SUNY RF
The Research Foundation for
The State University of New York

EMPLOYEE REQUEST FOR LEAVE

This form must be completed and returned to the office responsible for Research Foundation personnel before any request for leave will be approved. Questions about leave or this form should be directed to the office responsible for Research Foundation personnel.

Part I: Leave Request Data

Employee's Name: _____ Employee Number: _____
(*please print name)*

Employee's Department: _____ Employee's Supervisor: _____

Reason for Request: Check one

☐ Birth of Child ☐ Placement for Adoption/Foster Care

☐ Serious Health Condition of Employee *(requires form DB-450)*

☐ Care of Seriously Ill Family Member *(requires Certification of Physician or Practitioner form WH-380-F)*

If checked, provide name of seriously ill family member and relationship to employee

Name: _____ Relationship:_____

☐ Because of a qualifying exigency arising out of the fact that your spouse, son/daughter, or parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves. *(requires Certification Form WH-384)*

☐ Because you are the spouse, son/daughter, parent or next of kin of a covered service member with a serious injury or illness *(requires Certification Form WH-385)*

If checked, provide name of seriously ill family member and relationship to employee

Name: _____ Relationship:_____

☐ Other Leave. If checked, specify: _____

Date the request leave is to begin_____ Date you expect to return to work_____

Are you requesting intermittent leave? No____ Yes____ If Yes, explain intermittent periods. _____

_____

Are you requesting a reduced work schedule for FMLA leave? No____ Yes____ If Yes, explain schedule requested.

_____

Have you previously been approved for leave? No____ Yes____ If Yes, give the dates of the leave period.

_____

Part II: Employee Entitlement and Certification

I understand that:

- To be eligible form FMLA leave, I must have completed one year of service and have worked a minimum of 1250 hours during the 12 month prior to my leave
- During my period of leave, my group medical, dental and vision coverage will continue at the same level and under the same provisions that are in effect at the time leave begins and that I am fully responsible for my portion of the premium (s) one month in advance. If I fail to remit my premium within the required period, my coverage will cease as of the first of the month for which payment is past due
- I am responsible for notifying the Research Foundation immediately of any change(s) in the leave period
- Upon return from FMLA leave, I am entitled to be restored to my former position or an equivalent one, with equivalent pay, benefits and terms of employment, provided I am not a key employee under FMLA definition whose restoration would cause the Research Foundation to suffer substantial and grievous economic injury

Employee's Signature: _____ Date: _____

SUNY RF
The Research Foundation for
The State University of New York

Family and Medical Leave Act (FMLA) Leave Application for Continuation of Group Benefits

Before completing, please read document titled
"Information on Continuation of Benefits While on Family and Medical Leave" and ***FMLA Rates***

Employee's Name _____

Social Security Number _____

Address _____

_____

_____

Telephone Number:_____

Campus: _____

Leave Period: From _____ To _____

Continue:

_____ **Health Insurance**
The employee share of the biweekly premium must be paid for continuation of Health Insurance.

_____ **Dental & Vision**
Dental and Vision will be continued without charge.

_____ **Basic Life Insurance**
Basic Life continuation requires payment of the Foundation premium.

_____ **Optional Life Insurance**
Optional Life Insurance continuation requires payment of the employee premium.

_____ _____
Employee Signature Date

FMLA Leave has been previously approved for the period indicated.*

STONY BROOK, NEW YORK 11794-0751 TEL: 631-632-6180 FAX: 631-632-1350
http://www.sunysb.edu/hr/

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____Yes. If so, explain:

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. USE THIS FORM IF YOU BECOME SICK OR DISABLED **WHILE EMPLOYED** OR IF YOU BECOME SICK OR DISABLED **WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT**. USE **GREEN** CLAIM FORM **DB-300** IF YOU **BECOME SICK OR DISABLED AFTER HAVING BEEN UNEMPLOYED MORE THAN FOUR (4) WEEKS**.
2. YOU MUST COMPLETE ALL ITEMS OF PART A – THE **"CLAIMANT'S STATEMENT"**. BE ACCURATE. CHECK ALL DATES.
3. BE SURE TO DATE AND SIGN YOUR CLAIM (SEE ITEM 12). IF YOU CANNOT SIGN THIS CLAIM FORM, YOUR REPRESENTATIVE MAY SIGN IT IN YOUR BEHALF. IN THAT EVENT, THE NAME, ADDRESS AND REPRESENTATIVE'S RELATIONSHIP TO YOU SHOULD BE NOTED UNDER THE SIGNATURE.
4. **DO NOT MAIL THIS CLAIM UNLESS YOUR HEALTH CARE PROVIDER COMPLETES AND SIGNS PART B – THE "HEALTH CARE PROVIDER'S STATEMENT."**
5. YOUR COMPLETED CLAIM SHOULD BE MAILED **WITHIN THIRTY (30) DAYS AFTER YOU BECOME SICK OR DISABLED TO YOUR LAST EMPLOYER OR YOUR LAST EMPLOYER'S INSURANCE COMPANY**.
6. MAKE A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS BEFORE YOU SUBMIT IT.

PART A – CLAIMANT'S STATEMENT (Please Print or Type) ANSWER ALL QUESTIONS

Social Security Number

1. My name is _____
First Middle Last

2. Address _____
Number Street City or Town State Zip Code Apt. No.

3. Telephone Number: ( ) _____ 4. My age is _____ 5. Married (Check one) ☐ Yes ☐ No

6. My disability is (if injury, also state how, when and where it occurred) _____
_____

7. I became disabled on _____ a. I worked on that day ☐ Yes ☐ No
Month Day Year

b. I have since worked for wages or profit. ☐ Yes ☐ No If "Yes", give dates _____

8. Give name of last employer. If more than one employer during the last eight (8) weeks, name all employers.

EMPLOYERS			DATES OF EMPLOYMENT		AVERAGE WEEKLYWAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM Mo. Day	THROUGH Mo. Day Yr.	

9. My job is or was _____ _____
Occupation Name of Union and Local Number, if Member

10. For the period of disability covered by this claim
a. Are you receiving wages, salary or separation pay: ……☐ Yes ☐ No
b. Are you receiving or claiming:
(1) Workers' compensation for work-connected disability……☐ Yes ☐ No
(2) Unemployment Insurance Benefits……☐ Yes ☐ No
(3) Damages for personal injury……☐ Yes ☐ No
(4) Benefits under the Federal Social Security Act for long-term disability……☐ Yes ☐ No

IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 10a OR 10b, COMPLETE THE FOLLOWING:
I have ☐ received ☐ claimed from _____ for the period _____ to _____
Date Date

11. I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began……☐ Yes ☐ No
If "Yes", fill in the following: I have been paid by _____ From _____ To_____
Date Date

12. I have read the instructions above. I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled; and that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY ANY INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTATIAL FINES AND IMPRISONMENT.

Claim signed on_____
Date Claimant's Signature

If signed by other than claimant, print below: name, address, and relationship of representative. _____

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NYS WORKERS' COMPENSATION BOARD OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

SI TIENE DUDAS RELACIONADAS CON LA RECLAMACION DE BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA DE NUEVA YORK O ESCRIBA A: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 1241-0005

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

IMPORTANT: USE THIS FORM ONLY WHEN THE CLAIMANT BECOMES SICK OR DISABLED **WHILE EMPLOYED OR** BECOMES SICK OR DISABLED **WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT**. OTHERWISE USE GREEN FORM DB-300.

PART B – HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)
THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY AND THE FORM MAILED TO THE INSURANCE CARRIER OR SELF-INSURED EMPLOYER, OR RETURNED TO THE CLAIMANT WITHIN SEVEN DAYS OF THE RECEIPT OF THE FORM. For item 7d, give approximate date. Make some estimate. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks".

1. Claimant's Name _____ 2. Age _____ 3. Sex ☐ Male ☐ Female

4. Diagnosis/Analysis _____ Diagnosis Code _____

a. Claimant's Symptoms _____

_____

_____

b. Objective Findings _____

_____

5. Claimant Hospitalized? ☐ Yes ☐ No From _____ To _____

6. Operation Indicated? ☐ Yes ☐ No a. Type _____ b. Date _____

7. Enter Dates for the Following:
   a. Date of your first treatment for this disability ……
   b. Date of your most recent treatment for this disability …….
   c. Date claimant was unable to work because of this disability ……
   d. Date claimant will be able to perform usual work ……..
   (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)
8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? ☐ Yes ☐ No
   If yes, has form C-4 been filed with the Worker's Compensation Board? ☐ Yes ☐ No
   Remarks (attach additional sheet, if necessary) _____
   (If disability is pregnancy related, please enter the estimated delivery)

I affirm that I am a ☐ Chiropractor ☐ Physician ☐ Psychologist ☐ Dentist ☐ Podiatrist ☐ Nurse-Midwife	Licensed in the State of	License Number

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY ANY INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTATIAL FINES AND IMPRISONMENT.

Health Care Provider's Signature _____ Date _____

Health Care Provider's Name (Please Print) _____ Telephone Number ( ) _____

Office Address _____
Number Street City or Town State Zip Code

HIPAA NOTICE – In order to adjudicate a workers' compensation claim, WCL13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt fro HIPAA's restrictions on disclosure of health information.

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

PART C - EMPLOYER'S STATEMENT Must be completed in full, by employer only immediately following claimant's last day worked. For inquiries, call Matrix at (877) 315-9838.

Employer's Name…The Research Foundation of State University of New York Policy Number: #DBL251315…Div #……..
Employee's Date of Birth ……..Effective Date of Coverage……

Is this claimant a N.Y. employee? ☐ Yes ☐ No ☐ Full Time ☐ Part Time …….. Contrib. % paid by Employee - pre or post tax
Date of Employment ……. Contrib. % by Employer ……
Normal work week (check boxes to show usual days worked) ……..…

S	M	T	W	TH	F	S
☐	☐	☐	☐	☐	☐	☐

Date Employee last worked ……..…….. Number of Hours……..
Date Employee wages ceased…….
Date Employee returned to work ……..……..…
Has Employment terminated?……. ☐ Yes ☐ No
If so, date of termination……..……
Was Employee laid off or was layoff contemplated prior to disability? …….
If so, give day of layoff……..…….
Are wages being continued during disability? …… ☐ Yes ☐ No
If so, does your Employer request reimbursement … ☐ Yes ☐ No
Was Employee on the job when disability occurred? ☐ Yes ☐ No
Has claim been filed for Workmen's Compensation? ☐ Yes ☐ No
If yes, WC carrier name and address……..
Is Employee member of a union that provides
payment of weekly cash benefits?…… ☐ Yes ☐ No

Gross Earnings 8 weeks prior to disability					
	Week Ending			No. Days	
	Mo.	Day	Yr.	Worked	Gross Amount
1					
2					
3					
4					
5					
6					
7					
8					

If yes, give name and address of union……

Signed …….…… Employer……

Date……..Telephone Number……

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Mail To: 1st Reliance Standard Life Insurance Company
c/o Matrix Absence Management Inc.
Seven Skyline Drive - Suite 275
Hawthorne, NY 10532
Fax: 914-784-0024

Child Care Leave Policy

Child Care under the Research Foundation's General Leave Policy

Employees, regardless of sex, are entitled to leave without pay for child care for up to six months immediately following the date of delivery or adoption. Leave cannot extend beyond the period of appointment. The leave period includes the period of medical disability following childbirth.

Leave must be requested in writing. At the employee's request, paid time off (PTO), such as vacation or personal leave, may be charged; however, this leave cannot be used to extend the duration of child care leave. An employee who wishes to return from leave before his or her stated return date must be allowed to do so.

An employee returning from child care leave will be reinstated to his or her former position or appointed to a comparable position dependent upon the availability of work and funds.

When both parents are employed by the Research Foundation, the entitlement for the two employees is a combined total of 6 months immediately following the birth or adoption.

Frequently Asked Questions

Q-How many weeks am I allowed to be absent from work for the birth of my child?
A-You are allowed a total of 6 months of leave.

Q-What type of accruals am I allowed to charge?
A-The first 6-8 weeks will fall under Disability (please see Disability FAQ).

Q-After my 6-8 weeks of disability, am I allowed to be absent longer?
A-Yes, under the RF policy you are allowed to be absent for a total of 6 months of child care leave. Here are your options:

1. To continue charging sick leave accruals, you must provide an additional doctor's note that states you are still disabled. Your Health insurance premium is paid for with payroll deductions at the employee discount rate. You must also provide a return to work note from your doctor in order to return.
2. You can continue to be out charging full time or part time vacation, holiday or personal accruals during the remaining Child Care Leave period. Your Health insurance premium is paid for with payroll deductions at the discount rate. No return doctors' note required.
3. You can continue to be out on a Leave Without Pay (LWOP). Please note you will pay the full premium for your health insurance during this period, not the employee discounted rate. No return doctors' note required.

