Employee Leave Checklist
Maternity Leave
Employee's Own Serious Health Condition (pregnancy) and Parental Leave

Maternity Leave is a combination of leave for an Employee's Own Serious Health Condition and Parental Leave to bond with a newborn. You may be eligible for leave under the Family Medical Leave Act (FMLA) and the Oregon Family Leave Act (OFLA). These leaves entitle eligible employees up to 24 weeks of FMLA/OFLA leave. This includes up to 12 weeks of leave in a 12-month period for your own Serious Health Condition (pregnancy and recovery), in addition you may take up to 12 weeks under OFLA for parental leave. FMLA/OFLA protect your job and benefits. This leave is not a paid leave unless you have sick and/or vacation time to use. If you have Short Term Disability Insurance you may be eligible to use the wage replacement benefits it provides during the period of your own Serious Health Condition.

STEP 1: INFORMATION TO READ AND REVIEW

- □ FMLA Employee Rights Notice
- □ OFLA Employee Rights Notice
- □ OIT Notice of Employee Rights

STEP 2: COMPLETE LEAVE REQUEST FORM

- □ FMLA/OFLA Leave Request Form – complete and return to HR

STEP 3: MEDICAL CERTIFICATION

- □ Medical Certification – give to Medical provider and have them return to HR

STEP 4: LEAVE AND LEAVE BENEFITS

- □ If you have Short Term Disability Insurance
  - o Contact The Standard at 1-800-842-1707
- □ Complete your FMLA/OFLA Attendance Record/Leave Tracking Form and your Employee Leave slip every month

STEP 5: BENEFITS CHANGES (if you want to add new child to your benefits)

- □ Mid-Year Change Form - submit to HR within 30 days. Attach a copy of the birth record.
- □ Open Enrollment Correction Form - For babies born after Open Enrollment ONLY

STEP 6: LACTATION ACCOMMODATIONS

- □ Notify HR if you need accommodations prior to your return. HR will provide you key access and additional information on the current designated spaces.

STEP 7: RETURN TO WORK

- □ Notify HR at the time of your return

Employee Road Map to Medical Leave

Maternity Leave

1

Information to Read and Review

◊ FMLA Employee Rights Notice

◊ OFLA Employee Rights Notice

◊ OIT Notice of Employee Rights

2

Complete Leave Request Form

◊ FMLA/OFLA Leave Request Form—Complete and return to HR

3

Medical Certification

◊ Medical Certification—give to Medical provider and have them return to HR

4

Leave and Leave Benefits

◊ If you have Short Term Disability Insurance—Contact The Standard at 1-800-842-1707

◊ Complete your FMLA/OFLA Attendance Record/Leave Tracking Form and your Employee Leave slip every month

5

Benefits Changes (if you want to add new child to your benefits)

◊ Mid-Year Change Form—submit to HR within 30 days. Attach a copy of the birth record.

◊ Open enrollment Correction Form—For babies born after Open Enrollment ONLY.

6

Lactation Accommodations

◊ Notify HR if you need accommodations prior to your return. HR will provide you key access and additional information on the current designated spaces.

7

Return to Work

◊ Notify HR at the time of your return.

EMPLOYEE RIGHTS

UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

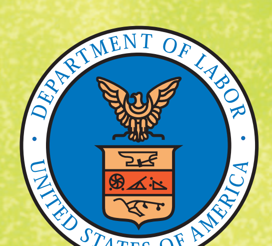
Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.



For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

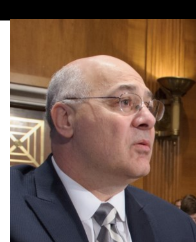
U.S. Department of Labor | Wage and Hour Division

WH1420 REV 04/16

BUREAU OF LABOR AND INDUSTRIES

Oregon FAMILY LEAVE ACT

Brad Avakian, Commissioner



NOTICE TO EMPLOYERS AND EMPLOYEES

The Oregon Family Leave Act (OFLA) requires employers of 25 or more employees to provide eligible workers with protected leave to care for themselves or family members in cases of death, illness, injury, childbirth, adoption and foster placement. ORS 659A.150-659A.186

When can an Employee take Family Leave?

Employees can take family leave for the following reasons:

- **Parental Leave** during the year following the birth of a child or adoption or foster placement of a child under 18, or a child 18 or older if incapable of self-care because of a mental or physical disability. Parental leave includes leave to effectuate the legal process required for foster placement or adoption.
- **Serious health condition leave** for the employee's own serious health condition, or to care for a spouse, same-gender domestic partner, custodial parent, non-custodial parent, adoptive parent, foster parent, biological parent, step parent, parent in law, parent of same-gender domestic partner, grandparent, grandchild, a person whom the employee is or was a relationship of in loco parentis, biological, adopted, foster or step child of an employee or the child of an employee's same-gender domestic partner.
- **Pregnancy disability leave** (a form of serious health condition leave) taken by a female employee for an incapacity related to pregnancy or childbirth, occurring before or after the birth of the child, or for prenatal care.
- **Sick child leave** taken to care for an employee's child with an illness or injury that requires home care but is not a serious health condition.
- **Bereavement leave** to deal with the death of a family member.
- **Oregon Military Family Leave** is taken by the spouse or same gender domestic partner of a service member who has been called to active duty or notified of an impending call to active duty or is on leave from active duty during a period of military conflict.

