St. Peter's Health

MEDICAL LEAVE OF ABSENCE REQUEST

INSTRUCTIONS AND FORMS

The forms in this packet are intended for use when a Team Member of St. Peter's Health is requesting a Medical Leave of Absence. If you have any questions, need assistance or are ready to submit these forms, please contact St. Peter's Health Leave Management Specialist.

REASONS TO UTILIZE THIS PACKET

- The birth of a child, or placement of a child with you for adoption or foster care.
- Your own serious health condition.
- You are needed to care for your spouse, child, sibling, parent or grandparent due to his/her serious health condition.
- A qualifying exigency arising out of the fact that your spouse, son or daughter, or parent is on covered active duty or call to covered active duty status with the Armed Forces.
- You are the spouse, son or daughter, parent, or next of kin of a covered service member with a serious injury or illness.

TO REQUEST A MEDICAL LEAVE OF ABSENCE

- Submit a completed "Form A: Request for Medical Leave of Absence."
- Take "Form C: Medical Leave Certification of Health Care Provider" to your provider to complete. Either you or your provider may submit this form, but it is your responsibility to make sure it is received by St. Peter's Leave Management Specialist. If you are requesting family leave to care for a family member, you will need to sign Form D and submit this form to the treating provider.
- Do you have a Short Term Disability (STD) policy? To file, call NY Life at 1-800-362-4462 as soon as you know when you will be out on leave. Please refer to page 12 of this packet. STD coverage starts at the same time your FMLA/ Medical Leave begins
- "Form B: Notice of Eligibility, Rights, and Responsibilities" will be completed and mailed to you by the Leave Management Specialist. It is attached to this packet for your reference only.

For a positive COVID-19 related absence:

- Provide proof of positive result or isolation order to the Leave Management Specialist.

TYPES OF APPROVAL

- Medical Leave of Absence-Family Medical Leave Act Eligible
- Medical Leave of Absence-Non-FMLA

CHANGING BENEFITS DUE TO A QUALIFYING EVENT

E.g. Adding a baby or adopting a child

- Please note instructions on page 11 of this packet.

BEFORE RETURNING TO WORK

- When your anticipated return to work is approaching, schedule a visit with your provider to obtain a completed "Form E: Release to Return to Work." Also, schedule a meeting with your director/manager to discuss work schedules, any possible restrictions and/or any special needs you may foresee. Any work accommodation will be coordinated with the Leave Management Specialist. This must be completed prior to your first day back at work.

- If you have been absent for more than 35 days, please contact Security at 406-431-9403 to ensure your badge is active.

Returning from a COVID-19 absence:

- Provide documentation from Employee Health or County Health Department ending isolation order or Form E from your PCP.

COMMUNICATION EXPECTATIONS WHILE ON LEAVE

- Throughout a leave of absence, it is imperative the team member stay in contact with their director/ manager and Brianna Goettel regarding any hours worked, the balance of accrued Personal Leave (PL), Extended Illness (EI) and leave hours and plans to return to work.
- Whenever possible, a check-in call is requested every two weeks while on a Medical Leave of Absence to ensure you are supported and St. Peter's is able to smoothly facilitate your leave.

St. Peter's Health

Dear St. Peter's Team Member,

I value you and your service to our patients and community. Our Gold Standard journey includes a commitment to excellence in all facets of our work and the manner in which we care for each other. I realize there may be life circumstances that I am unaware of and I want to ensure you are aware of St. Peter's resources available to assist team members experiencing personal or work-related difficulties. These services are free and confidential.

- The **Employee Assistance Program** offers confidential consultation services to help address difficult situations. To access this service, log on at mycigna.com using the employer ID "stpetershealth" or call 1-877-622-4327.

- **St. Peter's Chaplains** Kim Pepper and Trish Dick are available to staff of all faiths experiencing hardships and in need of emotional or spiritual support. Both Chaplains also offer support through St. Peter's **Facility Dog Program**. Blue Bonnet (handled by Trish Dick) and Mocha (handled by Kim Pepper) both offer additional therapeutic support to staff. Contact Kim & Mocha by calling 406-447-2409 or emailing kpepper@sphealth.org. Contact Trish & Blue Bonnet by calling 406-447-2409 or emailing mdick@sphealth.org.

- **McCall Elverum**, Employee Health Wellness Care Manager, is available to assist team members experiencing medical hardships by empowering them to manage conditions and navigate the health care system. Contact McCall by calling 406-437-8499 or emailing melverum@sphealth.org.

- **Tina Stern**, Behavioral Health Professional, is available to aid you and/or your family members experiencing struggles. Contact Tina by calling 406-457-4165 or emailing cstern@sphealth.org.

- The "**Real Support 4 Real Life,**" linked on the People Hub, is an online option to connect you with real support for life's challenges. Submissions are reviewed daily by St. Peter's Chaplains and Behavioral Health Professionals.

- **Employee Assistance/Employee Childcare Assistance Fund** is available to assist our team members experiencing financial hardship. Application for this fund may be made through our Employee Health and Wellness Team by calling 406-444-2128 or emailing wellness@sphealth.org

- If you or someone you know is ever in crisis and want help, call the **Montana Suicide Prevention Lifeline**, 24/7 (1-800-273-TALK or text "MT" to 741 741).

Remember, these helpful services are **free and confidential**. If you have not already utilized these programs, I encourage you to consider doing so.

Please also know that I care about you. I am here to support you and can help connect you to any of these resources.

Best Regards,

Brianna Goettel, Leave Management Specialist
St. Peter's Health 2500 Broadway, Helena, MT 59601
Phone: 406-444-2363
Fax: 406-444-2117
Email: bgoettel@sphealth.org

FORM A: REQUEST FOR MEDICAL LEAVE OF ABSENCE

Team member name: _____ Today's date:

Address:_____ City, State: _____ Zip: _____

Does your spouse work for St. Peter's Health? ☐ Yes ☐ No

Reason for taking leave: Please check one and complete follow-up information as necessary.

☐ The birth of a child, or placement of a child with you for adoption or foster care;

Note: For leave for the birth or placement of a child, intermittent or reduced workweek leaves are subject to approval.

☐ Your own serious health condition;

Note: Page 9 defines a "serious health condition" under the Family and Medical Leave Act.

☐ You are needed to care for your ☐ spouse ☐ child ☐ parent ☐ sibling or ☐ grandparent due to his/her serious health condition.

Name of the family member for whom you provide care: _____

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

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

☐ A qualifying exigency arising out of the fact that your ☐ spouse ☐ son or daughter ☐ parent is on covered active duty or call to covered active duty status with the Armed Forces.

☐ You are the ☐ spouse ☐ son or daughter ☐ parent ☐ next of kin of a covered service member with a serious injury or illness.

For leaves to be taken all at once, rather than on an intermittent or reduced workweek basis:

Date leave is to start: _____ Date I expect to return to work: _____

For leaves to be taken on an intermittent or reduced workweek basis:

Schedule of time needed off: _____

_____

_____

Team member's signature: _____ Date: _____

PLEASE SUBMIT TO:

Brianna Goettel, Leave Management Specialist
St. Peter's Health 2500 Broadway, Helena, MT 59601
Phone: 406-444-2363
Fax: 406-444-2117
Email: bgoettel@sphealth.org

SECTION I: NOTICE OF ELIGIBILITY

In general, an eligible team member must have worked for an employer for at least 12 months, worked 1,250 hours in the 12 months preceding the leave and work at a site with at least 50 team members within 75 miles. This form provides team members with the information required by 29 C.F.R. § 825.300(b). Section II provides team members with information regarding their rights and responsibilities, as required by 29 C.F.R. § 825.300(b), (c).

To: _____ Date: _____

On _____, you informed us that you needed leave from _____ through _____ for:

- ☐ The birth of a child, or placement of a child with you for adoption or foster care;
- ☐ Your own serious health condition, including illness, injury, impairment, or physical or mental condition
- ☐ You are needed to care for your ☐ spouse ☐ child ☐ parent ☐ sibling or ☐ grandparent due to his/her serious health condition.
- ☐ Due to a qualifying exigency arising from your ☐ spouse ☐ son or daughter ☐ parent is on covered active duty or call to covered active duty status with the Armed Forces.
- ☐ You are the ☐ spouse ☐ son or daughter ☐ parent ☐ next of kin of a covered service member with a serious health condition.

