

Family and Medical Leave (FMLA), California Family Rights Act Leave (CFRA) Pregnancy Disability Leave (PDL), and any other extended leave

# Leave of Absence Application

**CLEAR FORM** 

## **Instructions:**

- 1. Print or type clearly. Contact your department timekeeper for assistancecompleting these forms.
- **2.** For Military Leave requests, attach orders from Military Authority.
- 3. The applicant or a department designee will forward the completed application to the

department director (or designee) for signature.  City Manager signature is required for Administrative Leave only.  4. Send completed requests to: HRBenefits@sanjoseca.gov OR Fax: (408) 999-0862  5. Please reference Section 4 of the <a href="City Policy Manual">City Policy Manual</a> . (CSJ Intranet > Home > City Resources > Policies & Procedures > City Policy Manual)							
Employee Information:							
Name:	Employee ID:						
Department:	Personal E-mail:						
Home Phone:	Personal Cell Phone:						
<b>Department Contacts:</b>							
Timekeeper Name:	Timekeeper Phone: ————						
Supervisor Name:	Supervisor Phone:						
Leave Dates:							
nitial Leave Request from through (and including)							
Extension Request from through (and including)							
Correction/Adjustment from through (and including)							
Lagra Tuna							
Leave Type:  Continuous Intern	nittent	Irregular Ir	ntermittent				
Continuous	intern	iiiegulai ii	nemintent				
Leave of Absence Reason:  Birth of Child   Expected Due Date:	Seriously III:						
Please indicate here if application is for the person who is pregnant or given by  Adoption of a child   Arriving:	erth.	Domestic Partner	Child <18				
Placement of a child   Beginning:	Parent	Disabled Child >18	Adult Child				
Care for an ill / injured military service memb	Grandchild	Sibling					
My Own Serious Medical Condition:	Parent In-law	Designated Persor	n- Name:				
Work Related Not Work Relate	ed Military Leave						
Other Leave (list reason):	Active	Inactive					
	_	ave (Select Type):					
	Paid	Unpaid					



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### **Medical Certification:**

### Medical verification (Certification of Healthcare Provider) is required for FMLA/CFRA and/or PDL.

- ➤ This form can be found online at: www.sanjoseca.gov> Your Government > Departments & Offices > Human Resources > Leaves of Absence > Forms and Planning Tools
- ➤ Medical verification should be sent directly to: HUMAN RESOURCES; (Mail: City of San José, 200 E. Santa Clara Street, 4th Floor Tower, San José, CA 95113; Fax: (408) 999-0862; Email: HRBenefits@sanjoseca.gov).
  - Verification must state the date a serious medical condition commenced and its probable duration.
  - If you are requesting leave to care for a family member or designated person, that family member's Health
     Care Provider must state the date the serious health condition commenced and probable duration
  - Medical facts sufficient to support the need for leave
  - o Information sufficient to establish the family member/designated person is in need of care
  - Estimate of frequency and duration of leave required, and why such leave is medically necessary.
- > You must also write and sign a statement regarding what care you will provide in the Employee statement section of the Medical Certification.
- ➤ If taking time off to care for a "Designated Person", I attest that person is either related by blood or the equivalent to family relation and understand that I may only designate one person per 12 month period.
- Medical verification should NOT be attached to this form. Copies must not be retained in department personnel files. Your Department may contact Human Resources to verify that the information provided in your medical verification is appropriate for FMLA, CFRA and/or PDL.
- ➤ City-Paid Parental Leave Program requires proof of birth or placement of child. Document should contain date of birth/placement, parent/guardian name(s), and be an official document issued from a hospital or public agency.

### **Applicant Certification:**

➤I understand that if I qualify for FMLA, CFRA and/or PDL leave, I am eligible for continuation of the portion of my medical, dental, vision, life, and employee assistance program (EAP) insurance during FMLA, CFRA, and/or PDL leave, provided that I supply the required medical verification and that I portion of the cost of my insurance during this unpaid leave.

➤I understand that I must return to City service for at least 30 calendar days after the end of my FMLA, and/or PDL leave. If I do not, I may be required to repay the City of San José for any City-paid medical, vision, life, and EAP insurance contributions made on my behalf during any unpaid portion of my FMLA, and/or PDL leave. During my leave, I will notify the City of any change in my address.

