Leave of Absence

Important

Please contact Benefits Administration at (800) 716-2455, option 3, for assistance in completing the information contained within this packet.

All medical records and forms should be submitted with the bar-coded Medical Records Fax Cover Sheet (InSite > Human Systems Express > Associate Information > Medical Records Fax Cover Sheet). Please submit all medical records and forms with bar-coded Medical records Fax Cover Sheet to:

(252) 293-9085 (if faxing within BB&T)
(866) 923-8338 (if faxing from outside BB&T)
Instructions for Processing a Leave of Absence (LOA) and/or Family Medical Leave Act (FMLA) Leave

Please read the following instructions and complete all of the necessary paperwork/procedures accordingly. Please Note: Associates scheduled 19 hours or less are not entitled to short-term absence days.

1. The associate should complete the Request for Leave of Absence process through Workday prior to the anticipated leave. If the leave of absence process was not completed by the associate, the manager MUST complete the Leave of Absence process through Workday. This process should include the associate's last day worked; first day of leave; estimated last day of leave and leave type. Failure to complete this process in a timely manner may result in overpayment to the associate.

2. The manager or associate should print a copy of the appropriate Leave of Absence packet. Benefits Administration can provide guidance to the manager or associate in completing the appropriate documentation. The associate should be given the Certification for Serious Injury or Illness of a Current Servicemember for Military Family Leave, FMLA Poster and LOA/FMLA Certification. Benefits Administration will send the associate his/her FMLA Notice of Rights and Responsibilities. The associate should retain the FMLA Notice of Eligibility and Rights and Responsibilities and FMLA Poster for his/her records. The Certification for Serious Injury or Illness of a Current Servicemember for Military Family Leave must be completed by the attending physician. It is important that the Certification for Serious Injury or Illness of a Current Servicemember for Military Family Leave and the LOA/FMLA Certification be faxed in with a barcoded Medical Records Fax Cover Sheet to (252) 293-9085 (if faxing within BB&T) or (866) 923-8338 (if faxing from outside of BB&T) upon completion. Information provided on the Certification for Serious Injury or Illness of a Current Servicemember for Military Family Leave will determine the length of time the leave is approved and for which an associate will be paid during the leave of absence.

3. Upon receipt of the Certification for Serious Injury or Illness of a Current Servicemember for Military Family Leave and other forms, Benefits Administration will complete the Designation Notice and send it to the associate along with a general LOA cover letter which explains the associate's pay while on leave.

4. When the associate returns from leave of absence, the manager should process the return through the Workday System. It is important that the process be completed timely to ensure the associate is paid correctly.

Please Note: If there is a lapse in pay from BB&T, the associate is responsible for continuing payment of benefit premiums. (See HS Policy 7007 Families and Medical Leave and/or Military Family Leave).

All information regarding leaves of absence can be found in HS Policy 7002 Short-Term Absence Pay, 7003 Leaves of Absence, and 7007 Family and Medical Leave and/or Military Family Leave. If you have any questions concerning this information, please feel free to contact Benefits Administration at (800) 716-2455, option 3.
Documents and Procedures to Process Request for LOA and/or FMLA Leave

The following documents and/or procedures may be required for a LOA and/or FMLA request. Forms that need be sent to BB&T should be faxed with a bar-coded Medical Records Fax Cover Sheet to (252) 293-9085 (if faxing within BB&T), or (866) 923-8338 (if faxing outside of BB&T). If there are questions about any of these forms, please contact Benefits Administration at (800) 716-2455, option 3.

To be completed by Associate & Manager

1. Request for Leave of Absence through Workday - Required to formalize the request for a leave of absence for any reason.

To be completed by Benefits Administration

1. Notice of Eligibility and Rights & Responsibilities - Required to be provided to the associate by BB&T to document whether the associate is eligible for a FMLA qualified leave.

2. Designation Notice - Required to be provided to the associate by BB&T to document whether the absence is or is not FMLA qualified.

To be completed as designated below

1. Certification for Serious Injury or Illness of a Current Servicemember for Military Family Leave - Required for an associate's situation as a caregiver related to a current servicemember's injury or illness.

   (To be completed by the associate and/or the current servicemember for whom the associate is requesting leave and the health care provider.)

2. LOA/FMLA Certification - Required as confirmation that the associate was provided the FMLA Poster and Notice of Eligibility and Rights and Responsibilities.

   (To be completed by the associate.)
Certification of Health Care Provider for Serious Injury or Illness of a Current Servicemember for Military Family Leave

The “Certification for Serious Injury or Illness of a Current Servicemember for Military Family Leave” on the following pages requires completion by:

- Yourself and/or the current servicemember for whom you are requesting leave
- Servicemember’s health care provider

Notice to Provider of Health Care Information

The Genetic Information Non-discrimination 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 test, 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.

