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## EMPLOYEE LEAVE OF ABSENCE CHECKLIST

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### BEFORE THE LEAVE:

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**Notify your manager and Total Rewards**

- **Absent 5 Days or Less** Notify your manager and use available Paid Time Off (PTO).
- **Absent More Than 5 Days:** Notify both your manager and Total Rewards at [totalrewards@rymanhp.com](mailto:totalrewards@rymanhp.com) at least 30 days prior to your leave, if possible.

**File a claim with The Hartford.** (*Recommended within 30 days of the leave*)

- **Online:** [www.thehartford.com/mybenefits](http://www.thehartford.com/mybenefits) (Policy #: 715694)
- **Phone:** 888-301-5615

**Prepare for temporary system access changes**

- Company provided e-mail and ADP timecard will be temporarily disabled during leave.
- Ensure personal contact information is current in ADP so we can communicate with you.
- Coordinate with your manager regarding e-mail access during your leave, including options such as temporary reassignment, forwarding, or an out-of-office auto-reply.

**If this is a work-related illness or injury, notify your manager/HR immediately.**

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### DURING THE LEAVE:

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**Notify Total Rewards of paid time you would like to use**

- If you do not specify, the available time will be used in the following order:  
Vacation Rollover → Floating Holiday → Sick Leave → Vacation Time

**Pay your benefit premiums to maintain healthcare coverage**

- If you are using paid leave, premiums will be deducted from your paycheck as usual.
- If you are on unpaid leave or receiving short-term disability pay, premiums must be paid directly to Alight (YBR) to continue coverage.

**Keep your manager, Total Rewards, and The Hartford informed**

- Provide any updates regarding your leave or changes to your expected return date.
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### RETURNING TO WORK

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**Submit The Hartford's Fitness for Duty Certification Form (if applicable)**

- If you were on leave for 5 or more days due to your own medical condition, the form must be completed by a physician and presented to your manager or HR before returning to work.

**Notify manager of return-to-work date**

- Inform manager at least **3 days** before your expected return to get on the schedule

**Request workplace accommodation (if needed)**

- Consult with your manager and Total Rewards **before returning** so any necessary accommodation can be arranged.

**Upon your return to work, your email and ADP timecard access will be restored.**

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## LEAVE OF ABSENCE FREQUENTLY ASKED QUESTIONS

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### 1. How do I get paid during the short-term disability waiting period?

You can use your available time-off to cover the 7-day short-term disability waiting period. If you do not specify, the time will be deducted in the following order:

Vacation Rollover → Floating Holiday → Sick Leave → Vacation Time

If approved, short-term disability payments will begin on the 8<sup>th</sup> day (from The Hartford).

### 2. Will I get paid for company-recognized holidays while I am on leave of absence?

No. Holidays are only paid when an employee is in active status.

### 3. How do I pay my insurance premiums while I am on leave of absence?

If you are enrolled in the company's benefits, you must pay your benefit premiums to maintain healthcare coverage during your leave. If you are using paid time off (vacation, sick leave, parental leave, etc.), benefit premiums will be deducted from your paycheck as usual. If you are being paid through short-term disability or using unpaid time, you will pay benefit premiums directly to Alight ("YBR").

### 4. What if I can return to work before my anticipated return to work date?

If your leave was longer than 5 consecutive days due to your own illness or serious health condition, you must submit a **Fitness for Duty Certification Form**, completed by your physician, to your manager or Total Rewards **at least 3 days before your return**. This ensures you can be added to the work schedule, have proper system access, and receive accurate pay.

### 5. What happens when my short-term disability claim ends?

You are expected to return to work. If you are not medically able to return:

- You may request reasonable accommodation.
- If you are unable to return even with accommodation, you may apply for Long-Term Disability (LTD) benefits.
- If approved for LTD, your employment may end on the last day of the month, in which the LTD benefits are approved.

If you can return in a modified capacity, you may submit an accommodation request and still qualify for LTD.

### 6. Can I work remotely during leave?

You are not permitted to perform work while on medical or disability-related leave unless specifically approved as part of a return-to-work or accommodation plan.

### 7. What if I need accommodation?

Requests are evaluated through an interactive process to determine accommodation.

### 8. I am having a baby or adopting a child. How do I add them to my insurance?

Birth or adoption is a qualified family status change, allowing you to update your benefits. You have 31 days from the date of birth/adoption to add your child to your insurance coverage(s). Coverage will be retroactive to the date of birth/adoption.

To submit a family status change:

1. Visit [ybr.com/ryman](https://ybr.com/ryman) or call 888-438-9271.
2. Select "**Change your Coverage**" from the top of the page.
3. Click "**Having or adopting a child**" (cannot submit future-dated events).
4. Add dependents\* and update coverage as needed.

*\*When adding eligible dependents to coverage, you will be required to upload verification documents (ex. marriage license, birth certificate, etc.) through the Alight portal to confirm eligibility.*

## TYPES OF LEAVES

Leave can generally be taken in the following ways:

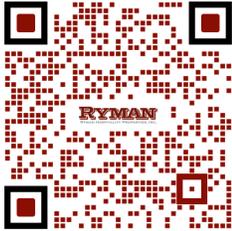
- **Continuous Leave:** A single, uninterrupted block of time.
- **Intermittent Leave:** Multiple, smaller blocks of time with work in between.
- **Reduced Schedule Leave:** Returning to work gradually on a limited schedule.

Note: Some leaves may run **concurrently** with another type of leave.

