APPLICATION FOR NEW YORK PAID FAMILY LEAVE BENEFITS

This application package is divided into three sections, as follows:

PFL 1, Part A  Employee Information - to be completed by the employee who is applying for Paid Family Leave benefits.

PFL 1, Part B  Employer Information – to be completed by the employer's authorized representative.

PFL 2  Bonding Certification – to be completed by the employee and attached to the applicable supporting documentation.

Submit completed application along with the required supporting documentation to:

The Hartford
P.O.Box 14306
Lexington, KY 40512-4306
Fax Number: (866) 411-5613
E-mail: PFL@thehartford.com
PART A - EMPLOYEE INFORMATION (to be completed by the employee)

1. Legal name (first name, middle initial, last name)

2. Other last names, if any, under which you have worked

3. Mailing address

4. Social Security Number

5. Date of birth (MM/DD/YYYY)

6. Primary telephone number

7. Preferred email address while on PFL (if available)

8. Gender

   [ ] Male  [ ] Female

9. Preferred language

   [ ] English  [ ] Español  [ ] Русский  [ ] Polski  [ ] Chinese  [ ] Italiano  [ ] Kreyòl ayisyen  [ ] 한국어  [ ] Other:

10. Race/Ethnicity - Optional (For purposes of health demographic only.) (U.S. Centers for Disease Control and Prevention (CDC) code set, version 1.0.):

    a. Is employee of Hispanic, Latino/a, or Spanish origin? (One or more categories may be selected.)

       [ ] Mexican  [ ] Mexican American  [ ] Chicano/a  [ ] Puerto Rican  [ ] Dominican  [ ] Cuban  [ ] Another Hispanic, Latino/a, or Spanish origin

       [ ] Not of Hispanic, Latino/a, or Spanish origin  [ ] Unknown

    b. What is employee's race? (One or more categories may be selected.)

       [ ] American Indian or Alaska Native  [ ] Black or African American  [ ] Asian Indian  [ ] Chinese  [ ] Filipino  [ ] Japanese  [ ] Korean

       [ ] Vietnamese  [ ] Other Asian  [ ] White  [ ] Native Hawaiian  [ ] Guamanian or Chamorro  [ ] Samoan  [ ] Other Pacific Islander

       [ ] Other:

11. Reason for PFL Request:

       [ ] Bond with Child  [ ] Care for Family Member  [ ] Military Qualifying Event

12. The Family Member is your:

       [ ] Child  [ ] Spouse  [ ] Parent  [ ] Parent-in-law  [ ] Grandparent  [ ] Grandchild

13. Will PFL be for a Continuous period of time and/or Periodic?:

       (Note: If dates are "Continuous", you 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".)

       [ ] Continuous

       [ ] Periodic

       PFL start date (MM/DD/YYYY) __________________________

       PFL end date (MM/DD/YYYY) __________________________

       [ ] Dates are estimated

       Identify dates periodic PFL will be taken:

       [ ] Dates are estimated

14. When submitting a request for PFL, 30 days advance notice is required. If providing less than 30 days's advance notice, please explain:

       (Note: If the explanation will not fit in the space provided on the form, enter "See Attached" and add an attachment with the explanation.)
### Employment Information (to be completed by the employee)

#### 15. Business name

#### 16. Date of Hire (MM/DD/YYYY) (Note: Enter the date of hire to the best of your recollection. If it has been more than a year since your date of hire, entering the year in which employment started is sufficient):

#### 17. Work location (Street address):

#### 18. Your average gross weekly wage during the last eight weeks prior to the start of PFL: $

(Note: Enter the best estimate of average gross weekly wage as this will also be confirmed with your employer. 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.

#### 19. Employer's telephone number for contact regarding this request:

#### 20a. Do you have more than one employer? □ Yes □ No

#### 20b. If yes, are you taking PFL from the other employer? □ Yes □ No

#### 21. Are you currently receiving Workers' Compensation Lost Wage Benefits? □ Yes □ No

#### 22. Your PFL benefit is 100% taxable. The federal government and State of New York allow us to withhold 10% of your benefit for Federal Income Tax (FIT) and 2.6% for State Income Tax (SIT) with your permission.

- 22a. Would you like us to withhold FIT? □ Yes □ No
- 22b. Would you like us to withhold SIT? □ 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.

### 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 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.

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**Employee's Signature**

**Date Signed (MM/DD/YYYY)**

- [ ] I am submitting this form in advance of my leave start date. I understand The Hartford will contact me to advise how to submit any required missing information.
PART B - EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address

2. Employer's contact name for questions related to PFL:

3. Employer's contact telephone number:

4. Employer's contact email address:

5. Employee's date of hire

6. PFL coverage effective date

7. Employee's Work Location:

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

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

<table>
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<tr>
<th>Week no.</th>
<th>Week ending date (MM/DD/YYYY)</th>
<th>Number of days worked</th>
<th>Gross amount paid</th>
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</table>

Total:

Calculated average gross weekly wage:

10. Actual days worked in the week prior to the start of the leave: (Check all days that apply)

    Sunday: [ ] Monday: [ ] Tuesday: [ ] Wednesday: [ ] Thursday: [ ] Friday: [ ] Saturday: [ ]

11. If employee received or will receive full wages while on PFL, will employer be requesting reimbursement? [ ] Yes [ ] No

    If Yes, please provide date range of reimbursement: From: [ ] Through: [ ]

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

13. PFL policy number:

14. Has this employee received NY disability benefits or PFL benefits within the 52 weeks prior to the start of this leave request that were not administered by The Hartford?

    [ ] Yes [ ] No [ ] Unknown as employment began within the last 52 weeks

    If yes, fill in the following:

    Paid by (Carrier Name/State):

    Dates Paid:
<table>
<thead>
<tr>
<th>Declaration and signature</th>
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<tbody>
<tr>
<td>□ 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.</td>
</tr>
</tbody>
</table>

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.

