



FMLA or Leave of Absence Medical Certification CARE OF FAMILY MEMBER

Instructions for Employee

- Notify your manager of your need for leave of absence (in accordance with your employer's FMLA and/or leave of absence policies).
- Ask your family members health care provider to complete the Medical Certification and provide it (fax number is below) to Voya within 15 calendar days.
- Consider following up with the health care provider to confirm the Medical Certification was completed and faxed to Voya. It is your responsibility to provide timely, complete and sufficient certification. Note: You may need to furnish your health care provider with any necessary authorization in order for the health care provider to release a complete and sufficient certification to support the leave request.

For purposes of qualifying for your FMLA, state and/or company leave, **you need to** provide a statement or description of appropriate medical facts for which FMLA leave is requested, or if you are in California, only a statement that, due to the health condition, your family member is incapacitated and requires care. **You are not required to** provide a diagnosis regarding your family members condition

Voya will notify you whether your leave and/or short-term disability has been approved or denied once we receive a complete and sufficient certification and if needed. Alternatively, we will notify you if additional information is required. Failure to provide a complete and sufficient medical certification may result in a denial of your leave request.

Instructions for Health Care Provider

Please answer fully and completely the two sections on the following pages and sign the form.

Step 1 — PATIENT'S CONDITION. Certify whether your patient has a "serious health condition" as the term is defined under the law (note: for more information on the definition of "serious health condition", you can refer to the U.S. Department of Labor website at <http://www.dol.gov/agencies/whd/fmla/>). Also include information sufficient to establish that the patient cannot perform the essential functions of his/her job as well as the nature of any other work restrictions, and the likely duration of such inability. If your patient's condition does not meet one of the definitions under the law, please indicate that. Do not provide information related to genetic tests or services.

Step 2 — DATES OF LEAVE. Provide the frequency and probable dates needed for leave.

- Consider **all of the dates** that your patient has had or will have to be out of work due to the serious health condition, even if the patient was initially treated by someone else (e.g., emergency room or ICU).
- If your patient's leave is intermittent (described in Step 2) **please provide your best estimate** of the frequency and duration of the patient's condition, treatments, etc.
- Terms such as "lifetime," "unknown" or "indeterminate" **may not be sufficient** to determine whether the patient's condition qualifies for a leave.

Step 3 — SIGNATURE. Sign the form and provide your type of practice/medical specialty.

Return the completed form via fax to Voya at 888-305-0605 before the listed due date. If you do not complete all steps in full and return it before the due date, your patient's leave request may be denied.

For purposes of California: The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with the Act, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

STEP 2 – DATES OF LEAVE. Based on the patient’s medical history and your knowledge of the medical condition, consider all dates the patient has been or will be unable to work by completing either of the below sections that apply. *All applicable sections must be completed.*

Answers of “unknown,” “indeterminate” or “lifelong” may not be sufficient to support the leave request.

Continuous Leave: Provide any single, continuous period of incapacity

- Start date of incapacity (*this may or may not be the first day absent from work*) _____ / _____ / _____
- Estimated end date of incapacity _____ / _____ / _____
- Will the employee require follow-up appointments? _____ No _____ Yes
 - If yes, complete the section below if appointments will result in absence(s) from work.

If intermittent leaves or a reduced work schedule are applicable, identify ALL absence needs below.

Intermittent Leave:

Leave Begin Date: _____ / _____ / _____

Leave End Date: _____ / _____ / _____

- Will the patient need to miss work for appointments or treatments? _____ No _____ Yes

If Yes – Estimated treatment schedule:

Frequency:

Up to _____ times per _____ (week/month/year)

Duration:

Lasting up to _____ hours **OR** _____ days

Please include the dates of any scheduled appointments and the time required for each appointment:

- Will the patient need to miss work for incapacity/flare-ups of the health condition? _____ No _____ Yes

If Yes – Estimate of absences needed for episodes:

Frequency:

Up to _____ times per _____ (week/month/year)

Duration:

Lasting up to _____ hours **OR** _____ days

- List all dates you have already treated the patient for the condition: _____

Reduced Schedule Leave:

- Will the patient need a temporary FIXED part-time schedule or require predictable, regularly scheduled absences? _____ No _____ Yes

If yes, complete the period the reduced schedule will be needed.

Start date of modified schedule:

_____ / _____ / _____

Probable date patient may return to their regular schedule:

_____ / _____ / _____

(Please indicate the hours of time the patient will need to miss each day)

Su	
M	
Tu	
W	
Th	
F	
Sa	

STEP 3 – SIGNATURE. Health Care Provider Information*:

Name:

Practice/Specialty and Credentials:

Street Address:

Fax Number:

City, State, ZIP Code

Signature:

Phone Number:

Date:

**If there is an additional treating physician, please attach a page with their information including name, specialty, and phone.*

Voya Fax: 888-305-0605 **Voya Phone:** 888-973-3652 (FMLA)

Voya Email: claims@yourbenefitexpert.com

Mail: Voya Employee Benefits, PO Box 9757, Portland, ME 04104