Spouse means a husband or wife, including common law marriage or same-sex marriage. A team member may take medical leave to care for an individual who assumed the obligations of a parent to the team member when the team member was a child or to care for a child for whom the team member has assumed the obligations of a parent.

This notice is to inform you that you:

- ☐ Are eligible for a medical leave protected under FMLA. (See Section II below for Rights and Responsibilities).
- ☐ Are **not** eligible for a medical leave protected under FMLA, because (only one reason need be checked);
  - ☐ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you have worked approximately months towards this requirement.
  - ☐ You have not met the FMLA's hours of service requirement. As of the first date of requested leave, you have worked approximately hours towards this requirement.
- ☐ Are eligible for a Medical Leave of Absence (Non-FMLA protected). This leave type does not provide job protection.

If you have any questions, concerns or simply wish to discuss your options, please contact Brianna Goettel, Leave Management Specialist. Additional information may be found on FMLA posters located in St. Peter's facilities or visit www.dol.gov/agencies/whd/fmla.

SECTION II: RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE

As explained in Section 1, you meet the eligibility requirements for taking Medical Leave of Absence either protected or unprotected under FMLA and still have medical leave available in the applicable 12-month period. However, in order for us to determine whether your absence qualifies as a Medical Leave of Absence, you must return the following information to us by _____. (Team member's must provide required certification within 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

continued >

☐ Sufficient health care provider certification to support your request for FMLA leave or Medical Leave of Absence. A certification form ☐ **is** ☐ **is not** enclosed.

☐ Sufficient documentation to establish the required relationship between you and your family member.

☐ Other information needed (such as documentation for military family leave):

_____

☐ No additional information requested.

If your leave does qualify for a Medical Leave of Absence, you will have the following responsibilities:

☐ The requested leave ☐ **will** ☐ **will not** be counted against your annual FMLA leave entitlement.

☐ Maintain ongoing communication with your department director and Leave Management Specialist regarding your leave start and planned return to work dates. You must submit status reports every 2 weeks communicating your intent to return to work. Additionally, for team members on intermittent leave:

- Provide as much advance notice as is feasible prior to scheduled appointments, treatments or other leave authorized under your medical leave.
- With unplanned absences, make every effort to call off at least two hours prior to your scheduled shift to communicate your need to exercise medical leave that day. Unplanned absences not related to approved medical leave will be considered unexcused per St. Peter's attendance policies.
- Timely submit hours worked prior to the end of the pay period to help ensure proper payment. Pay periods begin at 12:00 am (midnight) Sunday and end 14 days later at 11:59 pm Saturday.
- Promptly notify people_operations@sphealth.org or 406-444-2160 if you believe an error in pay or remaining leave calculations has occurred.
- If you are concurrently approved for a medical leave for your own serious medical illness as well as a medical leave to care for a family member, you must specify which case you are calling off for as this impacts whether you will be paid with PL or EI, if available.
- St. Peter's may require team members absent on an intermittent or reduced schedule basis to temporarily transfer to an available alternative position for which the team member is qualified, provided it is with equal pay and benefits, in order to accommodate such absences, department operations and patient care needs.

☐ During your leave of absence, your health insurance coverage will continue as it currently does with St. Peter's paying the employer's share of the premium and you continuing to pay your portion. Your premium payment may be deducted from your regular payroll, Personal Leave (PL), Extended Illness (EI) or a combination. If a time comes when there is no PL or EI left in your accrued hours bank, we can discuss requesting PL donations with your department director if you so choose. We realize managing premium insurance payments while on leave without pay could result in some anxiety and we are here to support you through this process. You may make premium payment arrangements to ensure health benefits continue while on leave through our People Operations Benefits Administrator, Kolene Gardner. Kolene may be contacted at 406-457-4307 or kgardner@sphealth.org. If you are unable to pay in full upon your return to work, we will work with you to arrange repayment. Please do not hesitate to reach out with any questions or concerns you may have.

☐ You will be required to use your accrued PL and EI during your Medical Leave of Absence. If your accrued PL or EI has been exhausted, you are entitled to take the remainder of your protected leave unpaid.

continued >

The birth of a child, or placement of a child with you for adoption or foster care or your own serious health condition:

- Your accrued personal leave of _____ will be counted as part of your medical leave of absence;
- Your accrued extended illness of _____ will be counted as part of your medical leave of absence.

