Standard Security Life Insurance Company P.O. Box 25339, Farmington, NY 14425
Phone: 800-477-0087 | Fax: 585-398-2854 | Email: claims@sslicny.com

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** (☐☐☐) ☐☐☐ - ☐☐☐☐

5a. **Employer's contact fax number** (☐☐☐) ☐☐☐ - ☐☐☐☐

6. **Employer's contact email address** _____

7. **Employee's date of hire** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

7a. **Last day employee worked:** (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

8. **Employee's occupation** Codes are available at: www.bls.gov/soc/2010/soc_alph.htm ☐☐ - ☐☐☐☐

8a. **Indicate occupation (code MUST be provided also):** _____

8b. **Indicate the employee's normal work days** ☐ Mon. ☐ Tues. ☐ Wed. ☐ Th. ☐ Fri. ☐ Sat. ☐ Sun.

8c. **Is the employee considered Full time** (Normal work schedule is 20 hours or more a week) **or Part time** (Normal work schedule is less than 20 hours per week)? ☐ FT ☐ PT

9. **Enter the last 8 weeks of gross wages for the employee and calculate the average gross weekly wage**

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:			

10. **If employee received or will receive full wages while on PFL, will employer be requesting reimbursement?** ☐ Yes ☐ No

10a. **If yes, what time period are you requesting reimbursement for? From** _____ **To:** _____

Form PFL-1 continued on next page

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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:

	Weeks	Days	Please provide specific dates for Disability:
Disability:			

	Weeks	Days	Please provide specific dates for PFL:
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: **Standard Security Life Insurance Company**

Mailing address: **P.O. Box 25339**

City, State: **Farmington, NY** | Zip code: **14425** | Country (if not U.S.A.):

14. PFL insurance carrier's telephone number (8 0 0) 4 7 7 - 0 0 8 7

14a. PFL insurance carrier's fax number (5 8 5) 3 9 8 - 2 8 5 4 **14b. Email:** claims@sslicny.com

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 _____