Who is Eligible?

To be eligible for leave, workers must be employed for the 180 day calendar period immediately preceding the leave and have worked at least an average of 25 hours per week during the 180-day period.

Exception 1: For parental leave, workers are eligible after being employed for 180 calendar days, without regard to the number of hours worked.

Exception 2: For Oregon Military Family Leave, workers are eligible if they have worked at least an average of 20 hours per week, without regard to the duration of employment.

Exception 3: For compensable Workers Compensation injuries, for certain Workers Compensation injuries involving denied and then accepted claims and for certain accepted claims involving more than one employer.

Exception 4: When an employee is caring for a family member with a serious health condition and the same family member dies, the employee need not requalify with the 25 hour per week average to be eligible for bereavement leave.

How much Leave can an Employee take?

- Employees are generally entitled to a maximum of 12 weeks of family leave within the employer's 12-month leave year.
- A woman using pregnancy disability leave is entitled to 12 additional weeks of leave in the same leave year for any qualifying OFLA purpose.
- A man or woman using a full 12 weeks of parental leave is entitled to take up to 12 additional weeks for the purpose of sick child leave.
- Employees are entitled to 2 weeks of bereavement leave to be taken within 60 days of the notice of the death of a covered family member.
- A spouse or same gender domestic partner of a service member is entitled to a total of 14 days of leave per deployment after the military spouse has been notified of an impending call or order to active duty and before deployment and when the military spouse is on leave from deployment.

What Notice is Required?

Employees may be required to give 30 days notice in advance of leave, unless the leave is taken for an emergency. Employers may require that notice is given in writing. In an emergency, employees must give verbal notice within 24 hours of starting a leave.

Is Family Leave paid or unpaid? Benefits?

- Although Family Leave is unpaid, employees are entitled to use any accrued paid vacation, sick or other paid leave.
- Employees are entitled to group health insurance benefits during family leave as if they continued working.

How is an Employee's job Protected?

Employers must return employees to their former jobs or to equivalent jobs if the former position no longer exists. However, employees on OFLA leave are still subject to nondiscriminatory employment actions such as layoff or discipline that would have been taken without regard to the employee's leave.

FOR ADDITIONAL INFORMATION:

Employer Assistance . . .971-673-0824
Portland 971-673-0761
Eugene 541-686-7623
Salem 503-378-3292

www.oregon.gov/BOLI

BOLI
Civil Rights Division
800 NE Oregon, #1045
Portland, OR 97232

Employees who have been denied available leave, disciplined or retaliated against for requesting or taking leave, or have been denied reinstatement to the same or equivalent position when they returned from leave, may file a complaint with BOLI's Civil Rights Division.

This is a summary of laws relating to Oregon Family Leave Act. It is not a complete text of the law.

January 2016

THIS INFORMATION MUST BE POSTED IN A CONSPICUOUS LOCATION

Notice of Employee Rights and Responsibilities
FMLA/OFLA Leave

<u>If your leave qualifies for FMLA and/or OFLA leave, you will have the following rights and responsibilities:</u>

Leave Entitlement: Effective the first day of your leave, time taken under the protected leave laws is counted against your leave entitlement. Generally you are entitled to 12 weeks of protected leave in a rolling 12-month period. The rolling 12-month period is measured backward from the date of any protected leave usage. Some leave types may be entitled to additional protected leave.

Paid Leave: You will be required to use your paid accruals (sick, vacation, etc.) during your FMLA/OFLA leave. This means you will use your paid leave (sick, vacation, etc.) and that such leave will also be considered protected under the FMLA/OFLA leave and counted against your protected leave entitlement.

- All Employees must use available accrued sick leave during FMLA/OFLA leave, unless the employee is on approved FMLA and is utilizing his/her short-term disability benefit.

- Classified Employees: Classified employees must use all accrued vacation leave during FMLA/OFLA leave before going in to unpaid status (leave without pay), unless the employee is on approved FMLA and is utilizing his/her short-term disability benefit. See the Oregon Public Universities/SEIU Collective Bargaining Agreement, Article 47-Vacation Leave, Section 14, regarding an employee's option to retain up to 40 hours of accrued vacation leave.

  Upon exhausting all accrued sick leave, classified employees may use accrued compensatory time, and/or personal leave during FMLA/OFLA leave.

  After exhausting all paid leave, classified employees may request hardship leave donations. See the Oregon Public Universities/SEIU Collective Bargaining Agreement, Article 40 – Sick Leave, Section 8.

- Unclassified Employees (faculty and administrative staff): Upon exhausting all accrued sick leave, unclassified employees may use accrued vacation leave time during FMLA/OFLA leave before going in to unpaid status (leave without pay).

- Employees may not go in and out of unpaid status, unless on approved FMLA/OFLA and receiving short-term disability benefits through Standard Insurance.

Benefits: Approved FMLA and OFLA Leave: Your health insurance coverage will continue provided you continue to contribute your portion of the premiums. Premiums will be deducted through normal payroll deduction when available. An employee who is in leave without pay status during FMLA and/or OFLA leave will be responsible to self-pay their portion of health insurance premiums directly to the University. Employee paid optional benefit premiums may be also be continued when self-paid by the employee.

If you do not return to work following FMLA and/or OFLA leave you may be required to reimburse the University for the employer share of health insurance premiums paid on your behalf during your leave.

Medical Certification: In order to determine whether an employee's absence qualifies for protected leave under the FMLA and OFLA leave laws, you may be required to provide a medical certification from a qualified health care provider within 15 calendar days of the receipt of your notice for eligibility to take protected leave. It is the

employees' responsibility to ensure a complete and sufficient medical certification is returned to Human Resources within the designated timeframe.

While on approved FMLA or OFLA leave, you may be required to furnish additional medical certifications if requested by Human Resources. The interval between re-certifying will not be less than 30 days, unless the circumstances for your leave have changed significantly.

Failure to provide a complete and sufficient Medical Certification may result in your leave being denied. Denied FMLA and/or OFLA is not protected under the leave statutes and the University may treat the absences as unexcused.

Periodic Check In: While on leave, you are required to check in periodically with Human Resources. You should provide information on your status, any change in circumstances, and if out for a continuous block of time, your intent to return work.

Status Changes: You are required to notify Human Resources if the status of your leave requirements changes. Status changes may include, but are not limited to: a need for continuous leave while on approved intermittent leave; a need for more intermittent leave than the amount currently approved; or a need for leave beyond the current approved end date. If you are on approved leave and no longer require time off for the approved reason, please contact Human Resources to close your file.

Leave Reporting: You are required to record any FMLA/OFLA leave taken on a leave tracking form which should be provided to Human Resources monthly.

Return to Work: If the status of your situation changes and you do not anticipate returning on your scheduled return date, you are expected to notify your supervisor and the Human Resources office as soon as possible.

When you return, you must be able to carry out the essential functions of your position. If your leave was for your own Serious Health Condition, you will be required to provide either a Return to Work form or a medical certification stating you are able to return to work without restrictions.

Reinstatement Rights: Upon returning from protected leave, you have the following reinstatement rights:

- FMLA: You must be reinstated to either the same position held when leave began or to an equivalent position. An equivalent position is one that is virtually the same as the employee's former position in terms of pay, benefits, and working conditions and must involve the same or substantially similar duties and responsibilities.
- OFLA: You must be reinstated to the position held when the leave began.

If you remain on leave after exhausting your protected leave entitlement (FMLA and/or OFLA), you will not have the reinstatement rights outlined above.

For additional information pertaining to leave, contact the Benefits Consultant at 541-885-1028.

Leave of Absence Request Form

EMPLOYEE INFORMATION			
Name:		**ID#:**	
Department:		**Job Title:**	
Employee Type:	❒ Classified ❒ Faculty ❒ Unclassified Admin		
Supervisor Name:			

Contact information while on leave	
Personal Email:	
Mailing Address:	
Phone:	

LEAVE INFORMATION	
I am requesting a leave of absence for the following reason:	
❒ My own serious health condition ❒ Birth of my child, and/or to care for the newborn child ❒ Placement of a child for adoption/foster care ❒ My child's NON-SERIOUS health condition	❒ To care for my family member with a serious health condition ❒ Qualifying military exigency leave ❒ Service member care leave (SMCL) ❒ Bereavement leave
If applicable, please specify the person the leave is for and the relationship:	
Name:	
Relationship:	

Is the condition due to an on-the-job injury or illness?	❒ Yes	❒ No	❒ N/A

I am requesting a leave of absence with the following schedule:			
❒ Full-time leave from		to	
❒ Intermittent leave from		to	
❒ Reduced-schedule leave from		to	
Describe proposed intermittent or reduced schedule:			

COMPENSATION DURING LEAVE			
Will you be applying for Short Term Disability (STD)?	❒ Yes	❒ No	❒ N/A
Will you be using leave during any STD waiting period?	❒ Yes	❒ No	❒ N/A
Will you be using leave to supplement your STD payment?	❒ Yes	❒ No	❒ N/A

Specify the types of leave you wish to use, the dates on which to apply it, and the total for each.

❒ Sick Leave			❒ Vacation			❒ Compensatory Time			❒ Leave without Pay		
From	To	Hours	From	To	Hours	From	To	Hours	From	To	Hours
Total Sick			*Total Vacation*			*Total Comp*			*Total LWOP*		

Use my special day on:		
Use my personal days on:		
I will use paid holidays on:		
I wish to retain		hours of vacation *(classified only, 40 hours maximum)*

________________________________ ____________________

Employee Signature **Date**

HEALTH CARE PROVIDER
CERTIFICATION FOR SERIOUS HEALTH CONDITION

This optional form is designed to help determine if an employee is eligible for leave under either or both the federal **Family and Medical Leave Act (FMLA)** and/or the **Oregon Family Leave Act (OFLA).**

▲Indicates that an affirmative answer to this question is *not required* for OFLA or concurrent OFLA & FMLA leave.

* Indicates categories that qualify as OFLA leave *only*.

Employers are *not required* to use this form in order to designate leave as OFLA or FMLA protected.

Information sought on this form relates only to the condition for which the employee is taking leave.

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) *and the Oregon Family Leave Act (OFLA)* provide that an employer may require an employee seeking FMLA*/OFLA* protections because of a need for leave to care for a covered family member with a serious health condition or *because of a need for leave due to employee's own serious health condition* to submit a medical certification issued by the health care provider of the covered family member *or a medical certification issued by the employee's own health care provider, whichever is appropriate.* 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' family members, created for FMLA purposes as **CONFIDENTIAL** medical records in separate files/records from the usual personnel files, 29 C.F.R. § 825.500(g), and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies. This also applies to OFLA. ORS 659A.186(2); ORS 659A.136.

