Family Medical Leave & Paid Family Leave Quick Reference Guide

Management Employees

If you need time off for a health or family situation and expect to be away from work for more than 5 consecutive workdays, a leave of absence may be needed. Please contact the benefits team at HR.services@nypa.gov or your local HR representative to start the process of requesting a leave of absence. If you are unsure as to whether a leave is required, please contact HR.services@nypa.gov for guidance.

Depending on the reason for your leave and your employee group, more than one policy may apply, including the Family Medical Leave Act (FMLA), Medical Leave, Disability, or NY Paid Family Leave (NYPFL). Many times, these different leaves will run at the same time. The info below is a brief overview of what to consider. The benefits team or your HR representative will meet with you to talk about your individual circumstances.

Things to consider:

- What is the reason for your leave?
- How long do you expect to be absent?
- How will you be paid while on leave? This could be a combination of NYPA policies, Paid Family Leave, or your accruals. In many cases, **you will be required to choose how you are paid from the available options on the leave request form**.
- Do you need to contact the Employee Assistance Program for support?

Before your leave:

☐ Request your leave at least 30 days before the planned start date or as soon as you know you would need time away from work by contacting your designated human resources representative, HR.services@nypa.gov, and informing your manager.
☐ HR will provide you with necessary paperwork to start the leave process. HR will advise if your leave may be covered under FMLA and whether you have met the 12 months and 1250 hours eligibility requirement.
☐ Set up time with a benefits team representative to go over options and types of leave you are eligible for. They will provide you with information, what action is required on your part, and paperwork to fill out and return.
☐ Complete and return the Leave Request Form as soon as possible.

For your own Health Condition:

If you are requesting a leave of absence for your own illness or condition, have your health care provider fill out the “Certification of Health Care Provider” and return it to HR.

To care for a Family Member:

If you are requesting a leave of absence to care for a family member, have your family member’s doctor complete the “Certification of Health Care Provider for Family Member’s Serious Health Condition”.

Parental Leave & Baby Bonding:

For birth parents, this can include medical recovery and family leave to care for a newborn. Starting January 1, 2025, birth moms may also receive up to 20 hours of sick time to be used for prenatal care.

For all parents, please speak with your HR Rep to determine what is needed.

Please note, if your leave is for baby bonding after the birth of the baby or to care for a family member with a serious health condition, you will need to take an additional step by calling Hartford to start a New York Paid Family Leave Claim.

Pay While on Leave

Some leaves, like NYPFL, have an income component. Others, like the FMLA address the absence, but do not provide any pay. The Benefits team will discuss the options with you. Employees may be able to use accrued time for an otherwise unpaid leave, or to supplement a paid leave like NY PFL.

After the request is submitted:

- Once all the necessary paperwork for the type of leave you have requested has been returned, you will receive a designation notice that will inform you if your leave was approved and if so, for what timeframe or frequency and duration.
- Further information may be needed to make a decision. If that is the case, HR will request it from you or ask you to follow up with your medical provider.
- If you are eligible for New York State Paid Family Leave you will receive a decision from The Hartford.

While out on Leave:

- ☐ Keep you manager up-to-date on your plans to return.
- ☐ Keep benefits up-to-date on your leave.

Returning to Work:

- ☐ Let your manager and benefits know at least 5 days prior to your return that you are ready to come back.
- ☐ If you are out for a medical leave for yourself, you will need your doctor to verify you are released to return to work. Please send Benefits a return-to-work authorization note for review as soon as you receive it. If you return to work and do not have the note, you will be sent home until you are released back to work.
    - o If there are any restrictions on your activities, we will notify the Office of Civil Rights & Inclusion to see if a reasonable accommodation is needed and can be made. This is separate from FMLA.

