employer's insurer
5b. Incorrect carrier - Carrier not the employer's insurer - Coverage canceled prior to claim
6a. Family Member's Health Condition does not qualify as serious, due to:
6b. Family Member's Health Condition does not qualify as serious - Common cold or flu without complication
6c. Family Member's Health Condition does not qualify as serious - Cosmetic treatment
6d. Family Member's Health Condition does not qualify as serious - Routine dental or orthodontia
7a. Person requiring care not a qualifying family member because:
7b. Person requiring care not a qualifying family member - Brother or sister
7c. Person requiring care not a qualifying family member - Aunt or uncle
7d. Person requiring care not a qualifying family member - Friend
8. Another employee of the employer took leave to care for the same person at the same time
9a. Employee received the maximum benefit in a 52-week period, prior period of benefits:
9b. Employee received the maximum benefit in a 52-week period - Partial denial, prior period of benefits:
10a. Request for Paid Family Leave not timely filed, request filed more than two weeks after end of leave period
10b. Request for Paid Family Leave not timely filed - Partial denial
11a. Employer was not given advance notice of foreseeable leave, employer received notice on:
11b. Employer was not given advance notice of foreseeable leave - Partial denial, employer received notice on:
12. Other. Explain any other denial reason: