Leave of Absence Packet

Table of Contents

DEPARTMENTAL LEAVE OF ABSENCE CHECKLIST

This form is to be completed by the department Human Resources unit.

Documents in the employee packet are used to:

- Inform an employee of their rights and procedures to follow under the County's policies for Leaves of Absence including Family Care and Medical Leave, Pregnancy Disability Leave, Disability Leave, Personal Leave, Administrative Leave, Military Leave, etc.
- Document a request for leave for any purpose, its approval or denial, and FMLA/CFRA/PDL designation if the employee is subject to FMLA/CFRA/PDL.
- Obtain medical certification of an employee's need for Family Care and Medical Leave, Pregnancy Disability Leave, and/or Disability Leave.
- Obtain medical certification that an employee is able to return to work from a Family Care and Medical Leave, Pregnancy Disability Leave, or Disability Leave.
- Review and document the steps required when an employee requests a leave of absence.

Reason for Leave

☐ Own serious health/medical condition ☐ Pregnancy ☐ To care for a newborn

☐ To bond with a newborn child or in connection with adoption or foster placement

☐ To care for a child, spouse, parent, grandparent, grandchild, sibling, domestic partner, or designated person* with a serious health condition

☐ On-the-Job Injury/Illness (OJI)

☐ Military ☐ Personal ☐ Educational ☐ Other: _____

*Designated person is limited to one (1) individual per rolling 12-month calendar and must be specified at the time of the leave request.

Test for Eligibility – FMLA/CFRA

Requested Leave Start Date: _____

Employee has: ☐ at least 12 months cumulative service

☐ worked at least 1,250 hours in the 12 months prior to leave start date

Is employee eligible for FMLA/CFRA? ☐ Yes ☐ No

Has this employee used FMLA/CFRA within the last 12 months? ☐ Yes ☐ No

Remaining entitlement: Weeks: _____ Days: _____ Hours: _____

Employee Information Packet

☐ Leave of Absence Request Form (all LOA's) **Date Provided to Employee:** _____

Provide to employee for medical LOA:

☐ Notices I and III (II if applicable) – Rights, Responsibilities & Eligibility under FMLA/CFRA/PDL

☐ Medical Certification Form (if EE did not already provide)

☐ Return to Work Certification Form **Provided By:** _____

☐ EDD Flyer Method: ☐ In Person ☐ Certified Mail

☐ Annual Leave Donation Request Forms (if applicable) ☐ Other: _____

Eligible for County Contribution towards Health Insurance

☐ FMLA/CFRA (maximum 12 weeks) ☐ PDL (maximum 4 months)

☐ Labor Code 4850 Leave (maximum 1 year)

Action Checklist

☐ Received Medical Certification Date: _____

☐ Copy of approved/denied LOA Request Form/ Notice IV given to EE Date: _____

☐ Copy of approved LOA Request Form sent to Supervisor Date: _____

☐ Received Return to Work Certification Date: _____

Department Name	Department Signature / Date

Employee Leave of Absence Request

Employees may request a leave of absence pursuant to Personnel Rule 7 – Leaves. Employees on leave without approval are considered Absent Without Leave (AWOL) and are subject to disciplinary action, up to and including termination. To request a leave of absence, please complete and submit this form, along with supporting documentation, to your department personnel representative prior to the start of your leave. This form must be completed when requesting a leave of absence (LOA), whether it is paid or unpaid.

Contact your department personnel representative with any leave-related questions. You may also contact Employee Benefits at (559) 600-1810 with questions related specifically to your health insurance coverage or other benefits.

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	EMPLOYEE ID
DEPARTMENT	EMPLOYEE PHONE	JOB TITLE

I am requesting: ☐ New Leave ☐ New Intermittent Leave ☐ Extension of my current leave

Last Day Worked: _____ Paid Leave Begin Date: _____ Anticipated End Date: _____

Unpaid Leave Begin Date: _____ Anticipated End Date: _____

REASON FOR REQUEST

☐ My Own Serious Health Condition
☐ Pregnancy Disability; Estimated Delivery Date: _____
☐ Baby Bonding; Baby's Date of Birth: _____
☐ Adoption or Foster Care Placement; Date of Adoption or Placement: _____
☐ Care for a Family Member or Designated Person with a Serious Health Condition: Relationship to Employee:_____
☐ On-the-Job Injury; Date of Injury: _____ ☐ Pending ☐ Approved ☐ 4850
☐ Military Leave
☐ Military Exigency Leave
☐ Military Leave to Care for a Covered Service Member
☐ Other (e.g., personal leave); Please specify: _____

PAY DESIGNATIONS

Check all that apply: Note: Annual leave must be used, unless you are collecting disability benefits (SDI, PFL etc.)

☐ Annual Leave Accrual
☐ Annual Leave Donations (donation request form required)
☐ Paid State or Federal Benefits Only (paid disability, paid family leave, etc.)
☐ Integrating Annual Leave with State Disability Insurance or Paid Family Leave
☐ Integrating Annual Leave with On-the-Job Injury Benefits
☐ Other; Please specify: _____

EMPLOYEE ACKNOWLEDGEMENT

By signing below, I certify that I understand that it is my responsibility to read the information in the Leave of Absence Packet as it contains important information about my health insurance coverage, rights and responsibilities, eligibility for protected leave, and other benefit information.

_____
Employee Signature / Date

Employee Leave of Absence Request (Page 2)

DEPARTMENT SECTION: Leave Designation/Protected Leave Eligibility

Employee's Unpaid Leave Begin Date: _____ Anticipated Leave End Date: _____

Employee has 12 months of service for FMLA/CFRA ☐ Yes ☐ No

Employee meets the 1,250 hours worked criteria for FMLA/CFRA ☐ Yes ☐ No

Average Weekly Hours employee worked* (including all mandatory shifts) (rounded to four decimals): _____

*For variable shift employees, calculate using a 12-month lookback for FMLA/CFRA and a 4-month lookback for PDL

PRIOR LEAVE USAGE

Please list all protected leave (including intermittent leave) used in the **12 months prior to the start date of this request**. Please include the duration and total amount of time used (weeks, days, and/or hours). The "Other Leave Usage" field may be used to include all relevant non-protected leave associated with this request.

Prior FMLA Usage **Total FMLA Entitlement Bank:** _____

Duration: _____ Leave Used: _____

Duration: _____ Leave Used: _____

Prior CFRA Usage **Total CFRA Entitlement Bank:** _____

Duration: _____ Leave Used: _____

Duration: _____ Leave Used: _____

Prior PDL Usage **Total PDL Entitlement Bank:** _____

Duration: _____ Leave Used: _____

Duration: _____ Leave Used: _____

Other Leave Usage

Duration: _____

Duration: _____

Please include Tracker for Intermittent and/or rolling Protected Leave Usage

LEAVE DESIGNATION

Please list leave type (e.g., FMLA, CFRA, PDL, ADA/FEHA, OJI, Personal) and duration. Complete the **Prior Leave Usage** section for **protected leave** (e.g., FMLA, CFRA, PDL), by indicating the total amount of time used in weeks, days, and/or hours (e.g., 2 weeks, 10 days, 80 hours). The **other leave usage** fields may be used to assist in tracking total leave periods.

Leave Type: _____ Duration: _____ Leave Used: _____

Leave Type: _____ Duration: _____ Leave Used: _____

Leave Type: _____ Duration: _____ Leave Used: _____

Leave Type: _____ Duration: _____ Leave Used: _____

APPROVAL

☐ **APPROVED** ☐ **DENIED**

_____

Department Representative Signature / Date

Leave of Absence Acknowledgment

EMPLOYEE NAME

IT IS MY UNDERSTANDING THAT:

A. **If I wish to request an extension of my leave**, I must submit a leave of absence request to my department prior to but no later than when my leave expires, along with the supporting documentation. Failure to timely submit a request will impact my health insurance eligibility. I further understand that if I fail to return to work when my leave expires or I do not submit a timely request for leave extension, I will be considered absent without leave (AWOL) and subject to disciplinary action up to and including termination.

B. **If I am eligible for disability insurance payments**, it is my responsibility to file a claim and send the necessary documentation to the carrier. If I am eligible to integrate my disability benefits with annual leave, it is my responsibility to complete and submit the appropriate documentation.

C. **If my leave is protected under FMLA and/or CFRA**, I am eligible to receive the County contribution towards health insurance premiums for up to 12 weeks if the leaves run concurrently, or up to 24 weeks if they run separately. If my leave is protected under PDL, I am eligible to receive the County contribution for up to 4 months. If I am eligible for military care giver leave under FMLA, I am eligible for up to 26 weeks.

D. **If my leave is protected under FMLA, CFRA and/or PDL and I elect to continue health insurance coverage**, I understand that I am responsible to pay my contribution towards the premium. (Note: Any dependents enrolled in the County health plan prior to my protected leave cannot be dropped during the protected leave period).

E. **If my leave is unpaid under FMLA, CFRA, and/or PDL**, the County's third-party administrator, ASI, will bill me for my contribution towards the health insurance premium. I understand that when my leave is unpaid, my health insurance coverage will be terminated and will not be reinstated until I make the required timely payment to ASI. If I fail to make payment to ASI by the due date, my health insurance coverage will remain terminated until I return to work or am eligible for COBRA.

F. **If I am on paid leave under FMLA, CFRA, and/or PDL**, and my paycheck sufficiently covers my health insurance deductions, my contribution towards the health insurance premium will continue to be taken from my biweekly paycheck deductions. If my earnings are not enough for the health insurance premium to be taken, I understand my health insurance coverage will be terminated and the County's third-party administrator, ASI, will bill me for my contribution towards the premium. My health insurance will not be reinstated until I make the required timely payment to ASI. If I fail to make payment to ASI by the due date, my health insurance coverage will remain terminated until I return to work or am eligible for COBRA.

G. **Once my protected leave expires**, or if I am on any other type of approved, unpaid leave, and want to maintain my health coverage, I understand that I may have the option to elect COBRA health coverage within 60 days after the date my previous health coverage ends or 60 days after the date of the COBRA election Notice, whichever is later. I also understand that if I choose to elect COBRA coverage, I must send my request to elect coverage, and any applicable premium, to the County's third-party administrator, Navia Benefit Solutions (Navia), before my enrollment can be processed. While on COBRA, I understand that failure to pay my contribution of the health insurance premiums in the timeframes required will result in the termination of my health insurance coverage and I will not be eligible to be re-enrolled until I return to work or receive a paycheck with sufficient pay to deduct my contribution towards the health insurance premiums. I also understand that while on COBRA, the County no longer pays any contribution towards the health insurance premiums.

(Continued)

Leave of Absence Acknowledgment (Page 2)

H. **Should I experience a qualifying life event that would allow me to make various health plan changes (e.g., birth, marriage, death, divorce, etc.) during my leave of absence**, I understand that it is my responsibility to contact the Department of Human Resources – Employee Benefits to complete and submit the required documentation to make any changes within the qualifying event time frame (e.g., 30 days). Failure to submit the required documentation within the allotted time frame may result in a denied request for any health insurance changes. Information on qualifying events can be found on the Human Resources – Employee Benefits website.

I. **If my disability is a result of an *on-the job* injury (OJI) and my leave qualifies for protection under FMLA/CFRA**, I understand that my FMLA/CFRA leave time will run concurrent with my OJI leave and will begin with the date of my disability (excluding 4850 Leave). I also understand that my workers compensation disability benefits will automatically be integrated with my accrued paid leave time unless I complete and submit the declination form.

J. **If I qualify for CFRA protected leave to care for a "Designated Person"**, I understand that I am designating this individual for a 12-month period beginning on the first date of approved leave. I also understand that I am limited to one (1) designation per rolling 12-month period and may not designate an alternate individual until this 12-month period expires.

K. **If I fail to return to work at the end of my approved leave**, I will be absent without leave (AWOL) and subject to disciplinary action up to and including termination. Moreover, if I have received any County contributions paid towards my health insurance premiums during my protected leave under FMLA, CFRA, and/or PDL, and I fail to return to work for at least 30 days following my leave, the County may recover from me the cost of premiums paid on my behalf. However, I will not be liable for the premiums if my failure to return to work is due to a continuation of my own serious health condition or other reasons beyond my control.

EMPLOYEE ACKNOWLEDGEMENT

By signing below, I certify that I understand that it is my responsibility to read the information included in the Leave of Absence Acknowledgement form as it contains important information about my leave of absence and health insurance.

_____

Employee Signature / Date

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA) AND THE CALIFORNIA FAMILY RIGHTS ACT (CFRA)

It is the County of Fresno's policy to provide a leave of absence to eligible employees in accordance with the Federal Family and Medical Leave Act of 1993 (FMLA) and the California Family Rights Act of 1993 (CFRA). This notice sets forth employee rights and obligations under these **protected leaves** and pursuant to County policy and/or Memorandum of Understanding (MOU).

Eligibility

Employees are eligible for FMLA/CFRA if they have at least 12 months of service and have worked at least 1,250 hours during the last 12 months prior to the requested leave. The 12 months need not be consecutive and prior County service for up to 7 years can be used to meet the 12 months of service.

Purpose of Leave – Qualifying Events

FMLA:

- For the employee's own serious health condition
- The birth of the employee's child and to care for a newborn
- The placement of a child with the employee in connection with adoption or foster care
- To care for an eligible family member (spouse, child, or parent) who has a serious health condition. A dependent child over the age of 18 must be incapable of self-care because of a mental or physical disability.
- For a "qualifying military exigency": the employee's spouse, son, daughter, or parent is a military member on covered active duty (or notified of an impending call or order to covered active duty) in support of a contingency operation
- To care for a service member or a veteran with a serious injury or illness, if the employee is the service member's spouse, son, daughter, parent or next of kin. Leave for this purpose can be for a period of 26 weeks in a 12-month period.

CFRA:

- For the employee's own serious health condition
- Birth of a child for purposes of bonding
- The placement of a child with the employee in connection with adoption or foster care
- To care for a qualifying family member or designated person, as defined by California Government Code section 12945.2, who has a serious health condition.
- For a "qualifying military exigency" for reasons related to deployment or military activities of employee's spouse, domestic partner, child, or parent who is a member of the Armed forces. Leave for this purpose can be up to 12 weeks in a 12-month period.

Length of Leave

FMLA/CFRA:

- The County utilizes the "rolling" 12-month period measured backward for determining protected leave eligibility for FMLA/CFRA. The 12-month period measured backward is from the date an employee uses any FMLA leave. Under the ''rolling'' 12-month period, each time an employee takes FMLA leave, the remaining leave entitlement would be the balance of the 12 weeks which has not been used during the immediately preceding 12 months.
- FMLA and CFRA will always run concurrently (i.e., at the same time), when leave is covered for the same qualifying reason under both acts. When leave is for Pregnancy (PDL), FMLA runs concurrent with PDL but CFRA does not.

Length of Leave (Continued)

FMLA/CFRA:

- The employee is entitled to a maximum of 12 work weeks when FMLA/CFRA protected leaves run concurrently. If FMLA/CFRA run separate, an employee can be entitled for up to 24 weeks.
- Leave on an intermittent basis or on a reduced work schedule may be requested when medically necessary for a serious health condition. When possible, the employee will attempt to schedule medical treatments in a way that would minimize disruption to their department.
- For bonding leave under FMLA, if married and both parents work for the County, the parents must share the 12 weeks of bonding leave. For bonding leave under CFRA, parents are entitled to a separate 12 weeks for bonding (sharing does not apply to CFRA).
- For CFRA baby bonding time, the minimum leave duration taken by the employee must be at least two (2) weeks. An employee may request and employer must allow a leave of less than two weeks duration on two (2) separate occasions. Additional requests must meet the required two-week minimum duration. If the employee requests to take bonding on an intermittent or reduced schedule basis (e.g. hours, days), the employer (department) must agree to the schedule.
- Eligible employees under the Military Caregiver Leave (FMLA) are entitled for up to 26 weeks of leave to care for a covered service member in a single 12-month period.
- Under FMLA/CFRA, eligible employees are entitled for up to 12 weeks for Military Exigency Leave.

Pay

FMLA/CFRA is normally unpaid leave; however, the employee may request or be required to utilize paid leave (e.g., annual leave, vacation, comp time, and sick leave) for all or a portion of the unpaid leave in accordance with the appropriate policies and Memorandum of Understanding.

The employee may be eligible for temporary disability payments under California State Disability Insurance (SDI), and/or California Paid Family Leave (PFL), or another disability plan which may cover the employee during their leave of absence. If eligible for SDI and/or PFL, the employee may elect to integrate their benefit with annual leave.

Advance Notice

A 30-day notice is required if the need for FMLA, and/or CFRA is foreseeable (e.g., the birth/adoption of a child or a planned medical treatment). If the employee fails to provide 30-day notice for a foreseeable leave, their department may postpone the leave until 30 days after the date on the notice. The 30-day notice does not apply to leave for “qualifying exigency”; the employee requesting this leave must provide notice as soon as practicable. If the need for leave is not foreseeable, the employee is required to provide notice within a reasonable time after learning of the need for leave. It is recommended that notice be submitted in writing.

Medical Certification

Written certification from a health care provider is required for either the employee’s own serious health condition or the serious health condition of a family member or designated person. It is required that a written certification include a statement of the medical facts supporting the need for protected leave. Failure to provide required certification within 15 calendar days of the date this notice is received may result in delay or denial of leave until the certification is provided. If the certification does not include the medical facts, the County, at its own expense, may require the employee to obtain the opinion of a second health care provider. If the second opinion differs from the original certification, the opinion of a third health care provider may be required. The opinion of the third health care provider shall be final and binding.

Recertification of the employee’s own serious health condition or the serious health condition of a family member or designated person may be required periodically. If required, the employee’s department will provide the employee with the County’s Health Care Provider Medical Certification form.

If the leave request is for bonding, the employee may be asked to provide written verification of the child’s birth, such as a copy of a birth certificate, foster care placement court order, custody order, etc.

Under Federal and State regulations, a “health care provider” is defined as: a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated to exist by x-ray), clinical psychologist, optometrist, nurse practitioner, nurse-midwife, clinical social worker, a physician assistant , or a Christian Science practitioner who is authorized to practice by the State and performing within the scope of the practice as defined by State law.

Medical Certification (Continued)

In addition, any health care provider from whom the County or the employee’s group health plan will accept medical certification to substantiate a claim of benefits; and a health care provider who practices in a country other than the United States, who is licensed to practice in accordance with the laws and regulations of that country.

Health Benefits

County health insurance benefits (medical, dental, vision, and prescription) will be maintained during protected leave (FMLA/CFRA) to the extent coverage would be maintained if the employee had been actively at work during the protected leave period. As long as the employee pays their portion of the health insurance premium for self and dependent(s), the County will continue to make its usual contribution towards the premium during the protected leave. If the employee fails to pay for their portion of the health insurance premium, including their dependent(s), their health benefits coverage will be terminated, and the employee will be responsible for the full cost of any services utilized.

If the employee is on a paid protected leave and their earnings are insufficient to deduct the entire health insurance premium from their paycheck, the employee will be billed for the premium.

When protected leave expires, the employee is no longer eligible to receive the County contribution towards their health insurance premium. If the employee remains on a leave of absence, if eligible, they will have the opportunity to elect Consolidated Omnibus Budget Reconciliation Act (COBRA) health insurance benefits. By electing COBRA, the employee is required to pay the full cost of the health insurance premium for self and/or dependent(s). Note: If the employee fails to remit premium payment while on protected leave, the employee will not be eligible to continue coverage under COBRA until the protected leave period expires. Navia Benefit Solutions (Navia) will bill the employee when eligible for COBRA, and the employee will remit payment directly to Navia. Refer to employee’s leave packet, “Important Information Regarding Health Benefits While on Leave of Absence”, for important information on the employee’s responsibility for premium payment and COBRA election (continued health coverage).

If the employee’s health insurance coverage lapses due to non-payment of the employee’s portion of the premium while the employee is on leave of absence, the employee’s health insurance coverage will automatically reinstate when the employee returns to work (providing the employee has sufficient net pay to cover their portion of the health insurance premium).

If the employee does not return to work at the end of their protected leave the County may recover its share of health plan premiums by taking deductions, to the extent permitted by law, from the employee’s unpaid wages, if any, vacation/annual leave/comp time pay, or other pay due to the employee, or by initiating legal action. However, the employee will not be liable for the premiums if their failure to return to work is due to continuation of their own serious health condition or other reasons beyond their control. The employee will be considered to have returned to work if they work for at least 30 calendar days commencing with their scheduled return date.

Administrative Solutions, Inc. (ASI), the County’s third-party administrator, will bill the employee for health insurance premiums while the employee is on unpaid leave or when their earnings are insufficient to deduct the entire health insurance premium from their paycheck.

For questions on health insurance coverage for protected leave or coverage when not eligible for protected leave, contact Employee Benefits at (559) 600-1810.

Reinstatement

The employee must be reinstated to the same position they had prior to taking the leave, or to an equivalent / comparable position provided that the employee returns to work immediately following the conclusion of their protected leave. If the employee’s position is unavailable (e.g., due to a temporary or indefinite layoff), they have no greater right to reinstatement than had they been continually employed during their protected leave.

Return to Work Clearance

If employee's leave was for their own serious health condition, they are required to present medical certification that clearly states the employee is able to return to work and perform the essential functions of their job. A return-to-work medical certification form is included in this packet. It is recommended that the employee use the form. If the employee elects not to use the form, a written release from the employee's health care provider is required.

County Designation of Protected Leave

By law, the County has an affirmative duty to designate leave as protected (FMLA/CFRA) if the leave meets the requirements listed above, regardless of whether the employee specifically requests a leave under FMLA and/or CFRA.

Privacy of Information

The principal purpose for requesting the information on the attached forms is to process requests for leaves of absence that are eligible for protection pursuant to FMLA/CFRA statutes and regulations, and County policy. The information employees provide may be subject to applicable privacy laws including, but not limited to, the California Confidentiality of Medical Information Act (as amended) and the Federal Health Insurance Portability and Accountability Act (HIPAA), as amended. Copies of the County's HIPAA Privacy Notice are available upon request. Information furnished on these notices may be used by various County departments for benefits, payroll, and human resources administration, and will be transmitted to the Federal and State governments if required by law.

Individuals have the right to review their own records in accordance with County Personnel Rules. Information on applicable policies may be obtained from the employee's department (human resources office), the Department of Human Resources, and the Human Resources web page.

The Department of Human Resources is responsible for maintaining the information contained on these forms.

Military Exigency Leave under FMLA/CFRA

Under FMLA/CFRA eligible employees with a spouse, child, parent, or domestic partner (under CFRA), on covered active duty or called to covered active-duty status in the National Guard, Reserves, or Regular Armed Forces in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, attending post-deployment reintegration briefings, and to care for a military member's parent who is incapable of self-care when the care is necessitated by the member's covered active duty. Contact your department Human resources to obtain the required certification form.

Military Caregiver Leave under FMLA

Under FMLA eligible employees may use their 12-week entitlement under FMLA, plus an additional 12 weeks for up to 26 weeks to take leave to care for a covered service member during a single 12-month period. A covered service member is either:

- a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, or is otherwise on the temporary disability retired list, for a serious injury or illness; or
- a covered veteran who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.

To be eligible for Military Caregiver Leave, the employee must be the spouse, son, daughter, parent, or next of kin of the covered service member. "Next of kin" means the nearest blood relative of the service member, other than the service member's spouse, parent, son, or daughter. Contact your department Human Resources to obtain the required certification form.

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE CALIFORNIA FAIR EMPLOYMENT & HOUSING ACT (FEHA), PREGNANCY DISABILITY LEAVE (PDL)

It is the County of Fresno's policy to provide Pregnancy Disability Leave (PDL) to eligible employees in accordance with the California Fair Employment and Housing Act. This notice sets forth employee rights and obligations under PDL. If the employee is eligible and the leave was requested pursuant to County policy or MOU's and qualifies as PDL, the employee will be entitled for up to four (4) months of PDL.

Eligibility

Employees are eligible for PDL upon date of hire; there is no required number of hours worked.

Purpose of Leave

PDL may be taken for an employee's disability due to pregnancy, childbirth, or related conditions.

Length of Leave

Employees are entitled to a leave of absence for the duration of their pregnancy disability up to a maximum of 4 months. Employees may also request leave on an intermittent basis or a reduced work schedule when medically necessary. Pregnant employees may request to be transferred to a less strenuous or hazardous position when medically necessary.

Pay

PDL is normally unpaid leave; however, employees may request or be required to utilize paid leave (e.g., annual leave, vacation, comp time, and sick leave) for all or a portion of the unpaid leave in accordance with appropriate policies and Memorandum of Understanding.

If eligible for Paid Family Leave (PFL), the County may require employees to use annual leave, vacation, or comp time but cannot require employees to use accrued sick leave.

Employees may be eligible during the unpaid portion of their PDL for temporary disability payments under SDI or another disability policy under which they are covered.

Advance Notice

A 30-day advanced notice is required if the employee's need for PDL is foreseeable. If the need for leave is not foreseeable, employees are required to provide notice within a reasonable time after learning of the need for leave. It is recommended that notice be submitted in writing.

Medical Certification

It is required that a written certification must include a statement of the medical facts supporting the need for the employee to take leave. Failure to provide required certification within 15 calendar days of the date employee receives this notice may result in delay or denial of leave until the certification is provided. Re-certification of the employee's pregnancy related disability may be required periodically. If required, the Department will provide the employee with the County's Health Care Provider Medical Certification form.

Health Benefits

County health insurance benefits (medical, dental, vision and prescription) will be maintained during any qualifying PDL leave for up to 4 months to the extent coverage would be maintained if the employee had been actively at work during the protected leave period. As long as the employee pays their portion of the health insurance premium for self and dependent(s), the County will continue to make its usual contribution towards the premium during the protected leave. If the employee fails to pay for their portion of the health insurance premium, including their dependent(s), their health benefits coverage will be terminated, and the employee will be responsible for the full cost of any services utilized.

If the employee is on a paid protected leave and their earnings are insufficient to deduct the entire health insurance premium from their paycheck, the employee will be billed for the premium.

When the 4 months of protected leave expires, the employee is no longer eligible to receive the County contribution towards their health insurance premium. If the employee remains on a leave of absence, if eligible, they will have the opportunity to elect Consolidated Omnibus Budget Reconciliation Act (COBRA) health insurance benefits. By electing COBRA, the employee is required to pay the full cost of the health insurance premium for self and/or dependent(s). Note: If the employee fails to remit premium payment while on protected leave, the employee will not be eligible to continue coverage under COBRA until the protected leave period expires. Navia Benefit Solutions (Navia) will bill the employee when eligible for COBRA, and the employee will remit payment directly to Navia. Refer to employee's leave packet, "Important Information Regarding Health Benefits While on Leave of Absence", for important information on the employee's responsibility for premium payment and COBRA election (continued health coverage).

If the employee's health insurance coverage lapses due to non-payment of the employee's portion of the premium while the employee is on leave of absence, the employee's health insurance coverage will automatically reinstate when the employee returns to work (providing the employee has sufficient net pay to cover their portion of the health insurance premium).

If the employee does not return to work at the end of their protected leave (PDL), the County may recover its share of health plan premiums by taking deductions, to the extent permitted by law, from the employee's unpaid wages, if any, vacation/annual leave/comp time pay, or other pay due to the employee, or by initiating legal action. However, the employee will not be liable for the premiums if their failure to return to work is due to continuation of their own serious health condition or other reasons beyond their control. The employee will be considered to have returned to work if they work for at least 30 calendar days commencing with their scheduled return date.

Administrative Solutions, Inc. (ASI), the County's third-party administrator, will bill the employee for health insurance premiums while the employee is on unpaid leave or when their earnings are insufficient to deduct the entire health insurance premium from their paycheck.

For questions on health insurance coverage for protected leave or coverage when not eligible for protected leave, contact Employee Benefits at (559) 600-1810.

Reinstatement

State law (FEHA) provides that employees must be reinstated to either the same or a comparable position to the one held before taking PDL, providing the employee returns to work once their protected leave expires.

Return to Work Clearance

Employees are required to present medical certification upon their return stating that they are able to return to work and perform the essential functions of their job. A return-to-work medical certification form is included in this packet. It is recommended that employees use this form. If employees elect not to use this form, a written release from their health care provider is required.

COUNTY OF FRESNO NOTICE III

NOTICE OF ELIGIBILITY AND RESPONSIBILITIES UNDER FMLA, CFRA, AND/OR PDL

This form is to be completed by the department Human Resources unit.

PART A – NOTICE OF ELIGIBILITY

TO (EMPLOYEE NAME)	FROM (DEPARTMENT REPRESENTATIVE)	DATE

On _____ , you informed us of the need for a leave of absence beginning on _____ for the purpose of:

(Check all that apply)

- ☐ The birth of a child, or the placement of a child with you for adoption or foster care
- ☐ Pregnancy disability. Estimated date of delivery is: _____
- ☐ To bond with child
- ☐ Your own serious health condition
- ☐ Need to care for a qualifying family member or designated person due to their serious health condition (please select one):
  - ☐ Spouse ☐ Child ☐ Parent/Parent-in-law ☐ Sibling ☐ Grandchild ☐ Grandparent
  - ☐ Domestic Partner ☐ Designated Person _____
- ☐ A "Military Exigency" for an eligible family member who is on covered active duty or called to covered active-duty status in support of a contingency operation as a member of the National Guard, Reserves, or Regular Armed Forces. Eligible family members include (please select one):
  - ☐ Spouse ☐ Child ☐ Parent ☐ Domestic Partner
- ☐ "Military Caregiver", the employee has an eligible relationship to a current service member or veteran with a serious injury or illness. Eligible relationships include (please select one):
  - ☐ Spouse ☐ Son or Daughter ☐ Parent ☐ Next of Kin

This notice is to inform you that you:

- ☐ Are eligible for FMLA, CFRA and/or PDL (See Part B below for responsibilities)
- ☐ Are not eligible for FMLA, CFRA and/or PDL because (only one reason need be checked, although you may not be eligible for other reasons):
  - ☐ You have not met the FMLA/CFRA 12-months of service requirement. As of the date of your requested for leave, you will have worked approximately _____ months towards this requirement.
  - ☐ You have not met the FMLA/CFRA 1,250 hours-worked requirement. As of the date of your request for leave, you would have worked approximately _____hours.
  - ☐ Other: _____

(CONTINUED ON PAGE 2)

PART B – ELIGIBILITY & RESPONSIBILITIES FOR TAKING FMLA/CFRA/PDL LEAVE

If you met Part A eligibility, you must return the following information to determine whether your leave qualifies for FMLA, CFRA and/or PDL leave:

- ☐ Sufficient Medical Certification – A medical certification form to support your request for FMLA, CFRA and/or PDL leave was not enclosed. Please provide sufficient medical documentation to support the need for the leave.
- ☐ Verification of Qualifying Family Relationship – Documentation is required to support leave to care for another person or to bond with a newborn or newly placed child in connection with adoption or foster care. Verification is not required when taking leave for a "designated person".
- ☐ Clarification Required – At least one of the above documents is unclear and/or incomplete. Clarification needed is as follows:

  _____
- ☐ Other information needed (please specify below):

  _____
- ☐ No additional information requested.

In accordance with FMLA, the County must allow at least 15 calendar days from receipt of this notice when requesting medical certification; additional time may be required in some circumstances. If sufficient information is not provided in a timely manner, your leave may be denied.