For leaves to care for a family member:

- Your accrued personal leave of _____ will be counted as part of your medical leave of absence.
- For MNA team members only, your extended illness of _____will be counted as part of your medical leave.

☐ Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ☐ **have** ☐ **have not** determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

☐ You ☐ **will** ☐ **will not** be required to present a fit-for-duty certification prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until certification is provided.

If the circumstances of your leave change and you are able to return to work earlier than the date indicated on this form, you need to notify us at least two business days prior to the date you intend to report for work.

If your leave does qualify as protected FMLA leave, you will have the following rights:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as the 12-month period measured forward from the date of your first FMLA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered service member with a serious injury or illness.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA protected leave. An equivalent position is one that is virtually identical to your former position in terms of pay, benefits, and working conditions. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered service member's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as protected under FMLA or Medical Leave of Absence (Non-FMLA) and whether or not it will count towards your leave entitlement under FMLA.

Please sign and return this form. If you have any questions, please do not hesitate to contact Brianna Goettel, Leave Management Specialist, at bgoettel@sphealth.org or 406-444-2363.

Team member's signature:_____ Date:_____

FORM C: MEDICAL LEAVE OF ABSENCE HEALTHCARE PROVDER CERTIFICATION

Team member's name:_____ Today's date: _____

Does the patient's condition qualify under any of the categories described? If so, please check as applicable:

- ☐ Health care
- ☐ Absence plus treatment
- ☐ Pregnancy
- ☐ Chronic conditions requiring treatments
- ☐ Permanent/long-term conditions requiring supervision
- ☐ Multiple treatments (non-chronic conditions)
- ☐ None of the above

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

   _____

   _____

   _____

2. When did the conditions commence, and what is the probable duration of the condition?

   Estimated disability period: from _____ to _____ (approximately).
   If the medical condition is pregnancy, indicate the expected delivery date.

3. Will it be necessary for the team member to work only intermittently or to work on a less than full schedule as a result of the condition? ☐ Yes ☐ No
   If so, what is the probable duration? _____

4. Is inpatient hospitalization of the team member required? ☐ Yes ☐ No
5. Is the team member able to perform work of any kind? ☐ Yes ☐ No
6. Is the team member able to perform the functions of their position? (Will provide essential functions of position if needed.) ☐ Yes ☐ No

Provider's name: _____

Type of practice: _____ Phone: _____

Address: _____

Provider's signature _____ Date _____

PLEASE SUBMIT TO:

Brianna Goettel, Leave Management Specialist
St. Peter's Health 2500 Broadway, Helena, MT 59601
Phone: 406-444-2363
Fax: 406-444-2117
Email: bgoettel@sphealth.org

FORM D: MEDICAL LEAVE OF ABSENCE TO CARE FOR A FAMILY MEMBER HEALTHCARE PROVIDER CERTIFICATION

TO BE COMPLETED BY THE TEAM MEMBER NEEDING FAMILY LEAVE TO CARE FOR A FAMILY MEMBER:

State the care you will provide and an estimated period of time during which the care will be provided. Please include a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.

_____

_____

_____

_____

_____

_____

Team member name: _____

Team member's signature: _____ Date: _____

TO BE COMPLETED BY THE FAMILY MEMBER'S PROVIDER:

For certification relating to care for the team member's seriously ill family member, complete the items below as they apply to the family member.

1. Is inpatient hospitalization of the family member (patient) required? ☐ Yes ☐ No
2. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? ☐ Yes ☐ No
3. After review of the team member's signed statement (see above) is the team member's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort). ☐ Yes ☐ No
4. Estimated time care is needed (including intermittent or on a part-time basis): from _____ to _____ (approximately).

Provider's name: _____

Type of practice: _____ Phone: _____

Address: _____

Provider's signature _____ Date _____

PLEASE SUBMIT TO:

Brianna Goettel, Leave Management Specialist
St. Peter's Health 2500 Broadway, Helena, MT 59601
Phone: 406-444-2363
Fax: 406-444-2117
Email: bgoettel@sphealth.org

St. Peter's Health

MEDICAL LEAVE OF ABSENCE HEALTHCARE PROVIDER CERTIFICATION - DEFINITIONS

Here and elsewhere on this form, the information sought relates only to the condition for which the team member is taking a Medical Leave of Absence.

