Informational Packet for Maternity Leave 2017-2018

(All information in this packet is subject individual situations and policy changes)

MATERNITY LEAVE 2017-2018

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Time you never get back...

Contact Information

- ★ Kristy Jamison
  - CUTA Rep for Maternity Leave
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- ★ Alicia Gallegos
  - CUSD Benefits Department
  - Ext 1311
  - Email: agallegos@ceres.k12.ca.us

MATERNITY LEAVE

- ★ Part 1: Regular Maternity Leave
  - Info for Dads
  - Forms
  - Duration
  - Sick Leave
  - Cost
  - Example
  - Insurance
- ★ Part 2: CFRA/Extended Leave
  - What is CFRA?
  - Forms
  - Cost
  - Example

MATERNITY LEAVE for DADS

- ★ Dad's OPTION 1 for Baby Bonding
  - Want Less than 2 weeks off
    - Would need to use 5 PN days by completing the Personal Necessity form
    - Can also use an additional 4 PL days but these days will be deducted from STRS

MATERNITY LEAVE for DADS

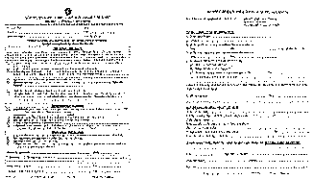
- ★ Dad's OPTION 2 for Baby Bonding
  - Want 2 weeks or more off
    - Would complete the Leave of Absence form and check the CFRA box
      - Your sick days will be used first then you will be deducted the sub rate for every additional day
      - If you have only worked for CUSD for one year, you will need to make sure that you qualify to take FMLA through our district.
    - Also need to complete #1-6 and 18 on the Cert. of Physician Form

Part 1: MATERNITY LEAVE for MOMS

- ★ Duration for Maternity Disability
  - The doctor can take you off work up to 4 weeks before your due date without medical reason.
    - You do not have to take all 4 weeks, unless otherwise told by your doctor.
  - You will have 6 to 8 weeks off after you deliver.
    - 6 weeks for a vaginal delivery
    - 8 week for a cesarean delivery
  - You also have 4 Personal Leave Days, but you must tell the district office when/if you want to use them.
    - Using these days results in the loss of STRS credit.

Part 1: MATERNITY LEAVE for MOMS

- ★ Forms
  - Certificated Employee - Leave of Absence Request
  - Report of Extended Illness Leave/Accident
    - If not turned in before leave starts a doctor's note is required



Part 1: MATERNITY LEAVE for MOMS

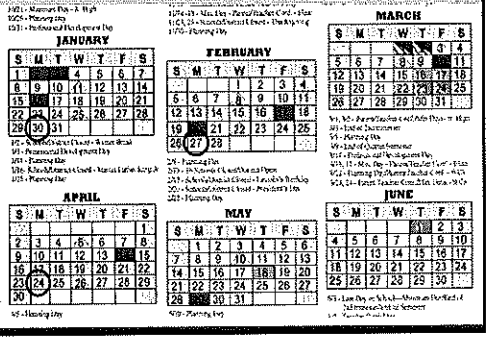
- ★ Sick Leave
  - ALL of your sick days will be used at the start of your maternity leave.
- ★ Cost
  - During *Regular Maternity Leave* you will pay for the cost of the substitute.
  - $120, $140, or $160 will be deducted from your check and you will receive what is left.

Part 1: MATERNITY LEAVE for MOMS

★ Example:
- Due Date
  Feb. 27

- Stop working on the 30th of Jan
- 14 days before delivery
- 14 - 10 sick days = 4 (4 sub days)($160)
- $640 will be deducted from your Feb. check.

- 8 weeks after delivery
- 33 more sub days will be deducted from your checks according to the number of days missed each month.
- 33(160)=$5280



Part 1: MATERNITY LEAVE for MOMS

★ Adding Baby to insurance
- You ONLY have 30 days to add your baby to your insurance policy.
- Depending on when you add your baby, you may see a double charge on your check.

