COVID-19 VACCINATION MEDICAL (INCLUDING PREGNANCY-RELATED) ACCOMMODATION QUESTIONNAIRE (FOR USE OUTSIDE OF CALIFORNIA)

Citi is committed to providing equal employment opportunities without regard to any protected status and a work environment that is free of unlawful harassment, discrimination, and retaliation. As such, Citi is committed to complying with all laws protecting individuals with disabilities or medical conditions. When requested, Citi will provide a reasonable accommodation for any known medical condition (including pregnancy-related) or disability of a qualified individual which prevents an employee/applicant from receiving a COVID-19 vaccine, provided the requested accommodation is reasonable and does not create an undue hardship for Citi and/or pose a direct threat to the health or safety of others and/or to the requesting individual.

To seek a reasonable accommodation related to Citi's COVID-19 Vaccination requirement due to a medical reason (including pregnancy-related), please complete the following steps:

(1) Call the administrator, MetLife at 1-888-830-7380 and follow the prompts to initiate your accommodation request for their review. Complete Part 1 of this form.
(2) Provide this form to your healthcare provider and have them complete Part 2. If you must forward this form to your personal email address or another address external to Citi, please enter "(Secure)" in the subject line. This will encrypt the email and allow it to exit through Citi's information security firewall.
(3) Once your healthcare provider has completed Part 2, he/she must return the fully completed form directly to MetLife by global fax to 1-800-230-9531 or email to bloomfieldmail@metlife.com.

Citi will use this information to engage in an interactive process to determine whether you are eligible for the requested accommodation and if so, to determine reasonable accommodations which would enable you to perform the essential functions of your position without posing an undue hardship or a direct threat of harm to you or others. If you refuse to provide the information sought, your refusal may impact Citi's ability to adequately understand your request or to effectively engage in the interactive process to identify possible accommodations.

Medical accommodations for the COVID-19 vaccine generally only will be considered if you provide written documentation by a licensed, treating medical provider of one of the following:

1. Documented severe or immediate-type allergic reaction to all available COVID-19 vaccines or an ingredient of all available COVID-19 vaccines, **or**
2. A documented medical condition or circumstance that makes immunization unsafe for you, including the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with COVID-19 vaccines; **or**
3. Other medical or pregnancy-related reasons that makes immunization contraindicated or unsafe for you.

PART 1: TO BE COMPLETED BY EMPLOYEE/APPLICANT

Name: _____

Employment Status (check one): □ Applicant □ Employee

GEID _____

MetLife Claim Number: _____

Job Title: _____

Work location: _____

Manager name: _____

I understand that Citi is requiring that U.S. employees comply with its mandatory vaccination policy. I am requesting an accommodation allowing me to remain/become actively employed by Citi even though I am not fully vaccinated against COVID-19 because of a medical condition (including pregnancy-related) or disability concern. If my medical condition or underlying need for an accommodation changes and I am able to receive the vaccination in the future, I understand I must notify Human Resources immediately.

I acknowledge that the information that I am submitting in support of my request for an accommodation is complete and accurate to the best of my knowledge. I have read and fully understand the above information on this form.

_____ _____

Employee/Applicant Name Date

PART 2: TO BE COMPLETED BY THE HEALTHCARE PROVIDER[1]

The individual's Healthcare Provider should review the following information and respond fully to the questions below:

At this time, Citi requires all of its U.S. employees to receive a COVID-19 vaccination as a condition of employment or continuation of assignment. Employee/applicant has requested an exemption/accommodation due to a medical condition (including pregnancy-related) or disability concern and asks to be permitted to work for Citi even though they are unvaccinated.

We ask that you complete this form so that we can assess the employee's/applicant's request and determine whether we can reasonably accommodate the individual without posing a significant risk of substantial harm to the health or safety of the individual or others. Please only provide information related to the condition(s) that support or are related to the employee's/applicant's request for accommodation not to receive the COVID-19 vaccine.

