Instructions For Completing Application For Anticipated Disability Leave

Please read the Instructions, the Application and the Conditions for Leave on the back of the Application completely before filling out the Application. Your supervisor will review the Conditions for Leave with you before you sign this Application. If there's something you don't understand or want more information about, be sure to ask your supervisor.

1. **Part 1: Employee Information** Please provide all the information requested in this part. If your address while you're on Anticipated Disability Leave will be the same as your mailing address, write "same as above" in that space. If you're not sure of the answer to some of the information requested, for example your net credited service date, ask your supervisor.

2. **Part 2: Request for Leave** Please provide the dates you would like your leave to begin and end. You can take up to six months of Anticipated Disability Leave.

   Check the nature of your anticipated disability. If you wish, you may leave this blank to preserve your privacy.

3. **Part 3: Acknowledgments** You and your supervisor *must* sign this section *after* your supervisor has review the Conditions for Leave with you.

4. **Part 4: For Physician Advisor Use Only** Do not write anything in this part.

5. **Part 5: For Benefits Delivery Office Use Only** Do not write anything in this part.

6. Please make a copy for your records and forward the original to the Benefits Delivery Office.

7. Your personal physician completes the G2518-MED and sends it directly to the Benefits Delivery Office.

8. After your disability begins you must report the absence as per the Absence Management Guidelines.

Please return to:
VERIZON BENEFITS
4 West Red Oak Lane
3rd Floor
White Plains, NY 10604

Application for Anticipated Disability Leave

(Verizon - North Associate Employees)

G2518-ADL
3-05

Clear Form

Please Print or Type

Part 1: Employee Information

Name of Employee: _____
Last First Middle Initial

Mailing Address: _____ Office Telephone Number: _____

_____ Social Security Number: _____

Payroll Code: _____ *Employee Status:* Other ____ Non-Management: ____ Regular: ____ Temporary: ____

Net Credited Service Date: _____ Company Department: _____

Job Title: _____ Department Contact (name): _____

Address During Leave: _____ Department Contact Phone Number: _____

Telephone Number During Leave: _____ Department Address: _____

Part 2: Request for Leave

I request an Anticipated Disability Leave, to begin on _____ and to continue through _____.

Estimated Date Disability Will Begin: _____

Nature of Anticipated Disability (you can leave this blank for reasons of privacy): ____ Surgery ____ Pregnancy ____ Other

Part 3: Acknowledgments

I hereby apply for an Anticipated Disability Leave of Absence, in accordance with the Company's leave program and subject to the conditions on the back of this form. I have read and understand these conditions.

Employee's Signature: _____ Date: _____

The above employee has applied for an Anticipated Disability Leave of Absence. I have reviewed the Verizon Leave Program and the conditions of the leave, as explained on the back of this form, with the employee.

Supervisor's Signature: _____ Date: _____

Part 4: For Physician Advisor Only

Attending Physician's Report/Physician's Certificate Submitted: ____ Yes ____ No

Approved by the Physician Advisor

Signature: _____ Date: _____

Part 5: For Benefits Delivery Office Use Only

Approved by the Benefits Delivery Office

Signature: _____ Date: _____

Date Leave Begins: _____ Date Leave Ends: _____ Actual Date Disability Begins: _____

Anticipated Disability Leave to be Followed by Care for Newborn Children Leave: ____ Yes ____ No

Please Read Conditions Before Signing

Conditions for Leave

Please read these Conditions for Leave before you complete your Application.

Salary Continuation Anticipated Disability Leave is an unpaid leave of absence.

Health Care Coverage Your coverage continues for the entire leave. During your leave, Verizon will pay the same amount it normally does for your coverage. If you contribute to the cost of your health care benefits, you must continue making contributions. You'll be billed monthly. If you receive a benefit credit, you will continue to receive this credit on a monthly basis during your leave.

Group Life Insurance Your Basic Group Life Insurance and Accidental Death and Dismemberment Insurance continue for the entire leave. Any Supplementary Life Insurance and Dependent Life Insurance you have continue until the end of the calendar month in which your leave begins. You may continue these coverages during your entire leave by paying the premiums. You may also reduce the amount of your Supplementary Life Insurance and Dependent Life Insurance coverages or stop your coverages while you're on leave. If you reduce or stop your coverages, they will be reinstated to the level you had before your leave began if you submit a Statement of Health within 31 days after returning to active employment and it's approved by the insurance company. If you don't submit a Statement of Health, or if you submit one and it isn't approved, your coverages won't be fully reinstated. If you're a management employee, you may apply to increase your coverage within 31 days of returning to work or wait until the next open enrollment period. You may apply to enroll for Dependent Life Insurance at any time after returning to work. Non-management employees may apply to enroll for or increase the amount of Supplementary Life Insurance and Dependent Life Insurance any time after returning to work. You must submit a Statement of Health when you apply to increase or enroll for Supplementary and Dependent Life Insurance. Your insurance will become effective on the day the insurance company approves the Statement of Health.

