

PLUMBERS, PIPEFITTERS & MES LOCAL UNION NO. 392 FRINGE BENEFIT FUNDS

1228 Central Parkway, Room 100 · Cincinnati, OH 45202-7500

Phone: 513-241-0444 · Fax: 513-241-1130 · Email: postmaster@local392fringefunds.com

FAMILY MEDICAL LEAVE AND BEREAVEMENT LEAVE FORM

Section I: Employee Information

Trade: Commercial Construction Residential

Name _____ SS# (last four) _____

Phone _____ Email _____

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 SUB Fund for the time you were paid.

Leave Commencement Date: _____ Duration: _____ Days _____ Weeks _____

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. The death of an immediate family member:
 spouse, child/stepchild, parent/stepparent, parent-in-law, sibling, grandparent
4. A qualifying exigency arising from the employee's: spouse, child, or parent
5. To care for a covered military service member: spouse, child, parent, or next of kin

Employee Signature _____ Date _____

Section II: Employer Information

EMPLOYER APPROVAL: The above employee is approved for a Family Medical Leave or Bereavement Leave Benefit based on the date and number of days/weeks noted above.

Employer Name _____ Phone # _____

Name of Employer Representative _____

Signature _____ Date _____



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FAMILY MEDICAL LEAVE AND BEREAVEMENT LEAVE INSTRUCTIONS

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 and provide the required documentation to the Fund Office:

- 1) Serious health condition – You must provide medical certification from a health care provider, confirming the serious health condition of your spouse, child or parent.
- 2) Birth of child – You must provide the Record of Birth from the hospital or a certified copy of the birth certificate, confirming the birth of a child. Member's name must be listed on both documents. You may only take the Family Leave Benefit to care for a newborn child within one year of the child's birth.

Placement of child – You must provide sufficient documentation that an adopted child has been placed in your home, and you must provide a certified copy of the final adoption papers 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) Bereavement – In order to be eligible for the Bereavement Benefit and to receive up to five (5) days of benefits in the event of the death of a child/stepchild or spouse, three (3) days of benefits in the event of the death of a parent/stepparent, parent-in-law or sibling, and one (1) day of paid leave after the death of your grandparent, you must provide a copy of the obituary.
- 4) Exigency – 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.
- 5) Care for covered service member – 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 service member,” you must provide: (1) written documentation from your employer, confirming your leave; (2) medical certification from a health care provider, confirming the covered service member's serious injury or illness; and (3) written documentation confirming the military status of the covered service member 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 service member” 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 service member must be a spouse, son, daughter, parent or next of kin.