FACULTY SHORT TERM DISABILITY PAY ELECTION FORM

SECTION ONE: (Please Print)

Employee Name: _____ T-_____

Office Number: _____ Mobile Phone Number:_____

Union Designation: _____ Personal Email Address: _____

SECTION TWO:

STD Leave Start Date: _____ Anticipated Return Date: _____

☐ I acknowledge that I must continue to pay my share of health insurance premiums during my leave. If necessary, I will make arrangements with Human Resources for payment.

☐ I acknowledge that I will receive 100% of weekly earnings equal to one month at full pay for each year of service, up to a maximum of 25 weeks. The remaining months will be paid at 70% of weekly earnings, not to exceed an overall maximum duration of 25 weeks.

SECTION THREE:

SHORT-TERM DISABILITY DESIGNATION FOR SCHOOL OF DENTISTRY FACULTY ONLY

1. Do you want to use PTO Accruals for the **5-day elimination period**?

   YES _____ NO _____

2. Do you want to use PTO Accruals to get to 100% PAY once you have used 100% of your years of service limit?

   YES _____ NO _____

SECTION FOUR:

EMPLOYEE SIGNATURE: _____ DATE: _____

SUPERVISOR NAME: _____ SUPERVISOR SIGNATURE: _____

SUBMIT FORM

FAX: 313-993-1015 OR EMAIL: benefits@udmercy.edu