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 (FMLA) 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/ 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****

Revised 12/18/2012

California
Fax Cover Sheet

Prudential
P.O. Box 13480
Philadelphia, PA, 19176

Control Number: 44910

Fax: 877-889-4885

Employee Name: _____

CRIS ID: _____

Last 4 of SSN: _____

Date of Birth: _____

Claim # (If you have one): _____

Work email address (sample: john.smith@ftr.com)**:** _____

Number of pages including Fax: _____

Date Faxed: _____

PERSONAL AND CONFIDENTIAL

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See attached CFRA Forms

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)

Diagnosis is NOT required under CFRA

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

Please describe any Medical Obstacles to Return to Work:

CFRA – Not Required

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

CFRA – Not Required

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

Not Required

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

See attached CFRA Forms

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):

CFRA – Not Required

Current Medications, Treatment, and Prognosis:

CFRA – Not Required

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)

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

Section A - CFRA Processing Form

(This section does not require medical information.)

TO BE COMPLETED BY EMPLOYEE

Employee Last Name	Employee First Name	Date Absent
Home Address (city, state, zip)	Home Telephone 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 circle 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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Section B *TO BE COMPLETED BY HCP*

FAIR EMPLOYMENT & HOUSING COMMISSION
CERTIFICATION OF HEALTH CARE PROVIDER
(California Family Rights Act of 1993 (CFRA))

1. Employee's Name:

_____

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

_____

3. Date medical condition or need for treatment commenced:

[NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT.]

_____

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

_____

5. The attached sheet describes what is meant by 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 under any of the categories described? If so, please check the appropriate category.

(1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____

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

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

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

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

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

_____

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

Yes	No	
☐	☐	Is it medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal work schedule in order to deal with the serious health condition of the employee or family member?
☐	☐	If the answer to 9 is yes, please indicate the estimated number of doctor's visits and/or estimated duration of medical treatment, either by the health care practitioner or another provider of health services, upon referral from the health care provider.

_____

_____

_____

_____

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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 he or she 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:

_____

_____

_____

_____

11. Signature of Health Care Provider:

_____ _____
Date

12. Signature of Employee:

X _____ _____

*Required Date

Please provide any out of work doctors notes (if applicable).
No diagnosis required

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A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital Care
   Impatient care (i.e., an overnight stay) 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.

2. 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.

3. Pregnancy [Note: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not CFRA.]
   Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Condition Requiring Treatment
   A chronic condition which:

   (1) Requires periodic visits for treatment by a health care provider, or by a nurse or 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.

5. Permanent/Long-Term Condition 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.

6. Multiple Treatments (Non-Chronic Conditions)
   Any period of absence to receive multiple treatments (including any period of recovery there from) 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), kidney disease (dialysis).

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