

Paid Family Leave STATEMENT OF RIGHTS

If you need to take time off from work to care for a family member, you may be entitled to Paid Family Leave benefits.

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 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 for full details.

Eligibility:

- If you have a regular work schedule of **20 or more hours per week**, you are eligible after **26 consecutive weeks** of employment with your employer.
- If you have a regular work schedule of **less than 20 hours per week**, you are eligible after working for your employer for **175 days**, which do not need to be consecutive.

Citizenship or immigration status is not a factor in your eligibility.

Benefits:

You can take up to 12 weeks of Paid Family Leave and receive 67% of your average weekly wage, capped at 67% of the New York State Average Weekly Wage. Generally, your average weekly wage is the average of your last eight weeks of pay prior to starting Paid Family Leave. Leave can be taken all at once or intermittently, but must be in full-day increments.

Rights and Protections:

- **Job protection:** Return to the same or comparable job after you take leave.
- You keep your **health insurance** while on leave (you may have to continue paying your portion of the premium costs, if any).
- Your employer is **prohibited from discriminating or retaliating** against you for requesting or taking Paid Family Leave.

Disputes:

If your Paid Family Leave claim is denied, you may request to have the denial reviewed by a neutral arbitrator. The insurance carrier listed below will provide you with information about requesting arbitration.

Discrimination Complaints:

If your employer terminates you without an employer, reduces your pay and/or benefits, or disciplines you in any way as a result of you requesting or taking Paid Family Leave, you may request to be reinstated by taking these steps:

1. Complete the *Formal Request for Reinstatement Regarding Paid Family Leave (Form PFL-DC-119)*.
2. Send your completed form to your employer and a copy of the completed form to: Paid Family Leave, P.O. Box 9030, Endicott, NY 13761-9030.
3. If your employer does not reinstate you or take other corrective action within **30 days**, you may file a discrimination complaint with the Workers' Compensation Board using the *Paid Family Leave Discrimination/Retaliation Complaint (Form PFL-DC-120)*. The Workers' Compensation Board will assemble your case and schedule a hearing.
4. There are other state and federal laws that protect employees from discrimination. Additional information is available at PaidFamilyLeave.ny.gov.

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. You must submit your completed request package to your employer's insurance carrier within **30 days** after the start of your leave to avoid losing benefits.
4. In most cases, the insurance carrier must pay or deny benefits within **18 calendar days** of receiving your completed request or your first day of leave, whichever is later.

You may obtain all forms from your employer, their insurance carrier listed below, or online at PaidFamilyLeave.ny.gov/Forms.

For more information, forms and instructions, visit PaidFamilyLeave.ny.gov or call the PFL Helpline (844)-337-6303

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law. Your employer's Paid Family Leave benefits insurance carrier is: Cardinal Disability Trust
NYDisability@glacierbaytpa.com (518) 724-3583 (f) (518) 608-5536
PFL-2115 (9/12/2)

PRESCRIBED BY THE CHAIR,
WORKERS' COMPENSATION BOARD
NYS Paid Family Leave
P.O. Box 9030, Endicott, NY 13761