EMPLOYEE SIGNATURE	DATE					
Leave Approval: APPROVE DO NOT APPRO						
My signature below certifies my acknowledgement of the lead approves the leave for all other specified leave reasons excelled the specified leave reasons excel						
PLEASE PRINT: SUPERVISOR (OR DESIGNEE) NAME A	ND TITLE	Optional				
SIGNATURE OF SUPERVISOR (OR DESIGNEE) Optional DATE						
DI FACE DRINT: DIDECTOR (OR DECICNEE) NAME AND	TITLE Da	avvius al				
PLEASE PRINT: DIRECTOR (OR DESIGNEE) NAME AND	IIILE Re	quirea				
SIGNATURE OF DIRECTOR (OR DESIGNEE) Required			DAT	E		
City Manager – Administrative Leave Only:		APPROVE		DO NOT APPROVE		
PLEASE PRINT: CITY MANAGER (OR DESIGNEE) NAME	AND TITI	F				
·	- AND IIIL	- <b>L</b>				
SIGNATURE OF CITY MANAGER (OR DESIGNEE)  DATE						



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Leave of Absence Schedule

Is this a <b>revised</b> Leave of Absence Schedule for an active le	ave?	Yes	No			
Is this an irregular intermittent leave?	,	Yes	No			
Note: This form may not be applicable for irregular intermittent leaves						
My work schedule each pay period is (hours per day):						
S= M= T= W= Th= F= S=	Anticipated return to work:					
S= M= T= W= Th= F= S=	Indicate acc	crual balan	ces as of:			
I am regularly scheduled to workhours per week	SIC: \	/AC:E	EXEC: COMP: PER:			
Instructions	•					

#### nstructions:

Print or type clearly. Use as many sheets as necessary to plan the entire duration of your leave. Contact your department timekeeper for assistance completing these forms.

I understand that the following is my request for the use of paid or unpaid time during my leave, in accordance with the <u>City'sLeave Policy</u>. I must submit a revised Leave of Absence Schedule prior to the pay period during which a change occurs. If I submit paid time which differs from the Leave of Absence Schedule and/or the City's Leave Policy, that paid time may not be paid.

Pay Period#	y Period# from through		through	LTD Claim Period					
	Regular	Paid Parental	Sick	Persona OR Executiv	Vacation	Comp	Holiday	Military	Lost Time
# of Hours									
F- Protected U-Unprotected		U F	U F	U F	U F	U F		U F	U F
Pay Period#		from	through		through	LTD Claim Period			
	Regular	Paid Parental	Sick	Persona OR Executiv	Vacation	Comp	Holiday	Military	Lost Time
# of Hours									
F- Protected U-Unprotected		U F	U F	U F	U F	U F		U F	U F
Pay Period#		from	throug		through	LTD Claim			aim Period
	Regular	Paid Parental	Sick	Persona OR Executiv	Vacation	Comp	Holiday	Military	Lost Time
# of Hours									
F- Protected U-Unprotected		U F	U F	U F	U F	U F		U F	U F
Pay Period#		from	through		LTD Claim Period				
	Regular	Paid Parental	Sick	Persona OR Executiv	Vacation	Comp	Holiday	Military	Lost Time
# of Hours									
F- Protected U-Unprotected		U F	U F	U F	U F	U F		U F	U F
Pay Period#		from			through			LTD CI	aim Period
	Regular	Paid Parental	Sick	Persona OR Executiv	Vacation	Comp	Holiday	Military	Lost Time
# of Hours									
F- Protected U-Unprotected		U F	U F	U F	U F	U F		U F	U F



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Pay Period#		from			through			LTD C	laim Period	
	Regular	Paid Parental	Sick	Persona OR Executiv	Vacation	Comp	Holiday	Military	Lost Time	
# of Hours										
F- Protected U-Unprotected		UJF	U F	U F	U F	U F		U F	U F	
Pay Period#		from			through				LTD Claim Period	
	Regular	Paid Parental	Sick	Persona OR Executiv	Vacation	Comp	Holiday	Military	Lost Time	
# of Hours										
F- Protected U-Unprotected		U F	U F	U F	U F	U F		U F	U F	
Pay Period#		from			through			LTD C	laim Period	
	Regular	Paid Parental	Sick	Persona OR Executiv	Vacation	Comp	Holiday	Military	Lost Time	
# of Hours										
F- Protected U-Unprotected		U F	U F	U F	U F	U F		U F	U F	
Pay Period#		from			through			LTD CI	aim Period	
	Regular	Paid Parental	Sick	Persona OR Executiv	Vacation	Comp	Holiday	Military	Lost Time	
# of Hours										
F- Protected U-Unprotected		U F	U F	U F	U F	U F		U F	U F	
Pay Period#		from			through			LTD C	laim Period	
	Regular	Paid Parental	Sick	Persona OR Executiv	Vacation	Comp	Holiday	Military	Lost Time	
# of Hours										
F- Protected U-Unprotected		U F	U F	U F	U F	U F		U F	U F	
Employee Sign	nature:			Р	rint Name:			Dat	e:	
Timekeeper Si	gnature:			Р	rint Name:			Dat	e:	
Notes:										

