MetLife

Certification for qualifying exigency for military family leave Family and Medical Leave Act (FMLA)

Metropolitan Life Insurance Company

Things to know before you begin

- Please complete all sections fully and completely.
- The FMLA permits an employer to require that an employee submit a timely, complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency.
- Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as *lifetime, unknown, as needed, indeterminate,* or the like, may not be sufficient to determine FMLA coverage.
- Your response is required to obtain a benefit. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave.
- The employer must give an employee at least 15 calendar days to return this form to the employer.
- Remember to include your First name, Last name and Claim number in the spaces provided on all pages of this form.

Reminder: Forms marked as lifetime, unknown, as needed, indeterminate or the like, may be returned as incomplete.

SECTION 1: Employee/Caregiver Information

Employee - First name	Middle name	Last name	Claim number

Name of Employer *(this is the employer of the employee requesting leave to care for current service member or veteran)*

SECTION 2: Military Member Information

Relationship of military member to Employee:

Please check ONLY one:

☐ Spouse ☐ Parent ☐ Step parent ☐ Adoptive parent ☐ Foster parent ☐ Adult child

☐ Other - specify relationship:

Name of military member on covered active duty or call to covered active duty status in a foreign country:

First name	Middle name	Last name

Period of covered military member's active duty:

First name	Middle initial	Last name	Claim number

Start date *(mm/dd/yyyy)*	End date *(mm/dd/yyyy)*

SECTION 3: Qualifying Reason for Leave

Describe the reason you are requesting FMLA leave due to a qualifying exigency *(including the specific reason you are requesting leave*):

Please check the appropriate reason for leave:

- ☐ Childcare and school activities
- ☐ Counseling
- ☐ Parental care
- ☐ Rest and recuperation
- ☐ Military events and related activities
- ☐ Post deployment activities
- ☐ Short notice deployment
- ☐ Financial and legal
- ☐ Additional activities - describe in the box below :

If the reason for FMLA leave is for *Childcare and school activities, Counseling, or Parental care* and the activity is not for yourself, please indicate the name, date of birth and relationship to the military member for whom the activity is for in the section below:

First name	Middle name	Last name

Date of birth *(mm/dd/yyyy)*	Relationship to the covered military member

A complete and sufficient certification to support a request for FMLA leave may include written documentation such as a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill of services for the handling of legal or financial affairs. Additional written documentation to support your leave request will include written confirmation of a military member's covered active duty or call to covered active duty status in a foreign country.

Please check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status:

- ☐ A copy of the covered military member's active duty orders is attached.
- ☐ Other documentation from the military certifying that the covered military member is on active duty orders *(or has been notified of an impending call to active duty)* in support of a contingency operation is attached.
- ☐ I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

Approximate timeframe of exigency:

Start date *(mm/dd/yyyy)*	End date *(mm/dd/yyyy)*

First name	Middle initial	Last name	Claim number

SECTION 4: Amount of Leave Needed

Continuous absence details: Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? If so, please estimate the beginning and ending dates for the period of absence:

☐ Single continuous absence period

Start date *(mm/dd/yyyy)*	End date *(mm/dd/yyyy)*

Intermittent absence details: Will you need to be absent from work periodically to address this qualifying exigency? If so, estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time *(i.e., 1 deployment-related meeting every month lasting 4 hours):*

☐ Intermittent absence/Reduced work schedule

Start date *(mm/dd/yyyy)*	End date *(mm/dd/yyyy)*

Estimate the frequency and the duration of related incapacity associated with the care of this qualifying exigency.

Example:

FREQUENCY: 02 times per: ☐ week, or ☒ month, or ☐ year

LENGTH: ___ minute(s) 01 hour(s) ___ full day(s)

FREQUENCY: ___ **times per**: ☐ week, or ☐ month, or ☐ year

LENGTH: ___ minute(s) ___ hour(s) ___ full day(s)

In the space provided below, please provide any additional relevant information specific to the need to take time away from work.

SECTION 5: Supporting Information

If the leave is requested to meet with a third party *(such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangement, to act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging, or appealing military service benefits, or to attend any event sponsored by the military or military service organizations)*, a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting *(i.e., either the telephone or fax number or email address of the individual or entity)*. This information may be used by MetLife to verify that the information contained on this form is accurate.

First name	Middle name	Last name

Title

Organization

First name	Middle initial	Last name	Claim number

Phone number	Fax number

Email address

Describe nature of meeting

Fraud notice: Any person who knowingly and with intent to injure, defraud, or deceive any person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information is/may be guilty of a crime and may be prosecuted and punished. Penalties may include fines, civil damages and criminal penalties, including confinement in prison.
I certify that the information I provided above is true and correct.

Sign Here	Signature of Employee	Date *(mm/dd/yyyy)*

SECTION 6: How to Submit this Form

Mail:
MetLife Disability
PO Box 14590
Lexington KY 40512-4590

Fax:
1-800-230-9531