Part 1: MATERNITY LEAVE for MOMS

★ American Fidelity - Long Term Disability Plan
- Starts paying on day 15 of your maternity leave.
- Payout is different depending on your salary
- They will call you 1 to 2 weeks after your due date and ask you questions about the birth to determine how much they need to pay you.
  - Example: Regular birth or Cesarean, Delivery date, etc....

PART 1: Regular Maternity Leave

★ American Fidelity - Long Term Disability Plan
- Differential Pay
  - Starts on day 61 of disability
  - Full benefits are paid for 60 days of leave
    - 60 - 14= 46 days
    - 30 days of full benefit followed by 16 days of your benefit daily rate (benefit divided by 30)
  - After the 60 days...Contact your insurance company and they can give your estimated amount.

PART 1: Regular Maternity Leave

QUESTIONS????

PART 2: CFRA/Extended Leave

★ **What is CFRA?**
- The California Family Rights Act (CFRA) provides certain employees with up to 12 weeks of job-protected leave per year.

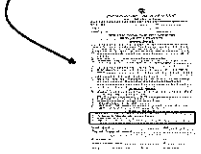
★ Duration
- You have 12 weeks to use over the course of 1 year.
- You do not have to use them all at the same time.
  - Under the CFRA, although employees do not need the employer's agreement to take intermittent bonding leave, an employee may be required to such leave in two-week minimum increments, with an exception for shorter increments on at least two occasions.
  - www.shrm.org

PART 2: CFRA/Extended Leave

★ **Cost of CFRA**
- **You will only be deducted the sub rate for each day of CFRA you choose to use after sick leave has been used.**
  - **Sub Rates: $120, $140, or $160**

PART 2: CFRA/Extended Leave

★ **CFRA Forms**
- **Certificated Employees - Leave of Absence Request**
  - **Yes, this is the same form you also fill out when taking Regular Maternity Leave but you will mark CFRA on the form this time.**



PART 2: CFRA/Extended Leave

★ CFRA Forms
- Birth Certificate:
  - This can be issued from the hospital or county.
- Doctors Note:
  - This is only required if you are returning with restrictions.
    - If returning with restrictions you will need to send a copy of the doctors note to payroll where it will be logged and sent to Personnel and your Principal. Once approved, you will be notified that you can return.

PART 2: CFRA/Extended Leave

★ Taking sporadic CFRA time.
- On the Leave of Absence Form
  - Dates of Absence: This time frame should be set to begin after your regular maternity leave ends and last no more than 60 days. According to the boundaries of CFRA you have one year to use the 60 days.
  - Total days absent: 60 days
  - By the CFRA box at the bottom of the page you will need to make a note that the 60 CFRA days will be used sporadically.
- On the Certification of Physician Form
  - #18 (last question) you will also want to mention that the 60 CFRA days will be taken sporadically as needed.
- A schedule of same form should be submitted with the paperwork so that it is available when being reviewed/approved by the Site and an Administrator from Personnel. A schedule is also needed so that absences are tracked correctly in Digital Schools.

PART 2: FMLA/Extended Leave

QUESTIONS????

Forms for Dads

Revised December 9, 2016

CERTIFICATED EMPLOYEES—LEAVE OF ABSENCE REQUEST

Reference – CUTA Articles of Agreement XIX

Employee Name: _____ Alt ID#: _____ Site: _____

Position(s): _____ Date: _____

Date(s) Of Absence: _____ Total Days Absent: _____

(*)PRIOR APPROVAL REQUIRED BY ASSISTANT SUPERINTENDENT, PERSONNEL

Employees are responsible for tracking their own time.

