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Instructions for Family Care Leave (FCL) of Absence Application

New York and New England Bargained for Employees

Please read the Instructions, the Application and the Conditions for Leave completely before filling out the Application. 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 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 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 application and Health Care Provider's Report along with supporting documentation. Supporting documentation includes, but is not limited to, a copy of a fax transmittal providing that your application and Health Care Provider's Report 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 application and Health Care Provider's Report timely.

If you exceed the approved frequency or duration of the leave, you will be required to submit an 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 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.

Part 1: Employee Information Please provide all 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 minimum period of FCL is 3 calendar days.** 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). Leaves over 30 calendar days must be entered into Manager's Self Service (MSS) by the employee's supervisor. If after submitting the leave request, the leave start date needs to be changed, a written statement signed by the employee and supervisor should be faxed to the Leave of Absence Team at (877) 660-2660.

Part 3: Acknowledgements After your supervisor has reviewed the Conditions for Leave with you; you, your supervisor and Director must sign this section.

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

Please submit completed application to:

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@metlifeservice.com

Application for Family Care Leave
(New York and New England Bargained for Employees)

G2518 - FCL
2016

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Part 1: Employee Information	
Employee Name:	
Employee's EMPLID:	Employee's NCSD:
Name of ill Family Member:	
Relationship to Employee:	Family Member's Date of Birth:
Employee's Address during Leave:	Employee's Telephone # during Leave:
Department Contact:	Department Contact Telephone #
Supervisor's Name:	Director's Name:

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

☐ Full Time Leave, to begin on __/__/____ and to continue through __/__/____

☐ Intermittent Leave, to begin on __/__/____ and to continue through __/__/____

Frequency _____ Duration _____

Part 3: Acknowledgements

I hereby apply for a Family Care Leave of Absence, in accordance with the Company's leave policy and subject to the conditions contained with this application, 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 no later than 25 calendar days from the date the leave commences. Please Read Conditions for Leave before Signing.

Employee Signature:	Date:

The above employee has applied for a Family Care Leave Absence. I have reviewed the Verizon Leave Policy and the conditions of the leave, contained with this application, 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 (G2518-REC) or the employee can access the form through the eWeb in order to recertify. Completed FCL Recertification form must be submitted to the Leave of Absence Team within 25 calendar days from the date the frequency or duration was exceeded.

Total Period of FCL Previously Taken:

Supervisor Signature:	Date:
Director Signature:	Date:

Health Care Provider's Report for Family Care Leave of Absence

G2518- FCL 2016

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Section A: (To be completed by the Employee)

In order for your 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 the Health Care Provider Report, it must be returned with the application to the Verizon Leave of Absence Team, either by fax: 1-877-660-2660 or mail: LOA Administrator, 500 Summit Lake Drive, 3rd Floor 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 Name:	
Employee's EMPLID:	Employee's NCSD:
Name of ill Family Member:	
Relationship to Employee:	Family Member'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 Health Care Provider Report is true and accurate.

Employee Signature: _____ 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 Health Care Provider Report and (b) clarify any information provided on the Health Care Provider's Report that is incomplete or unclear, either verbally or in writing. I hereby certify that the information provided on this Health Care Provider Report is true and accurate.

Family Member Signature: _____ Date: __/__/___

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

Please note: An incomplete Health Care Provider Report 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 __/__/__

☐ 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: 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:

Health Care Provider's Printed Name: _____ Type of Practice: _____

Address: _____ Phone # _____

Health Care Provider's Signature: _____ Date: __/__/___

VERIZON
Leave of Absence Team
500 Summit Lake Drive
3rd Floor
Valhalla, NY 10595

Family Care Leave
Fax Cover Sheet

Name: _____

EMPLID: _____

First Day of Leave: _____

Date: _____

Fax #: 1-877-660-2660

From: _____

Pages including cover sheet: _____

CONFIDENTIAL AND PRIVATE

Conditions for Leave

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

Health Care Coverage Your Medical, dental and vision care coverages will continue throughout the employee's leave. Verizon will contribute the amount it normally does for the employee's coverage as if the employee was actively employed. If the employee contributes to the cost of his/her health care benefits, he/she must continue making those contributions during the leave. The employee will be direct billed monthly to the address the company has on record. If the employee fails to pay their contributions the benefits will be cancelled and Verizon will seek reimbursement of any unpaid amounts.

Insurance Benefits Basic Life and Accidental Death and Dismemberment Insurance coverages will automatically continue throughout an employee's leave. Employees who want to continue their Long Term Care and/or Home and Auto insurance must contact the vendor directly.

Supplemental and Dependent Life Insurance Coverages continue until the end of the calendar month in which the leave begins. The employee may continue these coverages during his/her leave by paying the applicable premiums. The employee may also reduce the amount of Supplemental Life Insurance and Dependent Life Insurance coverages or stop the coverages while on leave. If the employee reduces or stops the coverages, the employee must reapply and submit a Statement of Health within 31 days after returning to active employment and it must be approved by the insurance company. If the employee does not submit a Statement of Health, or the employee submits one and it is not approved, coverage will not be fully reinstated. The employee may apply to enroll in or increase coverages any time after returning to work. The employee must submit a Statement of Health when he/she applies to increase or enroll for Supplemental and Dependent Life Insurance. The insurance will be effective on the day the Statement of Health is approved by the insurance company.

Credit for Service While on Leave Service credit is used to determine your seniority and the amount of the employee's retirement benefits. After an associate employee returns to work, he/she will receive service credit for up to the maximum leave duration which is 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 Savings Plan contributions and associated matching contributions will end with the employee's last paycheck prior to the unpaid leave. For employees who become disabled during the leave and qualify to receive Verizon sickness benefits, Savings Plan allotments will be deducted from disability benefits when they are paid. These contributions will be the same as those deducted from the employee's pay - unless the employee increases, reduces or cancels them.

Employees can make contribution/changes while on leave to take effect when pay resumes. In addition, employees can make investment election changes while on leave. Employees can also transfer past balances and take advantage of the plans withdrawal provisions. Employees who have an outstanding loan when the leave begins will receive a coupon book to use to make payments during the leave. Employees will not be able to make up for contributions missed during the leave period.

Payroll Deductions Payroll deductions will end with the employee's last paycheck prior to the leave. Bank loan payments, charitable and political contributions, and other payroll deductions are cancelled for the duration of the employee's leave. Upon return from leave, Medical contributions, Union and Pioneer dues will start automatically, but employees must re-authorize all other deductions before they will begin again.

Dependent Care Spending Account Participation Dependent Day Care Account contributions will end with the employee's last paycheck prior to the leave. If the employee returns to work in a different calendar year, the employee must re-enroll within 31 days of returning to work. While on leave, employees can continue to be reimbursed for eligible expenses incurred prior to the leave as long as all claims are submitted by May 31 of the following calendar year.

Health Care Spending Account Participation
Contributions will end with the last paycheck prior to the beginning of the FCL. While on leave employees can be reimbursed for health care expenses incurred before the leave began. If the employee chooses to continue to participate in the Health Care Account plan through COBRA, the employee can continue deposits on an after-tax basis and be reimbursed for eligible health care expenses incurred during the leave as long as the employee submits all claims by May 31 of the following calendar year.

If the employee continues participation through Cobra while on leave, the payroll deposits will be automatically reinstated when he/she returns to work. If the employee does not continue participation through Cobra and returns to work during the same calendar year, the employee must wait until the next open enrollment period to re-enroll. If the employee returns to work during the next calendar year, the employee may reenroll within 31 days of returning to work.

Health Reimbursement Account (HRA)
Employees who want to continue to use their Health Reimbursement Account while on leave may continue to participate through COBRA.

Concession Telephone Service
Concession Telephone Service will continue on the same basis as before the leave began.

Short and long Term Disability Benefits If an associate employee becomes disabled he/she may apply for benefits under the Verizon Sickness and Accident Disability Benefit Plan for New York Associates or the Verizon Sickness and Accident Disability Plan for New England Associates (the "Plan"). The employee should notify his/her supervisor t he/she is disabled. The leave will be cancelled, the employee will be returned to the payroll and benefits may be paid if the employee meets the eligibility requirements and it is determined that the employee is disabled according to the Plan provisions. **Note:** The leave must be canceled before any review occurs to determine eligibility for benefit payments.

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 and Holidays Employees cannot take vacation once the leave begins. If an employee returns to work during the calendar year in which he/she begins the leave, the employee will be eligible for vacation for that year. Employees will not lose vacation to which they are entitled except in cases where they return after the carryover deadline has passed. Employees will not be eligible for pay or compensatory time off for holidays, excused work days which occur while he/she are on a leave of absence. Further questions regarding vacation should be directed to the employee's supervisor**.**

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.