

Do you qualify for DBL/PFL Quarantine Benefits under New York's Emergency COVID-19 Paid Sick Leave as of January 4, 2022

The New York program is designed to help ease the financial burden for New Yorkers affected by the COVID-19 outbreak. It provides certain temporary emergency related benefits to employees who meet certain criteria. Some of the benefits must be provided by the employer, some through the employer's statutory insurance coverage.

Please note: this information will change as New York State changes or modifies their guidance.

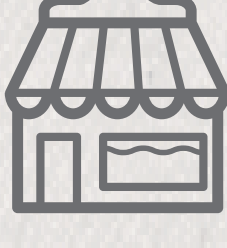
Whether you qualify for Emergency DBL/PFL Quarantine Benefits under the New York Program depends on several factors. Please use this checklist to help you determine if you may qualify:

YES

You have to meet **all** of the following criteria:

- 1 You've met overall DBL/PFL eligibility, meaning:**
Full-time employees: 26 consecutive weeks with your current employer for PFL, and 4 consecutive weeks with your current employer for DBL
Part-time employees: 175 days worked with your current employer for PFL, and 25 working days with your current employer for DBL

- 2 EMPLOYER'S SIZE as of 1/1/2020: 1-99 employees**



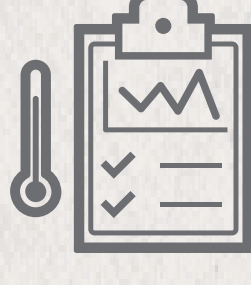
AND

- 3 Employee has to be under "Order of Quarantine"² issued by the State of NY, Department of Health, a local Board of Health, or any other governmental entity**



AND

- 4 Employee has to be unable to perform core job duties or any alternative responsibilities the employer may offer during the quarantine**



NO

EMPLOYER'S SIZE AS OF 1/1/2020:

100+ employees

Large employers have to provide 2 weeks of paid NY emergency sick leave.

Emergency DBL/PFL Quarantine Benefits do not apply.¹

You've haven't yet met overall DBL/PFL eligibility

EMPLOYER'S SIZE as of 1/1/2020: 1-99 employees



AND

Employee is under "Order of Quarantine" issued by the State of NY, Department of Health, a local Board of Health, or any other governmental entity



BUT

Employee **does NOT show any symptoms** or has not been diagnosed yet and **can work** while under quarantine



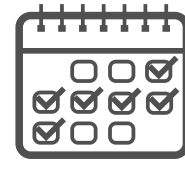
OTHER CIRCUMSTANCES NOT COVERED



- Employee is staying home due to
 - X** Official stay-at-home orders
 - X** "New York on PAUSE"
 - X** Social Distancing
 - X** Watching kids during school closures
 - X** Working from home
 - X** Voluntarily self-quarantining



- X** Being home or out of work because the business is temporarily closed. **Laid Off?** You may qualify for unemployment benefits. Visit www.ny.gov.



- X** Employee has already maxed out on their regular DBL benefit period (26 weeks) and PFL benefit period (12 weeks) in the preceding 52 weeks.
- X** Employee is under a 2nd or 3rd quarantine (or more), and the quarantine is NOT based off the employee's COVID-19 (+) test result.³

¹ Enhanced PFL/DBL Self-Quarantine benefits are not payable for employees of large employers. The employer is responsible for providing the employee with at least 14 calendar days of sick leave. Employees at larger employers who have been diagnosed with COVID-19 and are still out after 2 weeks of their employer-provided sick pay, may be eligible for basic, standard DBL benefits for the remainder of their quarantine (maximum benefit of \$170/week or, if the employer provides an enhanced DBL benefit level, at the respective coverage level of the policy in force). Form DB450 must be submitted for consideration of standard DBL benefits.

² Order of quarantine (OOQ), Self-attestation form or equivalent as determined by the NY Department of Health

³ Employees do not qualify for COVID-19 Quarantine Leave with more than 3 quarantines, and the 2nd and 3rd quarantine must be based on off the employee's own positive test result in accordance with NY DOL guidance issued 1/20/2021.