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# Human Resources Leave of Absence (LOA) Application Family and Medical Leave (FMLA), California Family Rights Act Leave (CFRA)

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## Continuation of Benefits Election Form

### Instructions:

- 1. Print or type clearly.
- 2. Include this form with your leave application and submit your completed request to: Human Resources-Employee Benefits, 4th Floor, City Hall, Fax: (408) 999-0862, or E-mail: HRBenefits@sanjoseca.gov.
- 3. If your leave is unpaid and you choose to continue any benefits, HR will send you a Continuation of Benefits Statement outlining amounts duewhile you are on leave. It is your responsibility to ensure you maintain payments. If this form is not completed upon submission of this application and you are on a protected leave, the City will default to Option 1A and the City will pursue all available remedies if payments are not made.
- **4.** If the leave is/becomes unpaid and not qualified for FMLA, CFRA or PDL, the employee will be contacted by Human Resources regarding continuation options. Employees on unpaid unprotected leave will be responsible for paying both the employee and City premium costs for benefits. Health Insurance may be continued through COBRA and subject to 2% administrative fee. Life Insurance, Long-Term Disability, and AD&D insurance can be continued based on corresponding policies.
- 5. If you intend to lapse coverage any coverage, you must notify HR regarding reinstatement of benefits within 30 days of returning to paid status.

Employee Name	Employee ID

### Please choose Option 1 (indicate A or B) or Option 2:

### **OPTION 1:**

I elect to continue the following benefits during any unpaid periods of my Leave of Absence. I understand that I am responsible for making timely premium payments and if the payment is more than thirty (30) days late, my health and insurance benefits may be dropped for the duration of the leave.

By selecting this option, Human Resources will maintain your eligibility for benefits coverage, and your benefits will remain active through the duration of your absence, contingent upon payment of your premium contributions. You will be responsible for paying the employee portion of the premium while on a unpaid protected leave of absence, and for paying the full premium (employee and City) while on an unpaid unprotected leave of absence. You will need to make arrangements with Human Resources and/or the City's COBRA administrator, to remit premiums to continue your benefits. **The City will pursue all available remedies if this option is elected and premium payments are not made.** 

### Choose one:

**OPTION A:** I wish to continue ALL available benefit programs in which I am enrolled

**OPTION B:** I wish to continue the following benefits programs: (Check only benefits programs you wish to continue.)

Medical Dental Vision

Long-Term Disability (LTD)\*\* Life Insurance\*\*\* EAP Cigna AD&D

### **OPTION 2:**

I elect to allow **ALL** of my benefits to lapse during the unpaid period of my Leave of Absence.

By selecting this option, Human Resources will terminate your eligibility for benefits coverage at the end of the month in which you stop receiving a paycheck paid through the City's payroll system. You are responsible for ensuring your benefit premiums are paid for the entire month. Please note, frequently employees on unpaid leave will owe premiums for the second half of the month in which they begin leave. Once your benefits have terminated, they will remain terminated until the first of the month following your return to work. Once benefit coverage has lapsed, you will not be able to re-activate coverage until you return to work in a paid status.

\*\*LTD continuation is based on leave reason and claim status. Unless on an active LTD claim, LTD can only be continued while on protected leave or for up to 90 days for non-FMLA, CFRA, PDL leaves. Options for continuation and terms of reinstatement will be outlined in a letter from Human Resources. In some cases, there will be no automatic reinstatement of original coverage/rates when you return to active City service and you may be subject to medical underwriting if your coverage is lapsed and wish to re-apply for the LTD Benefit.

\*\*\*Supplemental Life Insurance may be waived while on an approved leave; however, you must reinstate coverage within 30 days of your return in order to be guaranteed reinstatement to the original coverage amount.

Employee Signature	Date