20550 SOUTH CICERO AVENUE
MATTESON, IL 60443
TEL: 708/679-5800
FAX: 708/679-5740
WWW.RICH227.ORG

FAMILY OR MEDICAL LEAVE REQUEST FORM

INSTRUCTIONS FOR THE EMPLOYEE

- Complete the form and submit to Human Resources Department. You will be notified when the form is approved.

EMPLOYEE INFORMATION	
Employee Name:	
Location:	Position:

TYPE OF LEAVE
I request the following type of leave: Family Leave for the: ____ Birth of my child ____ Placement of a child with me for ______ Adoption or _____ Foster Care Anticipated date of birth or placement: ____________________________ ____ To care for a spouse, son, daughter, or parent with a serious health condition Family members full name: ____ Relationship to you: _____spouse ______parent ______ son or daughter ____ My own serious health condition: (specify)______________________________________ ____ ____ Exigency Leave (Military Leave) ____ Service Member Care Service Member full name: ____

AMOUNT OF LEAVE
I request that the leave be granted for the following period time: Start date: ____ End date: ________________________ I would like to use the following paid leave time if applicable: ______Sick ______Personal ______Sick Bank ______ Vacation ______ Number of days: ______________ Benefit Department Use: Days Available _____Sick ___________Personal _________Vacation Medical, Dental, and Vision Premiums can be found on page 2 of this document. Employee is responsible for premiums in the event all benefit time is exhausted.

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2018-2019 RATES

BLUE CROSS BLUE SHIELD PPO*	Admin, Exempt 12 Mon Classified Per Pay Period	Certified Per Pay Period	10 Month Classified 19 Pay Per Pay Period (30 hour/week staff)	Monthly Rate & Retiree Rate
Employee	35.17	49.24	44.43	703.49
Employee/Spouse	74.90	104.86	905.89	1497.96
Employee/Child(ren)	71.88	100.63	867.71	1437.51
Family	111.21	155.69	1404.83	2224.17

BLUE CROSS BLUE SHIELD BLUE ADVANTAGE HMO*	Admin, Exempt 12 Mon Classified Per Pay Period	Certified Per Pay Period	10 Month Classified 19 Pay Per Pay Period (30 hour/week staff)	Monthly Rate & Retiree Rate
Employee	28.30	28.30	35.75	566.01
Employee/Spouse	62.15	62.15	747.82	1242.95
Employee/Child(ren)	59.64	59.64	716.13	1192.78
Family	92.27	92.27	1128.35	1845.45

AETNA DENTAL PPO**	Admin, Exempt Per Pay Period	Certified Per Pay Period	10 Month Classified 19 Pay Per Pay Period (30 hour/week staff)	12 Mon Classified Per Pay Period	Monthly Rate
Employee	3.26	3.26	16.47	13.04	26.07
Employee/Spouse	9.07	9.07	45.85	36.30	72.59
Employee/Child(ren)	9.46	9.46	47.96	37.82	75.64
Family	14.04	14.04	70.92	56.15	112.29

AETNA DENTAL DMO (HMO)**	Admin, Exempt Per Pay Period	Certified Per Pay Period	10 Month Classified 19 Pay Per Pay Period (30 hour/week staff)	12 Mon Classified Per Pay Period	Monthly Rate
Employee	3.26	3.26	16.47	13.04	26.07
Employee/Spouse	6.27	6.27	31.69	25.09	50.17
Employee/Child(ren)	6.90	6.90	34.87	27.61	55.21
Family	10.40	10.40	52.55	41.61	83.21

GROUP VISION***	Per Pay Period	Monthly Rate

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Employee	$3.34	$6.68
Employee/Spouse	$6.68	$13.36
Employee/Child(ren)	$7.02	$14.04
Family	$11.36	$22.72

EMPLOYEE CERTIFICATION AND SIGNATURE
I certify that the information given above is true and correct to the best of my knowledge. I understand that misrepresentation or omission of the reason for leave or any of the facts supporting the need for leave will result in denial of the leave and will subject me to discipline up to and including termination. Signature: Date: