GROUP BENEFIT SOLUTIONS

NYL GBS Leave Solutions
Certification of Health Care Provider for Employee's Serious Health Condition

Date Prepared: _____

Must Be Returned By: _____

Employee Name: _____

Employer Name: _____

Leave ID: _____

Reason for requesting leave: _____

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

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b). If your certification is returned incomplete or insufficient, your employer must give you at least 7 calendar days to cure any deficiency. 29 C.F.R. § 825.305(c).

The Genetic Information Nondiscrimination Act of 2008 (GINA), and, where applicable, the California Genetic Information Nondiscrimination Act of 2011 (CalGINA), prohibits employers and other entities covered by GINA Title II, and where applicable CalGINA, from requesting or requiring genetic information of employees or their family members, except as specifically allowed by law. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information, unless failing to provide the information will result in an incomplete or insufficient certification. **(If the employee is seeking leave under the District of Columbia Family and Medical Leave Act, genetic information should not be provided under any circumstance.)** '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. "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

*PLEASE BE SURE TO RETURN ALL PAGES

Employee Job Title: _____Regular Work Schedule:_____

_____ _____

Employee Signature **Date**

NYL GBS Leave Solutions • P.O. Box 703509 • Dallas, TX 75370 • Fax: 866.931.5095 • Phone: 888.842.4462

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the 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 sign the form on the last page.

Subsection A: Must be completed for ALL types of leaves:

1. Provider's name: _____Phone #_____Fax #_____
   Address:_____ Email:_____
   Type of practice / Medical specialty: _____

Please complete the following:

2. Approximate date condition commenced:_____ Probable Duration of condition:_____

3. Date(s) you treated the patient for condition in the past 12 months:_____

4. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ___No ___Yes
   If yes, dates of admission in the past 12 months: _____

5. Will the patient need treatment visits at least twice per year due to the condition? ___No ___Yes

6. Was medication, other than over-the-counter medication, prescribed? ___No ___Yes

7. Is the medical condition pregnancy? __No __Yes, If yes, expected delivery date: _____

8. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes: If yes, explain_____

9. Is the employee unable to perform any of his/her job functions due to the condition based on the employee's own description of his/her job? __No __Yes:
   If yes, identify the job functions the employee is unable to perform: _____

10. 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) **(Note: If the employee is requesting leave under the California Family Rights Act or the Connecticut Family and Medical Leave Act, do not include diagnosis information)**:
    _____
    _____

Subsection B: Must be completed for all CONTINUOUS LEAVES:

1. Will the employee be incapacitated for a **single continuous period of time** due to his/her medical condition, including any time for treatment and recover? ____ No ____ Yes
If yes, estimate the beginning and ending dates for the period of incapacity:

Start Date _____ End Date _____

(Form is considered incomplete / insufficient if not provided for a continuous leave)

Subsection C: Must be completed for all REDUCED SCHEDULED LEAVES:

1. Is it **medically necessary** for the employee to work part-time or a reduced schedule because of the employee's condition? (this includes follow up treatment appointments) ___ No ___ Yes

If yes, estimate the part-time or reduced work schedule the employee needs:

_____ hour(s) per day _____ time(s) per week _____ time(s) per month

Start Date _____ End Date _____

(Form is considered incomplete / insufficient if not provided for a reduced / part-time leave)

Subsection D: Must be completed for all INTERMITTENT LEAVES.

1. Will the employee need intermittent time off, ____No _____Yes: if yes, estimate the beginning and ending dates for the period the patient needs to be out of work: Start Date_____ End Date_____

2. **OFFICE VISITS / TREATMENTS:**

Based upon the patient's medical history and your knowledge of the medical condition, estimate the maximum frequency of follow-up treatments/office visits that employee would need off work for related incapacity that the employee may experience over the next 6 months.