WCB NY GOV

STATE OF NEW YORK
Andrew M. Cuomo, Governor

WORKERS' COMPENSATION BOARD
Kenneth J. Munnelly, Chair

**STATEMENT OF RIGHTS
NEW YORK STATE DISABILITY BENEFITS**

TO ALL WORKERS WHO ARE INJURED WHILE WORKING OR WHO SUFFER FROM AN OCCUPATIONAL DISEASE

YOU MAY BE ENTITLED TO WORKERS' COMPENSATION BENEFITS

1. You should file a claim for benefits within two years of the date you are injured, unless your injury is very minor, requiring no medical treatment and causing no lost time from work. If you do not file within two years your right to benefits may be lost. Obtain and file a claim form (Form C-3, C-3A or C-3B for volunteer firefighters, or VAW-3 for volunteer ambulance workers) with the nearest Workers' Compensation Board office (see addresses below).
2. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work. (In volunteer firefighter's and volunteer ambulance workers' cases, compensation for lost time or loss of earning capacity may be payable from date of injury.)
3. You are entitled to obtain any necessary medical treatment related to your injury and you should do so immediately.
4. For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Board authorized and who is accepting workers' compensation patients. If, however, your employer is involved in a certified preferred provider organization (PPO) arrangement, you must obtain initial treatment for any workers' compensation injury or illness from the preferred provider organization. Employees participating in the statutory program are required to provide their employees with written notification describing their employees' rights and obligations under the program.
5. You should inform your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and your employer's insurance company, which is indicated at the bottom of this form.
6. You should not pay any medical providers directly for treatment of your work-related injury or illness. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
7. The employer is liable for the replacement or repair of an employee's prosthesis (e.g., artificial members, false teeth, eyeglasses), which has been lost or damaged in the course of employment, whether or not there was bodily injury to the employee. You are also entitled to be reimbursed for drugs, ointments or any apparatus properly prescribed by your doctor, and transportation and other necessary expenses going to and from your doctor's office or hospital. (You should get receipts for all such expenses.)
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire an attorney or licensed representative, you should not pay any fee. Any fee will be set by the Board.
9. Lost time and medical benefits are payable directly without a formal direction from the Board, unless your claim is disputed. If your claim is disputed on the grounds that your injury is not work-related or did not arise in the line of volunteer firefighter or ambulance worker duties, then you may qualify for disability benefits for non-work injuries. For more information on entitlement to disability benefits, contact the Workers' Compensation Board.
10. You should go back to work as soon as you are able; compensation is never as high as your wage. If you need help returning to work, or with family or financial problems because of your injury, you should contact the nearest Board office and ask for a rehabilitation counselor or social worker.
11. Your employer may not ask you to waive your right to compensation nor may your employer deduct any money from your pay to contribute to the payment of workers' compensation insurance premiums. Further, you cannot be discharged or discriminated against because you filed a claim for workers' compensation benefits.

IF YOU HAVE DIFFICULTY IN OBTAINING A CLAIM FORM OR NEED HELP IN FILLING IT OUT, OR IF YOU HAVE ANY OTHER QUESTIONS OR PROBLEMS ABOUT A JOB-RELATED INJURY OR DISEASE, CONTACT ANY OFFICE OF THE WORKERS' COMPENSATION BOARD.

This information is a simplified presentation of your rights under the Workers' Compensation Law. It is provided, as required by Section 110 of the Workers' Compensation Law, by your employer's insurance carrier:

INSERT NAME AND ADDRESS OF INSURANCE CARRIER

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 4614
BUFFALO, NY 14240-4614

KENNETH J. MUNNELLY
CHAIR

NYS Workers' Compensation Board, Centralized Mailing, P.O. Box 5205, Binghamton, NY 13902-5205

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.
ESTE RESUMEN ESTÁ ESCRITO EN ESPAÑOL AL DORSO www.wcb.ny.gov

C-4305 (9-16)
W31P5116

New York State Disability Benefits STATEMENT OF RIGHTS

If you are unable to work due to a non-occupational illness or injury, you may be entitled to disability benefits.

1. You may be entitled to statutory disability benefits for a non-work-related injury or illness (including disability due to pregnancy) beginning with the eighth consecutive day of disability. Disability benefits are paid **directly** to you by your employer's insurer, **not** through your employer, unless your employer is an approved self-insurer. You can take up to 26 weeks of disability at 50% of your average weekly wage, capped at \$770 per week. Generally, your average weekly wage is the average of your last eight weeks of pay prior to starting disability. Your employer or union may provide different benefits, at least as favorable as statutory, under an approved disability benefits plan or agreement.
2. If you also take Paid Family Leave, your combined total disability leave and Paid Family Leave in any consecutive 52-week period may not exceed 26 weeks. You cannot take Paid Family Leave and disability leave at the same time.
3. You can be treated by any physician, podiatrist, chiropractor, dentist, nurse, midwife, or psychologist who can certify your disability. Your medical bills are not covered, unless your employer and/or union provides for the payment of medical bills under an approved disability benefits plan or agreement.
4. Your employer may not ask you to waive your right to disability benefits. Employers may collect a maximum contribution of 60 cents/week to offset the insurance premium (unless the additional contribution is part of an approved plan). You cannot be discriminated or retaliated against for requesting or taking disability benefits.
5. If your claim is denied, your employer or employer's insurer is required to send you a **Notice of Rejection (Form DB-45)**, within 45 days of your claim filing, with the reason(s) benefits are not being paid. If you disagree, you have a right to request a review by the NYS Workers' Compensation Board (Board), which you can request by writing the Board at the bottom right address.
IMPORTANT: If, within 45 days of filing your claim, you do not receive benefits and do not receive a **Form DB-45**, promptly contact the Board at (877) 632-4996.