<u>Leave Type</u>	<u>Duration</u>	<u>Paid / Unpaid</u>	<u>Eligibility</u>	<u>Notes</u>
<b>Family Medical Leave of Absence (FMLA)</b>	Up to 12 weeks	Unpaid (job-protected)	12 months employed and 1,250 hours worked in the last 12 months	Consecutive or intermittent leave; available once per rolling 12-month
<b>Short-Term Disability (STD)</b>	Up to 25 weeks	Paid; 60% of regular base pay (up to \$2,500/week), or 70% (up to \$3,500/week) if enrolled in Buy-Up coverage	Full-time employees after 90 days of employment	7-day waiting period; Buy-Up coverage is optional and employee-paid; benefit payments issued by The Hartford
<b>Long-Term Disability (LTD)</b>	Through age 65 (or later per plan provisions)	Paid; 60% of regular base pay (maximum \$10,000 per month)	Full-time employees after 90 days of employment	Benefit payments issued by The Hartford; employment may end if unable to return to work with or without reasonable accommodation
<b>Company-Paid Parental Leave</b>	Up to 4 weeks	Paid	Full-time employees after 90 days of employment	Must be used in one-week increments within 12 months; leave tracked by The Hartford; payments issued through company payroll
<b>Company Personal Leave</b>	Up to 30–60 days	Unpaid	Employees not eligible for other leave types	Available once per rolling 12-month period; requests coordinated with department leadership and HR
<b>Americans with Disabilities Act (ADA) Accommodation</b>	Varies	Unpaid	Qualified individuals with a disability	Reasonable accommodation provided through the interactive process to enable performance of essential job functions
<b>Workers' Compensation</b>	Varies	Paid; per statutory or plan provisions	All employees	Work-related injuries or illnesses must be reported to a manager or HR immediately

**Note:** Refer to the Employee Handbook for details on other paid leave or time off, including Jury Duty, Bereavement, and applicable state-specific leaves.

## CONTACT LIST

Provider	Contact Info	QR Code
<b>Total Rewards</b>	<a href="mailto:totalrewards@rymanhp.com">totalrewards@rymanhp.com</a>	
<b>The Hartford</b>	<a href="http://www.thehartford.com/mybenefits">www.thehartford.com/mybenefits</a> 888-301-5615	
<b>Alight</b>	<a href="http://www.ybr.com/ryman">www.ybr.com/ryman</a> 888-438-9271	
<b>Benefit Showcase</b>	<a href="https://flimp.live/Ryman-Benefits">https://flimp.live/Ryman-Benefits</a>	



## FITNESS FOR DUTY TO RETURN FROM LEAVE CERTIFICATION

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An employee on medical leave due to their own serious health condition may not return to work without this release. Please provide the completed Fitness for Duty Certification Form to your manager and Total Rewards via email: [totalrewards@rymanhp.com](mailto:totalrewards@rymanhp.com). If you have any questions regarding the return-to-work process with Ryman Hospitality Properties, please discuss with your manager or contact us at [totalrewards@rymanhp.com](mailto:totalrewards@rymanhp.com).

TO: Health Care Provider

This form must be completed by you, as the employee's health care provider, before the employee can resume their job duties. Please use the following guidelines in completing this form:

- **Full, unrestricted duty** – the patient has no work restrictions and can return to his or her prior position.
- **Modified duty** – the patient has some work restrictions. Work restrictions must be specifically notated on pages 2 - 4 of this form.
- **Not released** – the patient is not released to return to work in any capacity.

**GINA PROVISION.** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

1. Employee Name: \_\_\_\_\_

2. Employee's Job Title: \_\_\_\_\_

3. Date of Examination: \_\_\_\_\_

4. Please indicate with a check mark the status of the employee's release for duty.

\_\_\_\_\_ Full, unrestricted duty effective \_\_\_\_\_.  
\_\_\_\_\_ Modified duty effective \_\_\_\_\_. (Please complete question 5.)  
\_\_\_\_\_ Not released for any type of duty.

5. If you are releasing the employee to modified duty, please complete the following:

a. Estimated date that employee will be able to return to full, unrestricted duty: \_\_\_\_\_.

b. Date of your next medical evaluation of the employee: \_\_\_\_\_.

c. Indicate the exact work restrictions which apply to the employee at this time on the chart below. Please use additional sheets of paper if needed.

**Complete this section if the employee is being released to modified duty.**

<b>PHYSICAL EXAMINATIONS</b>	<b>FULL UNRESTRICTED DUTY</b>	<b>MODIFIED DUTY (please specify)</b>	<b>NOT RELEASED</b>
Sedentary Lifting 0 to 10 pounds			
Light-Lifting 10 to 20 pounds			
Moderate-Lifting 20 to 50 pounds			
Heavy-Lifting 50 to 100 pounds			
Pulling/Pushing, Carrying			
Reaching or working above shoulder			
Walking (hrs)			
Standing (hrs)			
Sitting (hrs)			
Stooping (hrs)			
Kneeling (hrs)			
Repeated Bending (hrs)			
Climbing (hrs)			
Operating a motor vehicle, powered industrial truck, forklift, etc.			
Number of hours worked (per day or week)			
Finger Manipulation (typing)			
Pain (frequency, degree, signs)			
Other:			
<b>Behavioral Evaluation</b>	<b>FULL UNRESTRICTED DUTY</b>	<b>MODIFIED DUTY (please specify)</b>	<b>NOT RELEASED</b>
Understanding			
Remembering			
Sustained concentration			
Follow-through on instructions			
Decision making			
Receiving supervision			
Relating to co-workers			

6. Other restrictions, considerations or notes

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I certify that the above information is true and correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Health Care Provider

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Type of Practice

\_\_\_\_\_  
License No.

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

**Please provide a copy of this form to the employee and their employer via email:**  
[totalrewards@rymanhp.com](mailto:totalrewards@rymanhp.com)