PERSONAL NECESSITY

Up to 7 days annually, taken from sick leave. If no sick leave available – 100% pay deduction. By signing this Leave of Absence Request form, the employee understands and acknowledges that: (1) personal necessity leave may not be used for recreational activities nor for seeking or engaging in other paid or unpaid employment, and (2) if the employee violates this contract provision, the personal necessity day(s) will be changed to Unpaid Leave of Absence and the employee's salary will be reduced accordingly.

☐ 1. Death of a member of the employee's immediate family, as defined in the Bereavement Leave Section, when additional leave is necessary.

☐ 2. Death of a person not in the immediate family as defined in the Bereavement Leave Section.

☐ 3. **Prior notification not needed.** As a result of an emergency, accident, illness or medical need, involving an employee's person or property or the person or property of his/her immediate family: **Explanation Required:** _____

_____

☐ 4. Appearance in any court or before any administrative tribunal as a litigant.

☐ 5. **With prior approval,** business transactions or other activities which require the presence of the employee. **Explanation Required:** _____

_____

☐ 6. **With prior notice** for the adoption of a child when additional leave is necessary.

☐ 7. **With prior notice,** other personal and compelling concerns, except for recreational activities, or for seeking or engaging in other paid or unpaid employment. **This leave is limited to one (1) day per occurrence. Explanation required:** _____

_____

Miscellaneous Absences

☐ **BEREAVEMENT:** (Paid leave for death in immediate family, relationship & location required, documentation required for 300 or more miles one way for 4 or 5 days bereavement leave)

Relationship: _____ **Location:** _____

☐ **IN-SERVICE LEAVE:** (Principal approval is a prerequisite for granting this leave. One day each year.)

☐ **PERSONAL LEAVE:** (4 days a year are sub deduct, additional days are full per diem.)

☐ * **OTHER LEAVE OF ABSENCE - Explanation Required:** _____

☐ * **UNPAID LEAVE OF ABSENCE:** (No advancement of salary schedule while on unpaid leave, may participate in benefits program at employee expense, must notify district by _____ of intent to return)

Absences 6 days or more

(Requires medical verification – doctor's note and release to return to work as well as a Report of Extended Leave Form)

☐ **PERSONAL ILLNESS/EXTENDED ILLNESS LEAVE:** (Deducted from sick leave)

☐ **MATERNITY LEAVE:** (Deducted from sick leave)

☐ * **FMLA:** (Up to 12 weeks, deducted at 100% of pay if sick leave not available after all other available paid leaves are exhausted, additional paperwork required in advance of leave)

☐ * **CFRA (Baby Bonding):** (Up to 12 weeks of sub deduct after all other available paid leaves are exhausted, additional paperwork required in advance of leave)

Employee Signature: _____ Date: _____

Site Supervisor Signature: _____ Date: _____

*Assistant Superintendent Signature: _____ Date: _____

☐ **Approved** ☐ **Not Approved** Explanation: _____

_____

Distribution: WHITE & YELLOW – Payroll PINK – Site GOLDENROD – Employee

REPORT OF EXTENDED ILLNESS LEAVE/ACCIDENT

This form is to be completed and returned to: Ceres Unified School District
Attention: Personnel
P.O. Box 307, Ceres, CA 95307

TO BE COMPLETED BY EMPLOYEE

1. Employee's Name _____
2. Address _____
3. If this is a Maternity Leave, expected dates of absence are:
   From _____ Thru _____ (skip questions 4 & 5)
4. If illness or surgery request, expected dates of absence are:
   From _____ Thru _____
5. If injury/accident, please answer the following:
   a) Date you were first disabled? _____
   b) When did the accident happen? _____
   c) Were you at work when the accident happen? Yes _____ No _____
   d) Give a brief description of the accident: _____

_____

I hereby authorize the undersigned Physician to release information concerning my disability to my employer, Ceres Unified School District.