Employee Information

I am requesting to be out for Child Care Leave after my initial 6-8 weeks of disability and plan to return on _____. I am choosing to (**Please Check One):**

- ☐ I am charging other accruals which will be indicated on my time sheet (No sick leave can be charged).
- ☐ I am choosing to be on LWOP (charging no accruals) during the remaining Child Care Leave.

Name_____ RF Number_____

Department_____ Contact Phone Number_____

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division
(February 2013)

Fact Sheet #28E: Employee Notice Requirements under the Family and Medical Leave Act

Ongoing communication between the employee and employer is critical throughout the Family and Medical Leave Act (FMLA) process. It is important for the employee to let his or her employer know as soon as possible **each** time FMLA leave is needed and to respond to questions from the employer designed to determine if a particular leave request is FMLA-qualifying. If the employee fails to provide the employer with enough information to determine whether the leave is FMLA-qualifying, the leave may not be protected. The employee must also comply with the employer's policies for requesting leave unless unusual circumstances prevent him or her from doing so.

CONTENT OF THE EMPLOYEE'S NOTICE

The employee's notice to the employer may be verbal or written. The first time the employee requests leave, the employee is not required to specifically mention the FMLA. However, the employee is required to provide enough information for the employer to know that the leave may be covered by the FMLA, and when and how much leave the employee anticipates needing to take. For example, the employee may need to provide information showing that the employee has a condition that causes the employee to be unable to work, that he or she is needed to care for a qualifying family member who is under the continuing care of a doctor, or that a qualifying family member has been hospitalized overnight.

Once approved for a particular FMLA leave reason, if additional leave is needed for that reason, the employee must reference that reason or the need for FMLA leave. In all cases, the employer may ask additional questions and/or for a certification to determine if the leave is FMLA-qualifying.

An employer may require that an employee provide reasonable notice to the employer if the need for FMLA leave changes while the employee is out on FMLA leave. For example, the employer may require that the employee notify the employer if the employee's doctor determines that he or she can return to work earlier than expected or if his or her return to work will be delayed. The employer may also require that the employee provide periodic updates on his or her status and intent to return to the job.

TIMING OF THE EMPLOYEE'S NOTICE

Leave that is Foreseeable

In general, the employee **must** give the employer at least **30 days** advance notice of the need to take FMLA leave when he or she knows about the need for the leave in advance and it is possible and practical to do so. For example, if the employee is scheduled for surgery in two months, the need for leave is foreseeable and at least 30 days advance notice is required. If 30 days advance notice is not possible because the situation has changed or the employee does not know exactly when leave will be required, the employee must provide notice of the need for leave as soon as possible and practical. When the employee has no reasonable excuse for not providing at least 30 days advance notice, the employer may delay the FMLA leave until 30 days after the date

notice is provided. When the employee could not have provided 30 days advance notice, but has no reasonable excuse for not providing a shorter period of advance notice, the employer may delay the FMLA leave by whatever amount of time that the employee delayed in notifying the employer.

In the case of FMLA leave for a qualifying exigency, the employee must give notice of the need for such leave as soon as possible and practical, regardless of how far in advance the leave is needed.

For **planned medical treatment**, the employee must consult with the employer and try to schedule the appointment at a time that minimizes the disruption to the employer. The employee should consult with the employer prior to scheduling the treatment in order to arrange a schedule that best suits the needs of both the employee and employer. Of course, any schedule of treatment is subject to the approval of the treating health care provider.

Leave that is Unforeseeable

When the need for leave is unexpected, the employee **must** provide notice to the employer as soon as possible and practical. It should generally be practicable for the employee to provide notice of leave that is unforeseeable within the time required by the employer's usual and customary notice requirements. For example, if the employee's child has a severe asthma attack and the employee takes the child to the emergency room, the employee is not required to leave the child to report the absence while the child is receiving emergency treatment.