Incapacity–For the purposes of FMLA, incapacity is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

Serious Health Condition–A serious health condition means an illness, injury, impairment or physical or mental condition that involves one of the following:

1. **Health care**: Inpatient care (i.e., an overnight stay) in a health, hospice or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequence to such inpatient care.
2. **Absence plus treatment**: A period of incapacity two (2) of three (3) full consecutive calendar days or more days that also includes:
   - Being treated two (2) or more times by a health care provider; or
   - Is an in-person treatment at least once within seven (7) days of the first day of incapacity; or
   - Either is a regimen of continuing treatment initiated by the health care provider or is a second in-person visit for treatment (the necessary of which is determined by the health care provider) within thirty (30) days of the first day of incapacity; or
   - Being under the continuing supervision but not being actively treated by a health care provider due to a serious long-term or chronic condition; or
   - Any period of incapacity due to pregnancy or prenatal care
3. **Pregnancy**: Any period of incapacity due to pregnancy, or for prenatal care.
4. **Chronic conditions requiring treatments**: A chronic condition which:
   - Requires periodic visits for treatment by a health care provider or by a nurse or physician's assistant under the direct supervision of a health care provider;
   - At least twice a year for that condition; and
   - May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).
5. **Permanent/long-term conditions requiring supervision**: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The team member or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.
6. **Multiple treatments (non-chronic conditions)**: Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three (3) full consecutive calendar days in the absence of medical intervention or treatment, such as cancer/chemotherapy, radiation, severe arthritis (physical therapy), kidney disease (dialysis), etc.

Regimen of Continuing Treatment–Includes, for example, a course of prescription medication (e.g. an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves, or bed-rest, drinking fluids, exercise and other similar activities that can be initiated without a visit to a health care provider.

Treatment–Includes examination to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations or dental examinations.

Must be completed by the team member's health care provider and submitted to St. Peter's Health before the team member returns to work.

_____ is released to return to work on _____ .
Team member's name Date

Return to work orders (choose one): ☐ No restrictions
☐ Return to work with the following restrictions (check all that apply below)

Lifting:
- ☐ Up to 10# occasionally, or up to 5# frequently
- ☐ Up to 20# occasionally, or up to 10# frequently
- ☐ Up to 50# occasionally, or up to 25# frequently
- ☐ Over 50# occasionally, or up to 50# frequently
- ☐ Other: _____

_____

_____

_____

Absolutely No:
- ☐ Use of L hand
- ☐ Use of R hand
- ☐ Use of L upper extremity
- ☐ Use of R upper extremity
- ☐ Weight bearing – L foot
- ☐ Weight bearing – R foot
- ☐ Prolonged stand/sitting
- ☐ Repetitive activities
- ☐ Repetitive lifting
- ☐ Exposure to water
- ☐ Pushing/pulling
- ☐ Squatting
- ☐ Climbing
- ☐ Driving
- ☐ Twisting
- ☐ Bending
- ☐ Reaching
- ☐ Other: _____

Part-time (up to 20 hrs/wk)
Limited: _____
- ☐ Use of L hand
- ☐ Use of R hand
- ☐ Use of L upper extremity
- ☐ Use of R upper extremity
- ☐ Weight bearing – L foot
- ☐ Weight bearing – R foot
- ☐ Prolonged stand/sitting
- ☐ Repetitive activities
- ☐ Repetitive lifting
- ☐ Exposure to water
- ☐ Pushing/pulling
- ☐ Squatting
- ☐ Climbing
- ☐ Driving
- ☐ Twisting
- ☐ Bending
- ☐ Reaching
- ☐ Other: _____

Full-time (up to 40 hrs/wk)
Limited: _____
- ☐ Use of L hand
- ☐ Use of R hand
- ☐ Use of L upper extremity
- ☐ Use of R upper extremity
- ☐ Weight bearing – L foot
- ☐ Weight bearing – R foot
- ☐ Prolonged stand/sitting
- ☐ Repetitive activities
- ☐ Repetitive lifting
- ☐ Exposure to water
- ☐ Pushing/pulling
- ☐ Squatting
- ☐ Climbing
- ☐ Driving
- ☐ Twisting
- ☐ Bending
- ☐ Reaching
- ☐ Other: _____