Benefits

Management Family Medical Leave – FMLA

The following provides initial information for employees that need time off to care for a qualifying family member with a serious health condition or for bonding with a newborn, adopted or fostered child or to assist loved ones when a family member is deployed abroad on active military service. If you have 12 months of NYPA service, at least 1,250 hours over the past 12 months, this absence may qualify under the Family Medical Leave Act (FMLA). If you qualify, you may take up to 12 weeks of unpaid job protected leave in a 12-month period. **You must contact HR Services or your site HR Representative to schedule a time to discuss your leave.**

The following additional leaves run concurrently with FMLA when applicable:

Parental

NYPA provides up to 12 weeks of Parental Leave to bond with a newborn child or placement of a child for adoption or foster care, within one year of the birth or initial placement in the home. This leave runs concurrently with FMLA and PFL when applicable. You are eligible for Parental Leave on your date of hire. This leave can be taken consecutively, intermittently or a combination of both. For additional information see the links below.

NYS Paid Family Leave (NYSPFL)

This is a NYS program that provides employees who have worked for NYPA for at least 6 months with up to 12 weeks of job-protected paid time off to bond with a new child, care for a family member with a serious health condition or to assist loved ones when a family member is deployed on active military service. This time can be taken consecutively, intermittently in full days, or a combination of both. Employees taking Paid Family Leave receive 67% of the NYS average weekly wage, updated annually. You are required to apply for NYSPFL even if you are eligible to receive full pay under one of the other leaves.

Attached and listed below are the documents required to begin the leave process. These forms will be discussed with you during your leave consultation with a Benefits representative.

Leave Request Form

You must complete this form to initiate the leave process.

Certification of Health Care Provider for Employee's Serious Health Condition

This form must be completed by you and your family member's healthcare provider 30 days prior to the start of your leave or as soon as practicable.

NYS PFL Instructions

Follow the instructions on the attached document to apply for NYSPFL benefits.

Change-in-Status form

Complete this form to add your child to your benefit plans. For a newborn, this form should be submitted with a proof of birth letter from the hospital. You are expected to submit the birth certificate and social security number as soon as received.

Below are links to the NYPA policies relating to leaves.

- E.P. 3.3 Family & Medical Leave Act (FMLA)
- EP 3.12 Time away from work
- E.P 2.1 Salary Administration

LEAVE REQUEST FORM – MANAGEMENT

EMPLOYEE INFORMATION

Employee Name: Employee Location:

REASON FOR LEAVE OF ABSENCE (check all that apply)

More than one type of leave may apply, and some leaves run concurrently.

Family Medical Leave	**Paid Family Leave**
q Employee Medical Leave	❑ Baby Bonding
q Care for Family Member (FMLA)	❑ Care for Family Member (PFL)
q NYPA Parental Leave	❑ Service Member Care/ Exigency Leave
q Military Leave	❑ **Other**

q Service Member Care/ Exigency Leave

q Employee Medical Leave(non-FMLA)

❑ Personal Leave not covered by any other options

LEAVE TIMEFRAME

1. ❑ I am requesting consecutive leave (2 weeks or longer) for the following dates:

   Beginning on (date): Ending on (date):

2. ❑ I am requesting intermittent leave per the following schedule:
   (Intermittent leaves should have a set schedule and duration. Ex: Work 3 days, M-W-F for 1 month, starting ___ date.)

PAY WHILE ON LEAVE (check all that apply)

To be sure you can plan appropriately, you must specify what type of pay you wish to receive, based on the type of leave and your eligibility. Please select from the following option(s):

1. ❑ Employee Medical Leave

    a. Required – Use Sick Accruals until depleted then,
    b. Salary Continuation @ 50% (Applies after sick leave is exhausted, within the first 12 weeks of the leave)
    c. Optional--Subsidize 50% Salary Continuation for 100% pay total with: (select all that apply)

        ❑ Half-day Vacation
        ❑ Half-day Floating Holiday

2. ❑ NYPA Parental Leave/Salary Continuation--12 weeks at 100% Pay

    - **Required** – You must also apply for NY PFL through the Hartford.

3. ❑ Paid Family Leave to care for a family member with a serious health or condition (or other applicable):

    - **Required** – You must also apply for NY PFL through the Hartford.

    Pay options:

    ❑ Receive Paid Family Leave (PFL) benefit only (administered by The Hartford)

    OR

    ❑ Receive PFL and Subsidize with ❑ Sick ❑ Vacation ❑ Floating Holiday

4. ❑ Family Leave – Using Accruals Only

    - **Required** – You must also apply for NY PFL through the Hartford.

    Check all that apply: ❑ Sick ❑ Vacation ❑ Floating Holiday

5. ❑ Unpaid Leave – not covered by any policy and no accrued time available

EMPLOYEE CERTIFICATION AND SIGNATURE

I understand I am responsible for the cost of my insurance benefits if on unpaid leave and authorize Human Resources to make up insurance premiums owed upon my return to work.

Signature: _____ Date: _____ _____

Please provide a personal email and preferred phone # where we can reach you while on leave.

Email: _____ Phone # _____

MANAGER ACKNOWLEDGEMENT

The employee above has notified me of their intent to take a leave of absence.

Manager's Signature: _____ _____ Date: _____ _____

Please return the completed form to HR.Services@nypa.gov

Certification of Health Care Provider for Family Member's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor
Wage Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.
RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308**. Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer name: _____ Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

(3) The medical certification must be returned by _____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18
☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name: _____

(3) Briefly describe the care you will provide to your family member: (*Check all that apply)*

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation

☐ Physical Care ☐ Psychological Comfort ☐ Other: _____

(4) Give your **best estimate** of the amount of leave needed to provide the care described: _____

_____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy),* I am able to work _____ (*hours per day*) _____ (*days per week).*

Employee Signature _____ **Date** _____ *(mm/dd/yyyy)*

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that *involves inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (____) _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) Patient's Name: _____

(2) State the approximate date the condition started or will start: _____ *(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition lasted or will last: _____

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (*e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).*

_____

_____

Employee Name: _____

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

- ☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

- ☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
  Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

  The patient (☐ was / ☐ will be) seen on the following date(s): _____

  _____

  The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

- ☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*.

- ☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

- ☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

- ☐ **Conditions requiring Multiple Treatments**: (*e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

- ☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis)* _____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine if the benefits and protections of the FMLA apply.

(7) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery

_____ *(e.g. 3 days/week)*

Employee Name: _____

(9) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date: _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(10) Due to the condition it, (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Signature of
Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

Health & Wellness

NEW YORK STATE OF OPPORTUNITY. | NY Power Authority

Qualifying Change in Status Form

THIS FORM MUST BE RETURNED WITHIN 30 DAYS OF QUALIFYING EVENT

Part 1 – EMPLOYEE INFORMATION

Employee Name _____ Marital Status: ☐ Married ☐ Single

Employee Personnel # _____ ☐ MANAGEMENT ☐ IBEW ☐ UWUA

Date of Event Change _____ Location/Extension _____

Part 2 – BENEFIT CHANGES / ADD DEPENDENT(S) TO THE FOLLOWING PLAN(S)

☐ Medical – NYPA PPO	☐ Individual	☐ Family
☐ Medical – NYPA CHOICE (Management & UWUA only)	☐ Individual	☐ Family
☐ Medical – HMO _____	☐ Individual	☐ Family
☐ Dental	☐ Individual	☐ Family
☐ Other _____		

I request a change in coverage due to the following Qualifying Change in Status. (Check below all that apply.)
I understand such a request is subject to approval based on IRS regulations.

Part 3 – REASON FOR CHANGE AND DEPENDENT DATA

(a) Change in marital status: ☐ Marriage ☐ Divorce ☐ Legal Separation

New Spouse Name _____ Date of Birth _____ SSN _____

Ex-Spouse Name _____ Date of Birth _____ SSN _____

(b) ☐ Birth or adoption ☐ Acquired dependent with guardianship ☐ Death of dependent

☐ Change in spouse/domestic partner's employment/status: ☐ New Job ☐ Loss of Job

☐ Other: _____

Name _____ Date of Birth _____ SSN _____

Name _____ Date of Birth _____ SSN _____

Name _____ Date of Birth _____ SSN _____

Part 4 – Flexible Spending Accounts (FSA)

If you would like to change your election or start contributing to a Health and/or Dependent Care FSA, please indicate your new annual amounts below. To continue your participation, you must re-enroll each year during Open Enrollment.

Health Care FSA: ☐ Annual Amount _____ Effective Date _____

Dependent Care FSA: ☐ Annual Amount _____ Effective Date _____

I attest that the above information is true and accurate and that I have not misrepresented my family status. I understand I am required to provide documentation in support of this application (see list for valid forms of documentation). I understand that if I elect to participate in a contributory plan(s), I authorize NYPA to reduce my compensation each payroll period.

Employee Signature _____ Date _____

Type your name

Please return completed form to HR Services or your local HR representative.

Proof of Family Status Change (acceptable documentation)

Marriage - Marriage license

Divorce/legal separation - First and last page of divorce decree to include judges' signature

Birth or adoption - Birth certificate/adoption papers, (or satisfactory proof of support and guardianship if dependent child is other than your natural, legally adopted or stepchild residing with you)

Death of dependent - Death certificate

Change in spouse/domestic partner's employment status - Letter from spouse's employer or proof coverage has ended

Spouse/domestic partner becomes totally disabled - Attending physician's statement certifying total disability

FILE A NY PFL CLAIM W ITH CONFIDENCE

Your NY PFL Claim is managed by The Hartford. It's a user-friendly benefit that helps provide essential support services while you're away from your workplace.

NYPA: Power Authority of the State of New York

Policy Number:709424

TO FILE A CLAIM, CALL:

NYPA DEDICATED LINE

866-664-3128

Policy Number: 709424

Follow these steps to file a claim with The Hartford:

STEP 1: KNOW W HEN IT'S TIME TO FILE A CLAIM If you're absent from work, we can advise you on when to file your claim. If your absence is scheduled, call us within 30 days of your last day of work. If unscheduled, please call us as soon as possible.

STEP 2: HAVE THIS INFORMATION READY

- Name, address, policy number and other key identification information
- Name of your department and last day of active work
- The nature of your claim

STEP 3: MAKE THE CALL TO FILE YOUR CLAIM

With your information handy, call The Hartford at 866-664-3128.

You'll be assisted by a caring professional who'll take your information, answer your questions and file your claim.

GET SUPPORTIVE ASSISTANCE

Even after your claim has been filed, we may be in touch to check your progress, answer questions or obtain additional information from you. Our goal is to offer a smooth and hassle-free experience until you return to work. Feel free to also call us with anything that's on your mind. We're here to help.

RELAX AND STAY POSITIVE

You have the assurance of our knowledge, experience and understanding of what you are going through. We're with you all the way, so you can receive the benefits you qualify for and get back to your life.

QUICK FACTS

The Hartford's goal is to help get you through your time away from work with dignity and assist you in any way we can. Keep the card below in a safe place for future use. We'll be there when you need us.

TheHartford.com/ employeebenefits

(Please cut here and keep in your wallet.)

W HEN YOU CALL, THE HARTFORD W ILL ASK YOU TO PROVIDE:

- Name, address, policy number and other key identification information.
- Name of your department and last day of active work
- The nature of your claim.

This card is not proof of insurance

405109 08/20

UPDATED 11.23.20

IMPORTANT NOTICES CONCERNING MEDICAL INFORMATION

Privacy Law Notification

SECTION 94(1)(d) OF THE NEW YORK PUBLIC OFFICERS LAW REQUIRES THIS NOTICE TO BE PROVIDED WHEN COLLECTING PERSONAL INFORMATION FROM APPLICANTS FOR FAMILYAND MEDICAL LEAVE.

This information is requested pursuant to the Family Medical Leave Act of 1993. The principal purpose for which the information is collected is for the approval of family or medical leave and the maintenance of employee records in Human Resources in accordance with Section 96(1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e), and (1).

Failure to provide the requested information may result in a denial of an employee's request for family or medical leave.

This information will be maintained by the Vice President of Human Resources at the Power Authority of the State of New York located at 123 Main Street, White Plains, New York 10601 (914-681-6200), or when appropriate, at one of the various Authority facilities.

Genetic Information Nondiscrimination Act of 2008 (GINA)
Employee's Serious Health Condition and Family Member's Serious Health Condition

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits the New York Power Authority and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an Individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Please provide medical history information regarding your patient only to extent necessary to fully respond to all relevant items and/or the attached form.