To file a claim:

1. Obtain a **Notice and Proof of Claim for Disability Benefits (Form DB-450)**, either from the Board at wcb.ny.gov, or from your employer's insurance carrier, or your health care provider.
2. Follow instructions to complete/submit the form, which includes a section your health care provider must complete.
3. Submit the form within 30 days of your first day of disability. If your claim is not paid promptly, contact your employer or their insurer. If you file late, you may not be paid for any disability period more than two weeks before the date you filed. Late filings may be excused if you can show it wasn't reasonably possible to file earlier. No benefits are payable if you file more than 26 weeks after your disability begins, or after you return to work.

Do not assume that your employer has filed a claim on your behalf; filing a claim is your responsibility.

Note: If your disability is the result of an automobile accident, and you have filed a claim for no-fault benefits, you must also file a **Form DB-450** for disability benefits. If you do not file for disability benefits, the no-fault insurer may reduce your no-fault payments.

IMPORTANT: In such cases, if you are not entitled to disability benefits, immediately advise the no-fault insurer.

FOR HELP OBTAINING A CLAIM FORM OR FILING IT OUT, OR OTHER QUESTIONS ABOUT BENEFITS FOR YOUR NON-WORK-RELATED INJURY OR ILLNESS, PLEASE CALL (877) 632-4996. A BOARD REPRESENTATIVE WILL HELP.

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law. Your employer's disability benefits insurance carrier is: Cardinal Disability Trust
P.O. Box 9023, Endicott, NY 13761-9023
NYDisability@glacierbaytpa.com 518-724-3583 (f) 518-608-5536
DB-2715 (10/22)

PRESCRIBED BY THE CHAIR,
WORKERS' COMPENSATION BOARD
NYS Workers' Compensation Board
Disability Benefits Bureau
P.O. Box 9023, Endicott, NY 13761-9023
WCB NY GOV