If clarification is needed due to an unclear or incomplete medical note, clarifying information must be provided within 7 calendar days from receipt of this notice.

Date Part B documents are due: _____

If your leave qualifies as FMLA, CFRA and/or PDL, you will have the following responsibilities:

- Complete and submit Leave of Absence Request Form (attach supporting medical documentation)
- Complete and submit Leave of Absence Acknowledgement Form
- If you would like to continue your health insurance for yourself and your dependent(s) while on unpaid protected leave, you are responsible to pay for your portion of the health insurance premium.
- If electing to integrate with SDI, you must complete and submit the election form.

Once we obtain the information from you as specified above, we will inform you, within five (5) business days, whether your leave qualifies and will be designated as FMLA, CFRA and/or PDL.

If you have any questions after reviewing the documents provided to you regarding employee rights and responsibilities under the Family & Medical Leave Act (FMLA), the California Family Rights Act (CFRA) and/or Pregnancy Disability Leave (PDL), please contact your department representative below.

DEPARTMENT REPRESENTATIVE	PHONE NUMBER

_____

Department Representative Signature / Date

COUNTY OF FRESNO NOTICE IV

DESIGNATION NOTICE (FMLA/CFRA/PDL)

This form is to be completed by the department Human Resources unit.

TO (EMPLOYEE NAME)	FROM (DEPARTMENT REPRESENTATIVE)	DATE

We have reviewed your request for leave under the Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA) and/or California Pregnancy Disability Leave (PDL) and any supporting documentation that you have provided. We received your most recent information on _____ and determined:

☐ **Your leave request is approved and designated as:**

☐ FMLA leave only
☐ CFRA leave only
☐ FMLA and CFRA leave
☐ FMLA/PDL leave
☐ PDL leave only
☐ Other: _____

The FMLA/CFRA/PDL requires that you notify us as soon as practicable if dates of leave change or if requesting to extend your leave. Based on the information you provided, we are providing the following information about the amount of leave time that will be counted against your protected leave entitlement:

- Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: _____
- Because the leave you will need will be unscheduled (e.g. intermittent leave for flare-ups), it is not possible to provide the hours, days, or weeks that will be counted against your FMLA/CFRA/PDL entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

☐ **Your leave request is not approved based on the following:**

☐ Your request does not qualify for FMLA, CFRA or PDL.
☐ You have exhausted your FMLA/CFRA/PDL leave entitlement in the applicable 12-month period.
☐ Other: _____

If you have any questions after reviewing the documents provided to you regarding employee rights and responsibilities under the Family & Medical Leave Act (FMLA), the California Family Rights Act (CFRA) and/or Pregnancy Disability Leave (PDL), please contact your department representative below.

DEPARTMENT REPRESENTATIVE	PHONE NUMBER

_____
Department Representative Signature / Date

COUNTY OF FRESNO
HEALTH CARE PROVIDER MEDICAL CERTIFICATION FORM

Dear Health Care Provider:

To determine employee eligibility for state and/or federal protected leave, please complete the Health Care Provider Section on pages 1-2 of this form. If you have any questions, please call the department contact listed below. Thank you for your assistance.

EMPLOYEE SECTION

EMPLOYEE NAME | **PATIENT NAME (IF NOT EMPLOYEE)** | **PATIENT RELATIONSHIP TO EMPLOYEE**

REQUESTED LEAVE BEGIN DATE | **ANTICIPATED LEAVE END DATE**

DEPARTMENT CONTACT NAME | **PHONE**

☐ By checking the box to the left, I voluntarily authorize this provider to share information necessary to confirm **chiropractic care** qualifications pursuant to FMLA and CFRA definitions.

Employee Signature / Date

HEALTH CARE PROVIDER SECTION

LEAVE DESIGNATION

Leave is for: ☐ Employee's own serious health condition ☐ Family member or designated person's serious health condition

☐ Employee's own pregnancy disability

QUALIFYING REASON (at least one box must be checked below)

A serious health condition as defined by FMLA/CFRA is an illness, injury, impairment, or physical or mental condition that involves one or more of the following conditions. A pregnancy-related disability is defined by PDL/FMLA as any disability resulting from pregnancy, childbirth, or any other related medical condition. If the patient is under your care and meets any of these conditions, please check all appropriate boxes. If no conditions apply, please check "None of the above."

☐ **Inpatient Care** - Overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity or any subsequent treatment in connection with the overnight stay.

☐ **Incapacity Plus Treatment** - A period of incapacity for more than three consecutive, full calendar days, with treatment two or more times within 30 days of the first day of incapacity; or treatment on at least one occasion within 7 days of the first day of incapacity and results in a regimen of continuing treatment under the supervision of the health care provider.

☐ **Chronic Condition** - Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period. A chronic condition may cause episodic rather than a continuing period of incapacity.

☐ **Permanent or Long-Term Condition** - Continuing treatment for a long-term period of incapacity in which treatment may not be effective.

☐ **Condition Requiring Multiple Treatments** - Multiple treatments (including period of recovery) due to restorative surgery after an accident or other injury.

☐ **Pregnancy** - Continuing treatment for a period of incapacity due to pregnancy, childbirth, or a related medical condition.

☐ **Chiropractic** - Treatment consisting of manual manipulation of the spine to correct a subluxation confirmed by x-ray.

☐ **None of the Above**

CAREGIVER INFORMATION

If leave is for a **family member or designated person's serious health condition,** is the employee's presence necessary or beneficial to the patient? This may include, but is not limited to, psychological comfort and/or arranging for third-party care.

☐ Yes ☐ No

HEALTH CARE PROVIDER SECTION *(CONTINUED)*
COMPLETION OF THIS SECTION IS REQUIRED

PATIENT NAME

DURATION OF LEAVE

Please specify the type and duration of leave required.

Temporary and Total Disability/Care

If the patient's condition warrants the need for continuous and unbroken leave/care, please designate the period below.

LEAVE BEGIN DATE **ANTICIPATED LEAVE END DATE**

Intermittent Time Off

If the patient's condition warrants the need for periodic or episodic leave/care, please provide in detail the medical necessity, duration, and frequency needed.

MEDICAL NECESSITY (E.G., FLARE UPS, REHABILITATION, DOCTOR APPOINTMENTS, ETC)

INTERMITTENT LEAVE BEGIN DATE **ANTICIPATED INTERMITTENT LEAVE END DATE**

INTERMITTENT SCHEDULE REMARKS (E.G., EXCUSED 2 HRS/DAY IF NEEDED, UP TO 5 DAYS/MONTH; OFF 2 DAYS MONTHLY; ETC.)

Reduced Work Schedule

If the patient's condition warrants the need for a reduced work schedule, please provide in detail the medical necessity, duration, and frequency needed.

MEDICAL NECESSITY (E.G., LIMITED CAPACITY, RECOVERY, REHABILITATION, ETC.)

REDUCED SCHEDULE LEAVE BEGIN DATE **ANTICIPATED REDUCED SCHEDULE LEAVE END DATE**

REDUCED SCHEDULE REMARKS (MAY WORK MAX 4 HOURS PER DAY; MAX 3 DAYS/WEEK, ETC.)

Printed Name of Health Care Provider: _____

Signature of Health Care Provider: _____

Medical Health Care Specialty: _____

Date: _____

Phone: _____

Place Stamp Here

COUNTY OF FRESNO
RETURN TO WORK MEDICAL CERTIFICATION FORM

Health Care Provider:

Complete this form only when releasing employee to return to work.

Employee Name: _____

Is the employee able to perform the essential functions of their job with or without reasonable accommodations?

☐ Yes, no restrictions and/or accommodations.

☐ Yes, with restrictions and/or accommodations (please describe below)

Are the restrictions: ☐ Permanent ☐ Temporary – until what date: _____

Please describe the restrictions/accommodations below (please be as specific as possible):

_____

_____

_____

☐ No **If "No", do not complete this "Return to Work" Certification**. Please complete County Medical Certification Form or provide qualifying medical note to excuse employee from work.

Date Employee is Released to Return to Work: _____

Printed Name of Health Care Provider: _____

Signature of Health Care Provider: _____

Medical Health Care Specialty: _____

Date: _____

Phone: _____

Place stamp here

IMPORTANT INFORMATION REGARDING HEALTH BENEFITS WHILE ON LEAVES OF ABSENCE

HEALTH BENEFITS UNDER FMLA/CFRA/PDL (*PROTECTED*)

Coverage under the County's health benefit plan (medical, dental, vision and prescription) is maintained during any leave covered by FMLA, CFRA, and/or PDL, for up to 12 weeks under FMLA/CFRA if running concurrently, or up to 24 weeks if FMLA and CFRA run separately, and up to 4 months for PDL, to the extent coverage would be maintained if the employee had been actively at work during the leave period. As long as the employee pays their portion of the health insurance premium for self and dependent(s), the County will continue to make its usual contribution towards the premium during the protected leave. If the employee fails to pay for their portion of the health insurance premium, including their dependent's coverage, their health benefits coverage will be terminated, and the employee will be responsible for the full cost of any services they received.

If the employee's health benefits coverage lapses due to non-payment of the employee portion of the premium while the employee is on leave of absence, the employee's coverage will automatically resume when the employee returns to work (providing the employee has sufficient net pay to cover their portion of the health insurance premium deduction from their paycheck).

Once the protected leave (FMLA/CFRA/PDL) expires, the employee is no longer eligible to receive the County contribution towards their health insurance premium. If the employee remains on a leave of absence, and if they are eligible, they will have the opportunity to elect Consolidated Omnibus Budget Reconciliation Act (COBRA) health insurance benefits. By electing COBRA, the employee is required to pay the full cost of the health insurance premium for self and/or dependent(s).

If the employee does not return to work at the end of their protected leave (FMLA/CFRA/PDL), they will be liable for payment of the health plan premiums (medical, dental, vision, etc.) paid by the County during any unpaid portion of the employee's leave. The County may recover its share of health plan premiums by taking deductions, to the extent permitted by law, from unpaid wages (if any), vacation/annual leave/comp time pay, or other pay due to the employee, or by initiating legal action. However, the employee will not be liable for the premiums if their failure to return to work is due to the continuation of their own serious health condition or other reasons beyond their control. The employee will be considered to have returned to work if they work for at least 30 calendar days commencing with their scheduled return date. Contact Employee Benefits at 600-1810 for additional information.

