Print Form

Workers' Compensation Benefit Election Form

As the result of an injury/illness on _____ , assuming this injury/illness arose out of and in the course of my employment, I am entitled to Workers' Compensation Benefits. I elect to:

1. ☐ **Supplement my Workers' Compensation Benefits with my accrued** (indicate the order to be used by marking the blanks with 1, 2 or 3)**:**

   ____ Sick Leave
   ____ Vacation Leave
   ____ Compensatory Time

OR

2. ☐ **To use only:**

   ○ Workers' Compensation Benefits
   ○ Sick Leave Benefits
   ○ Vacation Benefits
   ○ Compensatory Time

- I understand that any supplemental pay over and above my Workers' Compensation Benefit will be subject to all taxes (Federal, State, Social Security and Medicare) and Retirement deductions.
- I further understand that my accrued leave will be reduced by an amount in direct proportion to the amount of supplemental pay I receive.
- I understand that if I elect to ***not*** supplement my Workers' Compensation Benefits, I will ***not*** accrue sick leave or vacation during that time.
- I understand that if I am off the payroll for more than 30 calendar days, Merit step increases will be delayed by the number of days I am off the payroll and I will not accrue sick leave or vacation during that time.
- I understand my UNI wage will be reduced by an amount of the Workers' Compensation Benefit payments I receive from the insurance carrier. The reduction of the UNI paycheck may be during the month after I receive the Workers' Compensation Benefits check due to the timing of when UNI receives notification of the Workers' Compensation payments I have received from the insurance carrier.
- I understand that my total compensation (Workers' Compensation Benefits and UNI wages) for the time I am off because of my injury/illness will not exceed my regular salary through UNI.
- I understand that if I am not in pay status, I will lose all university benefits except health care coverage, which will continue for up to four (4) months. These four (4) months will run concurrently with my FMLA rights.

I have been informed of my rights to Workers' Compensation and understand that my selection, as marked, will remain unchanged for the duration of this work related injury or disease.

_____ _____
Print Name University ID

_____ _____
Signature Date

Please complete and return this form to Therese Callaghan (273-6164) in Human Resource Services, 027 Gilchrist, 0034.

Revised 11/2012