



**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](mailto:benefits@udmercy.edu)**