DECATUR ISD FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION (NO OFFSET—ENGLISH VERSION)

Name _____ **Employee number** _____

Position _____ **Department/Campus** _____

This employee is absent from duty because of a job-related illness or injury beginning on _____ *(date of first absence attributable to illness or injury)*. If eligible, workers' compensation insurance may begin paying a percentage of the employee's current wages on the eighth day of absence from duty if an extended absence is required.

_____ _____

District authorized signature Date

Employee choice:

I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I also understand that the district will continue to pay its contribution toward the cost of my group health insurance coverage (if applicable) as long as I am on **paid** leave and/or family and medical leave (FMLA). I further understand that I will be responsible for paying all health insurance premiums if I am on **unpaid** leave that is not FMLA leave. I choose the following option:

- ❑ I choose to use only _____ days of available paid leave at this time.
- ❑ I choose to use all available paid leave. I understand that I will not receive workers' compensation weekly income benefits until I have exhausted all of my paid leave or to the extent that paid leave does not equal my pre-illness or -injury wage.
- ❑ I choose **not** to use any available paid leave at this time. I understand that I will not receive any regular salary payments from _____ISD while receiving weekly income benefits under workers' compensation. No available paid leave will be deducted from my leave balance. I further understand that by selecting this option, I will receive only workers' compensation wage benefits for any absences resulting from my work-related illness or injury, unless and until I communicate to the district a change in my decision.

_____ _____

Employee signature Date

For Claims Reporting Purposes Only:	
For all employees: Amount of leave paid to employee: $ ____.__ Daily rate: $ _____ Period of payment: from___/___/___ through___/___/___ for ____ days **or** ____ weeks	*For hourly employees only:* Hourly rate: $____.___ Number of hours paid: _____