NEW YORK STATE
Workers' Compensation Board

STATEMENT OF RIGHTS
NEW YORK STATE DISABILITY BENEFITS

ANDREW M. CUOMO, Governor

IF YOU ARE UNABLE TO WORK BECAUSE OF A NON-OCCUPATIONAL ILLNESS OR INJURY, YOU MAY BE ENTITLED TO DISABILITY BENEFITS

1. Your employer is required by law to provide for the payment of disability benefits to his/her employees.
2. Statutory disability benefits are payable for any non-work-related injury or illness (including disability due to pregnancy) beginning with the 8th consecutive day of disability. Benefits are payable for up to 26 weeks. The total amount of combined paid family and disability leave an employee may take in a 52 consecutive week period may not exceed 26 weeks. Benefit payments are based on your average weekly wage for the eight weeks immediately prior to your disability, and are subject to the maximum allowable by the law in effect on the initial day of disability. Your employer or union may provide for different benefits which are at least as favorable as statutory benefits under an approved Disability Benefits Plan or Agreement.
3. TO CLAIM BENEFITS you should file written notice and proof of disability (Claim Form DB-450) with your employer or the insurance carrier named below within 30 days of the first day of your disability, or all or part of your claim may be rejected. In no event should you wait more than 26 weeks from that date to file a claim. You may obtain Form DB-450 from your employer, its insurance carrier, your health care provider or by contacting the Workers' Compensation Board. (See address and telephone number below). Do not assume that your employer has filed a claim on your behalf; **claim filing is your responsibility.**
4. You are entitled to be treated by any physician, chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. Unlike workers' compensation, your medical bills will not be paid by your employer or the insurance carrier, unless your employer and/or union provides for the payment of medical bills under an approved Disability Benefits Plan or Agreement.
5. Disability benefits are to be paid directly to you by the insurance carrier, **not through your employer**, unless your employer is an approved self-insurer.
6. If your employer or the insurance carrier contends that you are not entitled to the payment of disability benefits, they are required to send you a Notice of Rejection, within 45 days of the filing of your claim, telling you the reasons benefits are not being paid. If you disagree with their rejection, you have a legal right to request a review of the rejection by the Workers' Compensation Board. **IMPORTANT:** If within 45 days of filing your claim you do not receive benefits and do not receive a Notice of Rejection (Form DB-451), promptly contact the Workers' Compensation Board at the telephone number below.
7. If your disability is the result of an automobile accident and you have filed a claim for no-fault benefits, you must also file a claim (Form DB-450) for disability benefits. If you do not file for disability benefits, the no-fault insurer may reduce your no-fault payments. **IMPORTANT:** In such cases, if you are not entitled to disability benefits, immediately advise the no-fault insurance carrier.
8. Your employer may not ask you to waive your right to disability benefits nor may your employer deduct more than 60 cents a week (unless the additional contribution is part of an approved plan) from your pay to contribute to the payment of disability benefits insurance premiums. You cannot be discharged or discriminated against for filing a claim for disability benefits.

IF YOU HAVE DIFFICULTY IN OBTAINING A CLAIM FORM OR NEED HELP IN FILLING IT OUT, OR IF YOU HAVE ANY OTHER QUESTIONS OR PROBLEMS ABOUT A NON-WORK RELATED INJURY OR ILLNESS, CONTACT ANY OFFICE OF THE WORKERS' COMPENSATION BOARD.

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law. Your employer's disability benefits insurance carrier is:

Cardinal Disability Trust
P.O. Box 1227
Latham, NY 12110
(518) 724-3559

Prescribed by the Chair,
Workers' Compensation Board

DB-2715 (5-19) Workers' Compensation Board, Disability Benefits Bureau, P.O. Box 9023, Endicott, NY 13761-9023
Customer Service: (877) 632-4996 • www.wcb.ny.gov
THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

C-4305 (9-16)
W31P5116

NEW YORK STATE
Workers' Compensation Board

STATEMENT OF RIGHTS

IF YOU ARE UNABLE TO WORK DUE TO A NON-OCCUPATIONAL ILLNESS OR INJURY, you may be entitled to disability benefits.

1. You may be entitled to statutory disability benefits for a non-work-related injury or illness (including disability due to pregnancy) beginning with the eighth consecutive day of disability. Disability benefits are paid **directly** to you by your employer's insurer, **not** through your employer, unless your employer is an approved self-insurer. You can take up to 26 weeks of disability at 50% of your average weekly wage, capped at \$770 per week. Generally, your average weekly wage is the average of your last eight weeks of pay prior to starting disability. Your employer or union may provide different benefits, at least as favorable as statutory, under an approved disability benefits plan or agreement.
2. If you also take Paid Family Leave, your combined total disability leave and Paid Family Leave in any consecutive 52-week period may not exceed 26 weeks. You cannot take Paid Family Leave and disability leave at the same time.
3. You can be treated by any physician, podiatrist, chiropractor, dentist, nurse, midwife, or psychologist who can certify your disability. Your medical bills are not covered, unless your employer and/or union provides for the payment of medical bills under an approved disability benefits plan or agreement.
4. Your employer may not ask you to waive your right to disability benefits. Employers may collect a maximum contribution of 60 cents/week to offset the insurance premium (unless the additional contribution is part of an approved plan). You cannot be discriminated or retaliated against for requesting or taking disability benefits.
5. If your claim is denied, your employer or employer's insurer is required to send you a **Notice of Rejection (Form DB-45)**, within 45 days of your claim filing, with the reason(s) benefits are not being paid. If you disagree, you have a right to request a review by the NYS Workers' Compensation Board (Board), which you can request by writing the Board at the bottom right address.
IMPORTANT: If, within 45 days of filing your claim, you do not receive benefits and do not receive a **Form DB-45**, promptly contact the Board at (877) 632-4996.