Important

Please contact Benefits Administration at (800) 716-2455, option 3, for assistance in completing the information contained within this packet.

All medical records and forms should be submitted with the bar-coded Medical Records Fax Cover Sheet (InSite > Human Systems Express > Associate Information > Medical Records Fax Cover Sheet). Please submit all medical records and forms with bar-coded Medical records Fax Cover Sheet to:

(252) 293-9085 (if faxing within BB&T)
(866) 923-8338 (if faxing from outside BB&T)
Notice to the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an associate seeking FMLA leave due to a serious injury or illness of a current servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the associate to provide more information than allowed under the FMLA regulations, 29 CFR 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of associates or associates’ family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.

SECTION I: For Completion by the ASSOCIATE and/or the CURRENT SERVICEMEMBER for whom the Associate Is Requesting Leave

INSTRUCTIONS to the ASSOCIATE or CURRENT SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an associate submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. 2613, 2614(c)(3). Failure to do so may result in a denial of an associate’s FMLA request. 29 CFR 825.310(f). The employer must give an associate at least 15 calendar days to return this form to the employer.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE (“DOD”) HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs (“VA”) health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125

INSTRUCTIONS to the HEALTH CARE PROVIDER: The associate listed on Page 2 has requested leave under the FMLA to care for a family member who is a current member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member’s active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a current servicemember’s serious injury or illness includes written documentation confirming that the servicemember’s injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember’s injury or illness existed before the beginning of the servicemember’s active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as “lifetime,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA coverage. Limit your responses to the servicemember’s condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 CFR 1635.3(f), or genetic services, as defined in 29 CFR 1635.3(e).
SECTION I: For Completion by the ASSOCIATE and/or the CURRENT SERVICEMEMBER for whom the Associate Is Requesting Leave:

(This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: ASSOCIATE INFORMATION
Name and Address of Employer (this is the employer of the associate requesting leave to care for the current servicemember):
Branch Banking & Trust (BB&T)

Name of Associate Requesting Leave to Care for the Current Servicemember:
___________________________________________________________

First    Middle    Last

Name of the Current Servicemember (for whom associate is requesting leave to care):
___________________________________________________________

First    Middle    Last

Relationship of Associate to the Current Servicemember:
Spouse☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin ☐

Part B: SERVICEMEMBER INFORMATION
(1) Is the Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?
Yes☐ No☐

If yes, please provide the servicemember’s military branch, rank and unit currently assigned to:

_______________________________________________________________________________________

Is the servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?
Yes☐ No☐

If yes, please provide the name of the medical treatment facility or unit:

_______________________________________________________________________________________

(2) Is the Servicemember on the Temporary Disability Retired List (TDRL)?
Yes☐ No☐

Part C: CARE TO BE PROVIDED TO THE SERVICEMEMBER

Describe the Care to Be Provided to the Current Servicemember and an Estimate of the Leave Needed to Provide the Care:

_______________________________________________________________________________________

_______________________________________________________________________________________
SECTION II: For Completion by a United States Department of Defense (“DOD”) Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs (“VA”) health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).

(Please ensure that Section I above has been completed before completing this section. Please be sure to sign the form on the last page.)

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider’s Name and Business Address:
____________________________________________________________________________________________

Type of Practice/Medical Specialty: ______________________________________________________________

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider, or (5) a health care provider as defined in 29 CFR 825.125:
_____________________________________________________________________

Telephone: (  ) _____________ Fax: (     ) ______________ Email: ___________________________________

PART B: MEDICAL STATUS

(1) The current Servicemember’s medical condition is classified as (Check One of the Appropriate Boxes):

☐ (VSI) Very Seriously Ill/Injured – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ (SI) Seriously Ill/Injured – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ OTHER Ill/Injured – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member’s office, grade, rank, or rating.

☐ NONE OF THE ABOVE (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a “serious health condition” under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.)

