MFRM FAMILY OF BRANDS

# Leave of Absence Statement
# —Eligible Employee—
# Family and Medical Leave Act of 1993 (FMLA)

**Please submit the completed Employee Statement and Health Certification by scan/email to leaves@mattressfirm.com or by fax to (888) 882-5016. You may also mail the documents to the Benefits Department, 5815 Gulf Freeway, Houston, Texas 77023. This information is due to the Leave Administrator immediately.**

## Part A — Employee Information (All Information is Required)

**Employee Name_____ Alternate Contact Name:_____**

**Street Address:_____ City & State:_____**

**Zip Code _____ Phone Number:_____ Alternate Contact Phone Number:_____**

**Email (Personal):_____ Preferred Method of Contact: _____Phone _____Email**

## Part B — Supervisor Information

**DM/Supervisor's Name (Required): _____Phone Number (Required):_____**

**Date you notified your DM/Supervisor of your leave (Required):_____**

## Part C — Leave Request Information (All Information is Required)

**First Date of FMLA: _____ Expected Return to Work Date: _____**

**____Continuous Leave _____Intermittent Leave**

## Part D — Paid Time Off (PTO) and Benefit Coverage, If Applicable (All Information is Required)

**Do you want the Leave Administrator to payout any unused PTO through your unpaid Leave of Absence until your return, or until PTO is exhausted, whichever occurs first?: ____ Yes ____No**

**If you are currently enrolled in Mattress Firm Benefits, you may "opt out" of Benefits Coverage and Benefit Premiums *during* your unpaid Leave of Absence. Do you wish to "opt out" *during* your unpaid Leave of Absence? ____Yes ____No**

****If you choose to "opt out" as indicated above, Benefit Coverage and Benefit Premiums will automatically commence upon return, no exceptions. If you do not "opt out" you will be responsible for submitting any Premium Payment.****

## Part D — Reason for Leave (All Information is Required)

**____ Self (Medical)** **____ Care of Spouse** **____ Care of Child** **____ Care of Parent**

**____ Birth of Child** **____ Adoption of child** **____ Foster Care of Child**

**____ Military Care-Giver** **____ Military Qualifying Exigency** **____ Leave is Work Related (Worker's Comp)**

**Employee Signature:_____Date: _____**