



Employee Name: _____

Phone Number: _____

Location & Title: _____

Employee ID: _____

TYPE OF LEAVE:

_____ Medical/Disability - medical certification required

_____ Military - military orders required

_____ Personal / Educational / Sabbatical / Family Member

_____ Delaware Paid Leave Program through the Department of Labor (DOL)

_____ I am also applying for FMLA in order to maintain my current health insurance coverage for twelve weeks. I understand that I may only use 12 weeks of FMLA during any year and medical certification is required. **FMLA IS ONLY PAID IF YOU HAVE SICK AND/OR VACATION LEAVE TO USE WHILE YOU ARE OUT OF WORK.**

Anticipated Leave Date: _____ Anticipated Return to Work Date: _____

EMPLOYEE LEAVE FOR MEDICAL REASONS: *By Delaware State Law, you are required to file a Short-Term Disability claim with The Hartford if you will be out of work for more than 15 days. If claim is approved, the Hartford will pay 75% of your gross salary for contractual days and you may choose to supplement 1/4 day of sick leave to receive 100% of your salary (if you have leave available to use).*

_____ *Yes, supplement*

_____ *No, do not supplement*

Employee Signature

Date

****HR USE ONLY****

1st day out: _____ AESOP/DSC updated: _____

Exhausted SL Benefit: _____ Contract Payoff: _____

STD claim #: _____ STD: _____ Max: _____

LTD packet: _____ RTW: _____ Salary Re-Calc: _____

Notes: _____
