STAFF SHORT TERM DISABILITY PAY ELECTION FORM

SECTION ONE: (Please Print)

Employee Name: ______________________________________ T-___________________________________

Office Number: ____ Mobile 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 must exhaust all of my accrued SICK days (with an option to reserve 40 hours in my sick bank) and will receive 100% pay during the period of disability leave. Once these sick days are exhausted, I can request to use vacation/personal days in order to receive 100% pay during the period of disability leave. Once I have exhausted existing accruals, I will receive 70% of my pay for the duration of my disability leave up to a maximum combined leave of 25 weeks.

SECTION THREE:

SHORT-TERM DISABILITY DESIGNATION

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

   SICK______ VACATION______ PERSONAL BUSINESS_______

2. Do You want to reserve 40 hours of SICK in your bank? (In lieu of exhausting all) YES _____ NO _____

3. Do You want to use Accruals to get to 100% PAY? (Before going into 70% STD) YES _____ NO ______

   IF YES, Which Accruals? SICK_____ VACATION_____ PERSONAL BUSINESS_____ANY/ALL_____

SECTION FOUR:

EMPLOYEE SIGNATURE: ____ DATE: _________________________

SUPERVISOR NAME: ______________________________ SUPERVISOR SIGNATURE: __________________________

SUBMIT FORM

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