PLUMBERS, PIPE FITTERS & MES LOCAL UNION NO. 392
Supplemental Unemployment Benefit Fund
1228 Central Parkway • Suite 100 • Cincinnati, OH 45202-2200
Phone (513) 241-0444 • Fax (513) 241-1130

Family Medical Leave Act (FMLA)

You must complete the upper portion of the gold form and have your employer complete the bottom portion.

In order to be eligible for the Family Leave Benefit and to receive up to twelve (12) weeks of benefits during a single twelve-month period, you must meet one of the following conditions:

1) You must provide a certified copy of a birth certificate, confirming the birth of a child, or written documentation from a health care provider, confirming the upcoming birth of a child, to the Fund Office Administrator. You may only take the Family Leave Benefit to care for a newborn child within one year of the child's birth.
2) You must provide sufficient documentation to the Fund Office Administrator that an adopted child has been placed in your home, and you must provide a certified copy of the final adoption papers to the Fund Office as soon as practicable. You may only take the Family Leave Benefit to care for an adopted child within one year of the placement.
3) You must provide medical certification from a health care provider, confirming the serious health condition of your spouse, child or parent to the Fund Office Administrator.
4) You must provide written documentation from an authorized military official, confirming the military service dates for your spouse, son, daughter or parent to the Fund Office Administrator. You may only take the FMLA Benefit for any "qualifying exigency" arising out of the fact that your spouse, son, daughter or parent is on "active duty" or has been notified of an impending call or order to active duty in the U.S. National Guard or Reserves in support of a contingency operation.
   A qualifying exigency includes short-notice deployment, military events and related activities, childcare and school activities, financial and legal arrangements, counseling, rest and recuperation, post-deployment activities and additional activities as defined under the FMLA in 29 C.F.R. Part 825.

In order to be eligible for the Family Leave Benefit and to receive twenty-six (26) weeks of benefits during a single twelve-month period to care for a "covered servicemember," you must provide: (1) written documentation from your employer, confirming your leave; (2) medical certification from a health care provider, confirming the covered servicemember's serious injury or illness; and (3) written documentation confirming the military status of the covered servicemember to the Fund Office Administrator. Please be aware that this 26-week leave is the maximum time period allowed and is not in addition to the 12-week leave provided above.

(A) A "covered servicemember" is a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness incurred in the line of duty on active duty.
(B) The covered servicemember must be a spouse, son, daughter, parent or next of kin.

In order to be eligible for the Family Leave Benefit and to receive up to three (3) days of benefits in the event of the death of a member of your immediate family, you must provide: A copy of the obituary, confirming the death of your spouse, child(ren), parent(s), parent(s)-in-law and siblings. Please note that the Plan provides only one (1) day of paid leave after the death of your grandparent(s).

<u>It is your responsibility to contact the Fund Office if returning to work before the time you stated. If you return to work, and you are being paid Benefits, you will be required to reimburse The Fund Office for the time you were paid.</u>

PLUMBERS, PIPE FITTERS & MES LOCAL UNION NO. 392
SUPPLEMENTAL UNEMPLOYMENT BENEFIT FUND (SUB Fund)
1228 CENTRAL PARKWAY, ROOM 100 CINCINNATI, OH 45202

FAMILY MEDICAL LEAVE ACT (FMLA) NOTIFICATION

Section I: Employee Information

Name (please print) _____ Date of Birth _____

Street Address _____ Social Security Number _____

City _____ State _____ Leave Commencement Date _____

Telephone _____ Weeks of Anticipated Leave _____

Reason Leave Requested: (check one)

1. ☐ A serious health condition affecting your ☐ spouse, ☐ child, or ☐ parent for which you are needed to provide care.
2. ☐ The birth of a child or the placement of a child with you for adoption or foster care.
3. ☐ A qualifying exigency arising from the employee's ☐ spouse, ☐ child, or ☐ parent.
4. ☐ To care for a covered military service member for whom the employee is ☐ spouse, ☐ child, ☐ parent, or ☐ next of kin.
5. ☐ The death of an immediate family member ☐ spouse, ☐ child(ren), ☐ parent(s), ☐ parent(s)-in-law, ☐ siblings, or ☐ grandparent(s).

Employee Signature _____ Date _____

Section II: Employer Information

Employer Name _____ Street Address _____

Telephone _____ City _____ State _____ ZIP _____

EMPLOYER APPROVAL: *The employee noted above is approved for an FMLA leave based on the date and number of weeks noted above.*

Name of Employer Representative _____ Signature _____ Date _____