For more information on New York Emergency COVID-19 Paid Sick Leave visit:

www.shelterpoint.com/covid-19

Have more questions? Email us at customerservice@shelterpoint.com





Instructions for taking Paid Family Leave for a Minor Dependent Child due to COVID-19 Quarantine/Isolation

1. Complete Sections 1 – 3 of this form and Part A of the [Request for Paid Family Leave \(Form PFL-1\)](#).
 - a. Leave Questions 11 and 12 blank on *Form PFL-1*.
 2. Give completed forms to your employer.
 - a. Employer completes Section 4 of this form and Part B of *Form PFL-1*, within 3 business days.
 3. Attach mandatory or precautionary order of quarantine or isolation.
 4. Submit all forms and order of quarantine/isolation to your employer’s PFL insurance carrier listed on Part B of *Form PFL-1*.
- For further guidance, visit the PFL website at PaidFamilyLeave.ny.gov.

SECTION 1 - PAID FAMILY LEAVE (PFL) REQUEST (to be completed by the employee)

Reason for PFL request: Care for minor dependent child subject to COVID-19 Quarantine/Isolation

SECTION 2 - MINOR CHILD INFORMATION (to be completed by the employee)

1. **Minor dependent child’s name** (first name, middle initial, last name)

2. **Minor child’s date of birth** (MM/DD/YYYY)

3. **Minor child’s mailing address**

City	State	Zip Code	Country (if not U.S.)
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SECTION 3 - EMPLOYEE ATTESTATION (to be completed by the employee)

My signature affirms that I am not physically able to perform work for my employer through remote access or similar means during my minor child’s mandatory or precautionary order of quarantine or isolation.

Employee Signature: _____ Date: _____

Print Employee Name: _____

SECTION 4 - EMPLOYER ATTESTATION (to be completed by the employer)

My signature affirms that this employee is not physically able to perform their work through remote access or similar means during their minor child’s mandatory or precautionary order of quarantine or isolation.

Employer Signature: _____ Date: _____

Print Employer Name/Entity: _____

The insurance carrier must pay or deny benefits within 18 calendar days of receiving your completed request. Your request cannot be considered incomplete solely because your employer failed to fill out Section 4 above or Part B of *Form PFL-1*.

If you disagree with the insurance carrier’s decision, or if payment is untimely, you may request arbitration with NAM (National Arbitration and Mediation) at nyspfla.com.



Request For Paid Family Leave (Form PFL-1) Instructions

- To request PFL, the employee requesting PFL must complete Part A of the *Request For Paid Family Leave (Form PFL-1)*. All items on the form are required unless noted as optional. The employee then provides the form to the employer to complete Part B.
- The employer completes Part B of the *Request For Paid Family Leave (Form PFL-1)* and returns it to the employee within three days.
- Additional forms are required depending on the type of leave being requested. The employee requesting leave is responsible for the completion of these forms.
- **The employee submits the completed *Request For Paid Family Leave (Form PFL-1)* with the required additional form to the employer's PFL insurance carrier listed on Part B of *Request For Paid Family Leave (Form PFL-1)*. The employee should retain a copy of each submitted form for their records.**

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

The employee requesting PFL must complete all required information.

Paid Family Leave (PFL) Request (to be completed by the employee)

Question 12: A child is defined as a biological, adopted, or foster son or daughter, a stepson or stepdaughter, a legal ward, a son or daughter of a domestic partner, or the person to whom the employee stands in loco parentis. A parent is defined as a biological, foster, or adoptive parent, parent-in-law, a stepparent, a legal guardian, or other person who stood in loco parentis to the employee when the employee was a child.

Questions 13: If dates are "Continuous", the employee must provide the start and end dates of the requested PFL. These dates should be the actual dates that the PFL will begin and end. If uncertain, estimate the start and end dates and indicate "Dates are estimated". If dates are "Periodic", enter the dates PFL will be taken. Please be as specific as possible. If the dates are unknown or estimated,

indicate "Dates are estimated".

If dates are estimated, the PFL carrier may require you to submit a request for payment **after** the PFL day is taken. Payment for approved claims will be due as soon as possible but in no event more than 18 days from the date of the completed request.

Question 14: If the employee is submitting the PFL request to their employer with less than 30 days' advance notice from the start date of the PFL, the employee must explain why 30 days' notice could not be given. If the explanation will not fit in the space provided on the form, enter "See Attached" and add an attachment with the explanation. Be sure to include the employee's full name and their date of birth at the top of the attachment.

Employment Information (to be completed by the employee)

Question 16: Enter the date of hire to the best of the employee's recollection. If it has been more than a year since the date of hire, entering the year in which employment started is sufficient.

Question 18: Enter the best estimate of average gross weekly wage. Include only the wages earned from the employer listed on this request form. **The gross weekly wage is the total weekly pay - including overtime, tips, bonuses and commissions - before any deductions are made by the employer**, such as federal and state taxes. If the employer is not able to supply this information, the employee can calculate their gross weekly wage as follows:

Step 1: Add all gross wages received (before any deductions) over the last eight weeks prior to the start of PFL, including overtime and tips earned. (See Step 3 for instructions for calculating bonuses and/or commissions.)