When the employee does not give timely notice of unforeseeable leave and does not have a reasonable excuse, the employer may delay or deny the FMLA leave. The extent of an employer's ability to delay FMLA coverage for leave depends on the facts of the particular case. For example, if it was possible for the employee to give notice of the need for leave the same day it was needed, but instead gave notice two days after the leave began, then the employer may delay FMLA coverage of the leave by two days.

EMPLOYER'S POLICIES FOR TAKING LEAVE

In general, the employer may require that the employee comply with the employer's normal policies for requesting leave. The employer can take action under its internal rules and procedures against the employee who fails to follow its usual and customary rules for requesting leave, as long as it does not discriminate against employees taking FMLA leave. The employer also can choose to waive the employee's notice requirements.

ENFORCEMENT

It is unlawful for any employer to interfere with, restrain, or deny the exercise of or the attempt to exercise any right provided by the FMLA. It is also unlawful for an employer to discharge or discriminate against any individual for opposing any practice, or because of involvement in any proceeding, related to the FMLA. *See* Fact Sheet 77B: Protections for Individuals under the FMLA. The Wage and Hour Division is responsible for administering and enforcing the FMLA for most employees. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress. If you believe that your rights under the FMLA have been violated, you may file a complaint with the Wage and Hour Division or file a private lawsuit against your employer in court.

For additional information, visit our Wage and Hour Division Website: http://www.wagehour.dol.gov and/or call our toll-free information and helpline, available 8 a.m. to 5 p.m. in your time zone, 1-866-4-USWAGE (1-866-487-9243).

This publication is for general information and is not to be considered in the same light as official statements of position contained in the regulations.

U.S. Department of Labor
Frances Perkins Building
200 Constitution Avenue, NW
Washington, DC 20210

1-866-4-USWAGE
TTY: 1-866-487-9243
Contact Us

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service-member during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor | Wage and Hour Division

WHD Publication 1420 · Revised February 2013

SUNY RF
The Research Foundation for
The State University of New York

Human Resource Services

Frequently asked questions about the Research Foundation's NEW YORK STATE SHORT TERM DISABILITY

What type of short-term disability benefits does the RF provide?

Employees are entitled to New York State statutory disability benefits. You are eligible immediately if it can be established that you had coverage with your immediate previous employer. If eligibility was not previously established, coverage begins after 4 consecutive weeks of service for full time employees; after 25 regular work days for part time employees. After a 7-day waiting period or after all sick leave accruals are exhausted, whichever occurs later, First Reliance Standard pays the employee 50% of their weekly salary to a maximum of $170 per week. You may also be covered under the Family and Medical Leave Act (FMLA) for the same period of disability, FMLA is limited to 12 weeks.

How long does disability last?

Disability can last for as long as 26 weeks, provided you have medical documentation. If you need to be out of work beyond the original expected return date, you need to contact your supervisor with any changes in your circumstances and stay in touch for the duration of your disability. **For maternity, disability will end six to eight weeks from the birth of the baby.**

Can I be turned down for disability payments?

Yes, final approval lies with the insurance company. If First Reliance Standard receives the disability form later than 45 days after your last day of work, it could be denied, or a claim could be questioned and the employee examined by a carrier-designated physician.

When do I start using my disability, sick leave accruals and FMLA?

All three run concurrently from the first day you are out on the disability.

If I have enough sick leave accruals to cover me for my absence, do I have to complete a Disability Claim form (DB-450)?

Yes, First Reliance Standard requires a Disability Claim Form (DB-450) from any employee who uses 2 or more weeks of continuous sick leave accruals.

If I have a lot of sick leave accruals, will the grant have to pay for all of it?

No, after 30 consecutive days of absence because of disability, the department submits an Employee Change Form requesting that further sick leave be charged to the "Fringe Benefit Pool".

What paperwork is needed?

Disability Claim Form (DB-450) – completed by employee and doctor. Return to Benefits – Z-0751.

RF Employee Change Form – completed by dept. administrator

- **"Leave with pay for disability"** – if employee wishes to charge ½ day vacation accruals.
- **"Leave without pay for disability"** – The date you use to put an employee out on a disability leave is the date they have exhausted their sick leave. Check with Payroll for accruals.
- **"Return from disability"** – Date the employee actually returns to work.

Time Sheets – Payroll requests all time sheets be filled out so that they will know what accruals have been used and the DB-450 can be submitted to First Reliance Standard by RF benefits.