Employer name: ____

Employer contact: ____

If this form is being completed for employee's own serious health condition, please also provide the following information:

Employee's job title: ____

Regular work schedule: ____

Employee's essential job functions:

____

____

____

____

Check if job description is attached: ☐

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to *patient's (your own or your covered family member's)* health care provider. FMLA/OFLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA/OFLA leave due to your own *or your covered family member's* serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA/OFLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in delay or denial of FMLA protection. 29 C.F.R. § 825.313. Your employer must give you 15 calendar days to return this form. 29 C.F.R. § 825.305(b), OAR 839-009-0260(4).

Employee's Name: ____

Patient's Name (*if different from employee*): ____

If patient is a child, date of birth (mm/dd/yyyy): ___/___/______

Patient's Relationship to Employee (*if employee is not the patient*):

☐	Spouse, *or*	☐ (**OFLA only*) Same-gender Domestic Partner
☐	Parent, *or*	☐ (**OFLA only*) Parent-in-law, *or* ☐ (**OFLA only*) Parent of employee's same-gender Domestic Partner
☐	Child, *or*	☐ (**OFLA only*) Child of employee's same-gender Domestic Partner
☐	Employee is currently *in loco parentis* (see definition below) to patient who is under age 18 or incapable of self-care due to disability. (Employee has financial or day-to-day responsibility for care of the patient – covered by OFLA and FMLA)	
☐	(**OFLA only*) Employee was *in loco parentis* to patient. (Employee had financial or day-to-day responsibility for care of the patient when the patient was under 18 – *OFLA only*)	
☐	Patient was *in loco parentis* to employee (Patient had financial or day-to-day responsibility for care of the employee *when employee was under 18*)	
☐	Grandparent (**OFLA only*)	
☐	Grandchild (**OFLA only*)	

"*In loco parentis*" means in the place of a parent, having financial or day-to-day responsibility for the care of a child. A legal or biological relationship is not required.

☐ (**OFLA only*) Check here if requesting "Sick Child Leave", which is available under OFLA for a child's non-serious health condition. (Completion of this form is only necessary *after* a 3rd occurrence of using Sick Child Leave during a "leave year".)

Employee Signature: ____

CONTINUED ON NEXT PAGE

SECTION III : For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Either your patient has requested leave under the FMLA/OFLA ***or*** *the employee listed above has requested leave under the FMLA/OFLA 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/OFLA coverage. Limit your responses to the condition for which the employee is seeking leave.

______________________________	______________________________
Printed Name of Physician/ Practitioner	Date Signed
______________________________	______________________________
Signature of Physician/ Practitioner	Type of Practice/ Field of Specialization
______________________________	______________________________
Address	Phone Number

PART A: MEDICAL FACTS

Note: *If* this form is being used for the purposes of filing for the certification of OFLA's *non*-serious health condition of a child, only complete **# 1*.**

1) Approximate date condition commenced: ____

   a) Probable duration of condition: ____

   b) Was the patient admitted for inpatient care in a hospital, hospice, or residential medical care facility?

      No-☐ **Yes**-☐ If "yes", dates of admission: ______________________

   c) Date(s) you treated the patient for the condition: ________________________________

   d) Was medication, other than over-the-counter medication, prescribed? **No**-☐ **Yes**-☐

   e) Will the patient need to have treatment visits at least twice per year due to the condition?

      No-☐ **Yes**-☐

   f) Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? **No**-☐ **Yes**-☐ If "yes", state the nature of such treatments and expected duration of treatment:

      ____

      ____

CONTINUED ON NEXT PAGE

2) Is the medical condition pregnancy? **No**-☐ **Yes**-☐ If "yes", expected delivery date: ___________

3) If patient is EMPLOYEE: Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   a) Is the employee unable to perform any of his/her job functions due to the condition?

      No-☐ **Yes**-☐

      If "yes", identify the job functions the employee is unable to perform:

      ____

      ____

4) Describe other 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):

   ____

PART B: AMOUNT OF CARE NEEDED When answering these questions, keep in mind that your patient's need for care may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

5) Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? **No**-☐ **Yes**-☐

   If "yes", estimate the beginning and end dates for any period of incapacity: ______________________

   If this certification relates to the employee's seriously ill family member(s), also complete the following:

   a) Does the patient require assistance for basic medical or personal needs or safety, or for transportation? **No**-☐ **Yes**-☐

   b) Would the employee's presence to provide psychological comfort be beneficial or assist in the patient's recovery? **No**-☐ **Yes**-☐

   c) If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration and frequency of this need: _____________________________________.

   Please explain the care needed by the patient:____

   ____

CONTINUED ON NEXT PAGE

▲ Affirmative answer to the following question is not required for *OFLA* or concurrent OFLA/FMLA leave.

Is this care medically necessary? **No**-☐ **Yes**-☐

6) 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:

____

____

▲ Affirmative answer to the following question is not required for *OFLA* or concurrent OFLA/FMLA leave.

