Sedgwick Claims Management Services, Inc.
PO BOX 14424
Lexington, KY 40512-4424

March 19, 2024

Phone: (866) 206-6769
Fax: (866) 315-0607
Email: starbucksmail@sedgwick.com

Ben Cave
409 North Park Avenue
Audubon, PA 19403

We value your privacy. For more on what personal information we may collect, how we may use this information and other important areas relating to your privacy and data protection, please read our privacy notice www.sedgwick.com.

Phone: (866) 206-6769
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Email: starbucksmail@sedgwick.com

March 19, 2024

Ben Cave
409 North Park Avenue
Audubon, PA 19403

Re: Starbucks Short-Term Disability (STD) Pay
Claim Number: 4A2403KWDV8-0001

Dear Ben,

You requested Short Term Disability beginning on **February 25, 2024**. Your leave request was also reviewed to determine if it qualifies for coverage under the Family and Medical Leave Act and/or State Leave, which would run at the same time as your Short Term Disability if you are eligible and approved.

We've confirmed that while you do not meet the eligibility requirements to apply for Family Medical Leave, you do meet the eligibility requirements to *apply* for Starbucks Medical Leave and Short Term Disability.

The Family Medical Leave Act (FMLA) provides job-protected time off to eligible partners for various leave reasons. Below is your eligibility status for Family Medical Leave. Also enclosed are the full Rights and Responsibilities under the Family and Medical Leave Act (FMLA).

Family Medical Leave Eligibility Status

- You do not meet the FMLA's basic eligibility requirements because:

- You have not met the FMLA 1,250 hours worked requirement. As of the first date of requested leave, you will have worked approximately 1203.96 hours towards this requirement.

If your first day of absence is in the future, we will review your eligibility again at the start of your leave. If you are not eligible for Family Medical Leave on that date, we will determine your eligibility for any other available leaves of absence.

In order for us to determine if your Starbucks Medical Leave and Short Term Disability request may be *approved*, you must return the documentation listed below no later than **April 08, 2024.** If complete information is not provided by the deadline, your leave may be denied. Short Term Disability pay will not be paid until sufficient information is received to make an approval determination. Once you submit your completed paperwork, we will inform you of the decision within 5 business days.

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What You Need to Submit

These forms will be used to make a determination on Starbucks Medical Leave and Short Term Disability.

1. **Completed and signed Attending Physician Statement (enclosed). Each field is required to be completed, including the return to work date and supporting medical documentation (i.e., office visit notes and treatment plan).**

    - You may also submit equivalent information from the medical provider (i.e., office visit notes, treatment plan, or an alternate form preferred by your provider). This documentation must include all the information requested on the Attending Physician Statement.
    - **NOTE:** All medical documentation must be signed by the treating provider or be on medical letterhead.
        i. If you would like Sedgwick to request medical information on your behalf, please complete and return the "Authorization for Release and Use of Medical Information" (enclosed).

Medical is required for your request to be considered complete. It is your responsibility to have your medical provider complete the Attending Physician Statement and supporting medical documentation. You should also notify your manager that you are applying for leave.

Failure to provide complete documentation by April 08, 2024 may result in your leave request being delayed or denied. If your leave is denied and you miss time away from work, your absence will be considered unapproved. An unapproved absence may result in corrective action, up to and including separation from employment, and may also have an impact on your continued benefits eligibility.

It is important that you read through this packet and return the necessary information **before April 08, 2024**. Please submit documentation to Starbucks leave of absence administrator (Sedgwick) in one of the following ways:

- Upload to: mySedgwick.com/Starbucks
- Email (include case number in subject line): Starbucksmail@sedgwick.com (4A2403KWDV8-0001)
- Mail: PO BOX 14424, Lexington, KY 40512-4424
- Fax: (866) 315-0607

Keep a copy for your records. Any medical information you share is considered confidential. This information is only shared on a need-to-know basis with Starbucks, Sedgwick, or outside medical professionals retained to review your leave request. Return-to-work information (e.g., restrictions) will be shared with your manager and/or Partner Resources contact on a need-to-know basis.

