Smyrna School District
Notification of Intent to Apply for Short Term Disability

YOU MUST CALL The Hartford Insurance Company at 1-877-484-9731 by the 15th day if you need to be out more than 30 consecutive calendar days (20-22 working days). Please complete this form if you intend to apply for Short Term Disability.

Employee Name: __________________________Empl ID: _______________

Phone number where you can be reached during this time: ___________________

Building: _________________________________Position: ___________________

Current balance - sick leave: ________

Current balance - vacation leave: ________
(where applicable)

First day Out: ______________

Projected date of return: ________________

If approved for a Short Term Disability by The Hartford Ins. Company:

Do you want to use your accumulated sick/vacation time in ¼ day increments to bring your salary to 100% while on short-term disability?

YES: ☐ (If yes, how many days do you wish to use) __________

NO: ☐

If not approved for a Short Term Disability by The Hartford, my time will continue to be charged to my sick/vacation balance.

____
Employee signature

____
Supervisor / Principal Signature

____
Date

- -

To be completed by District Office:

Verified: Sick days ______ Vacation days ______Date to begin STD __________

Date rec'd at Smyrna District Office: ______________