Is this care medically necessary? **No**-☐ **Yes**-☐

7) Will it be necessary for the employee to take leave only intermittently or to work on a less than full-time schedule basis because of the condition or treatment? **No**-☐ **Yes**-☐

If "yes", expected duration: ____

Frequency (Check One):

☐ One (1) to two (2) days per month
☐ Two (2) to three (3) days per month
☐ Three (3) to four (4) days per month
☐ Other - *Explain*: ____

Please explain how employee will use leave intermittently, being as specific as possible including frequency and duration of absences: ____

8) Will the patient require a regimen of treatment? **No**-☐ **Yes**-☐

If "yes", describe the nature of the treatments: ____

____

Estimated number of treatments: ____

Estimated interval between treatments: ____

Estimated or actual dates of treatments: ____

What is the duration (and any period required for recovery) for a treatment?

____

▲ Affirmative answer to the following question is not required for *OFLA* or concurrent OFLA/FMLA leave.

Is this care medically necessary? **No**-☐ **Yes**-☐

CONTINUED ON NEXT PAGE

▲ Affirmative answer to the following questions is not required for *OFLA* or concurrent OFLA/FMLA leave.

9) Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities or performing his/her job functions? **No**-☐ **Yes**-☐

▲ If "yes", is it medically necessary for employee to be absent from work during the flare-ups?

No-☐ **Yes**-☐ If "yes", please explain: ______________________________

Affirmative answer not required for OFLA or concurrent leave

____

▲ 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

Affirmative answers not required for OFLA or concurrent leave

▲ Does the patient need care during these flare-ups? **No**-☐ **Yes**-☐

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

____
____
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FMLA/OFLA ATTENDANCE RECORD / LEAVE TRACKING FORM

Name: ______________________________

Department: ______________________________

Employee ID#: ______________________________

Instructions: Please record the number of hours you were off each day while on FMLA/OFLA leave. Include holidays.
Do not include days you would not have been expected to be at work (your normal days off).
Return this form at the end of each month.

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
Jan																																	
Feb																																	
Mar																																	
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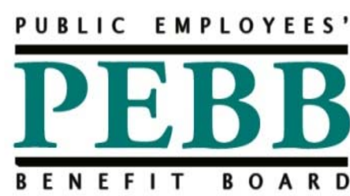
Jul																																	
Aug																																	
Sep																																	
Oct																																	
Nov																																	
Dec																																	

Employee's Signature: ______________________________

Date: ______________________________

Supervisor's Signature: ______________________________

Date: ______________________________



Midyear Change

- Office Use Only -

Approved by: ________ Date:_______

Effective Date:______________

See the Summary Plan Description for more information on benefits at www.oregon.gov/OHA/PEBB

1. Because I experienced a qualified midyear change, I want to:

☐ Add an individual to coverage ☐ Remove an individual from coverage (complete Section 5) ☐ Change my current plan enrollments

2. Contact Information **You must complete all fields.**

PEBB Benefit Number (P########), OR# or University ID

Last Name	First Name	M	Agency	Gender ☐ M ☐ F

Contact Address ☐ Check if New Address	Apt #	City	State	Zip

Residence Zip Code	Work Zip Code	Work Email	Personal Email (optional)

Date of Birth (mm/dd/yyyy)	Work Phone	Home Phone (Optional)

Are you Medicare Eligible? ☐ No ☐ Yes This will not affect enrollment.

Are you serving or did you ever serve in the military? ☐ No ☐ Yes

Do you authorize PEBB to send your name and address to Oregon Department of Veteran's affairs (ODVA) for the purpose of receiving benefit information? ☐ No ☐ Yes

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Non-Latino ☐ Unknown ☐ Refuse

Race: ☐ Asian ☐ White ☐ Unknown ☐ Refuse ☐ Other

☐ Black/African American ☐ American Indian Alaska Native ☐ Native Hawaiian/Other Pacific Islander

3. Family Coverage
List only the family members you want to either enroll or remove from coverage. Attach separate sheet if necessary.

Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Gender M F	Enroll Med ☐ Den ☐ Vision ☐
					☐ ☐	Cancel Coverage M ☐ D ☐ V ☐

Address: Complete only if different than in Section 1

Is This Dependent Medicare Eligible? ☐ No ☐ Yes This will not affect enrollment.

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Non-Latino ☐ Unknown ☐ Refuse

Race: ☐ Asian ☐ White ☐ Unknown ☐ Refuse ☐ Other
☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander

3a. If you listed a Domestic Partner, mark the type of Domestic Partnership

☐ Registered Certificate of Domestic Partnership (Copy not required) You have a registered certificate issued by an Oregon county clerk to you and your same sex partner.

☐ PEBB Domestic Partner Affidavit is a partnership between an eligible employee and an individual of the opposite sex, or same sex without a Certificate of Registered Domestic Partnership. If you are **adding a new domestic partner** by affidavit you must submit an affidavit along with this form to your payroll/HR benefit office. The individual's enrollment will not take effect if the affidavit is not submitted.

NOTE: Adding a Domestic Partner or Domestic Partner's children to your coverage when they are not your tax dependent(s) will lower your monthly net pay. For information see the Summary Plan Description http://www.oregon.gov/oha/pebb/Pages/spd.aspx page 17.

Is your partner, or are your domestic partner's children your federal tax dependents? If so complete and submit to your agency the Domestic Partner Certification for Dependent Tax Status **each plan year.** Imputed value won't be added to your pay.
http://www.oregon.gov/oha/pebb/Pages/forms.aspx

When an enrollment requires additional documents and affidavits your payroll or university benefit office must receive them along with your enrollment form or the individual's coverage will not take effect.