HEALTH BENEFITS WHILE ON UNPAID LEAVE (*NON-PROTECTED)*

If eligible, the employee will have the opportunity to continue their health benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA). By electing COBRA, the employee is required to pay the full cost of the health insurance premium for self and/or dependent(s).

CONTINUED HEALTH BENEFITS UNDER COBRA

If eligible and the employee elects COBRA coverage (continued health benefits while on a leave of absence) under the County's health benefits plan (medical, dental, vision and prescription), coverage will be maintained ONLY if the employee elects to continue coverage by completing a COBRA election form within 60 days after the date plan coverage ends or 60 days after the date of the COBRA election Notice, whichever is the later of the two. When eligible for COBRA the County's COBRA administrator, Navia Benefit Solutions (Navia), will mail the employee a COBRA election form (for the employee and enrolled dependents). Should the employee elect COBRA for self and dependent(s) they will be responsible to pay for the entire premium. ***NOTE: COBRA law does not require that separate billing/invoices be sent to COBRA-eligible beneficiaries. The COBRA Notice issued to employees contains all necessary information about COBRA benefits and enrollment requirements, including the health benefit premium amount and at what time premium payments are due; please carefully review the COBRA Notice.*** If the employee fails to continue to make payments, health benefit coverage will be terminated, and the employee will be responsible for the full cost of any services they received. **Contact Navia at (425) 452-3490** for more information on submitting COBRA premium payments. Contact Employee Benefits at (559) 600-1810 for questions regarding health coverage while on a leave of absence.

HEALTH PREMIUM BILLING: ADMINISTRATIVE SOLUTIONS, INC. (ASI) AND NAVIA

While Navia administers the COBRA leave billing, ASI, will bill employees for their health insurance premiums while they are on an unpaid protected leave (e.g. FMLA/CFRA/PDL) and for employees on paid leave when their earnings are insufficient to deduct the entire health insurance premium from their paycheck. Employees billed by ASI for health insurance premiums shall make their payments directly to ASI. Employees who have elected COBRA coverage will receive invoices from and make their payments to Navia. If the employee fails to pay for their premiums by the due date, their health insurance coverage will be terminated.

The employee must ensure they complete all necessary leave of absence paperwork and submit to their supervisor and/or department's human resources office. Contact Risk Management at (559) 600-1850 for information related to on-the-job injury or illness. Note: OJI leave runs concurrently (i.e., at the same time) with FMLA/CFRA.

EMPLOYEE COST – PLAN YEAR 2024
LOA HEALTH PLAN PREMIUM RATES

RATE INFORMATION

- Employees in Unit 1, 14, 35, 37 or 38, please contact DiBuduo & DeFendis Group at (559) 437-6750.
- Part-time employees, please contact Administrative Solutions, Inc. (ASI) at (559) 256-1320.
- All other employees covered under County Health Plans, please see below.

STANDARD BIWEEKLY RATES

Bargaining Units 2, 3, 4, 7, 10, 11, 12, 19, 22, 25, 30, 31, 36,39, 42, 43, UNR, MGT and SMG:

	PLAN 1		PLAN 2		PLAN 3	
Medical / Mental Health Prescription / Vision	Anthem EPO Yosemite EmpiRx / VSP		Anthem EPO Sierra EmpiRx / VSP		Anthem EPO Pismo EmpiRx / VSP	
Dental Plans	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO
Employee Only	$ 82.37	$ 71.80	$ 17.54	$ 6.97	$ 0.00	$ 0.00
Employee + Spouse / DP	$ 259.17	$ 244.09	$ 140.50	$ 125.42	$ 96.48	$ 81.40
Employee + Child(ren)	$ 145.39	$ 135.22	$ 41.36	$ 31.19	$ 2.81	$ 0.00
Employee + Family	$ 365.99	$ 350.47	$ 209.14	$ 193.62	$ 151.19	$ 135.67

	PLAN 4		PLAN 5	
Medical / Mental Health Prescription / Vision	Anthem PPO 250 EmpiRx / VSP		Anthem HDPPO 3000 EmpiRx / VSP	
Dental Plans	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO
Employee Only	$ 147.08	$ 136.51	$ 0.00	$ 0.00
Employee + Spouse / DP	$ 532.94	$ 517.86	$ 20.75	$ 5.67
Employee + Child(ren)	$ 419.88	$ 409.71	$ 0.00	$ 0.00
Employee + Family	$ 800.57	$ 785.05	$ 83.21	$ 67.69

	PLAN 6		PLAN 7	
Medical / Mental Health Prescription / Vision	Kaiser Permanente HMO Kaiser / Kaiser		Kaiser Permanente HDHP Kaiser / Kaiser	
Dental Plans	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO
Employee Only	$ 94.61	$ 84.04	$ 0.00	$ 0.00
Employee + Spouse / DP	$ 267.31	$ 252.23	$ 44.45	$ 29.37
Employee + Child(ren)	$ 157.65	$ 147.48	$ 0.00	$ 0.00
Employee + Family	$ 379.51	$ 363.99	$ 84.60	$ 69.08

Bargaining Unit 13:

	PLAN 1		PLAN 2		PLAN 3	
Medical / Mental Health Prescription / Vision	Anthem EPO Yosemite EmpiRx / VSP		Anthem EPO Sierra EmpiRx / VSP		Anthem EPO Pismo EmpiRx / VSP	
Dental Plans	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO
Employee Only	$ 107.37	$ 96.80	$ 42.54	$ 31.97	$ 18.23	$ 7.66
Employee + Spouse / DP	$ 409.17	$ 394.09	$ 290.50	$ 275.42	$ 246.48	$ 231.40
Employee + Child(ren)	$ 295.39	$ 285.22	$ 191.36	$ 181.19	$ 152.81	$ 142.64
Employee + Family	$ 515.99	$ 500.47	$ 359.14	$ 343.62	$ 301.19	$ 285.67

	PLAN 4		PLAN 5	
Medical / Mental Health Prescription / Vision	Anthem PPO 250 EmpiRx / VSP		Anthem HDPPO 3000 EmpiRx / VSP	
Dental Plans	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO
Employee Only	$ 172.08	$ 161.51	$ 0.00	$ 0.00
Employee + Spouse / DP	$ 682.94	$ 667.86	$ 170.75	$ 155.67
Employee + Child(ren)	$ 569.88	$ 559.71	$ 99.81	$ 89.64
Employee + Family	$ 950.57	$ 935.05	$ 233.21	$ 217.69

	PLAN 6		PLAN 7	
Medical / Mental Health Prescription / Vision	Kaiser Permanente HMO Kaiser / Kaiser		Kaiser Permanente HDHP Kaiser / Kaiser	
Dental Plans	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO
Employee Only	$ 119.61	$ 109.04	$ 0.00	$ 0.00
Employee + Spouse / DP	$ 417.31	$ 402.23	$ 194.45	$ 179.37
Employee + Child(ren)	$ 307.65	$ 297.48	$ 111.18	$ 101.01
Employee + Family	$ 529.51	$ 513.99	$ 234.60	$ 219.08

EMPLOYEE COST – PLAN YEAR 2024
LOA HEALTH PLAN PREMIUM RATES CONT.

COBRA MONTHLY RATES:

All Bargaining Units:

	PLAN 1		PLAN 2		PLAN 3	
Medical / Mental Health Prescription / Vision	Anthem EPO Yosemite EmpiRx / VSP		Anthem EPO Sierra EmpiRx / VSP		Anthem EPO Pismo EmpiRx / VSP	
Dental Plans	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO
Participant Only	$ 1,138.12	$ 1,114.75	$ 994.84	$ 971.47	$ 941.11	$ 917.75
Participant + Spouse / DP	$ 2,048.20	$ 2,014.87	$ 1,785.94	$ 1,752.60	$ 1,688.67	$ 1,655.34
Participant + Child(ren)	$ 1,796.73	$ 1,774.24	$ 1,566.82	$ 1,544.33	$ 1,481.64	$ 1,459.15
Participant + Family	$ 2,693.15	$ 2,658.84	$ 2,346.50	$ 2,312.20	$ 2,218.44	$ 2,184.14

	PLAN 4		PLAN 5	
Medical / Mental Health Prescription / Vision	Anthem PPO 250 EmpiRx / VSP		Anthem HDPPO 3000 EmpiRx / VSP	
Dental Plans	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO
Participant Only	$ 1,281.13	$ 1,257.76	$ 735.87	$ 712.50
Participant + Spouse / DP	$ 2,653.25	$ 2,619.92	$ 1,521.32	$ 1,487.99
Participant + Child(ren)	$ 2,403.38	$ 2,380.88	$ 1,364.53	$ 1,342.03
Participant + Family	$ 3,653.56	$ 3,619.26	$ 2,068.21	$ 2,033.91

	PLAN 6		PLAN 7	
Medical / Mental Health Prescription / Vision	Kaiser Permanente HMO Kaiser / Kaiser		Kaiser Permanente HDPPO Kaiser / Kaiser	
Dental Plans	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO
Participant Only	$ 1,165.18	$ 1,141.81	$ 890.72	$ 867.35
Participant + Spouse / DP	$ 2,066.20	$ 2,032.87	$ 1,573.68	$ 1,540.34
Participant + Child(ren)	$ 1,823.86	$ 1,801.37	$ 1,389.64	$ 1,367.15
Participant + Family	$ 2,723.02	$ 2,688.72	$ 2,071.25	$ 2,036.95

Notice to Employees

Employment Development Department
State of California

This employer is registered with the Employment Development Department (EDD) as required by the California Unemployment Insurance Code and is reporting wage credits to the EDD that are being accumulated for you to be used as a basis for:

UI

Unemployment Insurance

(funded entirely by employers' taxes)

Unemployment Insurance (UI) is paid for by your employer and provides partial income replacement when you are unemployed or your hours are reduced due to no fault of your own. To claim UI benefit payments you must also meet all UI eligibility requirements, including that you must be available for work and searching for work.

How to File a New UI Claim

Use one of the following methods:

- **Online:** UI Online℠ is the fastest and most convenient way to file your UI claim. Visit UI Online (edd.ca.gov/UI_Online) to get started.
- **Phone:** Representatives are available at the following toll-free numbers, Monday through Friday between **8 a.m. to 12 noon** (Pacific Standard Time) except during state holidays.