Employee signature _____ Date _____

ATTENDING PHYSICIAN'S STATEMENT

Nature of Disability _____
Did this disability arise out of the patient's employment? Yes _____ No _____
If yes, please explain: _____
What date did you first treat the patient for this disability? _____
Nature of surgical procedure _____
This patient has been continually disabled From _____ Thru _____
Does this patient have any restrictions? _____

WHEN SHOULD PATIENT BE ABLE TO RETURN TO WORK WITHOUT RESTRICTIONS?

_____

Date _____ Physician's Signature _____

Physician Name _____ Address _____

Phone # _____

White: Personnel Canary: Payroll Pink: Site Goldenrod: Employee

Regular Maternity Leave Forms

Revised December 9, 2016

CERTIFICATED EMPLOYEES—LEAVE OF ABSENCE REQUEST

Reference – CUTA Articles of Agreement XIX

Employee Name: _____ Alt ID#: _____ Site: _____

Position(s): _____ Date: _____

Date(s) Of Absence: _____ Total Days Absent: _____

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WHEN SHOULD PATIENT BE ABLE TO RETURN TO WORK WITHOUT RESTRICTIONS?

_____

Date _____ Physician's Signature _____

Physician Name _____ Address _____

Phone # _____

White: Personnel Canary: Payroll Pink: Site Goldenrod: Employee

American Fidelity Assurance Company

Our Family, Dedicated To Yours.®

Mail to: AFES Benefits Department
P.O. Box 25160
Oklahoma City, OK 73125-0160
Local: (405) 523-5025
Toll Free: 1-800-662-1113
Fax: 1-800-818-3453
www.americanfidelity.com

EMPLOYEE'S DISABILITY BENEFITS APPLICATION

Full Name: (last, first, middle initial)	Maiden Name	Account Number:
Residence: (street, city, state and zip code)		Social Security Number: - -
Mailing Address: (P.O. Box or street, city and zip code)		Date of Birth: / /
Telephone Number: (including area code) ( )	☐ Single ☐ Married ☐ Widowed ☐ Divorced	
Occupation:	Has your employment terminated?	If so, date:

Names & birth dates of spouse & dependents:

Name _____ Birth date ___/___/___ Name _____ Birth date ___/___/___

Name _____ Birth date ___/___/___ Name _____ Birth date ___/___/___

1. Date accident or illness began:

2. If accident, explain where and how it happened?

3. Have you ever had the same or similar condition in the past? ☐Yes ☐No If so, when? _____

If yes, names and address of treating physicians and/or hospitals:

4. Nature of illness or injury:

5. Dates of medical treatment:

Date of next doctor's appointment:

6. If hospitalized give full name(s) and addresses of hospitals: (attach additional list if necessary) Admit Date: ___/___/___ Discharge Date: ___/___/___

7. Full names and addresses of all treating physicians: (attach additional list if necessary)

8. Is your disability related to your employment/occupation? ☐Yes ☐No
If yes, have you or do you intend to file for Worker's Compensation? ☐Yes ☐No

9. On what date did you last work?_____ Dates of total disability: From _____ Thru _____
On what date did you return to work? Part Time ___/___/___ Full Time ___/___/___
If not returned to work, when do you anticipate returning to work?_____

10. If your request for benefits is approved, do you want us to withhold Federal Taxes from each benefit check? ☐Yes ☐No

If yes, amount: $ _____ (indicate amount per month $86.00 minimum)

11. Identify other income sources and amount of income for which you are receiving or may be entitled to receive during this disability

Your Social Security: (disability or retirement)	☐Yes ☐No	$_____Mo.	V.A. Benefits:	☐Yes ☐No	$_____Mo.		
Dependent Social Security:	☐Yes ☐No	$_____Mo.	Worker's Compensation:	☐Yes ☐No	$_____Mo.		
Sick Leave or Wage Continuation:	☐Yes ☐No	$_____Mo.	Other Disability Coverage:	☐Yes ☐No	$_____Mo		
Retirement: (normal early or disability)	☐Yes ☐No	$_____Mo.	(identify)_____				
State Disability Income	☐Yes ☐No	$_____Mo.	**Include a copy of your award or denial letter for any source in which one has been received.**				
Unemployment	☐Yes ☐No	$_____Mo					

Signature: _____ **Date:** _____
I certify this information is true and correct.