3b. Eligible Dependent Children – List only the family members you want to either enroll or remove from coverage. Adding (new) Children by Dependency or Grandchildren to your enrollment will require submission of the enrollment, appropriate affidavit, and may require legal documentation. Affidavits or legal documents are required along with the enrollment form or the individual's coverage will not take place.

Child Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Gender M F	Enroll Med ☐ Den ☐ Vision ☐
					☐ ☐	Cancel Coverage M ☐ D ☐ V ☐

Address: Complete only if different than Address in Section 2

Is This Dependent Medicare Eligible? ☐ No ☐ Yes This will not affect enrollment.

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Non-Latino ☐ Unknown ☐ Refuse

Race: ☐ Asian ☐ White ☐ Unknown ☐ Refuse ☐ Other
☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander

Child Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Gender M F	Enroll Med ☐ Den ☐ Vision ☐
					☐ ☐	Cancel Coverage M ☐ D ☐ V ☐

Address: Complete only if different than Address in Section 2

Is This Dependent Medicare Eligible? ☐ No ☐ Yes This will not affect enrollment.

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Non-Latino ☐ Unknown ☐ Refuse

Race: ☐ Asian ☐ White ☐ Unknown ☐ Refuse ☐ Other
☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander

3c. Eligible Dependent Children – continued

Child Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Gender M F	Enroll Med ☐ Den ☐ Vision ☐
					☐ ☐	Cancel Coverage M ☐ D ☐ V ☐

Address: Complete only if different than Address in Section 2

Is This Dependent Medicare Eligible? ☐ No ☐ Yes This will not affect enrollment.

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Non-Latino ☐ Unknown ☐ Refuse

Race: ☐ Asian ☐ White ☐ Unknown ☐ Refuse ☐ Other ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander

Child Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Gender M F	Enroll Med ☐ Den ☐ Vision ☐
					☐ ☐	Cancel Coverage M ☐ D ☐ V ☐

Address: Complete only if different than Address in Section 2

Is This Dependent Medicare Eligible? ☐ No ☐ Yes This will not affect enrollment.

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Non-Latino ☐ Unknown ☐ Refuse

Race: ☐ Asian ☐ White ☐ Unknown ☐ Refuse ☐ Other ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander

4. What changed in your life? (The event date must be included.)

See QSC Matrix at http://www.oregon.gov/OHA/PEBB in the Summary Plan Description

☐ Marriage	Date:	☐ Divorce or annulment	Date:
☐ Met eligibility for domestic partnership	Date:	☐ Termination of domestic partnership	Date:
☐ Birth	Date:	☐ Death of dependent or spouse	Date:
☐ Adoption or placement for adoption (legal documentation required)	Date:	☐ Dependent loses other medical group coverage	Date:
☐ Dependent gains other medical group coverage	Date:	☐ Employee gains other group coverag	Date:
☐ National Medical Support Notice (NMSN)	Date:	☐ Move out of current plan's service area	Date:
☐ Employment status change (describe) ______	Date:	☐ Loss of other group medical coverag	Date:
☐ Other reason (describe):			Date:

5. Did you terminate coverage for an individual?

Name and address for all dependents is required for COBRA notice.

Name	Address	City and State	Zip

6. Core Benefits (Medical/Dental/Vision)

Full Time employees are eligible for full time plans only. Part time employees are eligible for part time or full time plans. See your agency benefits office for premium share information.

6a. Medical Plans/Dental Plans:

Some plans have specific service areas and may not be available to you, be sure to review plan availability for your area.

- Opting Out is a choice of receiving cash instead of choosing a medical plan enrollment. Opt Out enrollees are eligible for dental, vision, and optional coverages. To Opt Out, complete Section 6c.

Medical: **Check one box below for your 2017 medical plan**

	Full Time	Part Time
AllCare PEBB	☐	☐
Kaiser Deductible (Kaiser vision included with full time plan)	☐	☐
Kaiser HMO (Kaiser vision included with full time plan)	☐	☐
Moda Summit	☐	☐
Moda Synergy	☐	☐
PEBB Statewide PPO	☐	☐
Providence Choice	☐	☐

Dental: **Check one box below for your 2017 dental plan. You must be enrolled in a medical plan or Opt Out to enroll in a dental plan.**

	Full Time	Part Time
Kaiser Permanente	☐	☐
MODA Premier	☐	☐
MODA PPO	☐	N/A
Willamette Dental	☐	N/A

☐ **I Decline all Dental Plan Enrollment**

6b. Vision Plan:

Both the full time Kaiser HMO and the Kaiser Deductible plan include Kaiser vision coverage and are not eligible for VSP enrollment. All other medical plans (full or part-time), including the Kaiser part-time plans and Opt Out, are eligible for enrollment in VSP coverage. You must be enrolled in a medical plan or Opt out to enroll in VSP. Note: When you enroll for the Plus Plan, you pay a premium share percentage for Basic Plan coverage (e.g. 1%, 3%, 5% etc.…) and the premium price difference between the Basic plan and the Plus Plan.

Enroll VSP Basic Plan –	☐
Enroll VSP Plus - Includes the Basic Plan and PLUS additional benefits	☐
I Decline all VSP Enrollment	☐

Information on the VSP Basic and VSP Plus is available at: http://www.oregon.gov/oha/pebb/Benefits/Vision.pdf

6c. Medical Opt Out

To enroll in Opt out you must attest at enrollment to having an alternative minimum essential medical coverage. You do not need to provide proof of alternative medical coverage. See information at: http://www.oregon.gov/oha/pebb/benefits/opt-out.pdf Opt Out employees receive a monthly cash amount in lieu of enrollment in a PEBB medical plan. Full time employees will receive a taxable $233 monthly, less $1 for basic life. Part-time employee amounts are pro-rated.

Opting Out of a medical enrollment is conditioned upon my understanding and attesting that the following statements are true:

- I and all other individuals for whom I reasonably expect to claim a personal tax exemption deduction for have, or will have, an alternative medical coverage considered to be minimum essential coverage through an employer sponsored medical plan for the taxable year 2017. The following coverages are not eligible to Opt Out against: Oregon Health Plan/Medicaid, Veteran's Benefit Administration Programs, Student Health, and individual market coverage.
- I understand my employer will not pay the monthly opt-out payment to me if my employer knows or has reason to know that myself or any other member of my expected tax family does not have or will not have the alternative coverage.
- I understand that I must renew this attestation each plan year and applicable tax year for which I want the Opt Out to apply.

☐ **Enroll me in Opt Out.**
By checking this box and signing the form (Section 13) I verify the above statements are true.

6d. Decline All PEBB Benefits ☐

If you decline core benefits (medical/dental/vision/employee basic life), you're choosing to not participate in any of the PEBB programs. You will not receive cash in lieu of the medical coverage and you are not eligible to enroll in any PEBB plans.

7. Other Spousal/Partner Employer Group Coverage **If you enroll in a medical plan and do not complete Section 5 a surcharge ($50) will be deducted each month from your 2017 pay.**

When your spouse or domestic partner **is enrolled in your PEBB medical coverage** and has access to medical coverage from their employer's sponsored group plan (i.e., a non- State of Oregon) but does not enroll for it, $50 will be added to your monthly PEBB premium.

Check one box:

☐ My spouse/domestic partner has PEBB coverage as an eligible employee (Includes a spouse who enrolls in Opt Out) ($0)
☐ My spouse/domestic partner has other employer group coverage available and enrolls for that coverage. ($0)
☐ My spouse/domestic partner has other-employer group overage available, but does not enroll in that coverage and is enrolled in PEBB coverage. ($50)
☐ My spouse/domestic partner does not have other-employer group coverage available.($0)
☐ I do not cover a spouse or domestic partner in a PEBB medical plan. ($0)

8. Tobacco Use **If you enroll in a Medical plan and do not complete Section 6 a tobacco surcharge ($25.00 per employee and $25.00 for spouse/partner enrolled in medical) will be deducted each month from your 2017 pay for PEBB coverage.**

Check one box:

☐ I currently use tobacco and, my spouse/domestic partner currently does not use tobacco. ($25)
☐ I currently do not use tobacco, and my spouse/domestic partner currently uses tobacco.($25)
☐ Both my spouse/domestic partner and I currently use tobacco.($50)
☐ Both my spouse/domestic partner and I currently do not use tobacco.($0)
☐ I currently use tobacco and do not have a spouse/domestic partner covered in PEBB. ($25)
☐ I currently do not use tobacco and do not have a spouse/domestic partner covered in PEBB. ($0)
☐ I do not enroll in PEBB medical plans.
☐ My or ☐ My spouse's or domestic partners' provider advised not to quit using tobacco (Medical Waiver). ($0)

9. Optional Life Insurances – Complete only the sections required for enrollment.

9a. Dependent Life Insurance

provides $5,000 of coverage for each of your PEBB eligible dependent (including spouse or domestic partner). Medical history is **not** required. Premium rate is a total of $1.29 per month. See information at: http://www.oregon.gov/oha/pebb/Pages/Dependent-Life.aspx

☐ Enroll for Coverage ☐ Cancel Coverage

9b. Employee Optional Life Insurance

Medical History Statement is required for a new enrollment or increases to existing coverage. Medical History Form ($20,000 increments, maximum $600,000). Rates and information at: http://www.oregon.gov/oha/pebb/Pages/Optional-Employee-Life.aspx

☐ Enroll or Increase Coverage	☐ Cancel Coverage	☐ Reduce Coverage to:
Newly eligible ONLY (Guarantee issue) ☐ $20,000 or ☐ $40,000 or ☐ $60,000 or ☐ $80,000 or ☐ $100,000 +	**Additional Amount Requested** (Medical History Required by Nov. 4, 2016) $___________=	**Total Amount** $_________

Required: Tobacco use status, check one

☐ I have used tobacco products in the previous 12 months. (Tobacco premium rates apply)

☐ I have not used tobacco products in the previous 12 months. (Non-Tobacco premium rates apply.)

9c. Spouse or Domestic Partner Optional Life Insurance

Medical History Statement required for a new enrollment or increases to existing coverage. Medical History Form ($20,000 increments up to maximum of $400,000). Rates and information at: http://www.oregon.gov/oha/pebb/Pages/Spouse-Partner-Life.aspx

☐ Enroll or Increase Coverage	☐ Cancel Coverage	☐ Reduce Coverage to:
Newly Eligible ONLY (Guarantee issue) ☐ $20,000 +	**Additional Amount Requested** (Medical History Required by Nov. 4, 2016) $___________=	**Total Amount** $_________

Required: Tobacco use status, check one

☐ I have used tobacco products in the previous 12 months. (Tobacco premium rates apply)

☐ I have not used tobacco products in the previous 12 months. (Non-Tobacco premium rates apply.)

