Application for Family & Medical Leave (FMLA) Or Leave of Absence

EMPLOYEE SECTION (all fields are required)

Employee Contact Information

Name _____

Employee ID # _____

Home Address _____

City _____ State_____ Zip Code _____

Personal Phone # _____

Personal Email _____

Please contact me about my leave via (select one)

☐ Postal mail & phone

☐ Personal email only (email *must* be provided above)

☐ Postal mail & personal email (email *must* be provided above)

If no personal email address is provided, the default will be postal mail & phone

Emergency Contact Information

Contact Name _____

Relationship _____

Personal Phone # _____

Personal Email _____

Reason for Leave (select one per application)

☐ Employee's Own Condition

☐ Family Member's Condition

- Family Member's relationship to you _____

- Family Member's date of birth *(MM/DD/YYYY)* _____

☐ Pregnancy, Maternity, Related Conditions (select one)

☐ Routine | ☐ Complications

- Estimated Due Date *(MM/DD/YYYY)* _____

☐ Parental Bonding (select one)

☐ Biological Child | ☐ Adoption | ☐ Foster

- Due Date/Initial Date of Placement *(MM/DD/YYYY)* _____

☐ Qualifying Exigency (military family leave)

- Service member's relationship to you _____

☐ Care for an Injured Service Member (select one)

☐ Recent Veteran | ☐ Current Service Member

- Service member's relationship to you _____

☐ Other (explain) _____

Leave Frequency & Dates of Leave (select all that apply)

☐ Continuous Leave – *Completely out of work on leave of absence*

Start Date *(MM/DD/YYYY)* _____

End Date *(MM/DD/YYYY)* _____

☐ Intermittent Leave – *Periodic treatment/appointments or flare-ups*

Start Date *(MM/DD/YYYY)* _____

End Date *(MM/DD/YYYY)* _____

☐ Reduced Schedule Leave – *Regularly scheduled absences or unable to work more than a set number of hours per day*

Start Date *(MM/DD/YYYY)* _____ End Date *(MM/DD/YYYY)* _____

I understand that in order to continue medical, dental, and vision benefits during FMLA leave when in an unpaid status, I must pay the monthly health care contribution rate required of or paid by active employees. I understand that health care contributions are due on the 1st of each month and failure to pay the required amounts will result in termination of my benefits.

Further, I understand that to keep my Long-Term Disability, Optional Term Life Insurance or Universal Life Insurance in force, I must contact MetLife, Prudential and/or Bankers Life and Casualty, to make payment arrangements for the time I am on unpaid leave. If I do not meet the eligibility requirements to be placed on FMLA, or if my reason for leave is not covered under the FMLA, and my approved continuous absence is unpaid, I will pay the full monthly cost of coverage under the direct pay provisions of my plan and failure to pay required amounts will result in termination of my benefits. See www.cityofchicago.org/benefits for information regarding direct pay rates.

I acknowledge the City of Chicago's right to recover the cost paid by the City to maintain my coverage in group health benefits (medical, dental, and vision) during any period of unpaid leave, should I fail to pay the required contribution.

If I fail to pay the required contribution amount, I understand that I could be billed for the full undiscounted cost of any claims paid on my (or my dependents') behalf after loss of eligibility. When I return to work after an approved leave (e.g., medical, FMLA, personal) I am responsible for calling the Benefits Service Center to reinstate coverage if coverage was discontinued during the leave or to continue coverage after the leave ends. The call to the Benefits Service Center must be made within 30 days after my return-to-work date and not before my return to work.

I also acknowledge that this is not a full representation of the Plan provisions and that I am responsible for ensuring full compliance with the City's Health Care Plans (and Amendments) and the City's Pre-Tax Contribution Plan which are available to me at www.cityofchicago.org/benefits.

Employee Signature	**Employee Work Phone**	**Date** (*MM/DD/YYYY*)

The department shall retain the completed original form in the employee's confidential medical file and provide a copy to the employee.

HUMAN RESOURCES LIAISON SECTION (do not leave any blanks)

Date employee notified department of the need for leave *(MM/DD/YYYY)* _____

Last day worked *(MM/DD/YYYY)* _____
Attach copy of Individual Time Record for 12 months immediately prior to leave start date

Employee meets 12+ months of employment with City in the last 7 years? ☐ Yes | ☐ No

Number of hours worked in 12-months immediately prior to leave start date _____
Do not count holidays, benefit time, or other leave time used except for USERRA-covered military leave as applicable

Meets FMLA requirements? ☐ Yes | ☐ No

Notified by department on date *(MM/DD/YYYY)* _____

Paid time to be used on leave _____

Date when no longer in paid status *(MM/DD/YYYY)* _____

Type of leave ☐ FMLA | ☐ Benefit Time | ☐ Personal Disability Leave | ☐ Personal Business Leave

☐ Employee is/will be undergoing the reasonable accommodation process to request a non-FMLA intermittent or reduced schedule leave

Human Resources Liaison Name (print)	**Human Resources Liaison Signature**	**Date** *(MM/DD/YYYY)*
Human Resources Liaison Work Phone	**Human Resources Liaison Work Email**	

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