EMPLOYEE PAY ELECTION FORM
SHORT-TERM DISABILITY & FAMILY MEDICAL LEAVE

SECTION ONE: (Please Print)

Employee Name: ____________________________________ T-_________________________________

Office Phone: _________________________________ Contact Telephone No:____________________

Supervisor's Phone: ____________________________

SECTION TWO:

STD/FMLA Leave Start Date: ______________________ Anticipated Return Date: ________________

Intermittent Leave Dates: ____

Reduced Schedule: ____

☐ 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 FMLA time is unpaid. Employees must use accruals for pay to continue when utilizing FMLA leave in accordance with the University's FMLA policy.

SECTION THREE:

FMLA & SHORT-TERM DISABILITY DESIGNATION

Do You want to keep 5 Days of SICK in your bank? (In lieu of exhausting all) YES ______ NO ______

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

IF YES, Which Accurals? SICK_____ VACATION_____ PERSONAL BUSINESS_____ ANY/ALL_____

5 day Elimination Period: Which Accurals? SICK_____ VACATION_____ PERSONAL BUSINESS_____ ANY/ALL_____

FMLA ONLY DESIGNATION

Do You want to keep 5 Days of SICK in your bank? YES ______ NO ______

Do You want to use Accruals to get to 100% PAY? YES ______ NO ______

IF YES, Which Accurals? SICK_____ VACATION_____ PERSONAL BUSINESS_____ ANY/ALL_____

SECTION FOUR:

EMPLOYEE SIGNATURE: ____ DATE: ________________________

SUPERVISOR NAME: ____________________________ SUPERVISOR SIGNATURE: _________________________

SUBMIT FORM

FAX: 313-993-1015 OR EMAIL: HR@UDMERCY.EDU