To file a claim:

1. Obtain a **Notice and Proof of Claim for Disability Benefits (Form DB-450)**, either from the Board at wcb.ny.gov, or from your employer's insurance carrier, or your health care provider.
2. Follow instructions to complete/submit the form, which includes a section your health care provider must complete.
3. Submit the form within 30 days of your first day of disability. If your claim is not paid promptly, contact your employer or their insurer. If you file late, you may not be paid for any disability period more than two weeks before the date you filed. Late filings may be excused if you can show it wasn't reasonably possible to file earlier. No benefits are payable if you file more than 26 weeks after your disability begins, or after you return to work.

Do not assume that your employer has filed a claim on your behalf; filing a claim is your responsibility.

Note: If your disability is the result of an automobile accident, and you have filed a claim for no-fault benefits, you must also file a **Form DB-450** for disability benefits. If you do not file for disability benefits, the no-fault insurer may reduce your no-fault payments.

IMPORTANT: In such cases, if you are not entitled to disability benefits, immediately advise the no-fault insurer.

FOR HELP OBTAINING A CLAIM FORM OR FILING IT OUT, OR OTHER QUESTIONS ABOUT BENEFITS FOR YOUR NON-WORK-RELATED INJURY OR ILLNESS, PLEASE CALL (877) 632-4996. A BOARD REPRESENTATIVE WILL HELP.

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DB-2715 (10/22)

PRESCRIBED BY THE CHAIR,
WORKERS' COMPENSATION BOARD
NYS Workers' Compensation Board
Disability Benefits Bureau
P.O. Box 9023, Endicott, NY 13761-9023
WCB NY GOV

New York State Department of Taxation and Finance

Certificate of Authority

Identification number
26-1487299

(Use this number on all returns and correspondence)

VALIDATED
4/16/2013

Dept. of Tax and Finance

MATCO ELECTRIC CORPORATION
SATHIEN TOVEY
3913 GATES RD.
VESTAL NY 13850-2823

is authorized to collect sales and use taxes under Articles 28 and 29 of the New York State Tax Law.

This certificate must be prominently displayed at your place of business. Applicant or other improper use of this certificate will cause it to be revoked. The certificate may not be photocopied or reproduced.

4050309100098 IDCS - 1070335 P000028-01 DYP-17-VL-R (9/10)

ESTADO DE NUEVA YORK
Andrew M. Cuomo, Gobernador

DECLARACION DE DERECHOS
JUNTA DE COMPENSACION OBRERA
Kenneth J. Munnelly, Presidente

A TODO EMPLEADO LESIONADO EN EL TRABAJO O QUE SUFRA DE ENFERMEDAD OCCUPACIONAL: USTED PUEDE TENER DERECHO A BENEFICIOS DE COMPENSACION OBRERA

