REQUEST FOR FAMILY OR MEDICAL LEAVE

Employee Notification

Request for Family or Medical Leave must be made in writing, if practical, at least 30 days prior to the date the requested leave is to begin.

Name Bridget Williams Date 3/22/16

School Class Position Para Professional

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I request a family or medical leave for one or more of the following reasons. I understand that a physician's certification and all required information must be submitted before this request is processed.

____ Because of the birth of my child, or because of the placement of a child with me for adoption or foster care.

____ In order to care for my spouse/child/parent who has a serious health condition.

✓ For a serious health condition that makes me unable to perform my job. THIS CONDITION ____ IS ✓ IS NOT WORK RELATED.

____ Requested intermittent or reduced leave scheduled _____

Leave to start 3/22/16 Expected return date 4/25/16

____ I would like to use my sick/personal days

✓ I would not like to use my sick/personal days

____ Original request for leave

____ Request for extended leave

Employee Signature Bridget Williams Date 3/22/16

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LEAVE APPROVAL

Principal/Designee Signature _____ Date 4-5-16

Superintendent Signature _____ Date 4/1/16

Board Secretary Signature _____ Date _____

Board President Signature _____ Date _____

03-23-16A07:55 RCVD

INITIAL DISABILITY CLAIM FORM - PHYSICIAN'S STATEMENT

***Policy Number:** P0E0K4V3

Policyholder Information: This * denotes a required field.

*Last Name	Suffix	*First Name	MI
Williams		Bridget	Y

*Date of Birth (mm/dd/yy): 11/05/71

Patient Information:

*Last Name	*First Name	*Date of Birth (mm/dd/yy)
Williams	Bridget	11/05/71

Physician Information:

*Phone Number	*Fax Number
708-873-4500	708-873-8451

*Physician's Name: SUNIL JOHN

*Address: 9550 West 167th Street

*City	State	Zip Code
Orland Park	IL	60467-

- Primary diagnosis for disability and ICD code: G72.9 Additional diagnoses: M62.82
- If due to an injury, please provide the date and details of the injury: / / NO
- Was this disability caused by an incident that occurred while performing the duties of his/her employment? ☑ No ☐ Yes
- Symptoms first occurred on: 3/6/16 If diagnosed with cancer, date of initial diagnosis: / /
- Patient first consulted you for this condition on: 3/10/16
- Was the patient treated for the primary diagnosis by another physician? ☐ No ☑ Yes
  If yes, physician's name: Mohammed Shamshuddin, MD
  Treating physician's address: 19550 Governors Hwy Phone Number: (708) 342-3000
  ***If filing for disability within the first two years of the policy, medical records may be requested.**
- Pregnancy claims: Date of delivery: / / ☐ Vaginal ☐ Cesarean
- If not delivered, expected delivery date: / /
- Please advise of any complications: Rhabdomyolysis
- First date of disability: 3/9/16
- Date patient was last treated: / / STILL ON TREATMENT
- Have you released the patient to return to work? ☑ No ☐ Yes (Date released: / /)
  Patient released to work: ☐ Full Time ☐ Part Time ☐ Light Duty
  If part time/light duty, please provide the date the patient is expected to return to full duty: 4/25/16 ERW SJ
- If patient has not been released, please provide the next appointment date: 4/18/16 Please also provide the date of expected release: 4/25/16
- Is patient permanently disabled? ☐ No ☐ Yes (Medical records will be required if permanent disability is indicated; please provide medical records to patient.)

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

PHYSICIAN'S SIGNATURE	DATE	TAX ID
Sulp	3/18/16	

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
For information or to check claim status, visit aflac.com or call 1-800-99-AFLAC (1-800-992-3522)
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)