

# BELLSOUTH APPLICATION & CERTIFICATION FOR LEAVE

FMLA Administrator  
 P.O. Box 9274  
 Des Moines, IA 50306  
 Fax: 1-888-757-1783

Form RF3104-  
 FMLA (4/05)  
 Sheet 1

<b>EMPLOYEE NAME:</b>	<b>EMPLOYEE SOCIAL SECURITY #:</b>
<b>PATIENT NAME IF DIFFERENT:</b>	

Failure to complete all required sections of the application and medical certification may result in the delay of your request.  
 Failure to return to work at the end of your leave period may be treated as resignation unless an extension has been agreed upon and approved in writing by the company.

<b>Section A - TO BE COMPLETED BY EMPLOYEE</b>	Does your spouse work for BellSouth? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>Yes</b> , please provide their name. _____		
Current Home Phone #:	Relationship To Employee <input type="checkbox"/> Self <input type="checkbox"/> Child <i>Birthdate</i> _____ <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Domestic Partner		
Current Home Street Address:	City:	State:	Zip:
If you seek leave for your own serious health condition, state the reason for the leave OR if the leave is for a child, spouse, parent or domestic partner, state the nature of the care you will be providing. _____ _____			

<b>Section B - SUPERVISOR INFORMATION</b>			
Supervisor Name	Phone #: (    ) <b>Voice Mail #:</b> (    )	Room # (if applicable)	
Street Address	City	State	Zip

<b>Section C - EMPLOYEE AUTHORIZATION</b>	
<ul style="list-style-type: none"> <li>■ I have read the reverse and understand the terms of the leave applying to my specific situation in connection with my request.</li> <li>■ I hereby authorize my company's health care provider to contact my or my family member's treating health care provider for clarification and authenticity of the medical certification.</li> </ul>	
<b>EMPLOYEE SIGNATURE</b>	<b>DATE</b>

<b>Section D - FORMAL LEAVE OF ABSENCE</b> (This section is not required for FMLA leaves of 30 consecutive days or less)			
If you are requesting a formal leave of absence, you must also complete this section.			
<b>Type of Leave Requested:</b>	<b>Leave Request:</b> From: ____/____/____ To: ____/____/____		
<input type="checkbox"/> ADL (Also complete Section E on pages 3-4)	<b>Short Term Disability end date</b> (If applicable) ____/____/____		
<input type="checkbox"/> CNC	<b>Child's Birthdate</b> ____/____/____		
<input type="checkbox"/> STD Appeal (craft only)	<b>Adoption/Placement Date</b> ____/____/____		
<input type="checkbox"/> Sickness New Hire (Also complete Section E on pages 3-4)	<b>Completed forms should be mailed or faxed to:</b>		
<input type="checkbox"/> DCL (Also complete Section E on pages 3-4)	<b>BellSouth Benefits Service Center Leaves Administrator</b>		
<input type="checkbox"/> FMLA Medical (Also complete Section E on pages 3-4) (FMLA Leaves greater than 30 consecutive days)	<b>PO Box 10450</b>		
	<b>Des Moines, IA 50306-0450</b>		
	<b>Fax 1-888-757-1783</b>		
Street Address While on Leave:	City:	State:	Zip:
Is Departmental Leave being extended into a Formal Leave? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Department Leave Start Date:    /    /			
All vacation, DP, HO, and FDP taken prior to the start of this leave? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, are you requesting to be paid in lieu of vacation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
NOTE: If applying for an <b>Anticipated Disability Leave</b> , you must contact your supervisor immediately when the disability begins, so you can be returned to active payroll for calculating your eligibility to sickness disability benefits.			
<b>SUPERVISOR SIGNATURE</b> (Must Sign to Proceed with Leave of Absence Request)			<b>DATE</b>

**PLEASE ENSURE FORMS ARE FILLED OUT COMPLETELY AND ACCURATELY**

**NOTE: THIS PAGE IS INFORMATIONAL ONLY AND DOES NOT NEED TO BE RETURNED WITH THE REST OF THE DOCUMENTATION.**

## Conditions For Anticipated Disability Leave, Care of Newborn Children Leave, Dependent Care And Medical Leave

In applying for an Anticipated Disability Leave, Care of Newborn Children Leave, or Dependent Care Leave, I understand the following guidelines will apply:

### **A. Benefits under the Short Term Disability Plan (ADL Only).** My Eligibility for benefits is as follows:

1. Disability benefits because of the stated anticipated disability described in this application will be paid to me after the seventh calendar day upon my furnishing satisfactory medical certification of actual disability to the Company Medical/Benefit Department. The maximum period for any payment to be paid is 52 weeks, providing I have more than six months of service in accordance with the terms of the Sickness and Accident Disability Benefit Plan. Subsequently, should an unanticipated disability occur which is related to the stated disability, appropriate benefits payments will be authorized upon receipt of satisfactory medical proof of disability by the Company Medical/Benefit Department. Should an unanticipated disability occur which is not related to the stated anticipated disability, there is no entitlement to any Sickness Disability Benefits under the Plan. Upon reinstatement to the active payroll at the beginning of the disability for which the leave is granted, I will receive benefits which were in effect prior to the actual certified disability period, and if I have at least six months equivalent service prior to the effective date of the leave. A sickness leave of absence will be granted if I have less than six months of equivalent service, prior to the effective date of this leave.