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Employer's authorized signature  
Date signed (MM/DD/YYYY)

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Title
Request For NY Paid Family Leave
Bonding Certification (Form PFL-2)

TO BE COMPLETED BY THE EMPLOYEE

Legal name (first name, middle initial, last name) Other last names, if any, under which you have worked

Mailing address

Social Security Number Date of birth (MM/DD/YYYY)

BONDING CERTIFICATION (to be completed by the employee)

1. Child’s name:

2. Child’s date of birth: (MM/DD/YYYY):

3. Does child live with the employee requesting PFL? □ Yes □ No If No, please provide mailing address for child:

4. Child’s Social Security Number:

5. Child’s gender □ Male □ Female

5. Child is employee’s: □ Biological child □ Stepchild □ Foster child □ Adopted child □ Legal ward
□ In loco parentis

6. Select one of the following and attach the document as required as evidence of the relationship. Note: this certification along with the required documentation listed below must be returned to The Hartford in order for us to process your request for PFL.

Parent of newborn child:
□ Child’s birth certificate; OR
□ Voluntary acknowledgment of paternity (Form LDSS-4418); OR
□ Court order of filiation; OR
□ Healthcare provider certification of pregnancy or birth; OR
□ Other documentation of parental relationship

Foster parent:
□ Letter of foster care placement or anticipated placement issued by county or city department of Social Services or authorized voluntary foster care agency

Adoptive parent:
□ Court document finalizing adoption; OR
□ Documentation in furtherance of adoption

7. Date of foster care or adoption placement, if applicable (MM/DD/YYYY):

BONDING CERTIFICATION (to be completed by the employee)

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.

Employee’s signature ____________________________ Date signed (MM/DD/YYYY) ____________________________

If you need assistance, please call (800) 549-6514
www.ny.gov/PaidFamilyLeave
NY PFL Tax Withholding and Electronic Funds Transfer (EFT) Request Form

Tax Withholding:
Your PFL benefit is 100% taxable. The federal government and State of New York allow us to withhold 10% of your benefit for Federal Income Tax (FIT) and 2.5% for State Income Tax (SIT) with your permission.

Would you like us to withhold FIT?  □ Yes  □ No
Would you like us to withhold SIT?  □ Yes  □ No

EFT Instructions:
1. Read the Terms and Conditions listed below.
2. Enter your name, address, home telephone number and Employee ID.
3. Complete the bank and account information for your Electronic Funds Transfer request.
4. You and all other parties to the account specified must sign this form.
5. Return the completed form to The Hartford Claims Office.

Note: Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the EFT Program.

Name: ____________________________
Address: ___________________________
Telephone Number: (  ) - ________________
Employee ID: _______________________
Name of Bank: _______________________
Bank Address: _______________________
Bank Telephone Number: (  ) - ________________
Type of Account (select one):
Checking: __________________________ Saving: _______________________
Account Number:____________________ Account Number:____________________
Bank Routing Number:__________________
Attach a voided blank personal check.
Indicate any other names on the account selected:

______________________________

AUTHORIZATION
I / We authorize (______________) and affiliated companies (herein after called The Hartford), to initiate credit entries (and to initiate, if necessary, debit entries and adjustments for credit entries made in error) to my (our) account indicated above and the Depository named above, hereinafter called Depository, to credit and/or debit the same to such account. I (we) acknowledge that the origination of A C H transactions to my (our) account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until The Hartford has received written notice from me (us) of its termination in such time and in such manner as to afford The Hartford and Depository a reasonable opportunity to act on it. I (we) understand I (we) should allow at least (#______) days for the first CREDIT to occur.

Signature(s): ________________________ Date: ________________________
TERMS AND CONDITIONS

Receiving benefits by direct deposit or electronic funds transfer is voluntary. If at any time during your leave you wish to revoke this EFT request, you can do so by contacting our office.

The Hartford will not be responsible for any banking fees charged for direct deposit or electronic funds transfer; however, The Hartford will not charge you any fees for depositing your benefits into this account.

I understand that this agreement may be terminated by me upon written notice to The Hartford.

The cancellation will be processed for the time period following receipt of the notice.

I understand that a change in the title of this account which alters the interest of any party terminates this authorization and that a new authorization must then be submitted to continue direct deposit/EFT.

I understand that it is my responsibility to inform The Hartford of any address changes immediately.

I further understand that any benefit payment forwarded to the financial institution covering a period of time after my death will be refunded to The Hartford. I agree that the financial institution shall have the right of offset for such a refund.

I authorize the financial institution specified in this authorization to provide The Hartford with my home address and the names of any joint account holders for the account specified herein.

I understand that I am responsible for verifying the accuracy of my account data and for promptly notifying The Hartford of any errors or changes including termination of my EFT request.

SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

As a party to this account, I understand that I am personally liable, both individually and as a member of the group of parties to this account, for the full amount of all benefit payments covering any period after the death of the disability benefit recipient. This is a liability to The Hartford. If I am entitled to any benefit as the beneficiary of the disability benefit recipient, the amount of my liability may be deducted from the amount payable to me. I agree that the financial institution shall have the right of offset for such a refund, and I authorize the financial institution to provide The Hartford with my home address.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to The Hartford or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so. The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately notify The Hartford if the authorization is cancelled by the financial institution. The financial institution can not cancel the authorization by advice to The Hartford.

________________________  ____________________
Signature:                   Date:

I certify that I have read and understand the Terms and Conditions of this EFT Agreement, including the SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

________________________  ____________________
Signature(s) of Other Persons on Account:                   Date

________________________  ____________________
Date:                   Date:

1 The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.