Return to Work Note from your doctor **must be** submitted to Benefits on the day you return to work.

SUNY RF
The Research Foundation for
The State University of New York

May I charge sick and vacation accruals and not apply for disability benefits?

No, if you do not have sufficient sick leave accruals, you are required to apply for Short-Term Disability. Even if you have sufficient sick leave accruals, you still need to complete a DB-450 so that First Reliance Standard can process it, if necessary.

Do I have to use all my sick leave accruals?

Yes, you must exhaust all sick leave accruals, not vacation or other accruals. Once all sick leave is finished, you can go out on a Leave Without Pay Disability and at that time your benefits continue without charge and you also receive a small payment from First Reliance Standard. You can charge ½ day vacation accruals at this time, if you wish. You would then be considered on Leave with Pay. You can not charge full day vacation accruals.

What time may I charge if I exhaust my sick leave before the NYS 7-day elimination period?

You may charge full vacation accruals and personal leave providing that you do not have any more sick leave. Once you have met the 7-day elimination period, you may then charge ½ day vacation and personal leave if you desire to supplement the disability income.

Is there anything that can hold up my disability payments?

Yes, the following can cause a delay or possible denial of disability payments:

- If the DB-450 arrives at First Reliance Standard later than 45 days after your last day of work.
- Late Time Sheets to Payroll
- Late Change Forms to Payroll could cause a salary overpayment

When must I start paying for my benefits?

Health, dental, vision and basic life insurance coverage continues throughout your disability. Health insurance deductions from your paycheck will continue while accruals are being used. Once the accruals end, all benefits continue at no cost, except for the optional life insurance (if enrolled). Paying the premiums directly to RF can continue your optional life insurance. When you are no longer considered disabled (no longer receiving a check from First Reliance Standard) but are still going to be out on a leave without pay, you are then required to pay the premiums for your health insurance if you want it to continue. If you do not pay for your benefits, you would run off the 28 days that you paid for upon enrolling in your health insurance. When you returned to work, you would have to meet the eligibility for health insurance as if you were a new employee and have a 42-day waiting period. If you were still being covered under FMLA, you would pay the same premium that you pay when you are on the payroll; otherwise, you pay the Leave Without Pay premiums. You would write a check payable to the Research Foundation on a bi-weekly, monthly or for the entire time you will be out basis and submit it to the Benefits Department, Z-0751.

What is the Child Care Leave Policy?

Employees are entitled to leave without pay for the Child Care Leave for up to six months immediately following the date of delivery or adoption. Leave cannot extend beyond the period of appointment. The leave period includes the period of medical disability following childbirth. At the employee's discretion, paid leave, such as vacation or personal leave may be charged on request; however, this leave cannot be used to extend the duration of child care leave.

What happens if an illness or injury last longer than 26 weeks?

If an employee is eligible, information and an application for Long Term Disability will be mailed to the employee.

