

Paid Family Leave NOTICE OF COMPLIANCE



Paid Family
Leave

Paid Family Leave insurance coverage provided by: THE STATE INSURANCE FUND
INSERT INSURER NAME HERE

Covering employees of: WESLEYAN UNIVERSITY
INSERT EMPLOYER NAME HERE

Paid Family Leave is employee-funded insurance that provides eligible employees job-protected, paid time off to:

- **BOND** with a newly born, adopted, or fostered child;
- **CARE** for a family member with a serious health condition (see [paidfamilyleave.ny.gov](https://www.paidfamilyleave.ny.gov) for eligible family members); or
- **ASSIST** loved ones when a spouse, domestic partner, child, or parent is deployed abroad on active military service.

Paid Family Leave may also be available for use in situations when you or your minor dependent child are under an order of quarantine or isolation due to COVID-19. See [PaidFamilyLeave.ny.gov/COVID19](https://www.paidfamilyleave.ny.gov/COVID19) for full details.

Paid Family Leave Request Process:

1. Notify your employer at least 30 days in advance, if foreseeable, or as soon as possible.
2. Complete and submit the **Request for Paid Family Leave (Form PFL-1)** to your employer.
3. Complete and attach the additional documentation as instructed on the request form and submit to your employer's insurance carrier listed below. Submit within 30 days after the start of your leave to avoid losing benefits.

You may obtain all forms from your employer, their insurance carrier listed below, or online at [PaidFamilyLeave.ny.gov/Forms](https://www.paidfamilyleave.ny.gov/Forms).

Employers should NEVER discriminate or retaliate against anyone who requests or takes Paid Family Leave

INSURER OR AUTHORIZED NEW YORK SELF-INSURER INFORMATION

Name: NYSIF Telephone: 888-875-5790

Address: PO Box 66699 Albany, NY 12206

Policy #: DB 7936 20-7 Effective date from: 06/14/2023 to 06/14/2024

Statutory Under a plan or agreement

Class(es) of employees covered: All Eligible Employees

For more information, visit [PaidFamilyLeave.ny.gov](https://www.paidfamilyleave.ny.gov) or call (844) 337-6303

PRESCRIBED BY THE CHAIR, WORKERS' COMPENSATION BOARD
THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

NEW YORK STATE INSURANCE FUND

WESLEYAN UNIVERSITY

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
NOTICE OF COMPLIANCE

New York State Disability Benefits

Disability Benefits For Employees

- 1. If you are unable to work because of an illness or injury, not work-related, you may be entitled to receive weekly benefits from your employer, his or her insurance carrier, or from the Special Fund for Disability Benefits.
2. To claim benefits you must file a claim form within 30 days from the first date of your disability, but in no event more than 26 weeks from such date.
3. Complete claim form DB-450 (Notice and Proof of Claim for Disability Benefits)
You may obtain the form from your employer, his or her insurance carrier, your health provider, any Unemployment Insurance Office, the Workers' Compensation Board's website (www.wcb.ny.gov) or any office of the Board.
IMPORTANT: Before filing your claim, your health provider must complete the "Health Care Provider's Statement" on the form showing your period of disability.
- If you are employed, or have been unemployed for four weeks or less when your disability begins, send the completed form to your employer or the insurance carrier named below.
- If you have been unemployed more than four weeks when your disability begins, send the completed form to the Workers' Compensation Board, Disability Benefits Bureau, 328 State Street, Schenectady, New York 12305.
4. You are entitled to be treated by any physician, chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. However, unlike workers' compensation, your medical bills will not be paid unless your employer and/or union provide for the payment of such bills under a Disability Benefits Plan or Agreement.
5. If you are ill or injured during the time you are receiving Unemployment Insurance Benefits, file a claim for Disability Benefits as soon as you sustain the injury or illness, by following the instructions outlined above.
6. If you are out of work in excess of seven days, your employer is required to send you a Disability Benefits Statement of Rights (Form DB-271S).
7. You may not take disability benefits at the same time as paid family leave benefits. The total amount of disability and paid family leave in a 52 week period cannot exceed 26 weeks.
8. Other information about disability benefits may be obtained by writing or calling the Workers' Compensation Board.

NYSIF
PO Box 66699
Albany, NY 12206

Policy #: DBL 7936 20-7

Effective From: 06/14/2023

To: 06/14/2024

[X] Statutory [] Under a Plan or Agreement

Class(es) of Employees Covered:

NYS Workers' Compensation Board
Customer Service: (877) 632-4996
www.wcb.ny.gov

PRESCRIBED BY THE CHAIR, WORKERS' COMPENSATION BOARD
THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Employers must post DB-120 so that all classes of their employees know who will pay their benefits.

