

Request for Leave or Chronic Illness Support



Please visit Publicis Groupe's [employee privacy notice and policy](#) to learn more about our practices concerning the collection and use of your personal information.

1 Employee & Company Information

Full legal name _____ Employee Career Settings ID _____
[Career Settings](#) > My Profile > under 'Profile' / 'User Information'

Expected absence days, if requesting a leave:

Start date _____ End date _____

continuous intermittent

If requesting intermittent leave, explain the frequency & duration: _____

I confirm that my personal information, including home address, personal phone number and email, are updated and accurate in Career Settings should anyone need to contact me during my leave (if applicable).

2 Type of Absence or Support

- | | | | |
|--|---|--|--|
| <p>Medical: Self
<i>Sick/Injured: non-work related</i></p> | <p>Maternity/Paternity
<i>Birth of a child, adoption</i></p> | <p>Kin Care
<i>You believe this absence may qualify for Family Medical Leave (FMLA)</i></p> | <p>Care for Military Service Member
<i>You believe this absence may qualify for Family Medical Leave (FMLA)</i></p> |
| <p>Medical: Care for a Family Member
<i>Your relationship to family member:</i></p> <p>_____</p> | <p>Worker's Comp
<i>Injured: work related</i></p> | <p>Bereavement
<i>Relationship to deceased:</i></p> <p>_____</p> | <p>Military Spouse Leave
<i>Attach documents that your spouse is on leave from military deployment</i></p> |
| <p>Cancer & Chronic Illness Support
<i>(Also get access to internal community and coaching)</i></p> | | <p>Other Reason for Absence:</p> <p>_____</p> <p><i>do not provide medical information</i></p> | |

3 Employee Acknowledgement

- I understand that I am required to effectively communicate and provide the Company—and its insurance provider: The Hartford, if applicable—any information and documentation requested to support this request pursuant to local, state and/or federal laws.
- I understand that my failure to do so may result in delay and/or denial of my request.
- I understand that in addition to completing this form, **I must initiate a claim to The Hartford regardless of whether I am currently requesting a leave of absence.** If I have any questions, I can contact The Hartford directly at 1-800-549-6514 weekdays from 8am - 9pm ET and reference Policy #342283.
 - [Click here for how to start a claim with The Hartford](#)
- Applicable to those applying for Working with Cancer chronic illness benefits, I understand that if I meet the eligibility criteria for benefits, the date I sign and return this completed form to HR is the effective date that benefits begin, including one year of job protection.

Signature _____ Date _____

Return completed form to your local HR team

For HR Department to Complete

Comments _____

Signature _____ Date _____