- May increase hours in increments (i.e. 2 hours/day, as tolerated): ☐ Yes ☐ No
  ☐ 2 Hours ☐ 3 Hours ☐ 4 Hours ☐ 5 Hours ☐ 6 Hours
- If currently on restrictions, is a follow-up appointment scheduled? ☐ Yes ☐ No Date: _____
- Anticipated return to full duty date: _____

  Released to return to FULL DUTY with NO RESTRICTIONS: ☐ Yes ☐ No Date: _____

Provider's name: _____

Type of practice: _____ Phone: _____

Address: _____

Provider's signature _____ Date _____

PLEASE SUBMIT TO:

Brianna Goettel, Leave Management Specialist
St. Peter's Health 2500 Broadway, Helena, MT 59601
Phone: 406-444-2363 Fax: 406-444-2117 Email: bgoettel@sphealth.org

St. Peter's Health

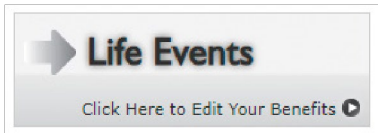
CHANGING BENEFITS DUE TO A QUALIFYING EVENT

If you have questions or issues regarding changing your benefits online using the instructions below, please contact a People Operations Benefits Administrator at 406-457–4307. Below are some important timelines to remember:

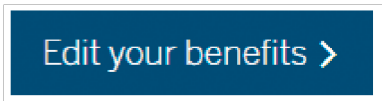
- Requests to change benefits due to a qualifying event, such as childbirth or adoption, must be made within 30 days of the qualifying event.
- If the request is not received within 30 days, team members will need to wait until St. Peter's Health Open Enrollment to make any changes to their plan. This open enrollment period normally occurs in November of each year.
- Proof of the qualifying event must be submitted to People Operations in addition to the change request being completed online.
- The Social Security number for a new baby will be required as soon as it is received. It must be added within 60 days of the qualifying event.

INSTRUCTIONS TO CHANGE BENEFITS

1. Log on to the HR InTouch Portal: https://stpetesmt.hrintouch.com
2. Enter your username and password (or contact People Operations if you do not remember your ID or password) 3. Select "Life Events"



4. Select "Edit your benefits"



5. Follow the prompts until you have completed your updates

Questions? Please contact:
Benefits Administrator
St. Peter's Health 2500 Broadway, Helena, MT 59601
Phone: 406-457-4307
Fax: 406-447-2530
Email: kgardner@sphealth.org

How to file your disability and leave claim.

1 BEFORE YOU FILE YOUR CLAIM

1. Notify your employer if you need to be out of work because of an illness, injury or pregnancy.
2. Have the following on hand:
   - Your Social Security number, birth date, home address, phone number and email address.
   - Dates and contact information for any health care providers or hospital/clinic visits.
   - Applicable workers' compensation claims.

2 FILE YOUR CLAIM

Choose **one** of the following:

Online*: myNYLGBS.com > Coverage>Disability (print your confirmation page.)

By phone at **(888) 842-4462** or (866) 562-8421 (español), 7:00 am – 7:00 pm CST and a representative will help you.

To automatically stay informed about your disability claim by text, sign up for text notifications by telling your New York Life Group Benefit Solutions (NYL GBS) claim manager or online at myNYLGBS.com after you've submitted your claim.

3 GIVE PERMISSION

Give NYL GBS permission to contact your health care provider or employer for claim-related information by answering "yes".

- During your claim call.
- Online after your claim has been submitted (you'll receive a notification).

4 CLAIM/LEAVE STATUS

- Online at **myNYLGBS.com** > Claims
- Contact us at **(888) 842-4462** or (866) 562-8421 (español), 7:00 am–7:00 pm CST.
- NYL GBS will send you FML, state, and/or company leave information, and your Family and Medical Leave Act (FMLA) rights.

5 ADDITIONAL RESOURCES

- Chat live with a NYL GBS representative on **myNYLGBS.com**.
- **Click here** for answers to frequently asked disability claim questions.
- **Click here** for answers to frequently asked leave questions.

If you haven't visited **myNYLGBS.com**, register today to easily file and manage all your claims in one place. in one place.

While you're out on disability or leave, keep your employer informed of your return-to-work plans. This is especially important if you need workplace accommodations, as some take time to put in place.

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