I authorize AFA to initiate credit entries to my account at the depository named below. This authorization is to remain in force and effect until AFA receives written notification from me of its termination in such time and in such manner as to afford AFA and the Depository opportunity to act on it. This authorization applies to benefits payable under all insurance policies held with AFA.

Signature: _____

NOTE: You will need to attach a voided check to begin direct deposit.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about my entire medical record, benefits payable, or benefit eligibility for this disability and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing American Fidelity Assurance Company (AFAC) who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles; and k) Workers' Compensation Carrier.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated. This authorization excludes disclosure of the result of a test for HIV if you have tested HIV positive but have not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that you have AIDS.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial or a delay of benefits.

I understand that I may revoke this authorization at any time by writing to AFES Benefits Department, PO Box 25160, Oklahoma City, OK 73125-0160 or by calling, toll-free, 1-800-662-1113. I understand that my right to revoke this authorization is limited to the extent that: AFAC has taken action in reliance on the authorization; or, the law provides AFAC with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original. I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations. For health insurance coverage this authorization will expire twenty-four months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first.

Signature (Patient) or Personal Representative (if applicable)	Printed Name (Patient)
Relationship of Personal Representative to Patient	Date

If authorization is supplied by a personal representative a description of the authority to act on behalf of the Insured must be included. Please retain a copy for your personal records, or you may request a copy from our company.

Warning: Any person who knowingly and with intent to injure, defraud, or deceive an insurer files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties.

California - For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

AR, DC, LA, MD, NJ, NM, TX, and WV - ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

DE, ID, IN, MN, OH, and OK - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Colorado - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

New Hampshire - Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Kentucky - Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Oregon - Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be guilty of insurance fraud.

Pennsylvania - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Arizona - For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Florida - Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Alabama - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Maryland - Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

American Fidelity Assurance Company

Our Family, Dedicated To Yours.®

American Fidelity Assurance Company
Mail to: AFES Benefits Department
P.O. Box 25160
Oklahoma City, OK 73125-0160
Local: (405) 523-5025
Toll Free: 1-800-662-1113
Fax: 1-800-818-3453

ATTENDING PHYSICIAN'S STATEMENT

Name of Patient:	Date of Birth:	Social Security Number:	Account Number:

DIAGNOSIS

Diagnosis: (including complications) ICDA Code:

Is disability due to injury or sickness arising out of or in the course of patient's employment? ☐ Yes ☐ No

Is disability the result of pregnancy? ☐ Yes ☐ No If yes, type of delivery: _____

Date pregnancy was diagnosed? ___/___/___ Date of delivery:(if delivered) ___/___/___ Expected date of delivery? ___/___/___

HISTORY

When did symptoms first appear or accident happen? ___/___/___ Date patient first consulted you for this condition? ___/___/___

Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, indicate when and describe:

Was the patient referred to you? ☐ Yes ☐ No If yes, full name and address of referring physician:

TREATMENT

Frequency of treatment: ☐ Monthly ☐ Weekly ☐ Other

Date of next appointment : ___/___/___

Nature of treatment being rendered (including surgery and any medications being prescribed)

List all dates of treatment or medical attention since the disability began:

Is patient still under your regular care for this condition? ☐ Yes ☐ No If no, please explain and provide name of the current treating physician:

Has the patient been confined to a hospital? ☐ Yes ☐ No Admitted: ___/___/___ Discharged: ___/___/___

If yes, give admit and discharge dates along with name and address of hospital. Admitted: ___/___/___ Discharged: ___/___/___

Name:_____ Address: _____

PROGNOSIS

Dates of total disability: (unable to work) From: _____ Through: _____

Disabled from: Patient's Job ☐ Yes ☐ No Any other work ☐ Yes ☐ No

Dates of partial disability? From: _____ Through: _____

If the patient is currently disabled, what is the anticipated length of disability?