1. Usted deberá presentar una reclamación de beneficios dentro del término de dos años del día en que fue lesionado, a menos que la lesión sea tan pequeña que no requiera tratamiento médico y que no cause interrupción en su forma de trabajo. Si no solicita dentro del término de dos años, puede perder sus derechos a beneficios. Consiga y entregue una forma de reclamación (Forma C-3, C-3A o VAW-3 para empleados voluntarios de bomberos o voluntarios de ambulancias) a la oficina más cercana de la Junta de Compensación Obrera (direcciones más abajo).
2. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, lo obliga a trabajar a sueldo más bajo o resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo. (Bomberos voluntarios y Trabajadores de Ambulancias Voluntarios pueden ser compensados desde el momento de su lesión).
3. Usted tiene derecho a recibir tratamiento médico relacionado con su lesión y debe notificarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropráctico o psicólogo (se refiere por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrón está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patrones que participan en este programa establecido por ley están obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa si que está acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañía de seguros de su patrón, que se inicia al final de esta forma.
6. No pague a ningún proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrón. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso o la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podrá ser responsable del pago de las facturas.
7. El patrón es responsable de la asistencia y reposición de aquellos implementos médicos que han sido perdidos o no han sido deteriorados como consecuencia del empleo, sin que importe el que el empleado haya o no sufrido lesión. (Ej. miembros, articulaciones, dentadura postiza, escayolas). Usted también tiene derecho a ser reembolsado por medicamentos, mulas, o cualquier otro implemento debidamente necesario por su médico o por transporte u otro gasto necesario para ir al médico o al hospital. (Obligación de recibir gastos justificados).
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado o por representante licenciado si usted así lo desea. Si es representado, no pague al abogado o al representante licenciado. Cuando la Junta decida su caso, los honorarios serán determinados por la Junta y descuentos de sus beneficios.
9. La compensación se paga inmediatamente, sin esperar por la adjudicación del caso, excepto cuando la reclamación es cuestionada. Si la reclamación es cuestionada en base a que la incapacidad no fue causada por un accidente relacionado con su trabajo o por una enfermedad ocupacional o por una lesión en el cumplimiento de su deber como bombero voluntario o como miembro voluntario del cuerpo de ambulancias, usted puede tener derecho a recibir beneficios por trabajador para lesiones fuera del trabajo. Si su reclamación es cuestionada y no está recibiendo beneficios por incapacidad, comuníquese con cualquier oficina de la Junta.
10. Responda a su trabajo tan pronto pueda. La compensación nunca es tan alta como su sueldo. Si necesita ayuda para regresar al trabajo o para recibir asistencia financiera o personal por causa de la lesión sufrida, comuníquese con la oficina más cercana de la Junta y solicite hablar con un trabajador social o con un consejero de rehabilitación.
11. Su patrón no puede solicitar que usted le devuelva de su derecho a compensación, ni puede depositar cantidad alguna de su paga para contribuir al pago de las primas del seguro. Usted no podrá ser despedido ni penalizado por solicitar una reclamación en la Junta.

SI TIENE DIFICULTAD EN CONSEGUIR UN FORMULARIO DE RECLAMACIÓN, O NECESITA AYUDA PARA LLENARLO O TIENE DUDAS SOBRE CUALQUIER SITUACIÓN RELACIONADA CON UNA LESIÓN O ENFERMEDAD COMUNIQUESE CON LA OFICINA MÁS CERCAÑA DE LA JUNTA.

Este resumen es una compilación de los puntos más importantes de sus derechos bajo la ley de compensación obrera. La sección 110 de la ley requiere de su patrón ofrecerle esta información.

INSERT NAME AND ADDRESS OF INSURANCE CARRIER
THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 4614
BUFFALO, NY 14240-4614

KENNETH J. MUNNELLY
PRESIDENTE

NYS Workers' Compensation Board, Centralized Mailing, P.O. Box 5205, Binghamton, NY 13902-5205

C-4305 (9-16)
W31P5116 www.wcb.ny.gov

THIS NOTICE IS WRITTEN IN ENGLISH ON THE REVERSE SIDE.

Paid Family Leave NOTICE OF COMPLIANCE

Paid Family Leave insurance coverage provided by: Cardinal Disability Trust

Covering employees of: Matco Electric Corporation

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

INSURER OR AUTHORIZED NEW YORK SELF-INSURER INFORMATION

Name: Cardinal Disability Trust Telephone: (518) 724-3559

Address: PO Box 1227, Latham, NY 12110

Policy #: DBLCE029 Effective date from: 01/01/2023 to: Until Cancelled

☒ Statutory ☐ Under a plan or agreement

Class(es) of employees covered: All Employees

For more information, visit 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.
PFL-520 (12/12)

RIGHT TO VOTE

Attention All Employees
Time Allowed Employees to Vote on Election Day
N.Y. Election Law Section 3-110

- As a registered voter, you may take off up to 3 hours, without loss of pay, to allow you time to vote.
- You may take time off at the beginning or end of your working shift, as your employer may designate, unless otherwise mutually agreed.
- You must notify your employer not less than 2 days before the day of the election that you will take time off to vote.

Employers: Not less than ten working days before any Election Day, every employer shall post conspicuously in the place of work where it can be seen as employees come or go to their place of work, a notice setting forth the provisions of this law. Such notice shall be kept posted until the close of the polls on Election Day.

Rev 04.12.2019