English	**1-800-300-5616**	**Cantonese**	**1-800-547-3506**	**Vietnamese**	**1-800-547-2058**
Spanish	**1-800-326-8937**	**Mandarin**	**1-866-303-0706**	**TTY**	**1-800-815-9387**

- **Fax or Mail:** When accessing UI Online to file a new claim, some customers will be instructed to fax or mail their UI application to the EDD. If this occurs, the *Unemployment Insurance Application* (DE 1101I), will display. For faster and more secure processing, fax the completed form to the number listed on the form. If mailing your UI application, use the address on the form and allow additional time for processing.

Important: Waiting to file your UI claim may delay benefit payments.

DI

Disability Insurance

(funded entirely by employees' contributions)

Disability Insurance (DI) is funded by employees' contributions and provides partial wage replacement benefits to eligible Californians who are unable to work due to a non-work-related illness, injury, pregnancy, or disability.

Your employer must provide the *Disability Insurance Provisions* (DE 2515) brochure, to newly hired employees and to each employee who is unable to work due to a non-work-related illness, injury, pregnancy, or disability.

How to File a New DI Claim

Use one of the following methods:

- **Online:** SDI Online is the fastest and most convenient way to file your claim. Visit SDI Online (edd.ca.gov/SDI_Online) to get started.
- **Mail:** To file a claim with the EDD by mail, complete and submit a *Claim for Disability Insurance (DI) Benefits* (DE 2501) form. You can obtain a paper claim form from your employer, physician/practitioner, visiting a State Disability Insurance office, online at EDD Forms and Publications (edd.ca.gov/Forms), or by calling 1-800-480-3287.

Note: If your employer maintains an approved Voluntary Plan for DI coverage, contact your employer for assistance.

For more information about DI, visit State Disability Insurance (edd.ca.gov/disability) or call 1-800-480-3287.
State government employees should call 1-866-352-7675.
TTY (for deaf or hearing-impaired individuals only) is available at 1-800-563-2441.

PFL

Paid Family Leave

(funded entirely by employees' contributions)

Paid Family Leave (PFL) is funded by employees' contributions and provides partial wage replacement benefits to eligible Californians who need time off work to care for seriously ill child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner. Benefits are available to parents who need time off work to bond with a new child entering the family by birth, adoption, or foster care placement. Benefits are also available for eligible Californians who need time off work to participate in a qualifying event resulting from a spouse, registered domestic partner, parent, or child's military deployment to a foreign country.

Your employer must provide the *Paid Family Leave* (DE 2511) brochure, to newly hired employees and to each employee who is taking time off work to care for a seriously ill family members, to bond with a new child, or to participate in a qualifying military event.

How to File a New PFL Claim

Use one of the following methods:

- **Online:** SDI Online is the fastest and most convenient way to file your claim. Visit SDI Online (edd.ca.gov/SDI_Online) to get started.
- **Mail:** To file a claim with the EDD by mail, complete and submit a *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F) form. You can obtain a paper claim form from your employer, a physician/practitioner, visiting a State Disability Insurance office, online at EDD Forms and Publications (edd.ca.gov/Forms), or by calling 1-877-238-4373.

Note: If your employer maintains an approved Voluntary Plan for PFL coverage, contact your employer for assistance.

For more information about PFL, visit State Disability Insurance (edd.ca.gov/disability)
or call 1-877-238-4373.
State government employees should call 1-877-945-4747.
TTY (for deaf or hearing-impaired individuals only) is available at 1-800-445-1312.

Note: Some employees may be exempt from coverage by the above insurance programs. It is illegal to make a false statement or to withhold facts to claim benefits. For additional information, visit the EDD (edd.ca.gov).

FLEXIBLE SPENDING ACCOUNT
UNPAID LEAVE OF ABSENCE ELECTION FORM

EMPLOYEE NAME	ID NUMBER	HOME / CELL PHONE	FSA PLAN YEAR

Employees on an unpaid leave of absence (LOA) who participate in a Health Care Flexible Spending Account have the option to either continue or revoke their account during their LOA. Specify which of the following options you wish to elect and return this form to Human Resources-Employee Benefits via email to **HRBenefits@fresnocountyca.gov**, fax to (559) 455-4787, or mail to **2220 Tulare Street, 14th Floor, Fresno, CA 93721**. Please contact Employee Benefits at (559) 600-1810 if you have any questions.

Select one of the options:

☐ **Option 1 – Continue**

By electing this option, I understand I am able to continue my participation in Health Care Spending while I am on an unpaid LOA. I understand that I am responsible for my contribution payments while on an LOA and elect the payment option below:

☐ **Pre-pay.** I elect to pre-pay all or a portion of the contributions for the expected duration of my LOA with pre-tax dollars from taxable compensation received prior to my LOA. **Please note that this election must be submitted to Employee Benefits at least thirty (30) days prior to the start of your LOA, regardless of paid/unpaid status.**

☐ **Pay as you go.** I elect to make after-tax contributions during my unpaid LOA. I understand that by electing this option, the County's third-party administrator, Administrative Solutions, Inc., will collect contributions on a biweekly basis during my LOA. I understand that if I fail to remit these contributions, my coverage will be revoked during my LOA and I will not be eligible to submit claims or utilize my ASIFlex Debit Card for expenses incurred during my LOA.

☐ **Option 2 – Revoke**

I agree to revoke my participation during my unpaid LOA. I understand that I will not be eligible to participate in the Health Care Spending during my LOA and am not eligible to submit claims for reimbursement or utilize my ASIFlex Debit Card for expenses incurred during the period I am on LOA.

Please note the following:

- Failure to return this form will result in your FSA account defaulting to Option 2 – Revoke status.
- If your coverage is revoked – either by choice or by failing to pay your contributions while on LOA – you may choose to lower your annual election or maintain your current annual election by increasing your biweekly contribution. You must complete the Flexible Spending Account: Return from Leave of Absence Election Form and return it to Employee Benefits within thirty (30) days from the date that you return to work.

_____
Employee Signature / Date

Employer's Use Only

Leave Begin Date: Scheduled Return Date: Collect for Pay Period(s): to

Plan Administrator's Signature/Date: _____

GROUP TERM LIFE PORTABILITY APPLICATION - EMPLOYEE (CA)

ReliaStar Life Insurance Company
20 Washington Avenue South, Minneapolis, MN 55401
Phone: 800-955-7736; Fax: 612-342-7626

IMPORTANT NOTE: The Employer and Employee must complete all pertinent information on the following pages.
MISSING OR INCOMPLETE INFORMATION WILL DELAY PROCESSING OF THIS APPLICATION.
Return the completed form to the address shown above.

EMPLOYER / ADMINISTRATOR

Read the certificate to determine eligibility for portability. Complete and sign Page 1 of this Portability Application form. Send this form to the Employee to complete the remaining pages. Include copies of beneficiary designations and assignments.

Employer or Group Name County of Fresno

Group Policy Number 708330 Account Number 001

Hire Date _____ Annual Salary at Termination $_____

Employee Name _____ Employee Birth Date _____

Date Last Worked _____ Coverage Termination Date _____

CURRENT COVERAGE INFORMATION

Employee Basic Life Insurance $_____ Coverage Effective Date _____

Employee Basic AD&D Insurance $_____ Coverage Effective Date _____

Employee Supplemental Life Insurance $_____ Coverage Effective Date _____

Spouse Supplemental Life Insurance $_____ Coverage Effective Date _____

Children's Supplemental Life Insurance $_____ Coverage Effective Date _____

EMPLOYER COMMENTS

_____

_____

_____

EMPLOYER ACKNOWLEDGEMENT

I certify that all above information is true and correct according to the records of the employer.

This form will be: ☐ Handed ☐ Mailed ☐ Emailed to the employee on the following date _____

Authorized Signature _____ Date _____

Print Name _____ Title _____

Email _____ Employer Phone (_____)_____

Employee Name _____

Group Policy Number 708330 Account Number 001

EMPLOYEE INFORMATION

Return the completed form to the address shown on Page 1. The insurer must receive this completed form within 31 days of the Coverage Termination Date. MISSING OR INCOMPLETE INFORMATION WILL DELAY PROCESSING OF THIS APPLICATION.

Employee Name _____ Employee Birth Date _____

Employee Billing Address _____ City _____ State _____ ZIP _____

Employee Phone (_____)_____ Employee SSN _____

PORTABILITY INFORMATION

The maximum amount allowed for portability is shown in the Portability Rider. Read the Portability Rider carefully to determine which coverage(s) are eligible for portability. You may only elect to port coverage that was in effect on the coverage termination date as shown on Page 1 of this Application. You will not be able to elect or increase ported coverage in the future.

Any life insurance amount that is not eligible for portability, or exceeds the maximum, may be converted to an individual policy. If you do not want to apply for portability and only want to receive information about conversion, you may skip the "Portability Elections" and "Evidence of Insurability" sections on this form.

Please contact the employer for copies of the certificate and riders describing coverage.

PORTABILITY ELECTIONS FOR EMPLOYEE COVERAGE

Employee Life Insurance **I Elect to Port *(Select one)*:** ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 10%

Will not exceed the lesser of $750,000 or 5 times Basic Yearly Earnings

Employee AD&D Insurance **I Choose to *(Select one)*:** ☐ Elect Coverage ☐ Waive Coverage

If elected, percentage will be the same as Employee Life.

Employee Life must also be ported.

Will not exceed Employee Life amount ported.

Employee Name _____

Group Policy Number 708330 Account Number 001

PORTABILITY ELECTIONS FOR SPOUSE COVERAGE

The use of "spouse" in this form means a person insured as a spouse under the Spouse Life Insurance Rider.

You must port Employee coverage in order to elect portability of Spouse coverage.

Spouse Name _____ Spouse Birth Date _____

Spouse Life Insurance **I Choose to *(Select one)*:** ☐ Elect Coverage ☐ Waive Coverage

If elected, percentage will be the same as Employee Life.
Will not exceed total Employee Life amount ported.
Maximum = $750,000

Employee Name _____

Group Policy Number 708330 Account Number 001

PORTABILITY ELECTIONS FOR CHILDREN COVERAGE *(**Applies ONLY to currently Insured Children of the Employee as defined by the Children's Life Insurance Rider.** Include additional pages if space is required for more Children.)*

The use of "child" or "children" in this form means a person insured as a child under the Children's Life Insurance Rider.

You must port Employee coverage in order to elect portability of Children's coverage.

Child Name _____ Child Birth Date _____

Child Name _____ Child Birth Date _____

Child Name _____ Child Birth Date _____

Child Name _____ Child Birth Date _____

Children's Life Insurance **I Choose to *(Select one)*:** ☐ Elect Coverage ☐ Waive Coverage

If elected, percentage will be the same as Employee Life.
Will not exceed total Employee Life amount ported.
Maximum = $25,000

Employee Name _____

Group Policy Number 708330 Account Number 001

EVIDENCE OF INSURABILITY FOR PREFERRED RATES

Portability is available at the standard rates shown on the attached sheet. If you want to apply for the preferred rates for you or your spouse, then you and your spouse must complete the questions below. If any questions are unanswered, the standard rates will apply.

The use of "spouse" in this form means a person insured as a spouse under the Spouse Life Insurance Rider.

Answer the following questions:

1. Are you terminating active employment due to an inability to perform the regular duties of your occupation? **Employee:** ☐ Yes ☐ No

2. In the last 5 years have you received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs?
   Employee: ☐ Yes ☐ No
   Spouse: ☐ Yes ☐ No

3. In the last 5 years have you been diagnosed, treated, or been given medical advice by a member of the medical profession for: any disorder or disease of the heart or blood vessels (excluding controlled high blood pressure); any kidney disease; any neurological disease or disorder; any liver disease; chronic lung disease (excluding asthma); cancer (excluding non-melanoma skin cancer); stroke; diabetes; rheumatoid arthritis; lupus; Crohn's disease; or ulcerative colitis?
   Employee: ☐ Yes ☐ No
   Spouse: ☐ Yes ☐ No

4. In the last 10 years have you been diagnosed by a member of the medical profession as having a positive HIV test or Acquired Immune Deficiency Syndrome (AIDS) in connections with an application for insurance?
   Employee: ☐ Yes ☐ No
   Spouse: ☐ Yes ☐ No

CONVERSION INFORMATION

If you want to receive life insurance conversion information because: (1) you do not want portability, or (2) your elected ported life amount(s) would be less than 100% of the terminating life coverage amount(s), then please check this box:

☐ Send Conversion Information

ACKNOWLEDGEMENT *(Return the completed form to the address shown on Page 1.)*

- I have read this form and all statements and answers that pertain to me.
- All statements and answers as they pertain to me are true and complete to the best of my knowledge and belief.
- I understand that the statements and answers will be used by the insurer to determine insurability.
- I have received ReliaStar Life Insurance Company's Consumer Privacy Notice and Insurance Information Practices Notice.

Employee Signature _____ Date _____

City and State _____

Spouse Signature[1] _____ Date _____

City and State _____

Owner Signature[2] _____ Date _____

City and State _____

[1] *Spouse Signature is required if Evidence of Insurability is completed above.*

[2] *Owner Signature is required only if the Owner is NOT the Employee.*

Premium Rates for Porting

Group Term Life Insurance

County of Fresno
Group Benefit Plan Number: 708330

Continued ("ported") group term life insurance coverage for insured person(s) will be billed directly by ReliaStar Life Insurance Company. The types of coverage for portability are based on the coverages available under the group policy, and what is approved for portability. Ported coverage is subject to the terms of the group policy.

Please see the chart below and use your current age to determine your cost.

Monthly Rates (per $1,000 of coverage):
Life Insurance—Employee, Spouse

Age	Standard Rate	Preferred Rate
<30	$0.14	$0.08
30-34	$0.18	$0.10
35-39	$0.24	$0.13
40-44	$0.36	$0.23
45-49	$0.56	$0.39
50-54	$0.92	$0.64
55-59	$1.62	$1.00
60-64	$2.90	$1.56
65-69	$5.20	$2.80

Accidental Death & Dismemberment (AD&D) Insurance—Employee
$.035

Children Life Insurance
$0.24

Premiums are billed on a quarterly basis. Each quarterly bill will include a $3.50 billing charge.

Rates shown are guaranteed until December 31 of the current year in which you are eligible to apply for portability.

Group Term Life Insurance is underwritten by ReliaStar Life Insurance Company, a member of the Voya® family of companies. Policy form number LP14GP, Certificate form number LC14GP, Rider form numbers LR14GP-SPR, LR14GP-CHR, LR14GP-ADD and LR14GP-PTS. Form numbers, product availability and provisions may vary by state.

04/15/2015

Request for Annual Leave Donations
Serious Health Conditions

Represented Employees, UNR, MGT, SMG & HDS

Annual Leave donations are permissible pursuant to Salary Resolution 600 & 700 or applicable Memorandum of Understanding (MOU). To qualify for Annual Leave donations under a **Serious Health Condition** for self or a qualifying family member, the following conditions apply:

- The employee must have suffered a serious health condition as defined by the Family Medical Leave Act (FMLA) or California Family Rights Act (CFRA); or
- The employee requires time off work to care for an FMLA/CFRA qualifying family member (child, parent, grandparent, grandchild, sibling, spouse, or domestic partner) with a serious health condition; and
- The employee must have exhausted all paid leave hours (Annual, Vacation, Sick, Comp Time, Accrued Holiday, etc.)

Requests for donations should be submitted to your Department Personnel Representative as early as possible to allow for timely processing. Contact your Department Personnel Representative for biweekly processing deadlines.

Last Name: _____ First Name: _____ Employee ID: _____

Department: _____ Job Title: _____ Last Day Worked: _____

Is the leave for self or relative? ☐ Self ☐ Relative Relationship to Relative _____

By signing below, I understand that if I do not meet the Annual Leave Donation Program conditions, I will not be eligible to receive donated hours. Additionally, I understand that I must solicit for my own donations which, depending on date received, may not be applied until the following pay period. In no circumstance will retroactive donations be approved.

Employee Signature/Date: _____

PLEASE RETURN THIS COMPLETED FORM, ALONG WITH SUPPORTING MEDICAL DOCUMENTATION, TO YOUR DEPARTMENT HR REPRESENTATIVE

FOR USE BY DEPARTMENT HR REPRESENTATIVES

Please complete and submit a copy to Human Resources - Employee Benefits by email to HRALDonations@fresnocountyca.gov by 4:00 p.m. on the **first Friday** of the pay period (unless otherwise notified) in which donations are being requested.

Donations to begin PP: _____ Is employee integrating? ☐ Yes ☐ No

If integrating, check all that apply: ☐ Work Comp (OJI) ☐ SDI ☐ PFL ☐ PORAC

Leave Designated As:

☐ FMLA/CFRA/PDL Dates eligible: _____ Prior usage last 12 months (dates): _____

☐ OJI ☐ Approved ☐ Pending

☐ ADA/FEHA Interactive letter attached? ☐ Yes ☐ No If no, please explain:

Is employee on intermittent leave? ☐ Yes ☐ No Intermittent/reduced schedule: _____

Processed by: _____ Date to HR: _____

EMPLOYEE BENEFITS AUTHORIZATION

A/L balance as of: Date: _____ Balance: _____

Leave Type: ☐ Total Disability ☐ Intermittent Leave

Initial Donations Approved From: _____ Through: _____

☐ APPROVED ☐ DENIED Authorized By: Date: _____

Request for Annual Leave Donations
Catastrophic Illness or Injury

Represented Employees, UNR, MGT, SMG, HDS

Annual Leave donations are permissible pursuant to Salary Resolution 600 & 700 or applicable Memorandum of Understanding (MOU). To qualify for Annual Leave donations due to a **Catastrophic Illness or Injury** for self or qualifying relative, the recipient must meet the following conditions:

- Has an unexpected and/or unplanned illness or injury, that is not chronic in nature, that would likely result in an imminent threat to loss of life and/or limb and that requires immediate medical intervention (treatment, surgery and/or rehabilitation) and that temporarily prevents the employee from working while he/she receives said medical care/treatment; **OR**
- Has a spouse, dependent child, or dependent grandchild (legal guardianship is required) with a catastrophic illness or injury that is verifiable, incapacitating, and life threatening and is so serious in nature as to require extensive, long-term medical treatment, prolonged hospitalization, or an extended recovery period and requires the employee to be present to care for the family member; **AND**
- The employee must have exhausted all paid leave hours (e.g., Annual, Vacation, Sick, Comp Time, Accrued Holiday, etc.)

This request, including extensions, must be accompanied by the **County of Fresno Catastrophic Illness or Injury Medical Certification Form** (page 2) completed by the treating physician. Requests for donations should be submitted to your Department Personnel Representative as early as possible to allow for timely processing. Contact your Department Personnel Representative for biweekly processing deadlines.

Last Name: _____ First Name: _____ Employee ID: _____

Department: _____ Job Title: _____ Last Day Worked: _____

Is the leave for self or relative? ☐ Self ☐ Relative Relationship to Relative _____

By signing below, I understand that if I do not meet the Annual Leave Donation Program conditions, I will not be eligible to receive donated hours. Additionally, I understand that I must solicit for my own donations which, depending on date received, may not be applied until the following pay period. In no circumstance will retroactive donations be approved.

Employee Signature/Date: _____

PLEASE RETURN THIS COMPLETED FORM, ALONG WITH SUPPORTING MEDICAL DOCUMENTATION, TO YOUR DEPARTMENT HR REPRESENTATIVE

FOR USE BY DEPARTMENT HR REPRESENTATIVES

Please complete and submit a copy to Human Resources - Employee Benefits by email to HRALDonations@fresnocountyca.gov by 4:00 p.m. on the first Friday of the pay period (unless otherwise notified) in which donations are being requested.

Donations to begin PP: _____ Is employee integrating? ☐ Yes ☐ No

If integrating, check all that apply: ☐ Work Comp (OJI) ☐ SDI ☐ PFL ☐ PORAC

Leave Designated As:

☐ FMLA/CFRA/PDL Dates eligible: _____ Prior usage last 12 months (dates): _____

☐ OJI ☐ Approved ☐ Pending

☐ ADA/FEHA Interactive letter attached? ☐ Yes ☐ No If no, please explain:

Is employee on intermittent leave? ☐ Yes ☐ No Intermittent/reduced schedule: _____

Processed by: _____ Date to HR: _____

EMPLOYEE BENEFITS AUTHORIZATION

A/L balance as of: Date: _____ Balance: _____

Leave Type: ☐ Total Disability ☐ Intermittent Leave

Initial Donations Approved From: _____ Through: _____

☐ APPROVED ☐ DENIED Authorized By: Date: _____

Catastrophic Illness or Injury
Medical Certification Form

Represented Employees, UNR, MGT, SMG, HDS

Dear Health Care Provider:

To determine employee eligibility for annual leave donations through the Fresno County catastrophic injury or illness program, please complete the Health Care Provider Section on this form. If you have any questions, please call Fresno County Human Resources at 600-1820.

