aetna[SM]

Family Medical Leave Act (FMLA) Certification for Family Member's Serious Health Condition[1]

Return completed form to: Aetna Life Insurance Company
PO Box 14560
Lexington, KY 40512-4560
Fax: 866-667-1987

SECTION I: For Completion by the EMPLOYEE:

INSTRUCTIONS to the EMPLOYEE:
Please complete Section I before giving this form to your family member's health care provider to fill out. The FMLA allows your employer[2] to require that you submit a timely, complete, and sufficient medical certification to support your request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, completion of this certification is needed for you to get or keep the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a delay or denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

Name of family member for whom you will provide care and that person's relationship to you:

_____
First Middle Last Relationship (e.g., spouse, mother)

If the family member is your son or daughter, date of birth: _____

Describe the care you will provide to this family member, and estimate the leave needed to provide care:

_____

_____

How many hours are you scheduled to work each week? _____

Please circle your scheduled work days: SAT SUN MON TUE WED THUR FRI

If your schedule varies each week, please check here: ☐

On the days that you work, are you scheduled to work the same number of hours each day? ☐ No ☐ Yes

What time are you scheduled to begin and end your work day? _____

Are you paid overtime if you work more than 40 hours in a week? ☐ No ☐ Yes

Employee's Signature: _____ Date: _____

[1] This Certification may also be used for certification of state leaves and employer's company leaves.
[2] Reference to your employer extends to Aetna in its capacity as your employer's third party administrator.

SECTION II: For Completion by the HEALTH CARE PROVIDER:

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Please answer all applicable sections fully and completely. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "as medically necessary," "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Please be sure to sign the form on the last page.

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 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. Please provide medical history information regarding your patient only to the extent necessary to fully respond to all relevant items below.

Patient's name: _____

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax: (_____)_____

PART A: MEDICAL FACTS

1. Please provide the following information regarding the patient's medical condition.

   Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

   ☐ No ☐ Yes If yes, dates of admission and duration of stay:

   _____

   Date(s) you treated the patient for the condition requiring leave: _____

   Most recent date of treatment by you or another provider: _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes

   Will the patient need to be treated again in the future for this condition? Please provide dates of any such treatments that have been scheduled, or, if no future treatments have been scheduled, please indicate when and how often they will be needed. _____

   _____

   Has medication, other than over-the-counter medication, been prescribed? ☐ No ☐ Yes

   Has the patient been referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ☐ No ☐ Yes

2. Is the medical condition pregnancy? ☐ No ☐ Yes

   If so, expected delivery date: _____

3. Explain the care the employee needs to provide to the patient, and why such care is medically necessary:

   _____

4. If the treating provider is a chiropractor, does the treatment being provided to the patient consist of manual manipulation of the spine to correct a subluxation as demonstrated by an X-ray? ☐ No ☐ Yes

5. Describe other relevant medical facts, if any, related to the patient's condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

   _____

   _____

PART B: AMOUNT AND NATURE OF LEAVE NEEDED When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

6. Please complete the following based on the patient's need for care provided by the employee. (Please select and complete one of the options below.)

   When will the employee need to be absent from work to care for the patient?

   ☐ From _____ through _____, with an expected return to work on _____.

   (If the employee will also need to be absent from work intermittently due to his or her condition before or after this time period, please complete question 7. If the employee will need to work a consistently reduced number of hours in order to care for the patient before or after this time period, please complete question 8.)

   ☐ Beginning on _____ and lasting for the following amount of time: _____.

   (If the employee will also need to be absent from work intermittently in order to care for the patient before or after this time period, please complete question 7. If the employee will need to work a consistently reduced number of hours in order to care for the patient before or after this time period, please complete question 8.)

   ☐ The employee will need to be absent from work to care for the patient intermittently, not for a specific timeframe. (Please complete question 7.)

   ☐ The employee can continue working, but will need to work a consistently reduced number of hours per day or per week. (Please complete question 8.)

7. If the employee will need to be absent intermittently, please provide the following information. The employee's work schedule may be available on page 1 for reference.

   - How long will the patient be affected by this condition? _____
   - Will the condition cause episodic or unpredictable flare-ups periodically requiring the employee to care for the patient? ☐ No ☐ Yes

If you answered yes to the previous questions, please estimate the frequency of flare-ups and the duration of care required over the next 6 months, based on the patient's medical history and your knowledge of the medical condition (e.g., 1 episode every 3 months lasting 2 days):

FREQUENCY: _____ time(s) every: _____ ☐ week(s) _____ ☐ month(s)

(Example: **__1__ time(s) every: _____ ☐ week(s) __3__ ☒ month(s)** to indicate "once every 3 months")

DURATION: _____ ☐ hour(s) _____ ☐ day(s) per episode

(Example: **_____ ☐ hour(s) __2__ ☒ day(s) per episode** to indicate "2 days per episode")

- Will intermittent absences be required due to the patient's follow-up or other medical appointments?
  ☐ No ☐ Yes

  If yes, please estimate the frequency of these appointments and the duration of absence required for these appointments, including the time it may take for the employee to travel with the patient to the appointments (e.g., 1 time every 3 months lasting 2 hours):

  FREQUENCY: _____ time(s) every: _____ ☐ week(s) _____ ☐ month(s)

  (Example: **__1__ time(s) every: _____ ☐ week(s) __3__ ☒ month(s)** to indicate "once every 3 months")

  DURATION: _____ ☐ hour(s) _____ ☐ day(s) per appointment

  (Example: **__2__ ☒ hour(s) _____ ☐ day(s) per appointment** to indicate "2 hours per appointment")

8. If the patient's condition will require the employee to work a reduced work schedule in order to care for the patient, please provide the following information. The employee's regular work schedule may be available on page 1 for reference.
   - How long will the patient be affected by this condition? _____
   - How many hours will the employee be able to work per day?

     Mon _____ Tue _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____

     Or: how many hours will the employee be able to work per week? _____
   - When will the patient's need for care allow the employee to resume his or her regular work schedule?

     _____

ADDITIONAL INFORMATION:
IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider **Date**