(2) Is the current Servicemember being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? Yes ☐ No ☐

(3) Approximate date condition commenced: _______________________________________________

(4) Probable duration of condition and/or need for care: ______________________________________

Page 3 CONTINUED ON NEXT PAGE Form WH-385 Revised May 2015
(5) Is the servicemember undergoing medical treatment, recuperation, or therapy for this condition? Yes ☐ No ☐

If yes, please describe medical treatment, recuperation or therapy:

____________________________________

PART C: SERVICEMEMBER’S NEED FOR CARE BY FAMILY MEMBER

(1) Will the servicemember need care for a single continuous period of time, including any time for treatment and recovery? Yes ☐ No ☐

If yes, estimate the beginning and ending dates for this period of time: ________________________________

(2) Will the servicemember require periodic follow-up treatment appointments? Yes ☐ No ☐

If yes, estimate the treatment schedule: __________________________________________

(3) Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments? Yes ☐ No ☐

(4) Is there a medical necessity for the servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? Yes ☐ No ☐

If yes, please estimate the frequency and duration of the periodic care:

____________________________________

____________________________________

____________________________________

Signature of Health Care Provider: ___________________________ Date: ___________________________

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.
LOA / FMLA Certification

The associate should receive information that explains the provision of a Leave of Absence and the Family Medical Leave Act (FMLA). Once the associate has received that information, he/she should sign below to acknowledge receipt.

Associates should complete this form if they are taking a leave of absence, requesting intermittent leave, or requesting FMLA (for any period of time).

The signature below certifies that I have received the FMLA Poster and the Notice of Eligibility and Rights and Responsibilities, and that I have read and fully understand the enclosed leave of absence terms and instructions.

_________________________________________    _________________
Associate’s Signature                           Date

_________________________________________    ______________________
Associate’s Name (Printed)                      B/C/D Number

Important

This completed form should be submitted with the bar-coded Medical Records Fax Cover Sheet (InSite > Human Systems Express > Associate Information > Medical Records Fax Cover Sheet). Please submit all medical records and forms with bar-coded Medical records Fax Cover Sheet to:

(252) 293-9085 (if faxing within BB&T)
(866) 923-8338 (if faxing from outside BB&T)

Please contact Benefits Administration at (800) 716-2455, option 3, for assistance in completing the information contained within this packet.

Benefit-Related Items to Consider

- Paying for Benefits or 401(k) Loans While On Leave: Your benefits premiums and 401(k) loan repayments, if applicable, will automatically be drafted from the same account that your BB&T pay was deposited. Your premiums will be drafted on the 15th of month and the last business day of each month. If the 15th of the month falls on a weekend or Holiday, your account will be drafted the business day prior.

- What happens if my premium draft is rejected due to non-sufficient funds? If your premium draft rejects, your benefits will be cancelled. Your next time opportunity to re-enroll for benefit coverage will be during annual enrollment for the next calendar year or when you return to active status. It will be your responsibility to request a benefit change by contacting Benefits Administration at (800) 716-2455, option 1, within 31 days of your return to active employment status.
Leave of Absence

“Place Associate on Leave” is used to put an associate on either a paid or unpaid leave of absence for more than 10 consecutive days. If the absence is for less than 10 consecutive days, use Time off. This process can be completed by the associate or their manager.

How do I get there?

Associates: To submit a Leave of Absence, click the Time Off icon and select Leave of Absence.

Managers: To complete a leave of absence for your direct reports, Click the Team Time Off icon on your Home Page and select Place On Leave.

Steps for the Leave of Absence Process:

Step 1: Request the Leave of Absence.

| Last Day of Work |  / /  | 6 |
| First Day of Leave |  / /  | 6 |
| Estimated Last Day of Leave |  / /  | 6 |
| Leave Type | *search* | (6) |

Enter the last day the associate worked before their leave started. *Note: if you key the first day of leave first then the system will auto fill this date.

Enter the first day of the associate’s leave.

Enter the estimated last day of leave. *Note: this is just an estimate and can be changed if the associate is not sure of their return date.

Click on the icon next to the text box to display a drop down list of leave types.

Click on medical or non-medical to find the appropriate leave type. *FMLA will be designated by Benefits Administration. If you have questions about which leave type to use contact Benefits Administration at 800-716-2455, option 3.*
Leave of Absence

Step 2: At this point, an associate will click the Submit button to route the Leave of Absence request to your manager. A manager will continue to Step 3.

Step 3: As a manager, you will see more information continued below:

- **Leave Impact**
  
  You do not have to complete anything in this section. The leave impact will populate depending on the leave type. This section shows you how the leave affects other areas. For example, if there is a check mark next to Payroll Effect, this means the associate will be unpaid during their leave.

- **Supporting Documents**

Step 4: Submit the Leave of Absence. It will route Benefits Administration for review and approval.

Step 5: Click the Done button when you are finished reviewing the request.
Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee’s child after birth, or placement for adoption or foster care;
- to care for the employee’s spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee’s job.

Military Family Leave Entitlements
Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service-member during a single 12-month period. A covered service-member is:
- (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, or is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

*The FMLA definitions of “serious injury or illness” for current servicemembers and veterans are distinct from the FMLA definition of “serious health condition”.

