CLEAR FORM

FMLA Notice Letter for West Employees

Dear Employee,

You may be eligible for leave under the Family and Medical Leave Act (FMLA) as described in the attachment "Employee Rights and Responsibilities under the Family and Medical Leave Act'', and applicable state laws The enclosed materials describe your rights and obligations under FMLA The company will comply with any state laws and contractual bargaining agreements. In order to be approved for FMLA, you must complete and submit the enclosed *Family and Medical Leave Act (HILA) Medical Certification Form* It is your responsibility to ensure that your completed form is received by our office via fax or mail, within 25 calendar days of your first day of absence or 25 calendar days from the date the absence was reported.

Note that you may apply for leave on an intermittent basis or reduced schedule. Please allow for appropriate mail time. We strongly recommend that you retain a copy of the application and proof of mailing or faxing for your records. Please remember that it is your responsibility to follow-up with your health care provider to ensure the completed form is received by our office Fees charged by health care provider for completion copying or faxing of the FMLA Medical Certification Forms are the responsibility of the employee.

If approved:

- Your leave will be counted against your 12-weeks per calendar year FMLA leave entitlement.
- Your FMLA leave may run concurrent with any periods of approved payments under any applicable plan, policy, program, or collective bargaining agreement.
- Recertification may be required if your leave exceeds the period designated by the health care provider. When applying for intermittent leave for a health condition which is chronic or requires periodic treatments or a reduced leave schedule, please be certain that your health care provider indicates the duration of the leave required on the *Family and Medical Leave Act (FMLA) Medical Certification Form.*
- If you fail to return to work upon the expiration of your FMLA leave and you have not obtained any other type of approved leave the company may treat your failure to return as a voluntary resignation unless your absence has been approved under the provisions of the Sickness and Accident Disability Benefit Plan.

Your FMLA request may be denied and therefore the absence may be subject to the provisions of the established attendance plan and practices in your area if:

- The completed form is not received by our office within 25 calendar days from the first day, of absence or 25 calendar days from the date the absence was reported.
- The information provided by your health care provider regarding your health condition does not establish a serious health condition under FMLA regulations.
- Your absence exceeds your remaining FMLA time.

If your absence is approved under the applicable disability plan within 39-days from the date the absence was reported into AMTS, the absence will also be approved under FMLA. However, you will not have another opportunity to apply for FMLA leave for this absence if your short-term disability is not approved within this 39-day period.

****I AM A CALIFORNIA, UNION REPRESENTED EMPLOYEE, ENTITLED TO CFRA****

California
Fax Cover Sheet

Prudential
P.O. Box 13480
Philadelphia, PA, 91716

Control Number: **44910**

Fax: 877-889-4885

Employee Name: _____

CRIS ID: _____

Last 4 of SSN: _____

Date of Birth: _____

Claim # (If applicable): _____

Work email address: _____

Number of pages including Fax: _____

Date Faxed: _____

PERSONAL AND CONFIDENTAL

****I AM A CALIFORNIA, UNION REPRESENTED EMPLOYEE, ENTITLED TO CFRA****

YOU HAVE 25-DAYS FROM YOUR FIRST DAY OF ABSENCE (FDA) TO SUBMIT THIS FORM

CFRA Processing Form

(This section does not require medical information)

TO BE COMPLETED BY EMPLOYEE

Employee Last Name	*Employee First Name*	*Date of Absence*
Home Address (city, state, zip)	*Phone Number*	*Work Telephone Number*
Supervisor/Absence Administrator Name	*Supervisor/Absence Administrator Email Address*	*Supervisor/Absence Administrator Telephone Number*

Type of Leave *(check one)*

☐ New Request ☐ Extension/Recertification

Reason for Leave *(check one)*

☐ A serious health condition that makes you unable to perform any one of the essential functions of your job.

☐ A serious health condition affecting your family member for which you are needed to provide care. Please check one of the following:

☐ Spouse ☐ *Child ☐ Parent ☐ Registered Domestic Partner

*Is your child over 18-years of age? ☐ Yes ☐ No

☐ The birth of your child, or the placement of a child with you for adoption or foster care for the period beginning _____ through _____.
Please attach proof of birth (document with mother's and/or father's name) or legal documentation of adoption or foster care.

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CERTIFICATION OF HEALTH CARE PROVIDER

***for California Family Rights Act (CFRA) or Family and Medical Leave Act* (FMLA)**

IMPORTANT NOTE: The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. *To comply with CalGINA, we are asking that you not provide any genetic information when responding to this request for medical information.* "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

1. Employee Name: _____

2. Patient's Name (if other than employee): _____

   Is patient the employee's family member (i.e., child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, domestic partner, or designated person)?

   Note: "child" includes a biological, adopted, foster child, a stepchild, a legal ward, a child of the employee's domestic partner, and a person to whom the employee stands in loco parentis. "Parent" includes a biological, foster, or adoptive parent, a parent-in-law, a stepparent, a legal guardian, or other person who stood in loco parentis to the employee when the employee was a child. A biological or legal relationship is not necessary for a person to have stood in loco parentis to the employee as a child. "Designated person" means any individual related by blood or whose association with the employee is the equivalent of a family relationship.

   ◯ Yes ◯ No

3. Date medical condition or need for treatment commenced [NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT CONSENT OF THE PATIENT]:

   _____

4. Probable duration of medical condition or need for treatment: _____

5. Below is a description of what constitutes a "serious health condition" under both the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). Does the patient's condition qualify as a serious health condition? ◯ Yes ◯ No

6. If the certification is for the serious health condition of the employee, please answer the following:

   Is the employee able to perform work of any kind? (If "No," skip next question) ◯ Yes ◯ No

   Is employee unable to perform any one or more of the essential functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.) ◯ Yes ◯ No

7. If the certification is for the care of the employee's family member, please answer the following:

   Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation? ◯ Yes ◯ No

   After review of the employee's signed statement (see item 10 below), does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member.) ◯ Yes ◯ No

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8. Estimate the period of time care is needed or during which the employee's presence would be beneficial:

_____

9. Please answer the following questions only if the employee is asking for intermittent leave or a reduced work schedule:

Intermittent Leave: Is it medically necessary for the employee to be off work on an intermittent basis due to the serious health condition of the employee or family member? ◯ Yes ◯ No

If yes, please indicate the estimated frequency of the employee's need for intermittent leave due to the serious health condition, and the duration of such leaves (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: ____ times per ____week(s) ____month(s) *Duration*: ____hours or ____day(s) per episode

Reduced Schedule Leave: Is it medically necessary for the employee to work less than the employee's normal work schedule due to the serious health condition of the employee or family member? ◯ Yes ◯ No

If yes, please indicate the part-time or reduced work schedule the employee needs:

Frequency: ____hour(s) per day; ____days per week, from _____ through _____.

Time Off for Medical Appointments or Treatment: Is it medically necessary for the employee to take time off work for doctor's visits or medical treatment, either by the health care practitioner or another provider of health services? ◯ Yes ◯ No

If yes, please indicate the estimated frequency of the employee's need for leave for doctor's visits or medical treatment, and the time required for each appointment, including any recovery period:

Frequency: ____ times per ____ week(s) ____ month(s) *Duration*: ____ hours or ____ day(s) per apt./treatment

ITEM 10 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE.
****TO BE PROVIDED TO THE HEALTH CARE PROVIDER UNDER SEPARATE COVER.

10. When family care leave is needed to care for a seriously-ill family member, the employee shall state the care the employee will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule:

_____

_____

_____

Printed Name of Health Care Provider: _____

_____

SIGNATURE OF HEALTH CARE PROVIDER DATE

_____

SIGNATURE OF EMPLOYEE **DATE**

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SERIOUS HEALTH CONDITION

"Serious health condition" means an illness, injury (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, domestic partner, or designated person of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse. A serious health condition may involve one or more of the following:

HOSPITAL CARE

Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care. A person is considered an "inpatient" when a heath care facility formally admits the person to the facility with the expectation that the person will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or transferred to another facility and does not actually remain overnight.

ABSENCE PLUS TREATMENT

(a) A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

1. Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
2. Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

PREGNANCY

[NOTE: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA]

Any period of incapacity due to pregnancy or for prenatal care.