EMPLOYEE SECTION

EMPLOYEE NAME | **PATIENT NAME (IF NOT EMPLOYEE)** | **PATIENT RELATIONSHIP TO EMPLOYEE**

REQUESTED LEAVE BEGIN DATE | **ANTICIPATED LEAVE END DATE**

☐ **If leave is for my own catastrophic illness or injury, by checking the box to the left, I authorize my health care provider to share my diagnosis at the bottom of this page.**

_____
Employee Signature / Date

HEALTH CARE PROVIDER SECTION

The County of Fresno's definition of a catastrophic illness or injury is described below. Please indicate if the leave is for the employee or their qualifying family member by checking the appropriate box:

Catastrophic Leave is for:

☐ **Employee** - A catastrophic illness or injury that is covered by this section is defined as an unexpected and/or unplanned illness or injury, that is not chronic in nature, that would likely result in an imminent threat to loss of life and/or limb and that requires immediate medical intervention (treatment, surgery and/or rehabilitation) and that temporarily prevents the employee from working while he/she receives said medical care/treatment.

☐ **Family Member - The employee's spouse, domestic partner, parent, child, or dependent grandchild** must have a catastrophic illness or injury that is verifiable, incapacitating, and life threatening and is so serious in nature as to require extensive, long-term medical treatment, prolonged hospitalization, or an extended recovery period and requires the employee to be present to care for the family member.

Please select the option the employee's catastrophic illness or injury relates to (if the box above the employee's signature line is checked please provide the diagnosis):

☐ **INVASIVE CANCER**
☐ **DEBILITATING STROKE OR HEART ATTACK MAJOR ORGAN TRANSPLANT**
☐ **MAJOR ORGAN TRANSPLANT**
☐ **SEVERE ACCIDENT/INJURY**
☐ **OTHER (please specify):** _____

Printed Name of Health Care Provider: _____

Signature of Health Care Provider: _____

Medical Health Care Specialty: _____

Date: _____

Phone: _____

Place Stamp Here

Agreement to Donate Annual Leave

Represented Employees, UNR, MGT, SMG & HDS

Pursuant to Salary Resolution Sections 600 & 700, I request to donate Annual Leave hours as specified below. If approved by the Department of Human Resources, I understand that this donation is unconditional and irrevocable, and shall be treated as though it had been earned by the **recipient** at their regular rate of pay.

Note: A maximum of 40 hours* per payroll year may be donated by the donor, and only if after the donation, the donor has a remaining balance of 120 hours of Annual leave/Sick/Vacation. Employees who have given official notification of their intent to separate from County employment **may not** donate under any circumstance.

*Donor **may** be approved for waiver of the 40-hr limitation for catastrophic illness or injury pursuant to Salary Resolution Sec 618.4.

Recipient's Name: _____ **Recipient's Department:** _____

Donor Name: _____ Donor Employee ID: _____

Donor Department: _____ Donor Work Phone: _____

Have you previously donated to a County employee in the current payroll year? ☐ Yes ☐ No

If yes, hours you donated: _____

In the section below, indicate your current balance and the number of hours you wish to donate

	Current Balance	Hours Donated
Annual Leave I/II/III/IV (AL/AL04)		
Sick Leave I/II (SV02)		
Vacation Leave I/II (SV02)		
Time Off Bank (TOB)		

Donor Signature/Date: _____

Witness Signature (other than recipient)/Date: _____

Please return this form to the recipient's HR representative

DEPARTMENT REPRESENTATIVE SECTION

Complete and forward a copy to Human Resources – Employee Benefits by email to HRALDonations@fresnocountyca.gov by no later than 12 pm on the 2nd Wed. of a pay period in which donations are to be applied, unless otherwise notified due to closures.

Recipient: ID #: _____ AL Bal: _____ as of PPE: _____

Integrating? ☐ Yes, Work Comp (OJI) ☐ Yes, Other ☐ No

Donor Info:

Donor maintains at least 120 hours after this request is applied? ☐ Yes ☐ No
(If no, the donor is not eligible to donate hours)

Processed By: Date to HR:

EMPLOYEE BENEFITS AUTHORIZATION (HR-Benefits will reply to the department with approval via e-mail)

Benefits Representative: Date of Approval:

SDI BENEFITS & INTEGRATION PACKET

State Disability Insurance & Paid Family Leave Benefits:
Integrating Accrued Paid Leave

California State Disability Insurance (SDI) provides short-term Disability Insurance (DI) and Paid Family Leave (PFL) wage replacement benefits to eligible workers who need time off work for qualifying non work-related illness or injuries.

ELIGIBILITY CRITERIA

- You must be covered by SDI. Employees in Units 2, 3, 4, 7, 11, 12, 13, 19, 22, 25, 30, 31, 36, 37, 39, 42, 43, as well as Unrepresented employees and Management employees (excluding Department Heads and Elected Officials) are currently covered by SDI;
- You must be on an approved leave of absence (LOA). Complete all required leave paperwork;
- You must have an approved SDI claim;
- DI benefits: you must have an illness or injury, either physical or mental, which prevents you from performing your regular and customary work. Disability also includes elective surgery, pregnancy, childbirth, or other related medical conditions;
- PFL benefits: your request must be to take time off from work to care for a seriously ill family member (child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner) or to bond with a new child entering the family through birth, adoption, or foster care placement.

BENEFITS

	Disability Insurance	**Paid Family Leave**
Benefit Period	Payable up to 52 weeks.	Payable up to 8 weeks within a 12-month period.
Waiting Period	7 days (annual leave hours must be used during this time). Subsequent claims filed within the same 12-month period may be subject to a new waiting period.	None.
Weekly Benefit Amount	Approximately 60-70% (depending on income) of wages earned 5-18 months prior to the claim start date.	Approximately 60-70% (depending on income) of wages earned 5-18 months prior to the claim start date.

PAY OPTIONS

You must select one of the options below by completing the DI / PFL Benefits Integration Election Form and returning it to your department's Personnel office.

1. Integrate paid leave with DI / PFL benefits;
2. Decline to use paid leave and collect only DI / PFL benefits; or
3. Receive only paid leave until balances are exhausted (this is the default option).

INTEGRATION

The DI / PFL Program allows for integration of benefits with your paid leave and has the effect of approximating full compensation by combining paid leave and SDI benefits. Please be advised that you will not accrue paid time off during your period of integration.

SDI Benefit	County Benefit (paid leave)	Total Benefit	Timesheet Coding
60% of your salary	Up to 40%* (submission of EDD benefit statement within 30 days of receipt is required)	Up to 100% of salary	Up to 40% paid leave, with 60% dock time (the waiting period, if applicable, is coded as paid leave)
70% of your salary	Up to 30%* (default)	Up to 100% of salary	Up to 30% paid leave, with 70% dock time (the waiting period, if applicable, is coded as paid leave)

*County Benefit dependent upon employee's available paid leave balance

EMPLOYEE RESPONSIBILITIES

1. **Complete the DI / PFL Benefits Integration Election Form** (required even if you are not electing to integrate).
    a. Option #1: If you elect to integrate, you must complete and submit the form timely, and you must continue integration until your LOA ends or your leave balances are exhausted. If your form is submitted late, integration of hours will begin once submitted (retroactive integration requests are not granted). If you receive more paid leave hours than you are eligible for due to your late request for integration, you must work with the State Employment Development Department (EDD) to return any overpayments.
    b. Option #2: If you elect to not use your paid leave and instead receive DI / PFL benefits only, you will be placed on an unpaid LOA. This election is irrevocable and will stay in effect until you return to work. There is one exception: you may elect to integrate your paid leave upon extension of your LOA by completing a new form; however, your form must be submitted before your extension begins, as retroactive integration requests are not granted.
    c. Option #3: If you elect to use your paid leave hours only, you will not collect SDI /PFL benefits and will be placed on a paid leave until your leave hours are exhausted.
2. **File a claim with SDI**.

    It is your responsibility to file an SDI claim. The County is not involved in the application/benefit payment processes. The role of the County is limited to verifying employment, pay rate, dates of absence, and integrating your annual leave (if applicable).
3. **Remit Health Premium Payment** (if necessary).

    If earnings are not sufficient to cover your premium deduction while integrating, health benefits will be terminated, and you will receive a billing notice. It will be your responsibility to remit premium payment timely to have your health coverage reinstated. Please ensure you provide your department with the required leave of absence documentation, including a medical note.

STATE DISABILITY INSURANCE
DISABILITY INSURANCE (DI) & PAID FAMILY LEAVE (PFL)
INTEGRATION ELECTION FORM

Name (Print): _____ **Employee ID:** _____

Last Day of Work: _____ **Duration of LOA:** _____

Please elect one of the options below (required):

1. **INTEGRATE**: I elect to integrate my paid leave with DI/PFL benefits during my LOA.	☐
2. **DI/PFL ONLY**: I elect to not use my paid leave with DI/PFL benefits during my LOA.	☐
3. **PAID LEAVE ONLY**: I do not intend to file a claim for DI/PFL benefits. I understand that I must use the maximum amount of paid leave that I'm eligible for during my LOA.	☐

In addition to your election above, by signing this form you agree to the following conditions:

1. Once you elect integration (Option #1 above), you may not alter this election until your paid leave is exhausted or until you return to work. There are no exceptions to this rule.
2. If you choose Option #2 above:
   a. You must use the lesser of forty (40) hours of paid leave or your entire leave balance to cover the waiting period for DI benefits (there is no waiting period for PFL benefits); and
   b. You may only change your election upon extension of your current LOA.
3. If you submit this Integration Election Form late, there is no retroactive integration – the County will not process a payroll adjustment to restore your leave balances.
4. If you are eligible for the 60% DI / PFL benefit and you submit your EDD benefit statement to your department within thirty (30) days of receipt, your integration formula will be adjusted to 40% paid leave and 60% dock time. (The default is 70% DI / PFL.)
5. During your LOA, you may choose the order in which your leave balances are exhausted by completing the table below:

Order	Type	Order	Type
	Annual Leave I		Sick Leave
	Annual Leave II		Vacation
	Annual Leave III		Time Off Bank
	Annual Leave IV		Other (specify):

I have read, understand, and will comply with the terms and conditions described in the SDI Benefits & Integration packet and Integration Election Form.

_____ _____
Signature **Date**