☐ 1-2 Months ☐ 2-3 Months ☐ 3-6 Months
☐ 6-12 Months ☐ More than 12 Months ☐ Permanent

When, in your opinion, will the patient recover sufficiently to return to work?

IMPAIRMENTS

Functional Limitations that render your patient totally disabled:

Current Treatment Plan:

Attending Physician's Name: (print)	Specialty:	Telephone #: ( ) -	Fax #: ( ) -
Street Address:	City:	State:	Zip Code:
Signature:	Federal Tax ID #:		Date:
Email address:			

American Fidelity Assurance Company

Our Family, Dedicated To Yours.®

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Mail to: AFES Benefits Department
P.O. Box 25160
Oklahoma City, OK 73125-0160
Local: (405) 523-5025
Toll Free: 1-800-662-1113
Fax: 1-800-818-3453
www.americanfidelity.com

EMPLOYER'S REPORT OF CLAIM

EMPLOYMENT

Name of Employer: CERES UNIFIED SCHOOL DISTRICT — Phone No.: (209)556-1500

Mailing Address: (include street, city, state and zip code): P.O Box 307, 2503 Lawrence St, Ceres CA 95307 — Fax No.: (209)537-7301

Name of Employee: — Social Security Number: - -

Address: (include street, city, state and zip code) — Phone No.: ( )

Date of Hire: — Effective date of employee's coverage: — Occupation: (please attach job description)

Status of employment at time employee last worked: ☐ Full-Time ☐ Part-Time ☐ Leave of Absence ☐ Terminated ☐ Retired

Number of hours worked per week at time of leave: _____

Number of contract days: _____ for _____ school year.

In-house days:
First Day _____
Last Day _____

Has employee's status of employment changed? ☐ Yes ☐ No If yes, current status and date of status-change? _____

PREMIUMS

Does employee participate in Social Security? ☐ Yes ☐ No If no, hired after 4/1/86? ☐ Yes ☐ No

Please furnish the percentage of the employee's AFA disability premium paid by the employer: 0 %

Are the AFA disability employee-paid premiums withheld before or after taxes?

Short Term Plan ☐ Before ☑ After **Long Term Plan** ☐ Before ☑ After

SALARY

CONTRACTED SALARY AT TIME OF DISABILITY

Annual: $_____ Effective Date: _____ ☐ 9 ☐ 10 ☐ 12 Month Work Schedule
☐ 9 ☐ 10 ☑ 12 Month Pay Schedule

DISABILITY

Date employee last worked: _____
Has employee returned to work? ☐ Yes ☐ No

Have AFA Disability premiums been withheld through the last date worked? ☑ Yes ☐ No

If Yes, date returned to work:

If not, what is the last date disability premiums were deducted? _____

Full Time: _____ Part Time: _____

OTHER INCOME

Did Employee's disability result from employment? ☐ Yes ☐ No

If yes, name, address and phone number of Worker's Compensation carrier: _____

Has employee made a claim for or is entitled to Worker's Compensation? ☐ Yes ☐ No

If yes, weekly rate of compensation: $_____

Provide: The final date the employee is entitled to fully paid sick leave _____

Is this employee eligible to receive any other form of wage continuation? ☐ Yes ☐ No If so, please advise the amount and the final date the employee is entitled to receive this pay. _____

The first date the employee is entitled to differential/sabbatical pay, if any _____

The last date the employee is entitled to differential/sabbatical pay _____

The daily rate of differential/sabbatical pay $ _____

Name, address and phone number of any other disability carrier: (include street, city, state and zip code)

Is employee vested for disability retirement benefits? ☐ Yes ☐ No

Remember - To attach a copy of the applicable school calendar for any contracted employee.