Any charges for the requested medical documentation are your responsibility. While on leave, periodic requests may be made for updated medical records. Failure at any time to provide the requested records may negatively impact your ability to receive approval for additional leave time and/or pay replacement.

What You Need to Know

- **Benefit Contributions:** While on leave of absence, you are responsible for paying any benefit contributions (including health coverage). You will receive a monthly invoice from Starbucks Benefits Center with payment information. **If payment is not made by your deadline, your benefit coverage will be cancelled.**

- **Maintaining Benefits Eligibility:** While on leave you are still subject to the ongoing benefits eligibility audits. To account for the time you are not working and on approved leave, you will receive a credit of up to 20 hours per week for a maximum of 26 weeks. These hours will count towards your total hours requirement during the measurement period and will be reflected as LOA (Leave of Absence) hours on your pay statement.

- **Pay:** Short Term Disability pay begins on the earliest of the following:
    - the 8th consecutive calendar day of absence,
    - the first full day of hospitalization,
    - or the first full day of absence following outpatient surgery if you are totally and medically disabled as a result of surgery

  You may elect to use available sick or vacation time during your Short Term Disability waiting period if you wish to receive pay replacement. If approved, disability benefits will be paid out directly from Starbucks leave of absence administrator (Sedgwick). Should you elect to use available sick or vacation time at any point instead of approved Short Term Disability pay, you must inform us prior to the processing of Short Term Disability pay for those dates (typically 1 week prior to the pay date). Use of sick or vacation pay does not extend the total duration of your leave or Short Term Disability benefits. You will be responsible to repay Starbucks for any benefits paid erroneously under the Short Term Disability Plan.

- **State Benefits or Other Income:** Your Short Term Disability pay may be offset by other sources of income payable during your period of disability. This may include but is not limited to state disability benefits. If you are receiving any other income, you must provide proof of the amount in the form of an award letter, pay stub or other documentation with your other paperwork, or as soon as you receive it. Until we receive that information, your Starbucks benefit payment will be reduced by the maximum amount of pay you may receive from other income. Any adjustments, if needed, will be made upon review of your documentation to ensure you receive your full entitlement. If you fail to disclose other income sources in a timely manner, it may result in an overpayment, for which you will be responsible to repay.

For more information about your benefits while on leave of absence, see the Starbucks Leave of Absence Frequently Asked Questions (FAQ) at www.mySedgwick.com/Starbucks. To request a paper copy of the FAQ, call (888) SBUX-411.

Work Restrictions

Starbucks is committed to making reasonable accommodations for work restriction requests to assist you in performing the essential functions of your job when you return to work. To request assistance with work restrictions, retail and non-retail partners or managers should contact the Partner Resources Support Center at (866) 504-7368. You will be contacted within 2 – 5 business days. Manufacturing partners should contact their Partner Resources generalist to initiate the request.

Sincerely,

Starbucks Partner Care Team

To check the status of your leave, go to www.mySedgwick.com/Starbucks

If you have questions, experience a change in your medical condition or a change in your return to work plans, please contact (866) 206-6769 (Monday – Friday, 7:00 a.m. – 8:30 p.m. Central Time).

SPANISH (Español): Para obtener asistencia en Español, llame al [(866) 206-6769].

Attending Physician Statement
Behavioral Health (page 1)

Phone: (866) 206-6769| Web: www.mySedgwick.com/Starbucks| Fax: (866) 315-0607
Email: Starbucksmail@sedgwick.com|Sedgwick, P. O. Box 14424, Lexington, KY 40512-4424

Patient Name: Ben Cave
Claim Number: 4A2403KWDV8-0001
Due Date: 04/08/2024

Once this form is completed, please return by email to **Starbucksmail@sedgwick.com** or fax to **(866) 315-0607**.

Section 1: Required information to support FMLA/State Leave

1. Will the patient 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 yes, estimate the beginning and ending dates for the period of incapacity: _____/_____/____through _____/_____/____
2. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? Yes ☐ No ☐
   If yes, dates of admission: _____/_____/____ through _____/_____/____
3. Date(s) you treated the patient for condition:_____
4. When is the patient's next office visit? _____/_____/_____
5. Was medication, other than over-the-counter medication prescribed? Yes ☐ No ☐
6. Is the medical condition pregnancy? Yes ☐ No ☐ If yes, expected delivery date:____/_____/_____
7. Is the patient unable to perform any of his/her job functions due to their condition: Yes ☐ No ☐
   If yes, identify the job functions the employee is unable to perform (use the list of the employee's essential functions or job description, if included, or answer this question based upon the patient's own description of his/her job functions)
   _____
   _____
8. Describe other relevant medical facts, if any, related to the condition for which the patient seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment). DO NOT INCLUDE DIAGNOSIS IF PATIENT IS IN CA OR CT:
   _____
   _____

Section 2: Required information to support Disability Benefits

The patient's current disability plan requires that medical information indicate an inability to perform the essential duties of his/her own job.

Patient's occupation:

_____

Have you recommended to your patient to stay home from work? ☐ Yes ☐ No If yes, effective what date?___/____/____

Please provide your rationale for recommending the patient stay home from work

_____

_____

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Attending Physician Statement
Behavioral Health (page 2)

Patient Name: Ben Cave
Claim Number: 4A2403KWDV8-0001

Can your patient return to work with accommodations? ☐ Yes ☐ No If Yes, effective what date? ____/_____/_____

Please describe accommodations:_____

_____

Your patient will be released to work full duty on: ____/_____/_____

Please support your opinion with the following information:

(Please attach all office notes, History & Physical, results of x-rays, laboratory tests, MRI Reports, etc, if relevant)

DIAGNOSIS

Primary: ICD Code: _____ Description: _____

Secondary: ICD Code: _____ Description: _____

COGNITIVE FUNCTIONING EVALUATION

Applied focus and concentration in session for periods of:

☐ 30 to 50 minutes ☐ 15 to 30 minutes ☐ 5 to 10 minutes ☐ less than 5 minutes

Expressed his/her current circumstances and responded to direct questions appropriately: ☐ Yes ☐ No

If No, was redirection needed? ☐ Yes ☐ No Please describe:_____

Reasoning and/or Judgment: ☐ Within normal limits ☐ Impaired If impaired, please describe:_____

Delusional ideations evident: ☐ Yes ☐ No If yes, please describe:_____

Hallucinations reported: ☐ Yes ☐ No If yes, please describe:_____

Memory functions: Four (4) unrelated words after five (5) minutes: ___Other testing results: _____

Able to perform five operations of serial 7's or 3's: ☐ Yes ☐ No

Exam findings: _____

Able to follow direction and verbalize directions given during exam? ☐ Yes ☐ No

If no, please describe:_____

Able to read a narrative paragraph from a magazine or newspaper and report the main concept/idea of the passage:

☐ Yes ☐ No

EMOTIONAL FUNCTION AND BEHVAIORAL OBSERVATIONS

Date of last exam: _____Behavior(s) and emotional state observed during exam: _____

_____

Able to spontaneously compose her/himself: ☐ Yes ☐ No If no, please explain:_____

Psychomotor activity and ability to apply effort: ☐ unremarkable ☐ Impaired If impaired, describe:___

Presented with appropriate dress and hygiene in session: ☐ Yes ☐ No If no, please describe: _____

Impulse control: ☐ Physical abusive behavior ☐ Verbal abusive behavior ☐ Substance abuse/addiction ☐ alcohol abuse/addiction ☐ Manic Behavior

Speech: ☐ Slurred ☐ Pressured ☐ Stammering ☐ Loud ☐ Soft ☐ Over Productive ☐ Under Productive

☐ Other (please describe)_____

Attending Physician Statement
Behavioral Health (page 3)

Patient Name: Ben Cave
Claim Number: 4A2403KWDV8-0001

Risk to self/others:

Suicidal Ideations ☐ Yes ☐ No Plan reported: ☐ Yes ☐ No If yes, please explain:_____

Homicidal Ideations ☐ Yes ☐ No Plan reported: ☐ Yes ☐ No If yes, please explain:_____

Able to report reasons for not harming self/others: ☐ Yes ☐ No If no, please explain:_____

Contracted for safety: ☐ Yes ☐ No If no, please explain:_____

PATIENT SELF REPORT OF ACTIVITIES OF DAILY LIVING

Is the patient currently performing any of the following?:

☐ Volunteer work ☐ Works at a lesser demanding job ☐ Attending school ☐ No work activities in any capacity

☐ Self-employment

Has the patient conceptualized the following areas as barriers in returning to work:

☐ Increase in work demands ☐ Conflicts with supervisor ☐ Anticipation of relapse

☐ Recent unfavorable work evaluation ☐ Dissatisfaction with the job ☐ Other (please specify)_____

Has the patient expressed or are you aware that she/he is experiencing any psychosocial stressors? ☐ Yes ☐ No If yes, please describe:_____

Significant weight changes: ☐ Yes ☐ No Current weight:_____

Previous weight:_____Date of previous weight:_____

Significant appetite changes: ☐ Yes ☐ No If yes, please describe diet:_____

Significant sleep disturbance: ☐ wakes more than twice per night ☐ sleeps less 4 hours or less ☐ sleeps 12 hours or more

Are any of the above weight, appetite, or sleep disturbances related to medication side effects? ☐ Yes ☐ No If yes, please describe:_____

Panic attacks: ☐ Yes ☐ No Please specify below:

- Frequency of panic attacks: _____
- Duration of panic attacks: _____
- Symptoms experienced during panic attacks: _____

Socialization problems: ☐ Yes ☐ No If yes, please describe:_____

Is patient able to: Clean/maintain residence: ☐ Yes ☐ No

Perform routine shopping: ☐ Yes ☐ No Pay bills: ☐ Yes ☐ No

Operate motor vehicle: ☐ Yes ☐ No If no to any of these, please explain:_____

TREATMENT

Date initiated care: _____/_____/_____

Inpatient care: Date(s) of hospitalization: _____/_____/_____

Partial hospitalization programs: _____ Date(s) of care: _____

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Intensive outpatient (IOP): Start date: _____/_____/_____ End date:_____/_____/_____

Days per weeks: _____ Hours per day: _____

Attending Physician Statement
Behavioral Health (page 4)

Patient Name: Ben Cave
Claim Number: 4A2403KWDV8-0001

Outpatient psychotherapy: Frequency: _____ Date of next visit: _____

Medication management: Frequency: _____ Date of next visit: _____/_____/_____

Current medications/changes in medication-list all medications and identify dates of new medications or dose adjustments: (attach list if necessary)

Medication	Dose	Frequency	Duration	New Med	Adjusted Med	Date Adjusted
				Yes ☐ No ☐	Yes ☐ No ☐	___/____/____
				Yes ☐ No ☐	Yes ☐ No ☐	___/____/____
				Yes ☐ No ☐	Yes ☐ No ☐	___/____/____
				Yes ☐ No ☐	Yes ☐ No ☐	___/____/____

Medication side effects: ☐ Yes ☐ No If yes, please describe:_____

Please attach all office notes, History & Physical, etc., if relevant.

Telephone Number: _____ Physician Printed Name: _____

Fax Number: _____ Physician Specialty: _____

Date Completed: _____ Physician Signature: _____

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.

Authorization for Release and Use of Medical Information (Instructions)

Instructions for Completing and Returning the Enclosed Release and Use of Medical Information Authorization Form:

1. Complete all applicable areas of the form.

2. If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Employee/Claimant's behalf.

3. Sign this form.

4. Email, fax or mail this form to expedite processing of your claim.

5. Retain the original for your records.

Return to:

Email: Starbucksmail@sedgwick.com

Please note your case number (found on the first page of this packet) in the subject line of your email.

Fax: (866) 315-0607

Mail: Sedgwick Claims Management Services, Inc.

PO Box 14424

Lexington, KY 40512-4421

Please note that your refusal to complete and sign this form may affect your eligibility for benefits under your employer's disability plan.

HIPAA: This Release and Use of Medical Information Authorization is designed to comply with the regulations issued by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

NOTE TO ALL HEALTHCARE PROVIDERS: 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.

- **Short Term Disability Income Benefits and Leaves of Absence are administered by Sedgwick**
- **Long Term Disability Income Benefits are insured and administered by Unum Group**

Unum and Sedgwick are independent entities and are not affiliated with each other.

* "Unum" means: Unum Group and its subsidiaries, Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company, and persons who evaluate claims for any of those companies.