Step 2: Divide the gross wages calculated in step one by eight (or the number of weeks worked if less than eight) to calculate the average weekly wage.

Step 3: If the employee received bonuses and/or commissions during the 52 weeks preceding PFL, add

the prorated weekly amount to the average weekly wage. To determine the prorated weekly amount, add all bonuses/commissions earned in the preceding 52 weeks and then divide by 52.

Example of a gross weekly wage calculation:

Week 1 - Gross wage including overtime	\$550
Week 2 - Gross wage	\$500
Week 3 - Gross wage	\$500
Week 4 - Gross wage	\$500
Week 5 - Gross wage	\$500
Week 6 - Gross wage	\$500
Week 7 - Gross wage, including overtime	\$600
Week 8 - Gross wage, including overtime	+ \$550
Total =	\$4,200
Divide by 8	÷ 8
Average Weekly Wage =	\$525
Bonus earned in preceding 52 weeks	\$2,600
Divide by 52	÷ 52
Prorated Weekly Bonus =	\$50

Form PFL-1 Instructions continued on next page

PART A - EMPLOYEE INFORMATION (to be completed by the employee) - continued from prior page*Form PFL-1 Instructions continued from prior page*

Average Weekly Wage	\$525
Prorated Weekly Bonus	+ \$50
Average Weekly Wage (including bonus) =	\$575

Please note that the employer is also required to provide this information in Part B of the *Request For Paid Family Leave (Form PFL-1)*.

If you are pre-submitting form: Indicate if the employee is pre-submitting their PFL request. Pre-submitting is defined as submitting the application in advance of an upcoming qualifying event, with certain required information missing due to the information being unknown at the time of the submitting. If pre-submitting is permitted by the carrier

or self-insured employer, the missing information must be supplied as soon as it is known. Benefits cannot be determined until all of the required information is provided.

The PFL insurance carrier or self-insured employer will provide the employee a notice within five days which 1) states the claim is pending; 2) identifies what information is missing; 3) instructs how to submit the missing information. **Once all information is supplied, the PFL insurance carrier or self-insured employer has 18 days to pay or deny the claim.**

If the carrier or self-insured employer does not permit pre-submitting, the carrier or self-insured employer must return the Request for Paid Family Leave within five days to the employee with an explanation that the claim should be re-submitted when all information is available.

Employee signs and dates, before giving this form to their employer to complete Part B.

PART B - EMPLOYER INFORMATION (to be completed by the employer)

The employer of the employee requesting PFL must complete all information in Part B.

Question 2: If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number.

Question 3: Enter the employer's Standard Industrial Classification (SIC) Code. Contact your carrier if you don't know your SIC code.

Question 8: The employee occupation code can be found at: www.bls.gov/soc/2018/major_groups.htm

Question 9: Enter the wages earned by the employee during the last eight weeks preceding the PFL start date. The gross amount paid is the employee's gross weekly pay, including any overtime and tips earned for that week, plus the weekly prorated amount of any bonus or commission received during the preceding 52 weeks. (For detailed steps, see Question 18 starting on page 1 of the instructions.) Calculate the gross average weekly wage by adding up the gross amounts paid, and then divide by eight (or number of weeks worked if less than eight).

Affirmation employee is eligible for PFL: An employee who regularly works 20 hours or more per week must have been in employment for at least 26 consecutive weeks. An employee who regularly works less than 20 hours per week must have worked 175 days.

Question 10: Failure to select "Yes" for requesting reimbursement from the insurance carrier, will result in a waiver of the right to reimbursement.

Question 11a: 'Disability' refers to NYS statutory required disability. If the answer is "none," enter a "0" for total weeks and days in Question 12b.

Question 11b: The maximum number of weeks available for NYS statutory disability and PFL in any 52 week period is 26 weeks. Specify the total number of weeks, as well as the number of additional days if the leave includes a partial week, taken for NYS statutory disability and PFL during the preceding 52 weeks.

Question 13, 14 & 15: Enter the Paid Family Leave or Disability/PFL insurance carrier's name, address and PFL policy number. If this employer is self-insured, enter the name and address of where the PFL request should be submitted for processing.

Employer signs and dates, and then returns to the employee requesting PFL within three business days.

Be sure to complete the appropriate additional PFL form(s) based on the type of PFL leave being requested.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).

