Sun Health®

LEAVE OF ABSENCE GUIDE ♥

UNITED STATES DEPARTMENT OF LABOR

Sun Health®

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This packet is intended to guide you through the leave of absence and/or FMLA process and answer any questions you might have. We understand taking a leave of absence can be stressful. Sun Health's intention is to help guide you and make this process as easy and stress-free as possible.

To request a leave of absence you must read and complete the applicable forms in this packet and submit to the Human Resources department. Please reach out to your designated Human Resources representative if you have any questions regarding this process. It is important to establish communication with your Human Resources representative to ensure proper compliance with company policies and applicable laws.

Below you will find the contact information to your Human Resources representative based on your location:

The Colonnade
(623) 236-3751

Administration
(623) 777-2655

La Loma Village
(623) 537-7448

Grandview Terrace
(623) 455-7653 or (623) 975-8059

WHAT IS A LEAVE OF ABSENCE (LOA)?

A Leave of Absence (LOA) is an approved period of time an employee is away from their regular work schedule that is longer than two (2) weeks paid vacation while maintaining their regular employee status. The reason for the leave of absence would be for a medical or personal leave of absence (where the leave does not qualify for protection under the Family Medical Leave Act (FMLA)).

Sun Health will consider an employee's request for a medical or personal leave of absence during their first year of employment.

Personal Leave of Absence is granted for a personal medical leave reasons, educational purposes, to care for a family member,[1] or newborn/child placed in the home only.

WHAT IS THE FAMILY MEDICAL LEAVE ACT (FMLA)?

The Family and Medical Leave Act (FMLA) provides eligible employees with up to 12 weeks of unpaid, job-protected leave per "*rolling*" year for any of the qualifying reasons:

- the birth of a child and to care for the newborn child within one year of birth;
- the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
- to care for the employee's spouse, child, or parent who has a serious health condition;
- a serious health condition that makes the employee unable to perform the essential functions of his or her job;
- any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" **or**
- Twenty-six workweeks of leave during a single 12-month period to care for a covered service member with a serious injury or illness if the eligible employee is the service member's spouse, son, daughter, parent, or next of kin (military caregiver leave).

Rolling year refers to Under FMLA regulations, a rolling year is defined as a 12-month period measured backward from the date an employee first uses leave.

FMLA Eligibility Criteria:

1. Has worked for the employer for at least 12 months as of the date the FMLA leave is to start.
2. Has at least 1,250 hours of service for the employer during the 12-month period immediately before the date the FMLA leave is to start.

WHAT IS MILITARY LEAVE?

The military family leave provisions of the Family and Medical Leave Act (FMLA) entitle eligible employees of covered employers to take FMLA leave for any "qualifying exigency" arising from the foreign deployment

[1] Family member is defined as an employee's spouse, parent or child as defined by the Family MEDICAL Leave Act (FMLA).

of the employee's spouse, son, daughter, or parent with the Armed Forces, or to care for a service member with a serious injury or illness if the employee is the service member's spouse, son, daughter, parent or next of kin.
See your Human Resources Representative for further information.

Employee responsibilities when starting a leave:

- Notify your manager and Human Resources representative of your need for a Leave of Absence.
- The employee is expected to complete the Leave of Absence Request Form and submit to your Human Resources representative at least 30 days prior to the start of the leave. When an employee becomes aware of a need for leave less than 30 days in advance, the employee must provide the Leave of Absence Request Form either the same day, the next business day, or as soon as reasonably practicable.
- Ensure your contact information, including emergency contact information is up to date in KRONOS so you do not miss any leave-related communication. Please refer to Links & Resources within the Leave of Absence Guide.

Employee responsibilities during an approved leave:

- Maintain regular contact with your Human Resources representative during your leave, especially if the circumstances of your leave change (for example, if you intend to return to work earlier than planned or if you need additional time off).
- You are required to use all available Paid Sick Time (PST) and Paid Time Off (PTO) when on leave.
- Depending on the type of leave, you may remain covered under your group health insurance and ancillary benefits. It is your responsibility to continue to pay your portion of the premiums. Please refer to Continuation of Benefits & Carrier Contact Information within the Leave of Absence Guide.

Employee responsibilities before returning to work:

- If your leave is for your own illness or injury, have your health care provider complete the Return to Work Release at least five days prior to your scheduled return to work date and send a copy to your Human Resources representative. If you will not be able to complete the essential functions of your job, you will also need to provide the Accommodation Worksheet completed to your Human Resources representative five days prior to your return.