Employee Name:_Ben **Case #**_4A2403KWDV8-0001

Authorization for Release and Use of Medical Information (Form)

I understand that Unum* ("Unum"; Starbucks Long Term Disability administrator), and Sedgwick Claims Management Services, Inc. ("Sedgwick") provide insurance and/or administrative services related to the Starbucks ("My Employer"): 1) disability income benefit plan; and 2) requests for leave under the Family and Medical Leave Act (FMLA), state leave laws, and /or My Employer's leave of absence policy ("Leave Request") (collectively, "My Employer's Benefit Plans and Programs").

So Unum and Sedgwick may obtain information necessary to determine my eligibility for benefits under My Employer's Benefit Plans and Programs, and evaluation and administration of claims, including providing assistance with return to work:

I AUTHORIZE THE FOLLOWING PERSONS to provide information to UNUM, SEDGWICK, and/or any of their agents, representatives or independent contractors via phone, email, fax, mail, or by direct interview (whether or not I am present during or notified of, such communications):

1. Any healthcare professional, physician, surgeon, dentist, pharmacy, benefits manager, or other medical service provider
2. Any hospital, clinic, laboratory, ambulance service, or other medical or medical-related provider, facility or service
3. Any insurance company, health plan, third party administrator, insurance producer, insurance service provider
4. Any employer, disability service administrator, group policyholders, contract holders, or benefit plan administrators
5. Any government entity, professional licensing body, attorney, financial institution or bank,
6. Any consumer reporting agency including credit bureau
7. GENEX Services, Inc., The Advocator Group and any other Social Security advocacy vendor
8. Any educational, vocational, or rehabilitation evaluator, professional, organization or program

For such determination of eligibility and evaluation and administration of claims, this Authorization is valid for **24 months** from the date signed below, or the duration of my claim or Leave Request, whichever period is shorter.

I understand that once received by Unum and/or Sedgwick, any privacy protections established by HIPAA may not apply to My Information, but other privacy laws continue to apply. Unum and/or Sedgwick may then disclose My Information only as permitted by law, including, state fraud reporting laws, or as authorized by me.

I also authorize Unum and/or Sedgwick to release My Information to the following (for the purpose of reporting claim status or experience, or so that the recipient may carry out healthcare operations, claims payment, administrative or audit functions related to any benefit, plan, claim or program): 1) any person performing business or legal services on their behalf in connection with my claims for disability income benefits and/or my Leave Request, 2) to representatives of My Employer's Benefit Plans or Programs, 3) service providers for my long term disability claim, statutory disability claim, health and wellness program, health assistant/advocates, or workers' compensation claim, 4) any person providing services or insurance benefits to (or on behalf of) my employer, any such benefit, plan, claim or Program, or any benefit offered by Unum, or 5) the Social Security Administration. Unum or Sedgwick will not condition the payment of insurance benefits on whether I authorize the disclosures described in this paragraph. For the purposes of these disclosures by Unum or Sedgwick, this authorization is valid for one year or for the length of time otherwise permitted by law.

Information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease. My information to be disclosed may include, but is not limited to, medical or health history, (but not psychotherapy notes) chart notes, prescriptions, diagnostic test results, x-ray reports, records received from other health care providers, information regarding pre-existing health or medical conditions or illnesses, as well as my occupation and employment activities, employee/employment records, applications for insurance coverage, prior claim files and claim history.

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If directly related to my claimed condition or illness, this information may include the following, Please check yes or no and initial:

HIV test results, HIV or AIDS	Yes ☐	No ☐	Initial _____
Psychiatric information	Yes ☐	No ☐	Initial _____
Information related to drugs or alcohol	Yes ☐	No ☐	Initial _____

I also permit Sedgwick to contact any healthcare provider who has submitted a medical certification to Sedgwick in connection with my leave request in order to authenticate, clarify, or obtain any information missing on the certification.

I understand that I may revoke this authorization at any time by writing to the Starbucks Partner Care team at the address noted above in the Instructions for this Authorization form. Revocation of this authorization will not apply to any information that Unum or Sedgwick request or disclose prior to receiving my revocation request.

