Instructions for Family Care Leave (FCL) of Absence Application

Please read the instructions and the Conditions for Leave on the back of this application before completing. Your supervisor should review the Conditions for Leave with you before you sign this application. If you have any questions or need additional information, call 1-855-814-9344.

Your family member's treating Health Care Provider (HCP) must complete the attached Health Care Provider's Report and this must be submitted with this completed application at least 4 weeks prior to the start of the leave, but no later than 25 calendar days from the date the leave begins. The request for Family Care Leave may be denied if the application is submitted without a completed Health Care Provider's Report, if the application and Health Care Provider's Report is received after 25 calendar days from the date the leave began or the application is incomplete. If you have any questions, please contact **FMLA/Absence Team at: 1-855-814-9344**.

If you exceed the approved frequency or duration of the leave, you will be required to submit a FCL Recertification Form within 25 calendar days from date the frequency or duration was exceeded. The family member's treating HCP must specifically designate coverage of any time (minutes, hours, days) that exceeds the current certification. Failure to submit a recertification form within 25 calendar days may result in a denial and you may be subject to disciplinary action.

If your request for leave is denied, you may request an administrative review of the denial. You will need to provide a copy of the completed certification form along with supporting documentation. Supporting documentation includes, but is not limited to, a copy of a fax transmittal providing that your form was faxed timely, documentation from your family member's treating HCP regarding a process delay, or documentation of any extenuating circumstances that prevented you from returning the form timely.

PART 1: Employee Information: Please provide all the required information.

PART 2: Request for Leave: Please check all that apply. If you are requesting a new FCL or an extension to a previously approved leave, you must provide the requested period of leave. The maximum period of FCL is 24 months within a ten-year period. If you exhaust 24 months of leave, you may be eligible for Family Medical Leave Act (FMLA).

PART 3: Acknowledgements: Both you and your supervisor must sign this section after your supervisor has reviewed the Conditions of Leave with you.

PART 4: For Absence Management Use Only: Do not write anything in this section.

After completing the application, please make a copy and keep it for your records. Mail or fax the completed application to the Absence Management Center for review.

Please submit completed application to:

Verizon Wireline Employees	**LOA Administrator** **500 Summit Lake Drive, 3rd Floor** **Valhalla, NY 10595** **Fax: 1-877-660-2660** **If you have any questions, please contact 1-855-814-9344 or send an e-mail to verizonleavemanagement@metlife.com**

G2518-FCL 2015

Application for Family Care Leave (Verizon – North Associate Employees)

Part 1: Employee Information

Employee's Name: _____ _____ _____ _____

Last	First	Middle Initial	EMPLID

Name of ill Family Member:	_____	Relationship to Employee	_____
Employee's Home Address:	_____	Employee's Home Telephone #:	_____
	_____	Employee's Work Telephone #:	_____
Net Credited Service Date:	_____	Company Department:	_____
Job Title:	_____	Department Contact:	_____
Address during Leave:	_____	Department Address:	_____
	_____		_____
Telephone # during leave:	_____	Department Contact Telephone #	_____

Part 2: Request for Leave (Please check all that apply)

☐ I request a Family Care Leave, to begin on ____/____/____ and to continue through ____/____/____

☐ I request FCL to be taken on an intermittent or reduced work schedule as follows:

☐ I request an extension of a Family Care Leave to begin on ____/____/____ and to continue through ____/____/____

Part 3: Acknowledgements

I hereby apply for a Family Care Leave of Absence, in accordance with the Company's leave program and subject to the conditions on the back of this form, including that this leave may be counted against my 12 weeks of FMLA annual entitlement. I have read and understand these conditions. My family member's treating Health Care Provider (HCP) must complete the attached Health Care Provider's Report describing the illness, the anticipated length of the illness and the length of time recommended for Family Care Leave. This must be submitted with this completed application at least 4 weeks prior to the start of the leave, but no later than 25 calendar days from the date the leave commences. **Please Read Conditions Listed on the Reverse Side before Signing.**

Employee Signature: _____ Date: _____

The above employee has applied for a Family Care Leave Absence. I have reviewed the Verizon Leave Program and the conditions of the leave, as explained on the back of this form, with the employee and confirmed the length of any previous Family Care Leave taken.

The employee's department is responsible to track the frequency and duration of the employee's leave. If employee exceeds the frequency or duration, the employee's department can provide the employee with a FCL Recertification Form Health Care Provider's Report or the employee can access the form through the eWeb @ Digital Workplace in order to recertify. Completed FCL Recertification form must be submitted to the Absence Management Center within 25 calendar days from the date the frequency or duration was exceeded.

Supervisor's Signature: _____ Date: __/__/__ Total Period of FCL Previously Taken: _____

District Level Signature: _____ Date: ____/____/____

Part 4: Absence Management Center Use Only

FCL Status: ☐ Approved ☐ Denied

☐ Full Time ☐ Intermittent ☐ Reduced Work Schedule

Certification Start Date ____/____/____ Certification End Date ____/____/____

Frequency _____ Duration _____

Signature: _____ Date: _____/_____/_____

Health Care Provider's Report for Family Care Leave of Absence (G2518-FCL 2015)

SECTION A: (To be completed by the Employee)

In order for your additional time off to be considered for FCL, it must be specifically designated as FCL qualifying by the treating Health Care Provider (HCP). Once the treating HCP completes, this FCL Recertification form must be returned to the VERIZON Absence Administration Center, either by fax: 914-741-1614 or mail: LOA Coordinator, 500 Summit Lake Drive, Valhalla, NY 10595. Please be advised that knowingly providing false or inaccurate information in this certification is a violation of the Company's Code of Business Conduct.

Employee's Name	EMPLID	NCSD ___/___/___
Patient's Name	Relationship to employee	Patient's Date of Birth ___/___/___

Does the patient require assistance for:

Basic Medical or Personal Needs	□ Yes □ No	Transportation	□ Yes □ No
Psychological Comfort	□ Yes □ No	Safety	□ Yes □ No

I hereby certify that the information provided on this certification form is true and accurate.

Signature of Employee: _____ **Date** ___/___/___

SECTION B: (To be completed by the Employee's Family Member)

By placing my signature below, I authorize my health care provider to **(a)** complete this form and **(b)** clarify any information provided on the form that is incomplete or unclear, either verbally or in writing. I hereby certify that the information provided on this certification form is true and accurate.

Signature of Family Member: _____ **Date** ___/___/___

SECTION C: (To be completed by the Family Member's Treating Health Care Provider)

Please note: Incomplete forms will be returned for completion and may result in denial of leave.

1. Describe the medical facts, including a brief statement as to how the medical facts meet the criteria for a Serious Illness. A Serious Illness is defined as an illness, injury, impairment or physical or mental condition that either involves inpatient care in a medical facility or continuing treatment by a health care provider. The term serious illness does not apply to short term conditions for which treatment and recovery are very brief.
   _____
   _____
2. Prescribed Treatment or Therapy _____
3. Length of time your patient has/will have this condition: From ____/____/____ Through ____/____/____
4. Please provide the following information - check all that apply and complete the corresponding information:
   - □ **Full Time Leave** - Taken in consecutive, full day increments
     Dates employee will need to be absent from work: From ____/____/____ Through ____/____/____
   - □ **Follow-up appointment(s) to Full Time Leave –** list dates employee will need to be absent from work:
     _____
     Duration of the follow-up appointment - employee's time away from work: # _____ (circle one: minutes/hours)
   - □ **Intermittent Leave** – Taken periodically over an extended period of time, with a likely frequency of: #____times per (circle one: week, month, year) probable duration of: #_____ per (circle one: minutes, hours, days, weeks) period of: # _____ (circle one: weeks, months)

SECTION D: (To be completed by the Family Member's Treating Health Care Provider

I certify that the above information is true and correct:

Treating Health Care Provider's Printed Name	Signature	Date

Type of Practice	Address	Phone #	Fax #

VERIZON
ABSENCE ADMINISTRATION CENTER
500 Summit Lake Drive
3 rd Floor
Valhalla, NY 10595

LEAVE OF ABSENCE

Fax Cover Sheet

Name: _____

EMPLID: _____

First Day of Absence: _____

Date: _____

Fax #: 1-877-660-2660

From: _____

Pages including cover sheet: _____

CONFIDENTIAL AND PRIVATE

Conditions for Leave

Please read these Conditions for Leave before you complete your application.

The Family and Medical Leave Act of 1993 (FMLA '93) Under FMLA '93, employer's must provide up to 12 weeks of unpaid leave in a 12-month period to administratively eligible employees for:

- Care of employee's child after birth or after placement of a child with the employee for adoption or foster care.
- Care of employee's spouse, son, daughter or parent, who has a serious health condition, or
- Employee's own serious health condition.

You may use any paid leave you're entitled to, such as vacation, instead of taking an unpaid leave of absence.

Recertification If you exceed the approved frequency or duration of the leave, you will be required to submit a FCL Recertification Form/Health Care Provider's Report within 25 calendar days from date the frequency or duration was exceeded. The family member's treating HCP must specifically designate coverage of any time (minutes, hours, days) that exceeds the current certification. Failure to submit a new Health Care Provider's Report within 25 calendar days may result in a denial and you may be subject to disciplinary action.

Administrative Review If your request for leave is denied, you may request an administrative review of the denial. You will need to provide a copy of the completed certification form along with supporting documentation. Supporting documentation includes, but is not limited to, a copy of a fax transmittal providing that your form was faxed timely, documentation from your family member's treating HCP regarding a process delay, or documentation of any extenuating circumstances that prevented you from returning the form timely.

Salary Continuation Family Care Leave is an unpaid leave of absence.

Health Care Coverage If you are an associate employee, your coverage continues for your entire leave on the same basis as when you were an active employee. During your leave, Verizon will pay the same amount it normally does for your coverage. If you contribute to the cost of your health care benefits, you must continue making contributions. You will be billed monthly. If you receive a benefit credit, you will receive a monthly check for this credit. If you do not continue coverage while you are on leave, coverage will be reinstated automatically on the first day of the following month after you return to active employment.

Group Life Insurance Your Basic Group Life Insurance and Accidental Death and Dismemberment Insurance continue for the entire leave. Any Supplementary Life Insurance and Dependent Life Insurance you have continue until the end of the calendar month in which your leave begins. You may continue these coverages during your entire leave by paying the premiums. You may also reduce the amount of your Supplementary Life Insurance and Dependent Life Insurance coverages or stop your coverages while you are on leave. If you reduce or stop your coverages, they will be reinstated to the level you had before your leave began if you submit a Statement of Health within 31 days after returning to active employment and it is approved by the insurance company. If you fail to submit a Statement of Health, or if you submit one and it is not approved, your coverages won't be fully reinstated. Associate employees may apply to enroll for or increase the amount of Supplementary Life Insurance and Dependent Life Insurance any time after returning to work. You must submit a Statement of Health when you apply to increase or enroll for Supplementary and Dependent Life Insurance. Your insurance will become effective on the day the insurance company approves the Statement of Health.

Service Credit You will receive service credit for the 24 months of approved leave over a ten-year period, even if you do not return to work at the end of your leave period.

Retirement Benefits Your right, if any, to receive a retirement benefit continues for the entire leave.

Savings Plan Participation If you participate in one of the Verizon Savings Plans, all allotments are suspended during the entire unpaid leave. Allotments will resume automatically when you return to active employment. You can make allotments/future investment changes while on leave to take effect when pay resumes. You can also transfer past balances and take advantages of the plan's withdrawal provisions. If you have an outstanding loan, you will receive a coupon book to use to make payments during your leave.

Dependent Care Spending Account Participation If you participate in the Dependent Care Spending Account Plan, no deposits will be made to your account while you are on leave. Deposits will resume automatically if you return to work during the same calendar year, and you may change the amount of our deposits within 31 days of your return if you have a qualifying life-style change. If you return to work in a different calendar year, deposits will not resume automatically; you must re-enroll within 31 days of your returning to work.

Health Care Spending Account Participation If you participate in the Health Care Spending Account Plan, no deposits will be made to your account while you are on leave. However, you can choose to continue to make deposits on an after-tax basis during your leave through COBRA. If you do, your payroll deposits will be reinstated when you return to work. If you do not continue to participate through COBRA and you return to work in the same calendar year, you will not be able to re-enroll in the plan until the next open enrollment period. If you return to work in the next calendar year, you may re-enroll in the plan within 31 days of returning to work.

Sickness Disability Benefits If you become disabled by sickness or injury during your leave, you may be eligible to receive Verizon sickness disability benefits. Contact your Department for more information.

Death Benefits If you are an associate employee hired before January 1, 1987, your mandatory beneficiaries may be eligible to receive a Sickness Death Benefit if you die during your leave.

Vacation Please discuss your vacation options and the vacation carry over rules with your supervisor before your leave begins.

Holidays You are not entitled to a day off in lieu of a holiday which occurs while you're on leave.

Guaranteed Reinstatement You are guaranteed reinstatement to your former job or one of similar pay and status if you return to work as scheduled. You can return to work earlier than scheduled during the first 12 weeks of approved leave, if this time is approved for FMLA. After the first 12 weeks, reinstatement may be deferred until a position is available, but no later than the date originally agreed upon for your return. If you are able to return to work earlier than scheduled because your family member no longer needs your care, you must notify your supervisor immediately. If your job or one of similar pay and status is available, you must return to work. If you do not, you lose your right to reemployment.

Paid Employment While on leave, you may not accept paid employment during your normal work hours.