### **B. Benefits and Telephone Concession**

1. I am covered for Death Benefits under the Pension Plan, providing I am survived by a qualified beneficiary.
2. If eligible for Basic Group Life Insurance at the beginning of this leave, such coverage will continue at company expense.
3. If receiving the reduced rate telephone service at the beginning of this leave, the concession will continue.
4. If enrolled in Universal Plus Life, coverage may be continued by contacting Seabury&Smith at 1-800-227-6013 so that I may be billed for my premiums.
5. If enrolled in STAP, or the Dependent Group Life Insurance Plan or the Dependent Life Plan, the coverage may be continued by paying the premiums to BellSouth Payroll.
6. If enrolled in Long Term Care, coverage may be continued by contacting John Hancock at 1-800-732-3220.

### **C. Medical Assistance Plan, POS or HMO Coverage, Dental Assistance Plan, and Vision Assistance Plan (if applicable after 1/1/97)**

1. I understand that I am applying for an Anticipated Disability Leave or a FMLA Medical Leave, and I will receive medical, dental, and vision coverage (if applicable after 1/1/97) at Company expense for a minimum of the first three (3) months of the leave effective with the date of the leave.\* If on an ADL, I may pay premiums for coverage in excess of three (3) months. If I pay for continuation of coverage during such subsequent months of ADL, reimbursement will be made by the Company for the month in which a certified disability begins. \*Note: If approved for a formal leave, please refer to your leave approval letter for benefit information.
2. I understand that if I am a regular employee, and I am applying for a Care of Newborn Children Leave or Dependent Care Leave, I will receive medical, dental, and vision coverage (if applicable after 1/1/97) at company expense up to the first six (6) months of the leave, effective with the date of the leave. \* I may pay premiums for coverage in excess of six (6) months. I am also responsible for any out-of-pocket amount I am currently paying. \*Note: If approved for a formal leave, please refer to your leave approval letter for benefit information.

### **D. Net Credited Service**

ADL/CNC - I understand that the first 30 days of the leave will be credited to my service upon return to work from the leave. I understand further that if my CNC leave is preceded by an ADL leave, only one 30 day credit will apply for both leaves. I also understand that if I returned to work from a leave within the past 12 months, there will be no service credit for the AD, CNC or combined AD/CNC leaves.

### **E. Deferred Vested Pension under the appropriate BellSouth Pension Plan**

If my employment terminates prior to my return to work, steps will be taken automatically to determine my eligibility to this type of pension. I will be advised by the Committee of the amount, and effective date of pension, if I qualify.

### **F. Reinstatement**

1. **If I am granted an Anticipated Disability leave and return to the active payroll, I will be expected to return to the same job or one of similar status and pay at the end of my certified disability period. If otherwise eligible, I may request to be placed on a Leave of Absence for Care of Newborn Child for a period of up to 3 months or to 6 months or 1 year from the child's birth at the end of my certified disability period.**
2. **If I am granted a Care of Newborn Children Leave, Dependent Care Leave, or FMLA Medical Leave, I will be entitled to guaranteed reinstatement to the same job or one of similar status and pay at the expiration of the leave. If a position of like status and pay for which I am qualified is not available, reinstatement may be deferred until the end of the leave, but in no case shall reinstatement be deferred beyond the expiration of the leave.**
3. **Reinstatement shall, however, be subject to the Labor Agreement which covers adjustments to the working force that may have occurred during my absence on leave.**

**G. Approval-** I further understand that if the applied for Leave is approved, it will be my responsibility to maintain close contact with my Department, and furnish all required medical information to the Benefit/Health Services Department.

**H. FMLA-** I further understand that the period of this leave shall count against what I am entitled to under the 1993 Family and Medical Leave Act, or state law

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Sheet 3

<b>EMPLOYEE NAME:</b>	<b>EMPLOYEE SOCIAL SECURITY #:</b>
<b>PATIENT NAME IF DIFFERENT:</b>	

**Section E - TO BE COMPLETED BY HEALTH CARE PROVIDER** \*AS DEFINED WITHIN SECTION 825.118 OF THE FAMILY AND MEDICAL LEAVE ACT OF 1993

1. **Does the patient's serious health condition qualify under any of the categories described? If so, please check the applicable category. NOTE:** A "Serious Health Condition" Criteria Under The Family And Medical Leave Act Defined: A " Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

(A) **Hospital Care:INPATIENT CARE** (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity<sup>2</sup>, or subsequent treatment in connection with or consequent to such inpatient care.

(B) **Absence Plus Treatment:** A period of incapacity<sup>2</sup> MORE THAN THREE CONSECUTIVE CALENDAR DAYS (including any subsequent treatment or period of incapacity<sup>2</sup>, relating to the same condition) **[document dates in Q. 3b]**, that also involves: (1) Treatment<sup>3</sup> two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by a health care provider, **[document in Q. 4]** or (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment<sup>4</sup>. **[document in Q. 4]**

(C) **Pregnancy:** Any period of incapacity<sup>2</sup> **[document in Q. 3b]** due to pregnancy, or for prenatal care **[document in Q. 4]**.

(D) **Chronic Conditions Requiring Treatments:** A chronic condition which:  
(1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider.**[document in Q. 4]**  
(2) Continues over an extended period of time (including recurring episodes of a single underlying condition; **[document in Q. 3a]** and  
(3) May cause episodic rather than a continuing period of incapacity<sup>2</sup>(e.g., asthma, diabetes, epilepsy, etc.). **[document in Q. 3b]**

(E) **Permanent/Long-term Conditions Requiring Supervision:** A period of incapacity<sup>2</sup> which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

(F) **Multiple Treatments (Non-Chronic Conditions):** Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity<sup>2</sup>, of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy) or kidney disease (dialysis). **[document in Q. 4]**

(G) **None:** The condition does not meet any of the above criteria and therefore is not a serious health condition covered by FMLA.

2. Indicate the medical facts that support your certification, including a brief statement as to how the medical facts meet the criteria of one of the above categories.

\_\_\_\_\_

3. **DATES & DURATION of ILLNESS**

3a. State the approximate date the condition commenced, and the probable duration of the condition. For pregnancy, please estimate the due date: \_\_\_\_\_.

<sup>1</sup> Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

<sup>2</sup> "Incapacity", for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

<sup>3</sup> Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations. (i.e., eye examinations, or dental examinations)

<sup>4</sup> A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medication such as aspirin, antihistamines, or salves: or bed-rest, drinking fluids, exercise, and other similar activities than can be initiated without a visit to a health care provider.

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3b	Is the patient incapacitated as a result of this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>IF YES</b> , please list all dates of the patient's incapacity whether scheduled on or away from work: <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <p style="margin: 0;">If the condition is <b>chronic or pregnancy</b>, list the likely frequency and duration of intermittent episodes of incapacity.</p>
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<b>4</b>	<b>TREATMENT</b>
4a	As a result of this condition, is it necessary for the employee to miss work due to their TREATMENT or the TREATMENT of the dependent they are caring for? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>IF YES</b> , could treatment be done outside normal business hours (i.e.: Monday - Friday, 8-5)? <input type="checkbox"/> Yes <input type="checkbox"/> No What are your office hours? _____
4b	List the probable number of treatments, type of treatments, and dates if known (Treatments may include office visits, physical therapy, occupational therapy, educational classes).  Was prescription medication given? <input type="checkbox"/> Yes <input type="checkbox"/> No
4c	If any of these treatments will be provided by another provider of health services (e.g., physical therapist, specialist), please state the nature of the treatments and dates or treatment schedule if known.

<b>5</b>	<b>WORK RESTRICTIONS FOR EMPLOYEE'S OWN ILLNESS (must also complete Q. 1-4c)</b>
5a	If medical leave is required for the employee's absence from work, is the employee able to perform work of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No
5b	If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job? (The employee will supply you with information about the essential job functions). <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the essential functions the employee is unable to perform:
5c	If neither 5a. nor 5b. applies, is it necessary for the employee to be absent from work for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>6</b>	<b>REQUIRED FOR DEPENDENT ILLNESS (must also complete Q. 1-4c)</b>
6a	If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs, safety, or for transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete 6c.
6b	If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete 6c.
6c	Please indicate the probable frequency and duration of this need.
6d	Is the leave for a son or daughter age 18 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, the child must be incapable of self-care because of a mental or physical disability <sup>5</sup> . Please indicate at least three activities of daily living that the child needs assistance with.  <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>

Health Care Provider Information:		Date:	Medical Speciality:	
Signature: _____				
Name(printed or typed): _____				
Phone Number: (     )	Street Address:	City:	State:	Zip:

When a request for additional medical information is made, please provide an updated signature and date authorizing the additional information. Failure to provide an updated signature will result in a delay of the employee's request.	
Health Care Provider's Signature: _____	Date: _____

<sup>5</sup> For purposes of FMLA, incapable of self-care means that the individual requires active assistance or supervision to provide daily self-care in three or more of the "activities of daily living". Mental or physical disability is defined as a physical or mental impairment that substantially limits one or more of the major life activities of an individual. These terms are defined by regulations issued by the Equal Employment Opportunity Commission under the Americans with Disabilities Act (ADA).