10. Disability Insurance
The benefits will replace a portion of salary when the employee has a qualified disability claim.

10a. Short Term Disability
The premium rate is 0.0064 times your gross monthly salary. Rates and information at: http://www.oregon.gov/oha/pebb/Pages/Short-Term-Disability.aspx

☐ Enroll for Coverage ☐ Cancel my Coverage

10b. Long Term Disability
The monthly premium is determined by the rate (listed next to the plan) time your gross monthly salary. Rates and information at: http://www.oregon.gov/oha/pebb/Pages/Long-Term-Disability.aspx

☐ Enroll for Coverage (select one)	☐ Change my Coverage (select one)	☐ Cancel my Coverage
	☐ 90 days – 60% (.0051)	☐ 90 days – 66 2/3% (.0106)
Waiting Periods – Coverage Level	☐ 180 days – 60% (.0018)	☐ 180 days 66 2/3% (.0027)

11. Accidental Death Dismemberment (AD&D)
Rates and information at: **http://www.oregon.gov/oha/pebb/Pages/ADD.aspx**

☐ Cancel My Coverage

☐ Employee only Coverage (premium = $1 per $50,000, $50,000 increments, max $500,000	Total Coverage Amount $_________
☐ Employee & Dependent Coverage (premium = $1.70 per $50,000, $50,000 increments, max $500,000)	Total Coverage Amount $_________

12. Beneficiary Designation
Entity Key: I – Individual, W – Will, T = Living Trust. Total of primary percentages must = 100%. Total of contingent percentages must = 100% You can change your beneficiary designation yourself anytime during the year at http://www.pebb.benefits.oregon.gov/members/!pb.main

☐ **Standard Order of Survivorship (No beneficiary listed)** ☐ **Designate the following as beneficiary. (List beneficiary)**

Name	Relationship	Address	Entity	Primary	Contingent	Whole %
				☐	☐	
				☐	☐	
				☐	☐	

13. Employee Signature and Authorization If you elected the Medical Opt Out, your signature indicates you agree to the terms of the Opt Out alternative coverage self-attestation.

I declare that the individuals listed on the enrollment form and I are eligible for the coverage requested. I understand the benefit elections made on this application are in effect for as long as I continue to meet PEBB's eligibility requirements, or until I elect to change them subject to the provisions of PEBB's plan. I have read the benefit materials and I understand the limitations and qualifications of the PEBB benefits program. If necessary, I authorize premium payments deducted from my pay.

I understand that:

- A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines.
- Knowingly making a false statement may subject me to termination of enrollment, denial of future enrollment, or civil damages.

I also understand that if I fail to report on this enrollment form a change that made an enrolled family member ineligible, PEBB may consider my omission an intentional misrepresentation of a fact material to my enrollment. In that case, PEBB may terminate the family member's coverage retroactively, pursuant to PEBB rules.

This form supersedes all forms and submissions I previously made for PEBB coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that they are subject to penalty for false claims.

____ ______________________

Employee Signature Date

If you DO NOT want premiums deducted on a before tax basis, initial here________.

Submit completed form to your agency payroll or university benefits office

Keep a copy of your benefit forms for your records.

Any alteration of this form may result in it being ineffective.

Employee Leave Sample Scenarios
Maternity Leave

weeks	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
Scenario 1: work up to delivery, natural delivery, no complications, has short term disability insurance																																				
OFLA *"Pregnancy Disability"*																																				
FMLA																																				
OFLA *"Baby Bonding"*																																				
STD (only if enrolled)	X																																			
Scenario 2: work up to delivery, c-section delivery, no complications, has short term disability insurance																																				
OFLA *"Pregnancy Disability"*																																				
FMLA																																				
OFLA *"Baby Bonding"*																																				
STD (only if enrolled)	X																																			
Scenario 3: doctor puts employee off work 4 weeks prior to due date, natural delivery, no complications, has short term disability insurance																																				
OFLA *"Pregnancy Disability"*																																				
FMLA																																				
OFLA *"Baby Bonding"*																																				
STD (only if enrolled)	X																																			
Scenario 4: doctor puts employee off due to complications, newborn is ill after 12 weeks of baby bonding, has short term disability insurance																																				
OFLA *"Pregnancy Disability"*																																				
FMLA																																				
OFLA *"Baby Bonding"*																																				
OFLA *"Sick Child Leave"*																																				
STD (only if enrolled)	X																																			

FMLA	Family Medical Leave Act: Federal law providing up to 12 weeks of leave during Pregnancy Disability and Baby Bonding
OFLA	Oregon Family Leave Act: State law providing up to 12 weeks of leave for "Pregnancy Disability"
OFLA	Oregon Family Leave Act: State law providing up to 12 weeks of leave for "Baby Bonding"
OFLA	*Oregon Family Leave Act: State law providing up to 12 weeks of leave for "Sick Child Leave" (very rare)*
STD	Short Term Disability: (if enrolled) 7 day waiting period, 13 weeks maximum while "disabled" by pregnancy/birth