Based on my medical opinion, the above person should not be immunized for COVID-19 for the following reasons (check all that apply):

☐ **Documented severe or immediate-type allergic reaction to all available COVID-19 vaccines or an ingredient of all available COVID-19 vaccines.**

[1] **A Note to Health Care Providers Assisting Our Employees/Applicants:**
The Genetic Information Nondiscrimination 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, you should not gather or 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 tests, 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.

If checked, please answer the following questions:

1. List vaccine ingredients to which the individual is allergic:

   _____

2. Please provide details regarding the documented severe or immediate-type allergic reaction:

   _____

3. Is there a COVID-19 vaccine currently approved in the United States (including those approved through the Emergency Use Authorization process) that the individual could safely receive?

   Yes___
   No____

   If yes, please indicate which vaccine _____.

4. If the individual's condition that precludes the individual from receiving a COVID-19 vaccine is temporary, state how long the limitation is expected to continue or if it is indefinite:

   _____ Days/Weeks/Months
   _____ Individual's condition is indefinite.

☐ **The individual's medical condition (including pregnancy-related) or medical circumstances are such that immunization with any of the COVID-19 vaccines is not considered safe. Please indicate the specific nature and probably duration of the medical condition or circumstances that contraindicate immunization with any COVID-19 vaccine.**

If checked, please answer the following questions:

1. Does the individual have a physical or mental condition that precludes the individual from receiving one of the COVID-19 vaccines?

   Yes___
   No____

   If yes, please specify the condition:
   _____

2. Is there a COVID-19 vaccine currently approved in the United States (including those approved through the Emergency Use Authorization process) that the individual could safely receive?

   If yes, please indicate which vaccine:

_____

3. Does the individual's physical or mental condition that precludes the individual from receiving any of the available COVID-19 vaccines substantially limit one or more major life activities? (In this context, "substantially limit" means to make achievement of the major life activity difficult. Whether achievement of the major life activity is "difficult" is an individualized assessment which may consider what most people in the general population can perform with little or no difficulty, what members of the individual's peer group can perform with little or no difficulty, and/or what the individual would be able to perform with little or no difficulty in the absence of disability. Please answer this question without consideration of any mitigating measures.)

   Yes___
   No____

   If yes, please specify the major life activity:
   _____

4. If the individual's condition that precludes the individual from receiving a COVID-19 vaccine is temporary, please state how long the limitation is expected to continue or if it is indefinite:

   _____ Days/Weeks/Months
   _____ Individual's condition is indefinite.

☐**Other medical or pregnancy-related reason. Please provide detailed information in a separate narrative that describes your medical opinion why an exemption/accommodation from Citi's mandatory vaccination policy is needed.**

1. Does the individual have a physical or mental condition that precludes the individual from receiving one of the COVID-19 vaccines?
   Yes___
   No____

If yes, please specify the condition: _____

2. Is there a COVID-19 vaccine currently approved in the United States (including those approved through the Emergency Use Authorization process) that the individual could safely receive? If yes, please indicate which vaccine _____.

3. Does the individual's physical or mental condition that precludes the individual from receiving any of the available COVID-19 vaccines substantially limit one or more major life activities? (In this context, "substantially limit" means to make achievement of the major life activity difficult. Whether achievement of the major life activity is "difficult" is an individualized assessment which may consider what most people in the general population can perform with little or no difficulty, what members of the individual's peer group can

perform with little or no difficulty, and/or what the individual would be able to perform with little or no difficulty in the absence of disability. Please answer this question without consideration of any mitigating measures.)

Yes___
No____

If yes, please specify the major life activity: _____

4. If the individual's condition that precludes the individual from receiving a COVID-19 vaccine is temporary, state how long the limitation is expected to continue:

_____ Days/Weeks/Months
_____ Individual's condition is indefinite.

_____ _____
Healthcare Provider's Signature **Date**

_____ _____
Area of Practice/Specialty **Phone Number**