LEAVE REQUEST FORM

Section 1: Employee Information

Employee Name_____ Employee Number_____

Job Title_____ Department_____

Preferred Phone Number_____ Supervisor Name_____

Personal Email Address _____

Section 2: Reason for Leave

Please indicate the reason for your leave. If you are unsure, select the option(s) that best describe your situation.

- ☐ My own serious health condition (including pregnancy, illness, or injury)
  - ☐ Related to a reported Workers' Compensation injury
- ☐ Caring for a family member with a serious health condition
  - Name of family member:_____
  - Relationship to you:_____
- ☐ Caring for a family member on the day of the family member's surgery
  - Name of family member:_____
  - Relationship to you:_____
  - Date of Surgery:_____
- ☐ Birth and bonding with newborn child (for the birthing parent)
- ☐ Bonding with a new child within 12 months of birth or adoption
- ☐ Bonding with a foster child within 12 months of placement
- ☐ Military family leave (qualifying exigency)
- ☐ Safety Leave (domestic violence, sexual assault, stalking)
- ☐ Personal Leave of Absence (Note: A personal leave of absence of more than 30 days may impact benefits)

Section 3: Leave Details

Anticipated Start Date:_____

Anticipated End Date:_____

Expected Return to Work Date:_____

Will the leave be taken intermittently (for example, a few days or hours at a time)?

◯ Yes ◯ No

If yes, please describe the anticipated intermittent leave schedule (including specific dates and times, if known):_____

Section 4 (if applicable): Short-Term Disability (STD) Salary Continuation*

If your leave is due to **your own serious health condition** or **to care for a dependent child with a serious health condition**, you may be eligible for Short-Term Disability (STD) Salary Continuation benefits. STD provides wage replacement during an approved leave for qualifying reasons. For details on what qualifies as a serious health condition and eligibility requirements, please refer to the Short-Term Disability Salary Continuation Plan on Stream.

Would you like to apply for Short-Term Disability Salary Continuation benefits?

◯ Yes, I want to apply for Short-Term Disability.

◯ No, I do not want to apply for Short-Term Disability at this time.

This benefit applies to full-time, United States employees of ALLETE Clean Energy, ALLETE, Inc., and Minnesota Power who are regularly scheduled to work an average of at least 40 hours per week, excluding: (1) all ALLETE Clean Energy Operating Site employees; and (2) all union employees represented by IBEW LOCAL 1593. Employees excluded from this plan, as well as employees of ALLETE Renewable Resources, Inc., should refer to the applicable Short-Term Disability Certificate on Stream for coverage and eligibility details.

Acknowledgement

By signing below, I certify that the information provided is true and complete to the best of my knowledge. I understand that I may be required to provide additional documentation to support my request and that failure to do so may delay or impact my eligibility for leave and/or benefits.

_____ _____

Employee Signature Date

Instructions for Submission

- Submit this form to Human Resources at hrabsencemanagement@allete.com.
- For foreseeable leave, submit at least **30 days in advance**. For unforeseeable leave, submit as soon as practicable.
- Human Resources will contact you regarding next steps and any required documentation.

Note:

This form is intended to help Human Resources determine which leave(s) and/or wage replacement benefits you may be eligible for, including FMLA, Minnesota Paid Family & Medical Leave, Day of Surgery Leave (for a relative), Paid Parental Leave, and Short-Term Disability (STD) Salary Continuation. HR will review your request and guide you through the appropriate process.

References on Stream:

- Time-Off Addendum (located at the back of the Employee Handbook)
- Minnesota Paid Family & Medical Leave Policy
- ALLETE Short-Term Disability Salary Continuation Policy