STATE OF NEW YORK
Andrew M. Cuomo, Governor

WORKERS' COMPENSATION BOARD
Robert E. Beloten, Chair

STATEMENT OF RIGHTS - DISABILITY BENEFITS LAW

IF YOU ARE UNABLE TO WORK BECAUSE OF A NON-OCCUPATIONAL ILLNESS OR INJURY, YOU MAY BE ENTITLED TO DISABILITY BENEFITS

1. Your employer is required by law to provide for the payment of Disability Benefits to his/her employees.
2. Statutory Disability Benefits are payable for any non-work related injury or illness (including disability due to pregnancy) beginning with the 8th consecutive day of disability. Benefits are payable for up to 26 weeks. Benefit payments are based on your average weekly wages for the eight weeks immediately prior to your disability, and are subject to the maximum allowable by the law in effect on the initial day of disability. Your employer or union may provide for different benefits which are at least as favorable as statutory benefits under an approved Disability Benefits Plan or Agreement.
3. TO CLAIM BENEFITS you should file written notice and proof of disability (Claim Form DB-450) with your employer or the insurance carrier named below within 30 days from the first day of your disability, or all or part of your claim may be rejected. In no event should you wait more than 26 weeks from that date to file a claim. You may obtain Form DB-450 from your employer, its insurance carrier, your health care provider or any office of the Workers' Compensation Board. (See addresses and telephone numbers below.) **Do not** assume that your employer has filed a claim on your behalf; **claim filing is your responsibility.**
4. You are entitled to be treated by any physician, chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. Unlike workers' compensation, your medical bills will **not** be paid by your employer or the insurance carrier, unless your employer and/or union provides for the payment of medical bills under an approved Disability Benefits Plan or Agreement.
5. Disability Benefits are to be paid **directly** to you by the insurance carrier, **not through your employer**, unless your employer is an approved self-insurer.
6. If your employer or the insurance carrier contends that you are not entitled to the payment of Disability Benefits, they are required to send you a Notice of Rejection, within 45 days of the filing of your claim, telling you the reasons benefits are not being paid. If you disagree with their rejection, you have a **legal right** to request a review of the rejection by the Workers' Compensation Board. **IMPORTANT:** If within 45 days of filing your claim you do not receive benefits and do not receive a Notice of Rejection (Form DB-451), promptly contact any office of the Workers' Compensation Board.
7. **If your disability is the result of an automobile accident** and you have filed a claim for no-fault benefits, you must also file a claim (Form DB-450) for disability benefits. **If you do not file for disability benefits, the no-fault insurer may reduce your no-fault payments. IMPORTANT**: In such cases, if you are not entitled to disability benefits, immediately advise the no-fault insurance carrier.
8. Your employer may not ask you to waive your right to disability benefits nor may your employer deduct more than 60 cents a week (unless the additional contribution is part of an approved plan) from your pay to contribute to the payment of disability benefits insurance premiums. **You cannot be discharged or discriminated against for filing a claim for disability benefits.**

IF YOU HAVE DIFFICULTY IN OBTAINING A CLAIM FORM OR NEED HELP IN FILLING IT OUT, OR IF YOU HAVE ANY OTHER QUESTIONS OR PROBLEMS ABOUT A NON-WORK RELATED INJURY OR ILLNESS, CONTACT ANY OFFICE OF THE WORKERS' COMPENSATION BOARD.

This information is a simplified presentation of your rights as required by Section 229 of the Disability Benefits Law. Your employer's disability benefits insurance carrier is:

First Reliance Standard Life Insurance Company
590 Madison Avenue, 29th Floor
New York, NY 10022 1-800-882-8700

Robert E. Beloten

ROBERT E. BELOTEN
CHAIR

100 Broadway Menands ALBANY 12241 (866) 750-5157	StateOffice Building 44 Hawley Street BINGHAMTON13901 (866)802-3604	111 LivingstonSt. 22nd Floor BROOKLYN11201 (800) 877-1373	295 Main Street Suite 400 BUFFALO 14203 (866) 211-0645	220 Rabro Drive Suite 100 HAUPPAUGE 11788 (866) 681-5354	175 FultonAvenue HEMPSTEAD11550 (866) 805-3630	215 W. 125th Street 3rd Floor NEW YORK 10027 (800) 877-1373	41 North Division St. PEEKSKILL 10566 (866) 746-0552	168-46 91st Ave. 3rd Floor QUEENS 11432 (800) 877-1373	130 Main Street W. ROCHESTER 14614 (866) 211-0644	935 James St. SYRACUSE 13203 (866) 802-3730

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.
ESTE RESUMEN ESTA ESCRITO EN ESPANOL AL DORSO.

www.wcb.state.ny.us

ESTADO DE NUEVA YORK
Andrew M. Cuomo, Gobernador

JUNTA DE COMPENSACION OBRERA
Robert E. Beloten, Presidente

DECLARACION DE DERECHOS - LEY DE BENEFICIOS POR INCAPACIDAD

SI USTED NO PUEDE TRABAJAR A CAUSA DE ENFERMEDAD O LESION NO RELACIONADA CON EL TRABAJO PUEDE TENER DERECHO A BENEFICIOS POR INCAPACIDAD

1. Su patrono está obligado por ley a proveer pagos de Beneficios por Incapacidad a sus empleados.

2. Beneficios por Incapacidad establecidos por ley son pagados por cualquier lesión o enfermedad no relacionada con el trabajo (incluyendo incapacidad debida a embarazo) comenzando a partir del octavo dia consecutivo de incapacidad. Los beneficios son pagados por 26 semanas. Los pagos de beneficios por incapacidad se basan en el promedio de su sueldo semanal durante las ocho semanas inmediatamente anteriores a su incapacidad y estan limitados al maximo permitido por ley el dia inicial de su incapacidad. Su patrono ó unión podran proveer en un plan o en un convenio beneficios diferentes que sean al menos tan favorables como los establecidos por ley.

