Renaissance
DENTAL • VISION • LIFE • DISABILITY

Renaissance Life & Health
Insurance Company of New York
PO Box 1596 Indianapolis, IN 46206

NEW YORK

PAID TIME OFF VERIFICATION NYS DBL/PFL

If wages are paid to employee during a period of disability or leave, submit with completed employer's statement

☐ Disability Claim

☐ Paid Family Leave Claim

Employee Name: _____

☐ Sick Time: From: _____ to: _____

☐ Vacation Time: From: _____ to: _____

☐ Personal Time: From: _____ to: _____

☐ PTO (Paid Time Off): From: _____ to: _____

☐ Salary Continuation: From: _____ to: _____

IF REQUESTING REIMBURSEMENT, PLEASE INDICATE ON THE CLAIM FORM.

By: X _____ **Date**: _____
(signature) (mm/dd/yyyy)

Title: _____ **Phone**: _____

Notes:

FOR QUESTIONS: 844-368-6485