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CONTINUATION OF BENEFITS & CARRIER CONTACT INFO

Benefit	During your leave	When you return from leave	Carrier	Contact Information
Health Benefits (Medical, Dental & Vision)	Continuation of your Health Benefits is optional. Should you choose continuation of health benefits, it is your responsibility to pay your portion of the premium(s). Sun Health will keep you informed of premiums, due dates and cancelations through the Continuation of Benefits Letter which will be provided to you during the start of your leave.	If benefit premiums are paid up to date, your current premium deductions will continue accordingly. If necessary, premium adjustments can be completed through regular payroll deductions.	Aetna for Medical & Dental VSP for Vision	Medical 1-855-586-6957 Dental 1-877-327-5832 www.aetna.com VSP 1-800-877-7195 or www.vsp.com
	Reminder: If necessary, add your new child to your health benefits within 31 days of birth or adoption. Please refer to Qualifying Event within Leave of Absence Guide.			
Retirement Plans	Because contributions must be based on earned wages, retirement contributions will cease while on unpaid leave. If you have a loan, those repayment deductions also cease. Call Fidelity Investment to discuss loan payment arrangements.	Retirement plan contributions resume through regular payroll deductions.	Fidelity Investments	1-800-835-5097 or netbenefits.com
Company Sponsored Life Insurance	Benefits will continue to be provided to eligible employees and company paid.	Benefits will continue to be provided to eligible employees and company paid.	Lincoln Financial	1-877-275-5462 or lfg.com
Flexible Spending Account (Health Care and/or Dependent Care)	You are responsible for your portion of the premium. Sun Health will keep you informed of premiums, due dates and cancelations through monthly Continuation of Benefits letter.	Benefit premiums will resume accordingly.	BASIC	1-800-473-0455 or basiconline.com
Supplemental Life Insurance (Employee, Spouse and/or children coverage)			Lincoln Financial	800-423-2765 or lfg.com Group # SHSC
Voluntary Short-Term Disability				
Voluntary Long-Term Disability				
Employee Assistance Program (EAP)				888-628-4824 or GuidanceResources.com
Pet Insurance			United Pet Care	602-266-5303 or unitedpetcare.com
Paid Time Off (PTO)	PTO will be utilized to supplement hours missed under leave.	PTO deposit will resume accordingly.	HR Representative	Review the Employee Portal
Paid Sick Time (PST)	PST will be utilized to supplement hours missed under leave.	PST deposit will resume accordingly.	HR Representative	Review the Employee Portal
All benefit information, Summary Plan Descriptions, contact information and flyers can be accessed through the employee portal.				

BENEFIT PAYMENT INFORMATION

Benefit continuation premium payments can be made out to Sun Health and mailed to:

Sun Health Administration
Attention: Director of Total Compensation
14800 W. Mountain View Blvd.
Suite 130
Surprise, AZ. 85374

Please note premium payment options, such as payment plan and/or payroll deductions once an employee returns from leave or has available PTO/PST, may be available. Please contact your Human Resources representative for additional information.

QUALIFYING LIFE EVENT

If you experience a qualifying life event during your leave such as:

- Marriage
- Divorce
- Birth or Adoption of a child
- Loss of health coverage

Contact your Human Resources representative within 31-days of the qualifying life event and submit your life event through KRONOS. You may obtain instructions on how to submit a life event through your Human Resources representative or the Employee Portal.

If you fail to submit your life event request within the required 31-day timeframe, you will be unable to do so until the next annual Open Enrollment. Supporting documentation of the life event must be provided to your Human Resources representative.

EMPLOYEE PORTAL

All policies and resources referenced throughout the guide can be found on the Sun Health Employee Portal which can be accessed from any device and no login is necessary. The Employee Portal website address is: http://employees.sunhealth.org

Once the link is accessed please go to HR Center>Policies and Procedures. You may also access this guide and any forms pertaining to your leave, benefits and wellness information.

COMPANY RESOURCES TO REFERENCE

Family Medical Leave Act (FMLA)
Medical and Personal Leave of Absence
Military Leave of Absence
Sun Health Employee Handbook
Paid Time Off- Exempt (Salaried) Employees
Paid Time Off- Non-Exempt (Hourly) Employees
Paid Sick Time
Lactation Support

*A complete list of company policies can be found in the Employee Portal> HR Center> Policies & Procedures

KRONOS

Before your leave begins it is your responsibility to ensure your employer has your most updated contact information, emergency contacts, beneficiary information. You may access KRONOS to do so at: https://secure4.saashr.com/ta/6144183.login

RESOURCES

Employee Assistance Program (EAP)

Sun Health employees (and anyone in your household) can call 24/7 to speak with confidential counselors at no cost. These counselors can help with family, parenting, addictions, emotional, legal, financial, relationships, stress, etc. They provide resources and coping strategies. Speak to a specialist by calling 888-628-4824 or at GuidanceResources.com.

Username: LFGsupport
Password: LFGsupport1

EAP Brochure

Employee Association Program

This association was created to provide monetary assistance to Sun Health employees during an unexpected event or combination of circumstances that jeopardizes the individual's health and welfare. Example of undue hardships include:

- Offering assistance in time of need e. g. funeral expenses for the death of an immediate family member or the travel costs to see an ailing close relative.
- Living expenses due to damage caused to an employee's dwelling (fire or storm)
- Significant loss of household income due to events such as robbery or emergency medical expenses.

Specific guidelines for what would be eligible for consideration can be found in the Employee Association FAQs.

Click here to view the brochure with the donation form.

Click here for the printable application or here for the electronic version. Completed applications can be submitted to your campus Human Resources representative or to Paola Rogel at Paola.Rogel@SunHealth.org.

DEPARTMENT OF LABOR

Sun Health is committed to providing you with all necessary information during your leave. Please see below links to access the United States Department of Labor information and forms.

https://www.dol.gov/whd/fmla/
The Employee's Guide to the Family Medical Leave Act

United Stated Department of Labor Forms:

WH-380-E Certification of Health Care Provider for Employee's Serious Health Condition (PDF)
WH-380-F Certification of Health Care Provider for Family Member's Serious Health Condition (PDF)
WH-381 Notice of Eligibility and Rights & Responsibilities (PDF)
WH-382 Designation Notice (PDF)
WH-384 Certification of Qualifying Exigency for Military Family Leave (PDF)
WH-385 Certification for Serious Injury or Illness of Covered Service member -- for Military Family Leave (PDF)
WH-385-V Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave

DISCLAIMER: EMPLOYEES ENGAGING IN FRAUD, DISHONESTY OR FALSIFICATION OF DOCUMENTS IN CONNECTION WITH A LEAVE OF ABSENCE ARE SUBJECT TO DISCIPLINARY ACTION UP TO AND INCLUDING TERMINATION.

LEAVE OF ABSENCE REQUEST FORM

Employee Name: _____ Date of Hire: _____

Location: _____ Position: _____

Section 1: I am requesting a leave to begin _____ and end on _____.
*We understand these dates may be approximate. Official documentation will govern the timeline of the leave.

Section 2: My request for a leave of absence is for the following reason:

- ☐ Medical Leave of Absence
- ☐ Personal Leave of Absence (please select reason below)
  - ☐ Educational Opportunity
  - ☐ Care for a Family Member
  - ☐ Spend time with a new baby or child placed in the home within the first 12 months

Section 3: Attestation: By signing below, I understand that:

- All leave requests must be supported by appropriate documentation based on the nature of the leave. I agree to comply with all company policies and submit timely and accurate documentation. Employees engaging in fraud, dishonesty or falsification of documents in connection with a leave of absence are subject to disciplinary action up to and including termination.
- Per the Paid Sick Time, Paid Time Off- Exempt (Salaried) Employees, and Paid Time Off- Non-Exempt (Hourly) Employees policies I am required to use all available PST and/or PTO for any absence from my regularly schedule as compliant with state and federal law. If my leave request is approved I am required to submit my Time Off Request through KRONOS if I have available PST or PTO.
- I am required to maintain regular communication with my Human Resources representative during my leave of absence, especially if the circumstances of my leave change.
- If I participate in Sun Health's benefits it is my responsibility to pay my portion of the premium owed. If I have insufficient PST or PTO to pay my benefit premiums, then I am responsible for sending payment for my benefit premiums each month. I understand that failure to complete premium payments will result in my coverage being terminated. I understand Sun Health will keep me informed of my benefit costs, due dates and cancellations.
- Unless this leave falls under federal or state protected leave regulations, my employer is not required to hold my current position until my return. Sun Health will make every effort to hold my position or upon my return to offer any available position for which I am qualified according to the needs of the business.
- By signing below I acknowledge that I have reviewed the applicable, Medical and Personal Leave of Absence policy.
- I have read and fully understand the information contained in this Leave of Absence Request Form and have received the Leave of Absence Guide.

