Notice of Family Medical Leave (FMLA)

Payroll Plus Corporation
Transport Leasing/Contract, Inc.
The Labor Source, Inc.

The TLC Companies has been informed that you plan to take a leave or are already out on a leave that may qualify under the federal "Family Medical Leave Act" (FMLA). The TLC Companies complies with regulations put in place under this law and want you to be aware of your FMLA rights and responsibilities. You will find our policy on this law in your employee handbook or you can call and request a copy from the FMLA Administrator.

Types of Absences Covered:

- The birth of a child and to care for the newborn child within one year of birth;
- The placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
- A serious health condition causing you to be unable to perform your job;
- To care for your spouse, child or parent who has a serious health condition.

Family Military Leave Absences

- Qualifying exigencies arising from the fact that an employee's spouse, child or parent that is a military member, is called to covered active duty in the National Guard, reserves or armed forces or notified of an impending call or order to such duty to a foreign country. Leave may be taken for short notice deployment, military events and related activities, childcare and school activities, financial and legal arrangements, counseling, rest and recuperation, post-deployment activities and additional activities. The amount of time for rest and recuperation leave may take up to 15 calendar days.
- Parental care leave to care for a military member's parent incapable of self-care when the care is necessitated by the member's covered active duty; or
- Spouse, child, parent or next of kin (nearest blood relative) of a covered service member or Veteran in the armed forces, including the National Guard and Reserves, who is injured in the line of duty or has a pre-existing injury or illness that was aggravated by service in the line of duty and undergoing medical treatment, recuperation, or therapy, are an outpatient or are on the temporary disability retired list for a serious injury or illness. (For Veterans, they must have been a member of the Armed Forces at any time during the 5-year period preceding the date of the treatment, recuperation or therapy) [Service Member Care Leave].

You may take up to 12 weeks of unpaid leave for all of the above listed leave of absences, except for Service Member Care Leave for which you may take up to 26 weeks of leave during only one 12-month period for the covered service member.

If you have a qualifying condition under FMLA, you are required to meet certain eligibility requirements. The client you are assigned to must have 50 or more employees within a 75 mile radius of your worksite. You must have worked for the TLC Companies, or the client that you are assigned to, for a minimum of 12 full months *(these do not have to be 12 consecutive 12 months).* If you have worked the minimum 12 months, you are also required to have worked 1,250 hours in the 12 months prior to your FMLA request. A "rolling" 12 month period is used. Your entitlement to FMLA is the balance of 12 weeks that have not been used in the immediately preceding 12 months (or balance of 26 weeks for Service Member Care Leave). If you have any questions about what situations qualify for FMLA or to find out if you have leave time available, please contact the FMLA Administrator.

If your or a family member's condition requires only periodic treatment, you may request FMLA on an intermittent basis. Intermittent leave can be taken in hourly increments and will be counted toward the 12-week allotment in the increments taken (or 26 weeks for Service Member Care Leave). TLC Companies does not have a "Personal Leave" policy. A medical leave that does not qualify under FMLA or a similar state or federal law is not allowed under company policy.

Please complete the enclosed **Leave Request form** if you would like us to determine your eligibility for FMLA. **You must return the form to us 30 days prior to the start of your leave, when possible***.* If your circumstance is an emergency situation, we will determine your eligibility if you submit the form as soon as you become aware of your FMLA rights. If your spouse, child or parent is on active duty (or has been notified of an impending call or order to active duty) in the armed forces in support of a contingency operation, you must provide reasonable notice. **If you do not return this request to have your leave designated as FMLA, you risk termination of your employment.** *TLC reserves the right to designate FMLA for you when appropriate.*

You also have certain responsibilities in order to keep your rights under the FMLA. **If we require a medical certification, you must return a completed certification from your physician (or your family member's physician) within 15 days or we may deny the leave**. All medical situations for you or a family member will require a medical certification. If you are out on maternity leave or a workers' compensation injury, a medical certification is not required. If you have any problems having the certification completed by your physician, please call the FMLA Administrator immediately. **Failure to complete and return a certification as required can result in your termination***.*

If you are participating in the TLC health plan, you are also required to continue to pay your share of the health insurance premium. You are required to pay the same portion of premium that you would normally pay if you were actively at work. Please complete the Continuation of Benefits form to choose your payment option. **If payment is not made timely or you fail to pay your premium, your group health insurance may be cancelled back to the last day covered by your last premium payment.**

You are entitled to take the full 12 weeks of FMLA even if you believe that you will not be able to return to work at the end of the leave (26 weeks for Service Member Care Leave). If you do not return to work, we will determine if you are eligible for more leave time under a state or federal law. If you are not eligible for more leave time, we will terminate your employment at the end of your FMLA. If you are enrolled in our health plan, **you will be required to pay back the company portion of premium that was paid for you during your leave**, unless your health condition is the reason that you are unable to return to work. Your obligation to pay back premium also applies if you fail to return to work for at least 30 days after your leave ends.

Please contact the FMLA Administrator with any questions about your leave rights. If you know that you do not qualify under the FMLA, you should still complete the attached form because you may qualify under a state law.

FMLA Leave Request Form

Return to: TLC Companies,
FMLA Administrator
6160 Summit Drive N., Suite 500
Brooklyn Center, MN 55430
(877) 248-8360 x7061
Fax (763) 569-2770

Payroll Plus Corporation
Transport Leasing/Contract, Inc.
The Labor Source, Inc.

To request a leave or an intermittent leave (reduced work schedule), please complete this form and return to the office listed above 30 days before taking leave or as soon as you know about the leave. **If you are already out on a leave, you must return this form within 15 days from the date postmarked.** *If you do not return this request form to our office in a timely manner, we may deny the leave, which could result in your termination.*

Name:	**Social Security Number:**
Requested Start Date of Leave:	**Original Date of Hire:**

1. I am requesting leave or an intermittent leave for the following reason *(You **must** check one)*:

- ☐ The birth or care of your newborn child or placement of a child with you for adoption or foster care
- ☐ A serious health condition that makes me unable to perform the essential functions of my job.
  (If choosing this option, a medical certification form must be completed.)
  Explain Health Condition: _____
- ☐ A serious health condition affecting my spouse, child or parent that I am needed to care for.
  (If choosing this option, a medical certification form must be completed.)
  Explain Health Condition: _____
- ☐ A spouse, child or parent called to active duty in the armed forces in support of a contingency operation
  (If choosing this option, please provide a copy of the military orders.)
  Explain: _____
- ☐ A serious injury or illness of a service member incurred in the line of duty and I'm the primary care giver
  (If choosing this option, a medical certification form must be completed.)
  Explain: _____
- ☐ A work related illness/injury that I want designated as FMLA leave.
- ☐ Other: _____

2. If I am eligible for FMLA leave, I ☐ *do* ☐ *do not* request such leave *(You must check one.* If you are requesting FMLA leave, you *must* complete the next line.*)* I realize that choosing not to have leave time designated as FMLA could result in termination.

I wish my FMLA leave, if eligible, to begin on this date: _____
(If intermittent leave, enter first date of the reduced work schedule).

3. I ☐ *do* ☐ *do not* have health insurance provided through TLC. If you have insurance with TLC, you must complete the Continuation of Benefits form. Failure to complete and return could result in the termination of your coverage.

4. If you are out on an approved leave, do you intend to return to work following the leave?
***(You must check one)*:**

- ☐ Yes. If so, indicate what date you believe you will return: _____
- ☐ No.

***Note**: Employees on leave due to personal medical reasons may be required to provide written evidence of fitness to return to their duties before returning to work. Failure to return to work on the anticipated date of return will be considered a resignation.*

After completing this form and any other required forms, please return to the office listed above. Any delays in returning these forms could delay your leave and could result in termination. Completing these forms is no guarantee of eligibility of FMLA. We will determine your eligibility and designate leave as FMLA when appropriate. Please contact TLC directly with any changes in your situation.

I certify that the information that I have provided to TLC is correct and that I want this information used to designate any FMLA leave that I am entitled to. I certify that I have read my rights and that all the information I have provided is to the best of my knowledge.

_____ _____

SIGNATURE (Your signature is required for TLC to use this information) **DATE**

Request for Continuation of Benefits During FMLA

Payroll Plus Corporation
Transport Leasing/Contract, Inc.
The Labor Source, Inc.

Employee Name: _____

Social Security No.: _____

Client Worksite: _____

TLC Companies
FMLA Administrator
6160 Summit Drive N. Suite 500
Brooklyn Center, MN 55430
Phone (877) 248-8360 x7061
Fax (763) 569-2770

While you are out on a qualified FMLA leave, you are obligated to continue payments for your benefits which you normally pay through payroll deduction. You have the right to waive your coverage for the duration of your FMLA leave and have coverage reinstated when you return to work.

This form must be completed if you want to continue your health insurance coverage during your leave. Failure to complete this form will result in the termination of your health insurance effective through the last day covered by your last premium payment.

1. I ☐ *want* ☐ *do not want* to continue my insurance during my medical leave. I understand that if I drop my coverage, it can be reinstated if I return to work when my leave ends. *I further understand that reinstatement does not happen automatically and that I am required to contact the benefits department as soon as I return to work.* **I understand that I must wait until the next open enrollment opportunity if I DO NOT reinstate my insurance within 30 days of returning to work.**

2. **Please complete if you want to continue coverage during your leave *(Check one only)*.**

   ☐ I will pay premiums monthly while I am out on leave and will be notified by TLC of the payments and due dates.

   ☐ I will pre-pay my premiums. I have made arrangements ahead of time in preparation for my leave and I will pay the premiums before I leave. I realize that if the full premium is not paid for before I return, I will be billed for the balance due and I must continue to make monthly payments.

   I choose to pre-pay my premiums (you must check one):

   ☐ on my next payroll check ☐ _____ (check date)

   ☐ My worksite employer pays 100% of my health insurance premium.

3. FMLA is a qualifying event which allows you to make a change to your medical, dental or vision insurance coverage. Please complete if you would like to change your coverage during your leave (i.e. drop vision/drop any dependents).

   I would like to change my coverage during my leave to: _____
   _____
   _____

Any changes made to my insurance during a medical leave will continue when I return unless I contact the benefits department. Failure to make payments in a timely manner can result in termination of my benefits. If I chose to pay when I return, I have authorization from the client I am assigned to and they have signed below. If I choose this method and do not have a client signature, I realize that I will be billed and will have to pay on a monthly basis.

SIGNATURE: _____ **DATE:** _____

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

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: TLC Companies; Kathy Miller (763) 585-7061; Fax (763) 569-2770

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her 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 to care for a covered family member with a 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. 29 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

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____

_____ _____
Employee Signature Date

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. 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. Page 4 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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: _____

   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. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (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: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? __ No __ Yes.

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

   During this time, will the patient need care? __ No __ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? __ 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: _____

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:
   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? __ No __ Yes.

   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

   Does the patient need care during these flare-ups? __ No __ Yes.

Explain the care needed by the patient and why such care is medically necessary:

_____

_____

_____

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.