3. PARA RECLAMAR BENEFICIOS **usted** deberá radicar una notificación y prueba de incapacidad (Formulario DB450) con su patrono ó con la compañia de seguros nombrada abajo dentro del plazo de 30 dias desde el primer dia de incapacidad o toda o parte de su reclamación podra ser rechazada. Bajo ninguna circunstancia usted debe esperar mas de 26 semanas desde esa fecha para radicar su reclamación. El formulario DB-450 lo puede conseguir a traves de su patrono, la compañia de seguros, el proveedor de servicios médicos o cualquier oficina de la Junta de Compensación Obrera.(Direcciones y telefonos mas abajo). **No** asuma que su patrono ha radicado la reclamación por usted. **La radicación de la reclamación es su responsabilidad.**

4. Usted tiene el derecho de ser atendido por cualquier médico, quiropractico, dentista, enfermera-partera, podiatra, o psicologo que usted seleccione. Contrario a como ocurre en compensación obrera sus cuentas médicas **no** seran pagadas por su patrono o su compañia de seguros a menos que el patrono y o la unión lo hayan dispuesto mediante un plan de beneficios o convenio.

5. Los beneficios por incapacidad le seran pagados a usted **directamente** por la compañia de seguros, **no a traves de su patrono,** salvo en los casos en que su patrono sea aprobado como auto asegurado.

6. Si su patrono ó la compañia de seguros reclama que usted no tiene derecho al pago de Beneficios por Incapacidad ellos tienen la obligación de enviarle un Aviso de Rechazo, dentro de los 45 dias siguientes ala radicación de su reclamación, explicandole las razones para no pagar los beneficios. Si usted no está de acuerdo con el rechazo, **tiene el derecho** de solicitar una revisión del mismo por la Junta de Compensación Obrera. **IMPORTANTE:** Si dentro del término de 45 dias de haber radicado su reclamación no recibe los beneficios ni tampoco recibe un Aviso de Rechazo (Formulario DB-451) comuniquese inmediatamente con cualquier oficina de la Junta de Compensación Obrera.

7. **Si su incapacidad es el resultado de un accidente automovilistico** y usted ha radicado una reclamación para beneficios por 'no-fault' tambien deberá radicar una reclamación (Formulario DB-450) para beneficios por incapacidad. **Si no radica reclamación para beneficios por incapacidad, la compañia de seguro podria reducir los pagos 'no fault' que le correspondan. IMPORTANTE:** en estos casos, si no tiene derecho a beneficios por incapacidad, avise inmediatamente a la compañia de seguros.

8. Su patrono no puede pedirle que renuncie a su derecho de recibir beneficios por incapacidad ni tampoco puede descontar mas de 60 centavos semanales (a menos que la contribución adicional sea parte de un acuerdo) de su paga para contribuir al pago de las primas de seguro para los beneficios por incapacidad. **Usted no puede ser despedido ni discriminado por radicar una reclamación de beneficios por incapacidad.**

SI TIENE DIFICULTAD EN CONSEGUIR UN FORMULARIO DE RECLAMACIÓN O NECESITA AYUDA PARA LLENARLO, O TIENE CUALQUIER OTRO PROBLEMA ACERCA DE UNA LESION O ENFERMEDAD NO RELACIONADA CON EL TRABAJO COMUNIQUESE CON CUALQUIER OFICINA DE LA JUNTA DE COMPENSACIÓN OBRERA.

Este es un breve resumen de sus derechos como lo requiere la Sección 229 de la Ley de Beneficios por Incapacidad. La compañia de seguro de su patrono para beneficios por incapacidad es:

First Reliance Standard Life Insurance Company
590 Madison Avenue, 29th Floor
New York, NY 10022 1-800-882-8700

Robert E. Beloten
ROBERT E. BELOTEN
CHAIR

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ESTA ENTIDAD EMPLEA Y SIRVE A PERSONAS CON INPEDIMENTOS SIN DISCRIMINAR EN SU CONTRA.
THIS NOTICE IS WRITTEN IN ENGLISH ON THE REVERSE SIDE.

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