_____ _____
Employee Signature **Date Submitted to Manager**

_____ _____ _____
Manager Signature **Manager Printed Name** **Date**

_____ _____
Human Resources Received By **Date**

○ APPROVED ○ DENIED Reason for Denial: _____

(File in personnel file with Employee Info Sheets)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____, (Employee/Patient Name) hereby authorize _____
(Health Care Provider Name)
agent(s) to disclose my health information as described in this release authorization.

Employee Name: _____ Date of Birth: _____

For the limited purposes of processing my request for a leave of absence, please release health care information to:

Sun Health Administration
Attention: Director of Total Compensation
14800 W. Mountain View Blvd.
Suite 130
Surprise, AZ. 85374

Release the following information:

- ☐ All health care information
- ☐ Healthcare information relating to the following treatment of condition(s):

  _____
- ☐ Health care information for the following dates: _____
- ☐ Other: _____

Expiration of Authorization: This authorization will remain in effect for one year from the date of my signature. Alternatively, I may revoke this authorization at any time, as set forth below, or the selection of another expiration date as follows:

- ☐ In 90 days: or
- ☐ Date: _____

Right to Revoke: I may cancel this authorization in writing as allowed by law by sending a written notice to Sun Health at the above contact information. This would not affect any actions already taken based upon my original request.

Right to Copy: I understand that I am entitled to keep or receive a copy of this authorization.

I understand that I am under no obligation to sign this form and acknowledge that I have had an opportunity to review and understand its contents.

I acknowledge that I am voluntarily signing this form to release my health information to Sun Health. Sun Health will only use the information released by the health care provider in order to assess the request for leave.

Employee/Patient Signature: _____ Date: _____

A PHOTOCOPY OF THIS AUTHORIZATION IS AS EFFECTIVE AS THE ORIGINAL

RETURN TO WORK/ACCOMMODATION RELEASE

Patient's First Name	MI	Last Name	Date of Birth

THE FOLLOWING TO BE COMPLETED BY THE EMPLOYEE'S HEALTH CARE PROVIDER

Health Care Provider Name: _____

Practice Name: _____ Phone Number: _____ Fax Number: _____

Practice Address: _____

I saw and treated this patient on _____ (Date).
Considering this patient's job duties and health condition, this patient may perform work in the following manner:

- ☐ The patient may return to work with no limitation on _____ (Date)
- ☐ The patient may return to work on _____ (Date) with the following restrictions:

- ☐ **Sedentary Work:** Occasionally lifting 10 pounds maximum with frequent lifting and/or carrying of lighter objects such as file folders and small tools. Although a sedentary job is generally considered one which involves sitting, a certain amount of working and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.
- ☐ **Light Work:** Occasionally lifting 20 pounds maximum, with frequent lifting and/or carrying of objects weighing up to 10pounds. Even though the weight lifted may be only negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.
- ☐ **Light-Medium Work:** Occasionally lifting 30 pounds maximum, with frequent lifting and/or carrying of object weighing up to 20 pounds.
- ☐ **Medium Work:** Occasionally lifting 50 pounds maximum, with frequent lifting and/or carrying of objects weighing up to 25 pounds.
- ☐ **Heavy Work:** Occasionally lifting 100 pounds maximum, with frequent lifting and/or carrying of objects weighing up to 50 pounds.

1.Patient May use foot/feet for repetitive movement as in operating foot controls:

- ☐ Yes
- ☐ No

2.Patient may:

	Minutes per hour or weight employee can perform task or any other comments
Bend	
Twist	
Climb	
Reach	
Squat	
Stand	
Walk	
Drive	
Lift	
Pull	
Push	

OTHER RESTRICTIONS OR INSTRUCTIONS:

- ☐ Any other restrictions that may have not been included above please list:

_____

- ☐ The above restrictions are in effect until _____ (Date) OR until patient is re-evaluated on _____ (Date).
- ☐ Patient is totally incapacitated at this time. Patient will be re-evaluated on _____ (Date).

Health Care Provider Signature:	Date: