CIGNA Leave Solutions®

Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave (Family and Medical Leave Act)

Date Prepared: Must Be Returned By:

Employee Name: Employer Name:

Leave ID: Reason for requesting leave:

Leave date(s)/Period(s) requested:

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form.

Return complete certification form to:
CIGNA Leave Solutions® P.O. Box 709015 Dallas, TX 75370-9015
Fax: 1-866-931-5095

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is: 1) a current member of the Regular Armed Forces, the National Guard, or the Reserves (collectively "Armed Forces") 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 is undergoing medical treatment, recuperation, or therapy, for a serious injury or illness and who was a member of the Armed Forced at any time 5 years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy.

For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty, or existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty, that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating. In addition, for purposes of FMLA leave in the case of a veteran, a serious illness or injury also includes a qualifying condition that manifested itself before or after the servicemember became a veteran.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness, as defined above, was incurred in the line of duty on active duty, and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above.

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.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave: (This section must be completed first before any of the below sections can be completed by a health care provider.)

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 employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information, unless failing to provide the information will result in an incomplete or insufficient certification.. '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.

Part A: EMPLOYEE INFORMATION

Name of Covered Servicemember (for whom employee is requesting leave to care):
_____

Relationship of Employee to Covered Servicemember Requesting Leave to Care:
□ Spouse □ Parent □ Son □ Daughter □ Next of Kin

Part B: COVERED SERVICEMEMBER INFORMATION

(1) Is the Covered Servicemember a current member of the Regular Armed Forces, the National Guard or Reserves? ___Yes ____No

If no, is the Covered Servicemember a veteran of the Regular Armed Forces, the National Guard or Reserves? ___Yes ____No

If the Covered Servicemember is a veteran of the Regular Armed Forces, the National Guard or Reserves, what were the dates that the veteran served as a member of the Armed Forces?
_____

If the Covered Servicemember is a current member or veteran of the Regular Armed Forces, the National Guard or Reserves, please provide the Covered Servicemember's military branch, rank and unit currently or, in the case of a veteran, the military branch, rank and unit which he or she was assigned to:
_____

Is the Covered Servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ___Yes ___No

If yes, please provide the name of the medical treatment facility or unit:
_____

(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)?
____Yes ____No

Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the Care to Be Provided by the Family Member to the Covered Servicemember and an Estimate of the Leave Needed to Provide the Care:

_____

_____

_____

SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider: _____

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

PART B: MEDICAL STATUS

(1) Covered Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

□ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

□ **(SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

□ **OTHER Ill/Injured** – Serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating

□ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Servicemember is being treated (Check one of the appropriate boxes):

□ Incurred in line of duty on active duty in the Armed Forces

□ One that existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces
□ One that manifested itself after the servicemember became a veteran

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ____Yes ____ No If yes, please describe medical treatment, recuperation or therapy:
_____

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? ___Yes ___ No
If yes, estimate the beginning and ending dates for this period of time:
_____

(2) Will the covered servicemember require periodic follow-up treatment appointments? ___ Yes ___ No If yes, estimate the treatment schedule._____

_____

(3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ____Yes _____No

(4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? ____Yes ____No If yes, please estimate the frequency and duration of the periodic care:

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

Duration: _____ hours or ___ day(s) per event.

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. The U.S. 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 AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**