The Workers' Compensation Board's (Board's) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board's administrative authority under Workers' Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)

Employee's date of birth (mm/dd/yyyy)

/ /

PART A: EMPLOYEE INFORMATION (to be completed by the employee) - Continued from previous page

13. Will PFL be for a continuous period of time and/or periodic?

SPL Note to claimant: Leave dates must be included with your claim. Dates cannot overlap other claims (e.g pregnancy DBL and bonding PFL). Gaps in between leave dates may not exceed 3 months. Any changes to leave plans must be communicated to Us and your Employer, when known.

Continuous PFL Start Date (mm/dd/yyyy) / / - PFL end date (mm/dd/yyyy) / / Dates estimated

Periodic Identify periodic dates to be taken: _____ Dates estimated

14. If providing less than 30 day's advance notice to the employer, please explain:

Employment Information (to be completed by the employee)

15. Business Name

16. Employee's date of hire (mm/dd/yyyy)

/ /

17. Employee's work location

Street Address _____

City, State Zip Code _____

18. Employee's average gross weekly wage (this data will be requested of both employee and employer).

19. Employer's phone number for contact regarding this request

() -

area code

20a. Does employee have more than 1 employer? Yes No

20b. If yes, is employee taking PFL from the other employer? Yes No

21. Is the employee currently receiving Workers' Compensation Lost Wage Benefits? Yes No

Disclosure Statement: Information regarding PFL benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Benefit Payment Preference for eligible ShelterPoint Claims

Please choose your preference for receiving benefit payments. Certain options may not be available depending on the leave pattern or benefit recipient. If your claim does not qualify for ACH/direct deposit, your benefit payments will automatically be issued via paper check. A completed enrollment form is required to participate in direct deposit.

Paper Check
 Direct Deposit (ACH)

Declaration and Signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I am hereby making a request for paid family leave benefits under the NYS Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief

Signature _____ Date (mm/dd/yyyy) _____

I am submitting this form in advance (see instructions about pre-submitting). I understand the insurance carrier will contact me to advise how to submit the required missing information.

End of Part A.

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)

Employee's date of birth (MM/DD/YYYY)
 [][] / [][] / [][][][]

PART B · EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address

Business name

Mailing address

City, State

Zip code

Country (if not U.S.A.)

2. Employer's FEIN [][] · [][][][][][][][]

3. Employer's Standard Industrial Classification (SIC) Code [][][][]

4. Employer's contact name for questions related to PFL

5. Employer's contact telephone number ([][][]) [][][] · [][][][]

6. Employer's contact email address

7. Employee's date of hire (MM/DD/YYYY) [][] / [][] / [][][][]

8. Employee's occupation (description or code) _____ [][] · [][][][]

Codes are available at: www.bls.gov/soc/2018/major_groups.htm

9. Enter employee's last 8 weeks of gross wages prior to the leave start date and calculate the average gross weekly wage

Quick tip: For bi-weekly or semi-monthly payrolls, enter the gross wages for the last 4 pay periods. See instructions for detail on what is included in wages, and for how to calculate for self-employed persons.

Week no.	Week ending date (MM/DD/YYYY)	Number of days worked	Gross amount paid
1			
2			
3			
4			
5			
6			
7			
8			
Calculated average gross weekly wage:			

9a. Select the days of the week the employee usually works:
 Mon Tue Wed Thur Fri Sat Sun

9b. Select whether the employee is **full-time** (regularly works 20+ hours per week) or **part-time** (regularly works less than 20 hours per week)
 Full Time
 Part Time

10. Will the employee continue to receive full wages from the employer while on paid family leave? Yes (provide detail in question 10a) No

10a. If you answered **YES** to the question above, provide the date(s) that the employee received/will receive **full wages** from the employer as a result of using **full days** of accrued sick/vacation/paid time off, or through an employer offered salary continuance program.

From: _____ **Through:** _____ Is the employer requesting reimbursement for this period? Yes No

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name) _____

Employee's date of birth (MM/DD/YYYY) / /

PART B · EMPLOYER INFORMATION (to be completed by the employer) - continued from prior page

Form PFL-1 continued from prior page

11a. In the preceding 52 weeks has the employee taken leave for: NYS Disability PFL Both Disability and PFL None

11b. Enter the total number of weeks and days taken for both Disability and PFL in the last 52 weeks:

Disability:

Weeks

Days

Please provide specific dates for Disability:

PFL:

Weeks

Days

Please provide specific dates for PFL:

12. Is the employee taking Family Medical Leave Act (FMLA) concurrently with PFL? Yes No

13. PFL insurance carrier's name and mailing address

PFL insurance carrier's name **ShelterPoint Life Insurance Company**

Mailing address **1225 Franklin Avenue, Suite 475**

City, State **Garden City, NY** Zip Code **11530** Country (if not U.S.A.)

