Pre-Birth CFRA Election Form

By signing this form, I understand that:

- I have not yet given birth;
- my qualifying healthcare provider has determined that, due to pregnancy, a continuation of leave is medically necessary;
- I have exhausted all available leave protections under California Pregnancy Disability Leave (PDL) and Family and Medical Leave Act (FMLA);
- in exhausting PDL and FMLA, my leave of absence will otherwise default to an accommodation under the Fair Employment and Housing Act/Pregnant Worker's Fairness Act (FEHA/PWFA), which is subject to COBRA billing rates for health insurance;
- as a reasonable accommodation, I am eligible for and have been offered a California Family Rights Act (CFRA) leave of absence which mandates employee premium-only billing for my health insurance. If I elect CFRA leave, the County will continue my contribution towards the health insurance premium;
- should I elect to utilize CFRA leave as a pre-birth accommodation:
    a. this leave will be deducted from my CFRA bank, which is limited to 12 weeks of leave per "rolling" 12-month period and includes, but is not limited to, use for CFRA bonding and CFRA health;
    b. my election will expire when one (1) of the following actions occur (whichever occurs first):
        i. my current leave period expires,
        ii. I am released to return to work,
        iii. my child is born, or
        iv. I have exhausted all CFRA leave available
- I must complete this election form any time my pre-birth disability leave is extended;
- if I wish to utilize CFRA leave after birth, I must submit a written request for bonding, regardless of my disability status.

Employee Election

☐	I request that my leave of absence **continue under FEHA/PWFA** and do not elect to use CFRA. I understand that by choosing this option, my health insurance, if administered through the County of Fresno, is subject to COBRA billing rates. Additionally, I understand that my leave will not be deducted from my CFRA bank.
☐	I request that my leave of absence be **transitioned to CFRA health** as a reasonable accommodation. I understand that by choosing this option, my health insurance, if administered through the County of Fresno, is subject to premium-only billing rates until CFRA protections are exhausted. Additionally, I understand that this leave will be deducted from my CFRA bank.

Employee Acknowledgment

By signing below, I certify that I understand the information provided on this form and that my election is irrevocable and will be effective for the duration of my current leave period.

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Employee Signature/Date