

NWA MANAGER**SECTION I**

Manager Instructions: Complete Section I, make a photocopy of the first page, and give the original to the employee for completion. After the employee returns the completed form, make a photocopy of the entire form and give the photocopy to the employee. 1. Employee Name _____

2. Case Number _____ 3. Date Request Form Given to Employee ____/____/____

4. Manager Base/Mail Stop _____ 5. Manager Phone No. _____

6. Manager Employee No. _____ 7. Manager Signature _____

NWA EMPLOYEE**SECTION II**

Employee Instructions: Read the entire form and complete all portions of Section III. Return completed form to your manager. A photocopy will be returned to you.

FML Notices. This list does not represent the FML policy its entirety. An employee who wishes to apply for FML is expected to read and abide by the complete FML policy, and to contact his or her manager if he or she has questions. To access the FML Policy, log onto www.nwapeople.nwa.com.

- If approved, the FML time you have requested will be deducted from your 12-workweek allotment.
- FML may be paid or unpaid consistent with applicable Company accrual usage policies and collective bargaining agreements.
- Employee due dates will be enforced absent unexpected and/or unusual facts or circumstances.
- An employee may only request FML in conjunction with specific dates of absence, i.e., dates on which the employee has already been absent from work for an FML-qualifying reason or for which the employee knows the specific dates of a scheduled, future FML-qualifying absence.
- Where leave is foreseeable, an employee must provide 30 calendar days advance notice.
- Where an absence has occurred that an employee believes may qualify for FML, the employee must notify the manager of his or her request to have the absence counted as FML within 4 calendar days of the date of absence.
- Where facts, conditions and/or circumstances related to an employee's FML request or authorization change, an employee must notify his or her manager of the change within 4 calendar days of the date of the change.
- Providing incomplete, false or misleading information for the purpose of obtaining FML will result in discipline up to and including termination of employment.
- An employee approved for FML must provide the specific FML case number when he or she notifies the Company that he or she wishes to use FML for an absence.
- An employee approved for intermittent FML for the purpose of attending medical appointments must consult with his or her manager and attempt to schedule his or her leave so as not to disrupt the needs of the operation.
- An employee must submit adequate medical certification completed by a health care provider to support a request for leave because of his or her own, or a qualifying family member's, serious health condition.
- Medical certification must be submitted within 15 calendar days of the date that a manager gives the blank form to an employee. If a manager mails the blank form to an employee, the due date is 18 calendar days from the date the manager mails the form.
- If the information on the medical certification form that an employee submits is judged by the Company to be incomplete, illegible and/or ambiguous, the employee may be allowed one opportunity to resubmit the certification form with all deficiencies corrected within 5 calendar days from the date the manager returns the form to the employee (8 calendar days if the manager returns the form to the employee via mail).
- Medical recertification will be required where an employee's FML usage coincides with other scheduled days off (e.g., RDO, VAC, HOL) on 4 or more occasions within a 6-month rolling period.
- Upon completion of FML, an employee may be required to submit a certificate of fitness for duty.
- Upon return from FML, employees will be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms as business conditions permit and subject to the terms of any applicable collective bargaining agreement.
- For the duration of an unpaid FML, the Company will maintain an employee's group health insurance coverage under any "group health plan" provided that the employee continues to make payments on the employee-pay portion of the premium in a timely manner.
- An employee who elects not to return to work after taking unpaid FML may be required to pay back the portion of the health insurance premiums that were paid by NWA during the unpaid period of FML.

Employee Instructions: Read the entire form and complete all portions of Section III. Return completed form to your manager. A photocopy will be returned to you.

8. Employee Name _____

9. Employee # _____

10. Hire Date ____/____/____

11. Base (Loc) _____

12. Job Title _____

13. Reason for FML Request _____

14. a. Is your request for FML for a past absence? Yes No
b. If "yes", list the specific dates of the *past* absence for which you are requesting FML _____

(Note: if your request is for both past and future absences, also answer question 15.)

15. a. Is your request for FML for a future absence? Yes No
b. If "yes", list the specific dates of the *future* absence for which you are requesting FML _____

(Note: if your request is for both future and past absences, also answer question 14.)

16. Is this request for your own condition or for that of a family member? Self Family Member

17. If you checked "Family Member":
a. State Family Member Name _____
b. Check your relationship to the family member:
 Spouse Mother Father
 Child under the age of 18 years old – Provide Child's Birthdate: ____/____/____
 Child age 18 or older and incapable of self-care because of a mental or physical disability
 Other (specify) _____

18. a. Is your spouse also employed at Northwest? Yes No
b. If "yes", state Spouse Name _____ and Employee # _____

19. Your Work Phone _____ 20. Your Home Phone _____

21. The best time to contact you by phone regarding your FML request is _____

22. The best phone number to contact you regarding your FML request is _____

Verification: I, _____, *acknowledge by signing below:*

(Employee - Print your First Name and Last Name Here)

- a) I have read Sections II and III of this form.
- b) At the end of my approved time away for FML, I may return to my previous position or an equivalent position as business conditions permit (subject to the terms of any applicable collective bargaining agreements).
- c) If I cannot return on the designated date, I must, in advance and in writing, request an extension of my FML if I have remaining FML available or request another type of Company leave.
- d) If I exhaust my eligible FML time and request another type of Company leave, I am no longer entitled to further Company paid medical and dental benefits.
- e) If I do not return from FML, unless excused by another Company leave, I will repay the Company any premiums paid by the Company on my behalf during my FML.
- f) Any personnel action, e.g. layoff, that would have affected me as an active employee will still apply to me during my time away on FML and upon my return.
- g) I understand that medical clarification of my serious health condition or serious health condition of my eligible family member if applicable, must be submitted within 15 calendar days of the date a manager gave me a blank form (18 calendar days if the manager mailed the form). If a complete, legible and unambiguous original certification form is not returned by the deadline, the FML request may be denied or, where appropriate, delayed. If the absence for which FML is being requested has already occurred and a complete, legible and unambiguous form is not provided by the deadline, the FML request may be denied and I may be subject to appropriate discipline for attendance, up to and including termination.
- h) The information that I have provided and will provide to the Company and to a health care provider in connection with my request for leave, and, where applicable, the information my family member has and will provide, is complete, true and correct.
- i) Neither I, nor my family member, nor any other person representing me or my family member, has or will complete information in the Health Care Provider sections of the FML Medical Certification Forms (A and B).
- j) Where applicable, I certify that my NWA-employed spouse and I have not requested more than a combined total of up to 12 weeks of FML within a 12-month period for the birth, adoption, foster care, placement of a child or for parents' serious health conditions.
- k) If any facts, conditions or circumstances that relate to my leave request and/or the leave period(s) change in any way, I will notify my NWA Manager of the change(s) within 4 calendar days after the date of the change(s).
- l) I will abide by the Company's Pass Travel While on Sick/Leave of Absence Policy as applied to employees on FML. I understand that violation of this policy may lead to discipline up to and including termination.
- m) Providing false information for the purpose of obtaining and/or maintaining FML will result in discipline up to and including termination.
- n) I have read and understand the FML Policy and agree to its terms and conditions. Violation of this policy may result in discipline up to and including termination.
- o) This is not an employment contract and is not intended to be one.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on : ____ / ____ / ____ By: _____
(Date) (Employee's signature)

Employee – please print your name: _____

Pay Option Agreement

Family Emergency /Adoption/Paternity

If this leave is to care for a family member, or adoption/paternity, and you are FMLA qualified, you may elect to use your vacation (sick pay may not be used). Company paid medical and dental coverage will continue as long as you remain on a FMLA leave.

WE WILL ASSUME YOU WANT AN UNPAID FMLA LEAVE UNLESS SPECIFIED BY YOU.

Please indicate your election below:

 I elect to use my vacation scheduled during the following period(s). I understand that my vacation will be used at a rate equal to trips or reserve days not flown and not at the rate of 3:30/day as vacation is normally paid.

Month and week of vacation I wish to have cancelled, in this order:

1st. Month _____ Week _____ 3rd. Month _____ Week _____

2nd. Month _____ Week _____ 4th. Month _____ Week _____

Additionally, once you have exhausted your current year's scheduled vacation, you may elect to use any or all of next year's vacation accrual while you are on your leave.

 Use some of next year's vacation in the amount of _____ hours.

 Do not use any of next year's vacation.

 Exhaust all of next year's vacation.

 I elect to take an unpaid leave to care for a family member, adoption or paternity care.

I understand that I will not receive any pay while I am on an unpaid FMLA leave, and my life insurance coverage will discontinue.

Thank you. Please sign below and return with all your completed FMLA paperwork to Inflight Administration.

Printed Name

Employee Number

Employee Signature

MEDICAL/MATERNITY LEAVE PAY OPTION FORM

PARTIAL MONTH FMLA LEAVES

If you are disabled for less than a full flying month and are FMLA qualified, the scheduled value of your missed trip(s) may be covered by your sick and then vacation and/or may be unpaid. Reserve flight attendants will be paid 4:15 for each day of reserve duty missed. If you are assigned a trip as a reserve flight attendant and have been notified of the assignment, the scheduled value of the trip will be covered. Vacation will be used at a rate equal to missed trips or missed reserve days and not at the rate of 3:30/day as vacation is normally paid.

FULL MONTH FMLA & NON-FMLA MEDICAL LEAVES

During a month in which you have no flying activity you may elect to receive sick pay credit from fifty (50:00) to eighty (80:00) hours per month in whole hour increments, per Section 15.3 of the Collective Bargaining Agreement. Once this election is made it may not be changed.

Note: CA/HI/NY based flight attendants need not use any sick or vacation. **All others must first exhaust sick bank, then may choose to use vacation or go to an unpaid status. WE WILL ASSUME YOU WANT TO EXHAUST YOUR SICK BANK AND THEN GO TO AN UNPAID STATUS UNLESS SPECIFIED BY YOU.**

Please make the following election(s):

During my full month FMLA or Non-FMLA medical leave, I elect to use _____ (50 – 80) hours of pay per month (leaves > 30 days only)

For **ALL** leaves, please make the following election(s):

- _____ UNPAID leave of absence (**CA/HI/NY based flight attendants only**).
- _____ Exhaust ALL SICK AND VACATION during my leave, including vacation I have accrued for use next year.
- _____ EXHAUST SICK bank and then go to an UNPAID leave of absence (do not use any vacation).
- _____ Exhaust SICK bank and then use VACATION. The current year's scheduled vacation must be exhausted before next year's accrual can be used and will be cancelled at 3:30 per day. Month and week of vacation I wish to have cancelled, in this order:
 - 1st. Month _____ Week # _____
 - 2nd. Month _____ Week # _____
 - 3rd. Month _____ Week # _____
 - 4th. Month _____ Week # _____
- _____ Additionally, once you have exhausted your current year's scheduled vacation, you may elect to use any or all of next year's vacation accrual while you are on your leave.
 - _____ **Use some of next year's vacation in the amount of _____ hours.**
 - _____ Do not use any of next year's vacation.

If you have vacation scheduled **during a period that you are disabled**, you may elect to:

- _____ Use the vacation for pay during your leave. The value of the vacation will be converted to FMLA vacation and will cover the value of missed trips/reserve days or to make up your 50-80 hours.
- _____ Defer the vacation and reschedule it from the Vacation Open Board upon your return. Any deferred vacation may not be carried-over to next year, and will be paid out at the end of the year.
- _____ Replace the vacation with sick (or unpaid for CA/HI/NY based flight attendants only) and receive a payoff for the value of the scheduled vacation, which tax laws require be taxed at an accelerated rate.

Thank you. Please sign below and return with all your completed FMLA paperwork to Inflight Administration.

Printed Name Employee Number Employee Signature Date