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

NEW YORK STATE INSURANCE FUND

WESLEYAN UNIVERSITY

ESTADO DE NUEVA YORK JUNTA DE COMPENSACIÓN DE LOS TRABAJADORES AVISO DE CUMPLIMIENTO

Beneficios por discapacidad del estado de Nueva York

Beneficios por discapacidad para empleados

1. Si usted no puede trabajar por una enfermedad o lesión, que no se relaciona con el trabajo, es posible que tenga derecho a recibir beneficios semanales de su empleador, de su compañía aseguradora o del Fondo Especial para Beneficios por Discapacidad.
2. Para reclamar los beneficios, debe presentar un formulario de reclamo dentro de un período de 30 días desde la primera fecha de su discapacidad, pero, en ningún caso, más de 26 semanas después de dicha fecha.
3. Complete el formulario de reclamo DB-450 (Aviso y constancia de reclamo de beneficios por discapacidad)
Puede obtener el formulario de su empleador, su compañía aseguradora, su proveedor de atención médica, cualquier oficina de Seguro por Desempleo, el sitio web de la Junta de Compensación de los Trabajadores (www.wcb.ny.gov) o cualquier oficina de la Junta.
IMPORTANTE: Antes de presentar su reclamo, su proveedor de atención médica debe completar la "Declaración del proveedor de atención médica" en el formulario donde se indica su período de discapacidad.
 - Si usted tiene un empleo, o ha estado desempleado durante cuatro semanas o menos cuando comienza su discapacidad, envíe el formulario completo a su empleador o a la compañía aseguradora que se indica a continuación.
 - Si ha estado desempleado durante más de cuatro semanas cuando comienza su discapacidad, envíe el formulario completo a Workers' Compensation Board, Disability Benefits Bureau, 328 State Street, Schenectady, New York 12305.
4. Tiene derecho a recibir el tratamiento de un médico, quiropráctico, dentista, enfermero obstétrico, podólogo o psicólogo de su elección. Sin embargo, a diferencia de la compensación de los trabajadores, sus cuentas médicas no se pagarán, a menos que su empleador o el sindicato respondan por el pago de dichas cuentas en virtud del acuerdo o plan de beneficios por discapacidad.
5. Si está enfermo o lesionado durante el período durante el que recibe los beneficios del seguro por desempleo, presente un reclamo por los beneficios por discapacidad siempre y cuando siga teniendo dicha lesión o enfermedad, siguiendo las instrucciones indicadas anteriormente.
6. Si no se presenta a trabajar durante más de siete días, su empleador debe enviarle una Declaración de derechos de beneficios por discapacidad (Formulario DB-271S).
7. Puede no aceptar los beneficios por discapacidad al mismo tiempo que los beneficios por licencia con goce de sueldo para asuntos familiares. El tiempo total de licencia con goce de sueldo para asuntos familiares y por discapacidad en un período de 52 semanas no puede superar las 26 semanas.
8. Puede obtener más información sobre los beneficios por discapacidad escribiendo o llamando a la Junta de Compensación de los Trabajadores.

NYSIF
PO Box 66699
Albany, NY 12206

Póliza N°: **DBL 7936 20-7**

Fecha de entrada en vigencia: **06/14/2023** Hasta: **06/14/2024**

Conforme a la ley Conforme a un plan o un acuerdo

Categoría(s) de empleados cubiertos:

Junta de Compensación de los Trabajadores del Estado de Nueva York (NYS Workers' Compensation Board)
Atención al cliente: (877) 632-4996
www.wcb.ny.gov

**ESTIPULADO POR EL PRESIDENTE DE LA JUNTA DE COMPENSACIÓN DE LOS TRABAJADORES (WORKERS' COMPENSATION BOARD)
ESTE AVISO DEBE SER PUBLICADO VISIBLEMENTE EN LOS ESTABLECIMIENTOS DE LOS EMPLEADORES Y EN LOS ALREDEDORES.
Los empleadores deben publicar el formulario DB-120 para que todas las categorías de empleados sepan quién pagará sus beneficios.**

LA JUNTA DE COMPENSACIÓN DE LOS TRABAJADORES EMPLEA Y ATIENDE SIN DISCRIMINACIÓN A PERSONAS CON DISCAPACIDADES.