Request for Family or Medical Leave
Gundersen Health System

Employee Information

Date of Request _____ Date of Hire _____

Name _____

Home Phone _____ Work Phone _____

Home Address _____

City _____ State _____ Zip Code _____

Employee Number _____ Department _____

Supervisor _____ Ext. _____

1. Requested Start _____ - End _____

2. Spouse Works for GHS ☐Yes ☐No ☐N/A
3. Leave Type (Please Circle One):

Continuous Continuous to Intermittent Intermittent to Reduced Schedule Intermittent

4. Leave Reason

☐ The birth of my son or daughter

☐ Adoption

☐ Foster Care

☐ My serious or chronic health condition

☐ To care for my child who has a serious or chronic health condition

☐ To care for my spouse, parent, domestic partner who has a serious or chronic health condition

☐ Because I am the spouse, child, parent, or next of kin of a veteran servicemember with a serious injury or illness

☐Because I am the spouse, child, parent, or next of kin of a current servicemember with a serious injury or illness

☐ Because of a qualifying exigency arising out of the fact that my spouse, child, or parent is on active duty or call to active duty status as a member of the National Guard or Reserves

Please complete the following if the reason for your leave is to care for a family member, covered servicemember, military veteran, or due to a qualifying exigency arising from the fact that a family member is on active duty or has been called to active duty status:

Family Member's Name: _____

Relationship to Family Member: _____

Please complete the following if the reason for your leave is for the birth or placement (foster care or adoption) of a child:

My spouse or domestic partner works for Gundersen Health System: ☐ Yes ☐ No

If Yes, Spouse's or Domestic Partner's Name: _____

Certification Information

A Certification of Health Care Provider, Certification of Qualifying Exigency for Military Family Leave, a Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave, or a Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave may be sent to you for completion.

☐ I understand that once I receive the form, I will have up to fifteen (15) business days to forward the completed form to the Human Resource Service Center and that my FMLA Request will not be approved without this completed form.

Acknowledgements

Agreement

☐ I certify that I understand, agree to, and meet the requirements and conditions set forth in Gundersen Health System´s Family and Medical Leave policy HR-520.

☐ I certify that I have read the employee notice attached to the Family and Medical Leave policy HR-520 (only applicable to employees physically working in Minnesota).

☐ I authorize Human Resources to edit my timecard in Kronos based on the information I provide when I report my FMLA hours in compliance with the FMLA policy.

☐ I agree that I have read, understand, and accept the terms and conditions outlined in the Benefit Premiums Agreement. Upon your return from leave, you authorize Gundersen to deduct the premium amounts the Company advanced on your behalf for your portion of the Group Benefit Premiums, as after-tax or pre-tax salary/wage reduction, as applicable.

Signature _____ Date _____

Please submit this request form to:

Gundersen Health System
HR Service Center
1900 South Avenue
Mailstop FS6-002
La Crosse, WI 54601

Or fax to the HR Service Center:
(608) 775-1423

For questions regarding this request form, please contact the FMLA Hotline at (608) 775-0630 (ext. 50630).

Gundersen Lutheran Administrative Services, Inc. – Benefit Premiums Agreement

The purpose of this Benefit Premiums Agreement (this "Agreement") is to set forth the details and your obligations related to the continuation of your group health, dental, disability, life insurance, and healthcare flexible spending account coverages during your leave. You acknowledge that you have read, understand and agree to the terms set forth in this Agreement.

During your leave, whether paid or unpaid, you generally will remain eligible for group benefits under the plans sponsored by Gundersen Lutheran Administrative Services, Inc. (the "Company") under the same conditions that would have been provided if you had been actively employed during the entire leave. The Company will continue to pay its portion of group health, dental, disability, and life insurance premiums (collectively, the "Group Benefit Premiums") that it was responsible for paying immediately prior to the leave, as required by applicable law. Likewise, you will continue to be responsible for paying your portion of the Group Benefit Premiums.

If you prefer you can choose not to retain some or all of your group benefit coverages during your leave; however, by completing the remainder of this form, we understand that you want to continue your current group benefit coverages during your leave. **[If you choose not to continue any of your current group benefit coverages during your leave, you may not be eligible for the discontinued coverage(s) immediately upon your return to work. (Note to Gundersen: Insert this for individuals who will not be on protected leave pursuant to the FMLA, but only if Gundersen's benefit plans provide for it.)]**

Payment of the Employee Portion of Premiums

Paid Leave

During any portion of leave that is paid, you will continue to pay the employee share of the Group Benefit Premiums in the form of payroll deduction in the same manner as prior to your leave (e.g., pre-tax or
post-tax as elected).

Unpaid Leave

During the portion of leave that is unpaid, the Company will accept responsibility for advancing payment of your share of the Group Benefit Premiums. These advanced amounts will be considered a debt due and owing to the Company, and the Company will recoup these advanced amounts as an after-tax or pre- tax salary/wage reduction based on the manner collected prior to your leave from your available taxable compensation (including any available, unused PTO, vacation and/or sick days) *after* you return from leave, as allowed by applicable law.

If your leave of absence is unpaid (or may become unpaid in the future), you agree to pay your portion of Healthcare FSA coverage by making a personal payment on an after-tax "pay-as-you-go" basis. This will be required for you to avoid a lapse in coverage.

Paycheck Deduction Authorization

By accepting this Agreement, upon your return from leave, you authorize the Company to deduct the premium amounts that you failed to pay or that the Company advanced on your behalf for your

portion of the Group Benefit Premiums, under the terms of this Agreement, as after-tax or pre-tax salary/wage reduction, as applicable. You understand that such deduction(s) will be made for your benefit and convenience.

Notwithstanding anything in this Agreement to the contrary, you may pay all or a portion of any Group Benefit Premiums you owe by check at any time during your leave or upon your return to work.

Failure to Return to Work / Separation from Employment

If you fail to return to work following the end of your leave, the Company is entitled to recover your portion of the Group Benefit Premiums you failed to pay or it advanced on your behalf through your coverage end date. In addition, you acknowledge and agree that any Group Benefit Premiums you fail to pay, or any advanced amounts paid by the Company which are not recouped in full, either because of your failure to return to work or the separation of your employment after returning to work, will remain a debt due and owing to the Company by you. You further acknowledge and agree that such amounts may be deducted from any of your outstanding or final paychecks. To the extent any obligation remains unpaid after such deductions, you agree that such amounts remain a debt due and owing to the Company that you must pay to the Company within thirty (30) days of your last day of employment with the Company.

Authorization & Acceptance

You may accept this agreement by checking the designated box on the FMLA application. By accepting this Agreement, you agree that you have read and understand this Agreement and accept the terms and conditions outlined above. Your further acknowledge and agree that if any action is brought to enforce any provision of this Agreement by the Company, you agree to pay all costs associated with the action, as well as any costs of litigation, including all reasonable attorney fees.

DEPARTMENT OF LABOR AND INDUSTRY

Nursing Mothers, Lactating Employees, and Pregnancy Accommodations employee notice

Note: This is applicable when physically working in the state of Minnesota.

Minnesota's Nursing Mothers, Lactating Employees, and Pregnancy Accommodations law (Minnesota Statutes § 181.939) gives pregnant and lactating employees certain legal rights.

Pregnant employees have the right to request and receive reasonable accommodations, which may include, but are not limited to, more frequent or longer breaks, seating, limits to heavy lifting, temporary transfer to another position, temporary leave of absence or modification in work schedule or tasks. An employer cannot require an employee to take a leave or accept an accommodation.

Lactating employees have the right to reasonable paid break times to express milk at work unless they are expressing milk during a break that is not usually paid, such as a meal break. Employers should provide a clean, private and secure room that is not a bathroom near the work area that includes access to an electrical outlet for employees to express milk.

It is against the law for an employer to retaliate, or to take negative action, against a pregnant or lactating employee for exercising their rights under this law.

Employees who believe their rights have been violated under this law can contact the Minnesota Department of Labor and Industry's Labor Standards Division at dli.laborstandards@state.mn.us or 651-284-5075 for help.

Employees also have the right to file a civil lawsuit for relief. For more information about this law, visit dli.mn.gov/newparents.