I understand that my revocation or my refusal to sign this authorization may cause a delay or denial of payment of disability benefits. I understand my healthcare providers will not condition my treatment, payment, enrollment or eligibility on my refusal to sign this authorization. I understand that my refusal to sign this authorization will not affect my eligibility for leave under the FMLA. I understand that a photocopy of this authorization is as valid as the original **and that I may request and receive a copy of this authorization.**

_____

Employee Signature Date

_____ _____

Employee ID (if applicable) Employee Date of Birth

_____

Authorized Representative Relation to Employee Date

We value your privacy. For more on what personal information we may collect, how we may use this information and other important areas relating to your privacy and data protection, please read our privacy notice www.sedgwick.com.

VOLUNTARY AUTHORIZATION TO SEEK CLARIFICATION OR AUTHENTICATION ON FMLA and/or State FMLA CERTIFICATION

Employee (Legal) Name: Benjamin Cave **Claim Number: C403180618200107AA**
Preferred/Known As Name: Ben Cave

In order to substantiate your leave request under the Family and Medical Leave Act (FMLA) and/or State FMLA, Sedgwick requires a health care provider certification ("FMLA Certification Form") to support your need for family and medical leave due to your own serious health condition or a family member's serious health condition. It is your responsibility to provide Sedgwick with a complete and sufficient certification. A certification is considered "incomplete" if one or more of the applicable entries on the certification form has not been completed. A certification is considered "insufficient" if the information provided is vague, ambiguous, or non-responsive. With your permission, once the certification has been submitted, the FMLA regulations allow Sedgwick, as the administrator of your employer's FMLA policy, to seek authentication or clarification from your health care provider if it is necessary to understand the meaning of a response or the handwriting on the medical certification.

I, _____, hereby authorize Sedgwick to make contact with my, or my family members, health care provider for the purpose of seeking authentication of the document or clarification of the information contained in the document. This Release and Consent does not authorize the disclosure of: 1) the identification of past, present, or future physical or mental health, or conditions of me or my family member; 2) the diagnosis or treatment provided to me or my family member; 3) payment for any health care received; or 4) genetic information. In addition, Sedgwick will not, nor does this Release and Consent authorize Sedgwick to, request information beyond that required by the FMLA Certification Form.

I understand, that I am, or my family member is, responsible for signing any releases or authorizations required under the Health Insurance Portability and Accountability Act (HIPAA) or other laws which would authorize the health care provider to discuss my certification for leave and provide the clarifications requested.

I acknowledge that this authorization is voluntary. However, if I do not provide a complete and sufficient certification form to Sedgwick and choose not to provide Sedgwick with this authorization, Sedgwick may deny the taking of FMLA leave.

I further understand that I have the right to revoke this authorization at any time by providing written notice to Sedgwick at the following address:

Sedgwick Claims Management Services, Inc.
PO BOX 14424
Lexington, KY 40512-4424

However, this authorization cannot be revoked if Sedgwick has taken action on this authorization prior to receiving written notice of such revocation. I also understand that I have a right to have a copy of

this authorization. This authorization is valid from the date of my signature below and shall expire one year from the date of this authorization.

_____ _____

Employee Signature Date

Your Rights and Responsibilities
Under the Federal Family and Medical Leave Act

The information below details your Rights and Responsibilities under the Family Medical and Leave Act (FMLA). Please review but note that no action beyond what is identified on the first page of this packet is required.

Basic Eligibility Criteria for FMLA

- Twelve-month length of service requirement (at the time your leave begins)
- 1,250 hours worked during the 12-month period immediately preceding your leave

If you have requested a first day of absence in the future, eligibility will be determined as of that date. If the number of hours worked in the 12 months preceding your first day of leave is different than the number of hours verified as of the date of this letter, you may not be eligible for FMLA leave and an amended notice of eligibility and rights & responsibilities will be sent to you.

If your leave qualifies under FMLA, you will have the following **rights and responsibilities** while on leave:

- You have the 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.
- Your health benefits must be maintained during any period of unpaid FMLA leave under the same terms and conditions as if you continued to work.
- 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.)
- 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 serious health condition 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 your employer for their share of health insurance premiums paid on your behalf during your FMLA leave.