14. PFL insurance carrier's telephone number () .

15. PFL policy number _____

Declaration and signature

I affirm the employee regularly works 20 or more hours per week and has been in employment for at least 26 consecutive weeks OR the employee regularly works less than 20 hours per week and has worked at least 175 days.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I am the person authorized to sign as the employer of the employee requesting PFL. My signature affirms that to the best of my knowledge and belief, the information I have provided is true and accurate.

Employer's authorized signature _____

Date signed (MM/DD/YYYY)

/ /

Title _____

Direct Deposit Enrollment and Authorization Form for New York Disability Benefits Law (“DBL”) and Paid Family Leave (“PFL”) Claims Payments

INSTRUCTIONS

PLEASE PRINT ALL INFORMATION LEGIBLY. This form must be fully completed, signed, and dated to be valid. Incomplete or ineligible submissions are unable to be processed and will not be accepted.

Eligibility for Direct Deposit: ShelterPoint Life Insurance Company (“Company”) offers Direct Deposit Payments for continuous DBL and PFL claims where benefit payments are being issued directly to the claimant/employee.

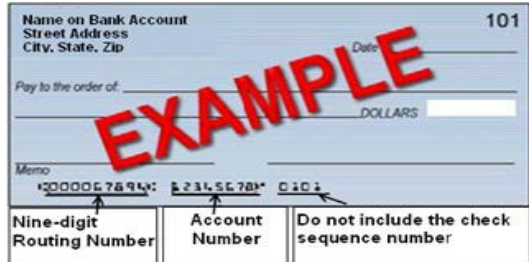
Direct deposit is not currently available for non-NY coverages, in situations where leave is being claimed intermittently, or where the Company is reimbursing your Employer due to continued payment of wages. As a result, direct deposit will not be implemented in these situations, and direct deposit payments will stop if your claim converts from continuous leave to intermittent leave and any future benefit payments due under the claim will be issued via check. In the event that a direct deposit payment is rejected due to inaccurate banking information, the rejected payment and any future benefit payments due under the claim will be issued via check until the bank information is corrected and an updated Enrollment and Authorization Form is submitted.

Required information: you must supply all requested information on this form. Fully completed, signed and dated forms may be sent to ShelterPoint Life by any one of the below listed methods:

- Submit electronically through our claimant portal
- Email to: claimforms@shelterpoint.com
- Fax to: 516-504-6414
- Mail to: ShelterPoint Life, 1225 Franklin Avenue-Ste 475, Garden City NY 11530

If you have any questions regarding this form, please contact our Customer Service Department at 1-800-365-4999 during normal business hours. **Please allow up to 10 business days for set up of your direct deposit request.**

REQUIRED INFORMATION (please print all information LEGIBLY)

1. <u>Claimant Name (First name, Last name)</u>	2. <u>Social Security Number or I-TIN (9 digits)</u> <div style="border: 1px solid black; display: flex; justify-content: space-around; width: 100%;"> - - </div>
3. <u>ShelterPoint Life Claim Number(s)</u>	
4. <u>Account Type</u> <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account	
5. <u>Banking Information</u> Bank Name: _____ Bank Routing Number (ABA#): _____ Bank Account Number: _____	 <p style="font-size: 24px; color: red; text-align: center; opacity: 0.5;">EXAMPLE</p>

AUTHORIZATION AND SIGNATURE

I authorize ShelterPoint Life Insurance Company (“Company”) to deposit any benefits I am eligible to receive directly into the bank account I have indicated above or to such other account as the bank or any successor bank designates as my account. I also authorize the Company to debit my account for any deposits made in error, or the Company reserves the right to request the return of such funds through other mechanisms. I also understand that the direct deposit service will stay in effect until I notify the Company in writing of cancellation or until I am no longer eligible for or due payments, whichever comes first. I acknowledge that if I am also covered under another ShelterPoint Disability / Paid Leave policy, this request will also apply to any other current open claim(s) that are eligible for direct deposit, if approved by the Company. I understand that I have the opportunity to view my EOBs and payment history via claims portal registration on shelterpoint.com.

Check this box if you **do not** want to receive paper EOBs in the mail if your direct deposit request is approved.

Claimant Signature

Date (mm/dd/yyyy)