



## Global Medical Response Employee Foundation

### Application for Assistance

#### **Purpose:**

The purpose of this program is to provide financial assistance to our full and part-time employees in times of severe financial need/hardship due to catastrophic events beyond their control and where all other avenues of support have been exhausted. Qualifying events are determined by the Foundation's bylaws and applicable non-profit organization tax law. The AMR Employee Charitable Foundation may provide grant assistance to AMR employees who meet eligibility requirements as outlined below.

#### **Donations:**

The Foundation may accept donations from employees, non-employees, and other organizations. Employees of AMR and their subsidiaries may make donations in the form of 1) cash, 2) payroll deduction, or 3) Paid Time Off (PTO).

#### **Participant Eligibility:**

Eligible employees are those who meet the *Employment Classifications* policy for full and part-time classifications and are employed within AMR and its subsidiary companies. Eligibility to participate in the National Employee Relief Fund begins upon the first day of employment.

Participant eligibility includes both donation of paid time off/vacation and receiving the employee relief donation subject to the criteria and administration guidelines set forth below.

Before an employee may request relief from the Foundation, they must utilize all but eighty (80) hours of their PTO balance.

#### **Qualifying Event Criteria (please check all that apply):**

The following reflect potential qualifying catastrophic events that may create a financial hardship and the maximum relief assistance available per event. Note that not all such events will meet the criteria for relief assistance. Any individual item, or combination of items below, has a maximum of \$10,000.

Death of employee or relative

Uncontrollable loss of income resulting in potential eviction or loss of residence/home

Non-insured emergency or traumatic medical expenses;

Hospitalization or incapacitation of employee or relative, thus resulting in employee's inability to work for greater than seven- (7) consecutive days; or

Complete home loss due to fire or other natural cause.



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#### **Frequency of Requests and Limits of Relief Dollars Available:**

Eligible employees may be approved to receive total relief payments not to exceed \$10,000 per qualifying event in any 12 month period. Employees may make more than one request for relief for a qualifying event in a 12 month period, subject to qualifying criteria and the approval of the Charitable Foundation Committee.

Eligible employees may request consideration for the Employee Relief Fund by completing and submitting the Foundation Request for Assistance form (see below). The form must be received within forty five (45) business days of the qualifying event. The Charitable Foundation Committee Chairperson will notify and forward a copy of the request to the respective HR leader within 16 business hours upon receipt of the request. The HR leader will verify with Payroll that the employee has utilized all but 80 hours of their own PTO or Vacation and work with the Committee Chairperson to answer any questions and provide any requested documentation related to the request.

Requests may also be submitted on an employee's behalf by HR or the local operation's Manager, Director, CEO, VP or SVP.

The Committee will review the request and provide a relief dispensation decision to the HR Leader within ten (10) business days. The HR leader is responsible for notifying the employee, Payroll and the employee's direct leader of the decision.

Because the need for funds are due to an urgent matter, a manual payroll check will be issued or wire sent within two (2) business days following receipt of the verified emergency relief approval and may be sent via overnight mail delivery to the employee's home.

#### **Denial and Appeal:**

If the employee's request is denied, the Committee Chairperson will notify the HR leader and send a formal denial letter to the employee. The employee may appeal the request denial within three (3) business days of date of denial. Appeals will be reviewed by Foundation officers and a decision on the appeal rendered within three (3) business days of receipt.

All documentation including the Foundation Request for Assistance form, PTO Donation forms and written decision will be kept in a secure file by the HR leader for a minimum of one (1) year from date of request.

The National Employee Relief Fund can be discontinued by the Company at any time, with or without notice.

Employees wishing to donate PTO must fill out the PTO Donation form and forward it to their respective HR leader or directly to the Foundation. Individuals making donations to the Foundation will receive an annual letter from the Foundation indicating the total amount of their donation for the calendar year for tax purposes. Donations of PTO hours will be totaled at the straight-time hourly base rate of the donating employee. Employees wishing to donate to the Foundation via payroll deduction should complete the payroll deduction authorization form and submit to their HR leader.



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|                           |   |
|---------------------------|---|
| Employee Name:            |   |
| SSN# or Employee ID#:     | Phone#:   |
| Employee Mailing Address: |   |
| City:                     | State/Zip:  |
| Alternate Phone:          | Email:  |
| Job Title:                | Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> |
| Work Location:            |   |
| Local HR Representative:  | HR Phone:   |
| Date of Event:            | Date of Request:  |

**EVENT SUMMARY:** Please provide a summary of the catastrophic event and the financial losses associated with the event. Attach additional sheets if necessary. Include all supporting documentation.

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**INSURANCE COVERAGE:**

Do you have insurance to cover any portion of the loss or event? Yes  No

Type of insurance: \_\_\_\_\_ (life, homeowners, medical, workers comp, etc.)

Amount Covered: \$ \_\_\_\_\_ Amount Not Covered: \$ \_\_\_\_\_

|                 |
|-----------------|
| Please Explain: |
|                 |
|                 |

**EMPLOYMENT:**

Number of days missed due to the event \_\_\_\_\_ Number of days missed unpaid \_\_\_\_\_

If a medical event, do you have short term disability insurance to cover unpaid time? Yes  No



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**OUT OF POCKET EXPENSES:**

**Please list all uncovered expenses associated with the event and provide supporting documentation/receipts/invoices.**

|   |    |
|---|----|
| Non-Insured medical expenses excluding co-pays & deductibles: | \$ |
| Temporary Housing:  | \$ |
| Car Rental Expenses:  | \$ |
| Funeral/Burial Expenses:                                      | \$ |
| Travel Expenses:  | \$ |
| Other:  | \$ |
| Other:  | \$ |

**Have you exhausted all personal sources of income or savings that can help you cover the losses to include, but not limited to, reducing unnecessary household expenses, 401K disbursements/loans and family assistance?**

Yes  No

|                 |
|-----------------|
| Please Explain: |
|                 |
|                 |

**Have you applied for available relief programs from local, state and/or federal agencies?**

Yes  No

|                 |
|-----------------|
| Please Explain: |
|                 |
|                 |



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**DISCLOSURE OF FINANCIAL INFORMATION:**

**Total Monthly Income- all Sources**

- Employee Salary
- Spouse Salary
- Child Support/Alimony
- Rental/Investment Income
- Other
- TOTAL**

**\$ Monthly Income:**

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

**Total Monthly Expenses**

- Mortgage/Rent
- Utilities
- Gasoline/Transportation
- Credit Cards
- Bank/Car Loan Payments
- Food
- Medical/Pharmacy
- Other
- TOTAL**

**\$ Monthly Expenses:**

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

I certify that all information provided above in this form is true and complete. I understand that any false information or omission may disqualify me from further consideration for relief payments.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**SUBMISSION OPTIONS:**

- **Email** completed form to:  
charitablefoundation@amr.net
- **Mail** completed form to:  
GMR Employee Foundation, Human Resources  
6363 S. Fiddlers Green Cir., 14<sup>th</sup> Floor  
Greenwood Village, CO 80111
- **Return** completed form to:  
Local HR Representative for submission



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*Section below to be completed by the Foundation Committee*

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| <b>Date Received:</b>  |
| <b>Any relationship between recipient and officers, directors of key employees of or substantial contributors to the EVHC Charitable Foundation? (circle):</b> Yes    No |
| <b>Supporting documentation provided (circle):</b> Yes    No <b>Qualifying Event (circle):</b> Yes    No   |
| <b>Comments:</b>   |
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