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