(e.g., Duration: ___3_____ hours per visit/treatment
Frequency: ___3_____ times per __1___ (week(s) / month(s) (circle one))

Duration: _____ hours per visit/treatment
Frequency: _____ times per _____ week(s) / month(s) (circle one)
(**Form is considered incomplete / insufficient if not provided for an intermittent leave**)

3. **INCAPACITY:**

Based upon the patient's medical history and your knowledge of the medical condition, estimate the maximum frequency of incapacity that employee would need off work over the next 6 months.

(e.g., Duration: ___3_____ hours per day or ___2___ days per episode
Frequency: ___3_____ times per ___1___ week(s) / month(s) (circle one))

Duration: _____ hours per day or _____ days per episode
Frequency: _____ times per _____ week(s) / month(s) (circle one)
(Form is considered incomplete / insufficient if not provided for an intermittent leave)

ADDITIONAL INFORMATION:

_____

_____

_____ _____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. The U.S. Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

Return completed certification form to:

NYL GBS Leave Solutions
P.O. Box 703509 Dallas, TX 75370
Fax: 866.931.5095
Email: FMLACertifications@newyorklife.com

Disclosure Authorization

GROUP BENEFIT SOLUTIONS

Claimant's Name: _____

NOTE: This authorization is designed to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and relates to information necessary to administer benefits and services under Employer's employee health and welfare plan(s) ("the Plan") and statutory and/or private leave of absence or job accommodation programs. "Employer" is defined to mean your employer, or your family member's employer to the extent benefits, services, or leave are being sought under your family member's employer's Plan. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers may not be able to process your (or your family member's) request for benefits or services under the Plan or statutory and/or private leave of absence or job accommodation programs.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; social security disability advocate or representative; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits, to provide access to or copies of this information (whether by written, telephonic or electronic means) to Life Insurance Company of North America; New York Life Group Insurance Company of NY (Life Insurance Company of North America and New York Life Group Insurance Company of NY shall be collectively referred to as "Insurance Company"); and any other individual or entity (including nonaffiliated third parties) that provides services to or insurance benefits on behalf of the Plan and/or Employer's statutory and/or private leave of absence or job accommodation programs. If I am also covered by Cigna Health and Life Insurance Company or its affiliates ("Cigna"), I authorize Insurance Company to disclose the health and other information described above to Cigna to assist me with my health coverage and to provide its services and benefits. This information will be shared to coordinate benefits and provide other services to you.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes or genetic information.

I agree and understand that any information obtained with this authorization may be used and disclosed for the following purposes: 1) evaluating and administering coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan; 2) evaluating and administering services related to Employer's statutory and/or private leave of absence or job accommodation programs; 3) determining my eligibility for any governmental benefits similar to or that coordinate with benefits available to me under the Plan and assisting me in applying for such benefits; and 4) evaluating and administering benefits or services under any other plans sponsored by or offered through Employer such as health management, disease management, wellness, or employee/member assistance programs.

I understand that the information disclosed under this authorization is subject to re-disclosure and may no longer be protected by HIPAA or other federal regulations governing the privacy of health information, although it may continue to be protected by other applicable privacy laws and regulations. I further understand that if any information is used for services relating to Employer's leave of absence or job accommodation programs, that information may be disclosed to Employer at any time. Additionally, I understand that information may be disclosed to the employee who elected my coverage or submitted a claim for benefits under my coverage, or requested leave.

This authorization shall be valid for 12 months or the duration of my claim for insurance benefits, whichever is longer. I also understand that Insurance Company will maintain a copy of this authorization, and that I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke - I understand that the Plan, insurers, or other providers of services or benefits related to the Plan or Employer's statutory and/or private leave of absence or job accommodation programs who rely on this authorization may not be able to evaluate or administer any request for benefits, coverage or services and that any request for benefits, coverage or services may be denied as a result. I may revoke this authorization by sending written notice to the Claim Manager handling the claim.

(Claimant's Signature)_____ (Date Signed) _____

(Print Name)_____ (Date of Birth) _____

I signed on behalf of the claimant as_____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.