Service Credit You earn service credit for the first 30 days of leave if you return to work and for the entire period you're disabled.

Retirement Benefits Your right, if any, to receive a retirement benefit continues for the entire leave.

Savings Plan Participation If you participate in one of the Verizon Savings Plans, all allotments are suspended during the entire unpaid leave. Allotments will resume automatically when you return to active employment. You can make allotment/future investment changes while on leave to take effect when pay resumes. You can also transfer past balances and take advantage of the plan's withdrawal provisions. If you have an outstanding loan, you will receive a coupon book to use to make payments during your leave.

Dependent Care Spending Account Participation If you participate in the Dependent Care Spending Account Plan, no deposits will be made to your account while you're on leave. Deposits will resume automatically if you return to work during the same calendar year, and you may change the amount of your deposits within 31 days of your return if you have qualifying life-style change. If you return to work in a different year, deposits will not resume automatically; you must re-enroll within 31 days of your return to work.

Health Care Spending Account Participation If you participate in the Health Care Spending Account Plan, no deposits will be made to your account while you're on leave. However, you can choose to continue to make deposits on an after-tax basis during your leave through COBRA. If you do, your payroll deposits will be reinstated when you return to work. If you don't continue to participate through COBRA and you return to work in the same calendar year, you won't be able to re-enroll in the plan until the next open enrollment period. If you return to work in the next calendar year, you may re-enroll in the plan within 31 days of returning to work.

Sickness Disability Benefits If you become disabled by sickness or injury during your leave, you may be eligible to receive Verizon sickness disability benefits. Contact your Department and Benefits Delivery Office for more information.

Death Benefits If you're a management employee hired before July 1, 1985, or a non-management employee hired before January 1, 1987, your mandatory beneficiaries may be eligible to receive a Sickness Death Benefit if you die during your leave.

Vacation Please discuss your vacation options and the vacation carry over rules with your supervisor before your leave begins. You can't receive payment for unused vacation days while you're on leave.

Holidays You aren't entitled to a day off in lieu of a holiday which occurs while you're on leave.

Guaranteed Reinstatement You are guaranteed reinstatement to your former job or one of similar pay and status if you return to work as scheduled after your disability ends. If you are taking Anticipated Disability Leave before you have a baby, and you plan to take Care for Newborn Children Leave, you are guaranteed reinstatement to your former job or one of similar pay and status if you return to within 12 months of your child's birth. If you're a management employee, your right to reemployment at the end of your leave may be affected by the Verizon Force Management Plan (FMP).

Paid Employment While on leave, you may not accept paid employment during your normal work hours.

Anticipated Disability Program

Attending Physician's Report of Anticipated Disability

G2518-MED
3-05

CONFIDENTIAL

(This section to be completed by employee)

To Dr. _____ _____
Name of Attending Physician | Telephone No.

_____
Address of Attending Physician (street/City/State/Zip Code)

As my attending physician, please assist me by completing this form so that I may receive and benefits I may be entitled to from Verizon. You are authorized to furnish all necessary information to the Company's Benefit Delivery Office concerning my anticipated disability.

Please mail this form directly to:

Benefits Delivery Office
4 West Red Oak Lane
3rd Floor
White Plains, NY 10604

_____ _____
Employee's Signature | Date

(This section to be completed by attending physician)

Attending Physician's Report

This is to certify that my patient _____
Employee's Name

will become disabled on or about _____ because of
Date

☐ Pregnancy Estimated Date of Delivery _____

☐ Surgery Estimated Date of Surgery _____

Type of Surgery _____

☐ Other Medical Treatment _____
Nature of Treatment

Hospitalization is planned to begin on _____

_____
Diagnosis/Remarks (Specify Nature of Disability)

PLEASE NOTE: **This report must be received by the Company's Benefit Delivery Office before a leave of absence can be approved for your patient.**

_____ _____
Attending Physician's Signature | Date