CHRONIC CONDITIONS REQUIRING TREATMENT

A chronic condition, which:

1. Requires periodic visits for treatment by a health care provider, or by a nurse of physician's assistant under direct supervision of a health care provider;
2. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
3. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

PERMANENT/LONG-TERM CONDITIONS REQUIRING SUPERVISION

A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

MULTIPLE TREATMENTS (NON-CHRONIC CONDITIONS)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).

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AUTHORIZATION TO RELEASE AND DISCLOSE HEALTH INFORMATION

Grievance # : _____

Date Sent to Grievant: _____

This authorization to receive information is being requested of you to comply with the terms of the California Confidentiality of Medical Information Act.

AUTHORIZATION

I, _____, herby authorize and request the release and disclosure of all my medical health information (including my medical history diagnostic test results, physical examination findings, treatment plans and any other information related to my mental or physical condition) to the Communications Workers of America for the purpose of processing the grievance through its contractual stages.

- This authorization is effective immediately and shall automatically expire after all activities in connection with the above stated grievance have been fulfilled.

- I understand I have the right to revoke this authorization at any time by providing written notice. I further understand that the revocation will not apply to information that has already been released pursuant to this authorization.

- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I further understand that if I refuse to sign this authorization, CWA may not receive necessary medical information.

- I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for re-disclosure by the recipient and the information may not be protected by federal confidentiality rules.

- I understand upon request, I have a right to receive a copy of the authorization form after it has been signed.

Print Name: _____

Signature: _____ Date**:** _____

Copy Requested: **YES** ☐ **NO** ☐

Copy Received: **YES** ☐ **NO** ☐

Prudential

Group Disability Insurance

The Prudential Insurance Company of America
Disability Management Services
P.O. Box 13480, Philadelphia, PA 19176
Tel: 800-842-1718 Fax: 877-889-4885
www.prudential.com/forphysicians

Attending Physician Statement

1 Employee Information

Employer's Name

Control Number (required)

Employee First Name

MI

Last Name

Claim Number

Social Security Number

Date of Birth (MM DD YYYY)

Gender ☐ Male ☐ Female

I hereby authorize the release of information requested on this form by the below named physician for the purpose of claim processing.

Employee Signature X

Date (MM DD YYYY)

The Employee is responsible for the completion of this form without expense to Prudential.

2 To Be Completed by Attending Physician

Clinical Diagnosis **ICD Code is Required**

Primary:

Secondary:

Secondary:

Pregnancy EDC (MM DD YYYY)

Actual Delivery Date (MM DD YYYY)

Date when significant loss of function occurred: (MM DD YYYY)

Do you feel the claimant is competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

Return to Work Target Date (MM DD YYYY)

☐ Full-Time ☐ Part-Time ☐ With Limitations (functions lost)

Please describe Return to Work Plan and provide any corresponding Limitations:

DIAGNOSIS IS NOT REQUIRED UNDER CFRA

Please describe any Medical Obstacles to Return to Work:

Nature of Medical Impairment (i.e., loss of function):

Are there any Non-Medical Factors which have a significant impact on Functional Abilities (i.e., interpersonal, financial, family)?

Check all that apply to this disability:

Work Related	Accident	Sickness	Maternity	Motor Vehicle Accident	If MVA, in what State did it occur?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Other Treating Physicians or Consultants:

First Name

Last Name

Specialty

Telephone Number

Prudential

Employee First Name | MI | Last Name

Claim Number | Date of Birth (MM DD YYYY) | Employee's Social Security Number

2 Attending Physician Information (Cont'd)

Other Treating Physicians or Consultants

First Name | Last Name

Specialty | Telephone Number

Date of Surgical Procedure (MM DD YYYY)

Relevant tests and surgical procedure (s) performed (please be specific):

Current Medications, Treatment, and Prognosis:

First Visit (MM DD YYYY) | Last Visit (MM DD YYYY) | Next Visit (MM DD YYYY) | Was Claimant hospital confined? ☐ Yes ☐ No

If yes, please provide name and address of hospital:

From (MM DD YYYY)

To (MM DD YYYY)

3 Physician Information

First Name | MI | Last Name

Primary Telephone Number | Fax Number

Office Address | Suite

City | State | ZIP Code

Specialty

4 Fraud Notice

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

I have read and understand the terms and requirements of the fraud warning and I certify the above statements are true.

Physician Signature X

Date (MM DD YYYY)