FAILURE TO DO SO COULD RESULT IN DELAYED BENEFITS

I hereby certify that the above named employee is a member of our Group Disability Program. The Information stated above is correct to the best of my knowledge and belief.

Authorized signature of employer firm or authorized official: _____

Title: BENEFITS SPECIALIST Date: _____

E-mail Address: _____ Extension: _____

CFRA Forms

Revised December 9, 2016

CERTIFICATED EMPLOYEES—LEAVE OF ABSENCE REQUEST

Reference – CUTA Articles of Agreement XIX

Employee Name: _____ Alt ID#: _____ Site: _____

Position(s): _____ Date: _____

Date(s) Of Absence: _____ Total Days Absent: _____

(*)PRIOR APPROVAL REQUIRED BY ASSISTANT SUPERINTENDENT, PERSONNEL

Employees are responsible for tracking their own time.

PERSONAL NECESSITY

Up to 7 days annually, taken from sick leave. If no sick leave available – 100% pay deduction. By signing this Leave of Absence Request form, the employee understands and acknowledges that: (1) personal necessity leave may not be used for recreational activities nor for seeking or engaging in other paid or unpaid employment, and (2) if the employee violates this contract provision, the personal necessity day(s) will be changed to Unpaid Leave of Absence and the employee's salary will be reduced accordingly.

☐ 1. Death of a member of the employee's immediate family, as defined in the Bereavement Leave Section, when additional leave is necessary.

☐ 2. Death of a person not in the immediate family as defined in the Bereavement Leave Section.

☐ 3. **Prior notification not needed.** As a result of an emergency, accident, illness or medical need, involving an employee's person or property or the person or property of his/her immediate family: **Explanation Required:** _____

_____

☐ 4. Appearance in any court or before any administrative tribunal as a litigant.

☐ 5. **With prior approval,** business transactions or other activities which require the presence of the employee. **Explanation Required:** _____

_____

☐ 6. **With prior notice** for the adoption of a child when additional leave is necessary.

☐ 7. **With prior notice,** other personal and compelling concerns, except for recreational activities, or for seeking or engaging in other paid or unpaid employment. **This leave is limited to one (1) day per occurrence. Explanation required:** _____

_____

Miscellaneous Absences

☐ **BEREAVEMENT:** (Paid leave for death in immediate family, relationship & location required, documentation required for 300 or more miles one way for 4 or 5 days bereavement leave)
Relationship: _____ **Location:** _____

☐ **IN-SERVICE LEAVE:** (Principal approval is a prerequisite for granting this leave. One day each year.)

☐ **PERSONAL LEAVE:** (4 days a year are sub deduct, additional days are full per diem.)

☐ * **OTHER LEAVE OF ABSENCE - Explanation Required:** _____

☐ * **UNPAID LEAVE OF ABSENCE:** (No advancement of salary schedule while on unpaid leave, may participate in benefits program at employee expense, must notify district by _____ of intent to return)

Absences 6 days or more

(Requires medical verification – doctor's note and release to return to work as well as a Report of Extended Leave Form)

☐ **PERSONAL ILLNESS/EXTENDED ILLNESS LEAVE:** (Deducted from sick leave)

☐ **MATERNITY LEAVE:** (Deducted from sick leave)

☐ * **FMLA:** (Up to 12 weeks, deducted at 100% of pay if sick leave not available after all other available paid leaves are exhausted, additional paperwork required in advance of leave)

☐ * **CFRA (Baby Bonding):** (Up to 12 weeks of sub deduct after all other available paid leaves are exhausted, additional paperwork required in advance of leave)

Employee Signature: _____ Date: _____

Site Supervisor Signature: _____ Date: _____

*Assistant Superintendent Signature: _____ Date: _____

☐ **Approved** ☐ **Not Approved** Explanation: _____

_____

Distribution: WHITE & YELLOW – Payroll PINK – Site GOLDENROD – Employee