EXHIBIT 1
DISQUALIFICATION OR WITHDRAWAL FORM

Employee's Name_____

Social Security Number _____

Seniority Date _____

Effective_____the above named employee
(Date)

has been disqualified / has withdrawn / rejected (Circle One)

From Vacancy Number _____

Job _____
(Number and Title)

At _____
(District / Plant / Department – Location)

Qualifying period for employee began _____
(Date)

Reason for disqualification or withdrawal:

_____

Employee returned to the last qualified job listed below on _____
(Date)

Job Number and Title _____

District/Plant/Department _____

Location and Section _____

_____ _____
Employee's Signature Supervisor's Signature

_____ _____
Date Date

ORIGINAL TO LABOR RELATIONS
COPY TO UNION OFFICE

NIPSCO

Exhibit 2
Sick Leave Claim Form

NORTHERN INDIANA PUBLIC SERVICE COMPANY
SICK LEAVE CLAIM FORM
TO BE COMPLETED BY EMPLOYEE (Incomplete forms will be returned to the employee and no benefits will be paid until a completed form is received

Name:	Home Phone:	Hire Date	Employee ID Number
Job Classification:	Work Phone	Location/Dept	
Last Day Worked:	First Day of Sick Leave	Returned to Work on	
Illness O Injury O	Is Illness/injury a result of your occupation?	No O Yes O	

NATURE OF ILLNESS/INJURY (If injury, describe when, where and how it occurred)

I affirm that the information contained on this form is true and correct.

Employee's Signature: _____ Date: _____

TO BE COMPLETED BY PHYSICIAN (Incomplete forms will be returned to the employee and no benefits will be paid until a completed form is received)

IS THIS EMPLOYEE UNABLE TO WORK DUE TO THIS ILLNESS OR INJURY: No O Yes O

DIAGNOSIS OR NATURE OF ILLNESS/INJURY:

DATE ILLNESS/INJURY BEGAN	DATE(S) EXAMINED FOR THIS CLAIM

In your medical opinion, did the illness/injury or symptoms diagnosed from this examination prevent the employee from working beginning with the first day of sick leave, shown in the box above, prior to this examination? No ☐ Yes ☐

Yes ☐ Comments

Was Hospitalization Required? No O Yes O	Was Medication Prescribed? No O Yes O
If yes, Admittance date _____	Was surgery required: No O Yes O
Discharge date:	If yes, date of surgery

O THE EMPLOYEE IS NOT RELEASED TO RETURN TO WORK ESTIMATED DATE OF RETURN:

O THE EMPLOYEE IS RELEASED TO RETURN TO WORK RETURN TO WORK DATE:

LIST LIMITATIONS, if any *(No Diagnostic Information)*

Expected Duration of Limitations:

If Re-exam is necessary, on what date?

As a result of your authorization of absence from work, employer may incur a liability for Sick Leave Benefits. This form may only be signed by a Licensed Physician, Licensed Nurse Practitioner, Physician Assistant, or Oral Surgeon

Signature _____ Specialty/Practice Print Name _____

Date Signed Phone:

110546 Rev. 8-2011 Retention 10 Years SEND ORIGINAL TO PAYROLL ATTN: LEAVE COORDINATOR

EXIHIBIT 3
MEDICAL RELEASE FORM

Dear Dr._____:

To qualify for Sick Leave Benefits, employees of NORTHERN INDIANA PUBLIC SERVICE COMPANY must have their private physician substantiate that they are physically unable to perform their assigned work.

My claim for benefits has been withheld pending further investigation and analysis. I would appreciate if you would supply the Chief Company Doctor for NORTHERN INDIANA PUBLIC SERVICE COMPANY with copies of my medical records or a summary report noting the day or days that I was seen by you, the factors, treatment, test results, and diagnosis concerning this specific illness/injury.

I hereby authorize Dr._____to release to the Chief Company Doctor for NORTHERN INDIANA PUBLIC SERVICE COMPANY all medical records required to process my claim for Sick Leave Benefits which relate to the illness/injury for which I was treated by you for the following period:

Begin Date:_____ To: _____

Thank you for your cooperation.

X_____ X_____
Employee Signature Witness

X_____ LABOR RELATIONS Date Signed

ALL MEDICAL INFORMATION SHOULD BE SENT DIRECTLY TO
CHIEF COMPANY DOCTOR:
Sylvia McKnight, M.D., CONCENTRA
6423 Columbia Ave; Hammond, IN 46320
Phone: (219) 937-3632 Fax: (219) 937-4715

Please send a COPY TO THE EMPLOYEE:
Name: Employee Name
Address: Employee Address

Exhibit 4
Wellness Day Form
NORTHERN INDIANA PUBLIC SERVICE COMPANY
NIPSCO UNION "WELLNESS DAY" AUTHORIZATION FORM
TO BE COMPLETED BY EMPLOYEE:

Employee Name: _____
Employee ID: _____
Employee Signature: _____ Date: _____

TO BE COMPLETED BY ATTENDING PHYSICIAN OR PROVIDER:

Date of **Wellness Exam/Preventive Screening***: _____
Physician or Provider Name: _____
Physician or Provider Address: _____
Telephone Number: _____
Authorized Signature: _____

Attending Physician or Provider: "Wellness Day" shall cover preventive medical visits, tests and procedures only.

Employee:

- NIPSCO Union employees are eligible for one wellness day per calendar year. The wellness day will be equal to one of your regularly scheduled days. The day cannot be used in increments and must be used as a single day.
- Wellness Day must be scheduled in advance with supervisor. Youmust return this form to supervisor immediately upon returning to work.
- Time off that does not meet these eligibility requirements will result in the day off being an unpaid PB day (personal business day).
- Applicable WorkBrain time code that you must enter: ***Wellness-BU***
- Time off does not guarantee that your claim will be covered at 100%. If you are NOT enrolled in a NiSource medical plan, you are able to utilize this wellness day but will NOT receive any coverage for any services.

If you are enrolled in the NIPSCO PPO or HDPPO plan, all in network preventive medical screenings are covered at 100%. Please contact Anthem at 1-800-228-2891 if you have any questions related to coverage for specific services.

Supervisor:

- Supervisor should retain this form in employee file for remaining calendar year.
- Supervisor should confirm that the wellness time entered into WorkBrain reflects a normally scheduled standard day and employee meets the eligibility requirements as noted above.