RESET FORM

LEAVE OF ABSENCE MEDICAL CERTIFICATION
CARE OF FAMILY MEMBER

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(the "Company")
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INSTRUCTIONS FOR EMPLOYEE

Checklist Before Submission:

- ☐ Complete **Section 1: Employee Information**
- ☐ Ensure **Treatment Provider** completes **Sections 2 and 3 (if applying for short-term disability benefits)**
- ☐ Notify your manager about your leave per company/FMLA policies.
- ☐ Provide certification to Voya within **the timeframe outlined in your letter**
- ☐ Follow up with your provider to confirm timely submission.
- ☐ Submit completed form via the contact options above.

Important: *You may need to authorize your provider to release complete, sufficient certification. A formal diagnosis is not required for FMLA qualification. If you are applying for both STD and Leave benefits, please make sure your treating provider completes ALL sections of the form.*

SECTION 1: EMPLOYEE INFORMATION

Employee's Name _____ Claim ID _____

Last 4 digits of Social Security Number _____ Date of Birth _____

Employer's Name _____ Regular Work Schedule _____

Name of family member whom requires your care _____ Family Member's Date of Birth _____

Select the relationship of the family member to you. The family member is your: ☐ Spouse ☐ Parent ☐ Child, under age 18

☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability ☐ Other, please describe _____

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include in loco parentis relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary

1. Briefly describe the care you will provide to your family member: **(Check all that apply)**

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation ☐ Physical Care ☐ Psychological Comfort ☐ Other

2. Give your best estimate of the amount of leave needed to provide the care described _____

3. If a reduced work schedule is necessary to provide the care described, give your best estimate of the reduced schedule you are able to work.

From _____ to _____ I am able to work _____ (hours per day) _____ (days per week)

Signature _____ Date _____

INSTRUCTIONS FOR TREATING PROVIDER

The employee listed above has requested leave under the FMLA to care for your Patient. Answer all applicable questions fully and completely. Several questions seek a response as to the frequency and 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 "indefinite" 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.

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 than 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.

SECTION 2: MEDICAL FACTS & AMOUNT OF LEAVE FOR LEAVE (TO BE COMPLETED BY TREATING PROVIDER)

1. If the patient is a dependent child age 18 or older, is the patient **unable to perform** three or more Activities of Daily Living or Instrumental Activities of Daily Living? ☐ Yes ☐ No

2. Select ALL reasons applicable to the patient's need for care from a family member:

☐ Inpatient care (hospital, hospice, residential medical care facility)

Facility Name _____

Dates: Admission _____ Discharge _____

☐ Pregnancy related incapacity

Expected date of delivery: _____

☐ Short Term Incapacity, plus treatment

- ☐ Two (2) or more in-person treatments within 30 days
- ☐ One (1) examination, plus continuing treatment under the supervision of a healthcare provider

☐ Long-Term / Chronic, plus treatment

☐ Lifelong / Chronic Incapacity, plus treatment

- ☐ Requires two (2) or more visits per year
- ☐ Causes episodic incapacity / flare-ups
- ☐ Periods of incapacity would occur without treatment *(e.g. asthma, diabetes)*

☐ **The patient does not have a health condition requiring care from a family member**

3. Describe Appropriate Medical Facts:

Does the patient require care from a family member? ☐ Yes ☐ No

Was the patient prescribed medication not available over the counter? ☐ Yes ☐ No

Was the patient referred to other health care provider(s)? ☐ Yes ☐ No

If yes, please list: _____

Explain the care needed by the employee for the family member and why such care is medically necessary. _____

_____

_____

Describe any other relevant medical facts regarding the patient's health condition for which a leave is requested (i.e. symptoms, diagnosis, hospitalization, office visits, medication, treatment plan, referrals). _____

_____

_____

STEP 2 – DATES OF LEAVE

Based on the patient's medical history and your knowledge of the medical condition, consider all dates the employee has been or will be unable to work as a result of the family member's condition by completing either of the below sections that apply. **All applicable sections must be completed.**

Answers of "unknown," "indeterminate" or "lifelong" may not be sufficient to support the leave request.

☐ **Continuous Leave: Provide any single, continuous period of incapacity.**

Start date of incapacity (this may or may not be the first day absent from work) _____

Estimated end date of incapacity _____

Will the patient require follow-up appointments? . . . . . ☐ Yes ☐ No

If yes, complete the section below if appointments will result in the employee's absence(s) from work.

If intermittent leaves or a reduced work schedule are applicable, identify ALL absence needs below.

☐ **Intermittent Leave:**

Leave Begin Date: _____

Leave End Date: _____

Will the employee need to miss work for appointments or treatments?
☐ Yes ☐ No

If yes, complete the estimated treatment schedule:

Frequency:
Up to _____ times per _____ (week/month/year)

Duration:
Lasting up to _____ hours **OR** _____ days

Please include the dates of any scheduled appointments and the time required for each appointment:

_____

Will the employee need to miss work as a result of patient's incapacity/ flare-ups of the health condition? ☐ Yes ☐ No

If yes, complete the estimate of absences needed for episodes:

Frequency:
Up to _____ times per _____ (week/month/year)

Duration:
Lasting up to _____ hours **OR** _____ days

List all dates you have already treated the patient for the condition:

_____

☐ **Reduced Schedule Leave:**

Will the employee need a temporary FIXED part-time schedule or require predictable, regularly scheduled absences as a result of the patient's condition?

☐ Yes ☐ No

If yes, complete the period the reduced schedule will be needed.

Start date of modified schedule: _____

Probable date employee may return to their regular schedule: _____

In the table below, indicate the hours of time the patient will need to miss each day.

Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

STEP 3 – HEALTHCARE PROVIDER INFORMATION & SIGNATURE *(If there is an additional treating physician, please attach a page with their information including name, specialty, and phone.)*

Name _____ Practice/Specialty and Credentials _____

Phone (_____)_____ Fax (_____)_____

Email _____

Address _____

City _____ State _____ ZIP _____

Signature _____ Date _____

FRAUD WARNINGS

Alabama, Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Washington, West Virginia: Any person who, knowingly with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Arizona: For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.