

ACCRUED TIME ELECTION OPTION

Employee: Please complete this form if you are off work for more than 3 days due to a work-related accident, illness, or injury.

Employee's Name: _____ SSN: XXX-XX _____

Date of Injury/Illness/Accident: _____ / _____ /20_____

Last Day Worked: _____ / _____ /20_____

I elect the following option (Initial only one):

_____ **Option 1:**

Receive a Workers' Compensation payment totaling two-thirds (2/3) of my average weekly wages. I **do not** want to supplement the remaining one-third (1/3) using any eligible and available accruals.

_____ **Option 2:**

Receive a Workers' Compensation payment totaling two-thirds (2/3) of my average weekly wages **PLUS** one-third (1/3) of gross basic wages using any eligible and available accruals after the appropriate tax deductions, benefit premium payments and retirement contributions are made.

Under Option 1, the following will apply:

- No contributions will be made to the Mandatory Retirement Plan, Supplemental Retirement Plan, Flexible Spending Plan, Health Savings Account and Qualified Transportation Program.
- The University will not make matching contributions to the Mandatory Retirement Plan.
- You must make payment arrangements directly with your Union for Union Dues, and other third parties as applicable for other payments, e.g. court ordered wage deductions.
- You must pay the same contribution rate to continue health benefits (medical, dental and/or vision) until you return to active duty and regular pay status. You will be billed by a third-party administrator and must make payments for your share of the premiums monthly. The University's obligations to maintain health benefits cease if you fail to pay your share of the premiums. For any billing questions, please contact Leave Administration at leaveadministration@uchicago.edu.

I have read and understand all my options as presented above. By signing this form, I authorize my department to make the appropriate entries to my attendance record in accordance with the option that I have chosen until I return to active work duty. I understand that I may change my election at any time by completing a new **Accrued Time Election Option** form. If you have questions concerning Workers' Compensation benefits, please contact Risk Management: WCclaim@uchicago.edu

Employee Signature: _____ Date: _____