

Request for Paid Parental Leave/FMLA

Date: _____ Business Unit: _____

Name: _____ Email: _____

Address (street, city, state, zip): _____

Phone: _____

Leave Period

Beginning on: ____/____/____ Expected return: ____/____/____

PTO Used: _____

You are requesting to take Paid Parental Leave for a period of up to 8 consecutive weeks. During the first 4 weeks of leave, you will receive 100% of your salary. During weeks 5-8, you will receive 60% of your salary. Under the Family and Medical Leave Act (FMLA), you are able to take another 4 weeks unpaid, for a total of 12 consecutive weeks; and under the USHG policy, you are also eligible to take an additional 4 weeks of unpaid leave for a total of 16 weeks. This request will therefore also serve as a request for FMLA leave. Please see the USHG Employee Handbook for further information.

Benefits While On Leave

While on approved FMLA leave, if already enrolled, your medical, dental, and vision insurance coverage will continue, as well as your 401(k) and voluntary benefits. During the time you are unpaid, you will be expected to pay your portion of your insurance premiums, and the restaurant will continue to pay its portion. If you miss payments you will risk losing your benefit coverage after a 30-day grace period. In addition, during the unpaid portion of your leave, you will not have any 401(k) deductions or match.

Please contact your accounting office to make arrangements regarding the timely payment of your premiums, but if you have questions regarding your eligibility or any other aspect of FMLA leave, please contact us at peopleandculture@ushgnyc.com

1. I understand that my health benefits will be maintained during this period of paid and unpaid leave under the same conditions as if I continued to work.
2. I understand that if I do not return to work after my FMLA leave ends, I may be required to reimburse the restaurant for all insurance premiums paid on my behalf during my FMLA leave, except if I am unable to return to work:
 - a. Because of the continuation, recurrence, or onset of a serious health condition that would entitle me to FMLA leave
 - b. Because of circumstances beyond my control.
3. I understand that if I fail to pay my share of my benefits premium while on unpaid FMLA leave, the restaurant may deduct the premium from any pay received during or after my FMLA leave period, and/or discontinue my benefits after a 30-day grace period.
4. I understand that this form must be signed and submitted to USHG People and Culture for approval for this to be designated as Paid Parental and FMLA leave.
5. I understand the terms as they are outlined above and agree to make arrangements with USHG to make timely payments for any health/dental, vision and voluntary benefits that I will maintain during the unpaid portion of my Parental and FMLA leave.
6. To receive Paid Parental Leave for 8 weeks, I understand that I will be asked to provide proof of the birth or adoption of my child within three days of their birth or adoption (if I have not filed for Short Term Disability) Failure to do this may result in the discontinuation of pay.

Employee Signature

Manager Signature/Approval