Mutual of Omaha Insurance Company
Health Services Department
PO Box 3692 | Omaha, NE 68103-0692
p 402-351-2016 | 800-780-0304
f 402-351-6297

FAMILY MEDICAL LEAVE NOTIFICATION OF ELIGIBILITY AND RIGHTS AND RESPONSIBILITIES

Shraddha Parajuli
4520 Brookridge Ave
McKinney, TX 75071

To:Shraddha Parajuli, shraddhaparajuli834@gmail.com Employee #: 102859
CC:
From: Theresa Lampmann, RN, BSN, 402/351-6525
Date: 02/26/2025
RE: Case# 331206-120366

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and worked at a site with at least 50 employees within 75 miles.

Part A - NOTICE OF ELIGIBILITY
Health Services has been notified of your need to take Family/Medical Leave for: (check one)
__X__ The birth of a child, or placement of a child with you for adoption or foster care;
___ Your own serious health condition;
___ You are needed to care for child/parent/ or spouse due to his/her serious health condition.
___ A qualifying exigency arising out of the fact that your son/daughter/parent/spouse is on active duty or call to active duty status with the armed forces.
___ You are the spouse/son/daughter/parent/next of kin of a covered service member with a serious injury or illness.

This notice is to inform you that: (chose one)
__X__ You are eligible for FMLA leave (see Part B below for Rights and Responsibilities).

___ You are **not** eligible for FMLA (only one reason need be checked, although you may not be be eligible for other reasons) due to:
- ___ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately ___months toward this requirement.
- ___ You have not met the FMLA's 1,250-hours-worked requirement.
- ___ You do not work and/or report to a site with 50 or more employees within 75 miles.
- ___ Other:

If you have questions, contact Health Services, Theresa Lampmann, RN, BSN at 402/351-6525 or view FMLA poster ? http://associateaccess.mutualofomaha.com/human-resources/documents/fmla_poster.pdf

Part B ? RIGHTS AND RESPONSIBILITIES(MARK ONE OF THE 3 BOXES)
___ As explained in Part A, you meet the eligibility requirements for taking FMLA leave and you still have FMLA leave available in the applicable 12-month period. Your FMLA is approved. You will

receive a separate Designation Form outlining further reporting and return to work requirements.
__X__ As explained in Part A, you meet the eligibility requirements for taking FMLA leave, however in order for us to determine whether your absence qualifies as FMLA, further information is needed (see attached medical certification form.) You must return the certification form within 15 calendar days of this notice**. Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. REPORT ANY LEAVE WHILE WAITING FOR APPROVAL.** If sufficient information is not provided in a timely manner, your leave may be denied.

___ While eligible, your FMLA request is denied because you have exhausted the 12 work weeks of FMLA in a rolling 12-month period.

___ While eligible, your FMLA request is denied because the reported condition is not a FMLA "qualifying condition".

Comments:

If your leave does qualify as FMLA leave you will have the following **rights and responsibilities** while on FMLA leave:

1) You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as a "rolling" 12-month period measured backward from the date of any FMLA leave usage.
2) You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on
3) Health Services will track all FMLA absences. You must exhaust all Personal Time and/or Puerto Rico Paid Sick Leave before vacation or unpaid leave time is approved. You will be required to use any Short Term Disability Benefits for which you are eligible during an FMLA leave. Disability Leave for the birth of a child and for your own serious health condition, including workers' compensation leave (to the extent that it qualifies), will be designated as FMLA leave and will run concurrently with FMLA.
4) Your Health Benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work. If you normally pay a portion of the premiums for your health insurance, these payments will continue during the period of FMLA leave. Benefits will discuss arrangements for payment with you. You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or , at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work. We will do the same with other benefits (e.g. life insurance, disability insurance, etc.)
5) You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
6) If you do not return to work following FMLA leave for a reason other than:1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
7) While on leave, you will be required to furnish Health Services Department with periodic reports of your status and intent to return to work, as appropriate for the particular leave situation per Health Service's determination and comply with all management reporting requirements.
8) While on FMLA leave, **YOU MAY NOT ACCEPT OR PERFORM ANY WORK OR PROVIDE SERVICES OF ANY NATURE FOR COMPENSATION UNLESS OTHERWISE AGREED IN WRITING BY THE VICE PRESIDENT OF HUMAN RESOURCES.**

To review Mutual of Omaha's FMLA policy, click on this link to the H.R. Policy Manual.
https://confluence.mutualofomaha.com/confluence/display/MOPSI/Human+Resources+%28HR%29+Policies+and+Standards

EMPLOYEE RESPONSIBILITIES REGARDING FMLA LEAVE

To protect the employee's privacy, medical information should not be shared outside of Health Services.

1. The employee must contact his/her manager or designated personnel during the first half-hour of each scheduled workday or absence, unless authorized by the manager to call at another time and frequency. The employee must inform management that the leave is due to a Family and Medical Leave Act (FMLA) condition.

2. The employee must comply with the following Health Services Department Reporting and Communication requirements:

    - Assure that you complete your section of the FMLA "Certification of Health Care Provider" form and that the provider properly completes and returns the form to the Health Services Department within 15 calendar days of request. Failure to return a completed form within this time frame may result in denial of FMLA certification.
    - It is your responsibility to provide the Case Manager with periodic medical status updates and return all Health Services Department phone calls promptly. Be sure to provide the Case Manager with a telephone number where you can be reached.
    - If applicable, ensure that the Health Services Department receives a completed "Work Status Report/Fitness for Duty" form or medical release prior to returning to work at the workplace OR working from home. Abide by all medical restrictions that you receive from your provider.

3. **WHILE ON FMLA LEAVE, YOU MAY NOT ACCEPT OR PERFORM WORK FOR WAGES OR PROFIT UNLESS OTHERWISE AGREED TO BY THE COMPANY.**

4. Comply with the following:

INTERMITTENT ABSENCE REPORTING REQUIREMENTS

1. On the day of your unscheduled absence, follow your department's absence reporting guidelines within ½ hour of your scheduled reporting time. You must state that the absence is due to your "own or family FMLA reason".
2. A confirmatory reporting email must be sent to your department manager with a "cc" to your Health Service case manager.
    - If you fail to request or report a FMLA qualified absence within **2 business days** upon your return to work, you may not assert at a later date that the prior absence qualified as FMLA leave.

        - **Mark email subject as "own or family FMLA".**
        - **Do not include medical information.**
        - **State the date and the number of hours you were absent in no less than 15-minute increments** (i.e., 4/18/24-4.25 hours and 4/19/24- 8 hours).
        - FMLA leave is unpaid time off. If you have PTO, you must notify your manager to code your time off with PTO. After your PTO is depleted and you want to be compensated for your FMLA, you are encouraged to include notification to management to code your time off with vacation, if applicable.

Failure to follow the communication and reporting guidelines noted above, may result in a referral to HR and/or performance management.

All absences that occur during your regularly scheduled workday that are connected to your FMLA condition(s) need to be reported, irrespective of how the time is coded for pay purposes. This reporting requirement includes instances where time is "made up" for pay purposes throughout the work week.

Exception: FMLA related absences where time is made up on the same business day do not need to be reported to Health Services. It is important to note that management approval is required in these instances.

For questions, contact your case manager: Theresa Lampmann, RN, BSN, 402/351-6525

MANAGER'S RESPONSIBILITIES REGARDING FMLA LEAVE

1. Code employee's time utilizing sick-time reporting codes. There are different codes for hourly (nonexempt) and salaried (exempt) employees.

    a. Employee can work with management to make up the time for pay purposes.

    b. If the employee is unable to make up time, they must utilize personal time first and then either vacation time or unpaid time.

2. Manager must contact Health Services if employee is out for more than 3 days for a medical condition.

3. Management must contact Health Services if an employee requests any accommodation for any employee medical condition.

4. Do not accept or ask for medical documentation. Health Services will be responsible for determining the need for medical documentation.

5. Ensure performance management does not account for FMLA protected leave.

For questions, contact the case manager: Theresa Lampmann, RN, BSN, 402/351-6525

To review Mutual of Omaha's FMLA policy, click on this link to the H.R. Policy Manual: https://confluence.mutualofomaha.com/confluence/display/MOPSI/Human+Resources+%28HR%29+Policies+and+Standards

Mutual of Omaha Insurance Company
Health Services Department
PO Box 3692 | Omaha, NE 68103-0692
p 402-351-2016 | 800-780-0304
f 402-351-6297

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

Date: 02/26/2025 Due date: 03/13/2025

Employee Name: Shraddha Parajuli Date of Birth: 11/05/1995

Instructions to Employee: It is your responsibility to ensure that this form is properly completed and returned to Health Services Department within 15 calendar days. Failure to return a properly completed form could result in denial of FMLA certification. **Please complete** your reported health condition before giving form to your provider:

Your reported health condition:

Your job description has been sent to you. Provide to your HCP along with this form Yes __ No _X__

Instructions to 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 provide your business information and sign the form on the last page.

Providing employee's job description? Yes___ No _X___

Part A: Medical Facts

1. Please describe the 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):

   _____
   _____
   _____

2. State the approximate date the condition started or will start: _____(mm/dd/yyyy)

3. Provide your best estimate of how long the condition lasted or will last: _____

4. Use the information provided by the employer (job description) to answer this question. If no job description provided, 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? Yes___No___
   If so, identify the job functions the employee is unable to perform:

   _____
   _____

Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B:

☐ **Inpatient Care**: The patient (☐has been/☐is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s):

_____

☐ **Chronic Conditions**: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Incapacity plus Treatment**: (e.g. outpatient surgery, strep throat)
Due to the condition, the patient (☐has been /☐is expected to be) incapacitated for more than three consecutive, full calendar days from _____(mm/dd/yyyy) to _____ (mm/dd/yyyy).

The patient (☐was/☐will be) seen on the following date(s): _____

The condition (☐has /☐has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment) _____

☐ **Pregnanc**y: The condition is pregnancy. List the expected delivery date: _____(mm/dd/yyyy)

☐ **Permanent or Long-Term Conditions**: (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ None of the above: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy)
no additional information is needed. Go to page 3 to sign and date the form.

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

_____

_____

Return to Work Date (if known): _____ Estimated_____ or Actual _____

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? Yes___No___

If so, are the treatments or the reduced number of hours of work medically necessary?
Yes_____No_____

Estimated 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:
_____hours 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? Yes___ No___
   Is it medically necessary for the employee to be absent from work during the flair-ups?
   Yes___ No___ If so explain:
   _____

8. 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:

_____
_____
_____

Print Health Care Provider Name **Type of Practice/Medical specialty**

Address **Telephone Number** **Fax Number**

Signature of Health Care Provider **Date**

Questions can be addressed and forms can be sent c/o:

Attention: Theresa Lampmann, RN, BSN
Mutual of Omaha
PO Box 3692
Omaha, NE 68103

Telephone: 402/351-6525
Fax: (402) 351-6297
Toll Free: (800) 780-0304

Or may return the completed form to the employee.