Benefits and Protections
During FMLA leave, the employer must maintain the employee’s health coverage under any “group health plan” on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

*Special hours of service eligibility requirements apply to airline flight crew employees.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee’s job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer’s operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer’s normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer’s normal call-in procedures.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees’ rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee’s leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.
Leave of Absence Resources and Information

Life Event Changes: Instructions for Changing Benefit Elections in Workday

LIFE EVENT CHANGES - IMPORTANT FACTS

The federal tax law says you cannot change your benefit elections during the calendar year unless you have a change in family or employment status. You have 31 days from the date of the Life Event to change your benefit coverage levels for:

- Marriage, divorce, or legal separation;
- Death of a spouse or dependent;
- Birth or adoption of a child of the associate;
- Leave of absence by associate or spouse;
- Termination or commencement of spouse's employment;
- Or, dependent fulfills or ceases to fulfill eligibility requirements.

Read on for step-by-step instructions to complete your Life Event Change through the Workday system (Note: You must follow all of the steps below in order to complete the change).

PART ONE: SUBMITTING YOUR LIFE EVENT CHANGE

1. From the InSite homepage, click on the Workday button on the left side of the page. Or, click the Workday button on the right side of the BBTBenefits.com homepage.
2. Click the Benefits icon.
3. Click “Benefits” under “Change.”
4. Click the arrow beside the Benefit Event Type field.
5. Choose your Life Event from the Benefit Event Type drop-down menu.
6. Click the calendar symbol beside Benefit Event Date.
7. Select the Benefit Event Date from the calendar.
8. Click “Submit.”
9. Your Life Event Change has been submitted in the Workday system. Click “Done.”
10. Submit your supporting documentation including the effective date coverage began or ended to

Leave of Absence: Serious Injury or Illness of a Current Servicemember for Military Family Leave
PART TWO: CHANGING YOUR BENEFIT ELECTIONS

Once any documentation you submitted has been reviewed and approved, a task will be generated in your Workday Inbox. Below are instructions for you to complete your Benefit Change task through the Workday system.

1. Access Workday.
2. Click the Inbox button in the upper-right corner of the screen.
3. Click on the Inbox task to change your benefits.
4. Make your necessary changes on the next 6 screens. *Note: Your personalized associate cost will be displayed across the top of your enrollment screens as you proceed.*
5. Read through the final page that reviews your changes (use the scroll bar to see the entire page.).
6. Check “I Agree” at the bottom of the page. This acts as your electronic signature.
7. Click “Submit.”
8. If you want to print a copy of your changes for your records, click “Print.”
9. When you are finished with the page, click “Done.”

Your premiums will be adjusted for the Life Event Change, and you will receive a pay adjustment notification if applicable.

Benefit-Related Items to Consider

Paying for Benefits or 401(k) Loans While On Leave

- Your benefits premiums and 401(k) loan repayments, if applicable, will automatically be drafted from the same account that your BB&T pay was deposited. Your premiums will be drafted on the 15th of month and the last business day of each month. If the 15th of the month falls on a weekend or Holiday, your account will be drafted the business day prior.
- You can print a copy of your current coverage elections and premiums on Workday.
- Depending on the timing of leave, your first premium draft may be adjusted based on your paid through date. You may contact Payroll at (800) 716-2455, option 2, for more details.

What happens if my premium draft is rejected due to non-sufficient funds?

- If your premium draft rejects, your benefits will be cancelled. Your next time opportunity to re-enroll for benefit coverage will be during annual enrollment for the next calendar year or when you return to active status. It will be your responsibility to request a benefit change by contacting Benefits Administration at (800) 716-2455, option 1, within 31 days of your return to active employment status.

Payroll-Related Items to Consider

- Name, Home Address, State and Federal Tax Withholding and Direct Deposit Account Changes - Make any necessary changes on Workday.

Other Items to Consider

- Employee Assistance Program (EAP) - BB&T’s EAP is a program designed to help you cope with a variety of life’s challenges such as emotional health issues, family and other personal problems, and work-life balance difficulties. The EAP is available at no cost to BB&T associates and members of their households. For more information about the EAP, you may contact MHN at members.mhn.com, access code: bbt, or at (800) 925-4525.
- John Hancock Long Term Care Insurance Policies - Set up alternate payment while on Leave of Absence. Contact Matt Lo (617) 572-1231 or Angela Robinson-Burke (617) 572-5313.
- Travelers Customer Service - Set up alternate payment while on Leave of Absence by calling (800) 842-5075.
- AFLAC - Set up alternate payment while on Leave of Absence by calling (800) 433-3036.