MEMORANDUM

TO: WC Coordinator

FROM: ____________________________ Date of Injury: _________________________
Employee-Claimant Name (print)

SUBJECT: Sick/Vacation Pay During Receipt of Workers' Compensation Disability Benefits

I understand that there is a three (3) calendar day wait period, pursuant to Chapter 386, HRS, before I am eligible for receipt of workers' compensation (WC) wage loss replacement benefits. Therefore, I must account for these days of absence due to work-related injury/illness by using personal leave (sick, vacation, or leave without pay). I further understand that the WC wage loss replacement shall be paid only for those periods of authorized temporary total disability (TTD) or temporary partial disability (TPD) at the rate of 2/3 of my average weekly wage (AWW) which shall not be more than the specified State maximum AWW and not less than the specified State minimum AWW. I further understand that the University permits me to use my accrued sick and vacation leave with the intent to provide me with income additional to my WC wage loss replacement, in accordance with applicable H.R.S. provisions. Finally, I understand that WC wage loss replacement will be sent directly to me at the mailing address shown on the UH Form 79, Report of Work-Related Injury/Illness, or as otherwise reported. With this understanding, I hereby make the following election which shall be effective to the date my disability ends, unless superseded by a subsequent UH Form 41 (OHR), Sick/Vacation Pay During Workers' Compensation Disability Benefits:

Option 1: _____ **WC Benefits Only (66 2/3% of weekly wages, not to exceed the specified State maximum)**

I elect ***not*** to supplement my TTD or TPD benefits with available accrued sick and/or vacation leave while absent due to work-related disability. I understand that I will be placed on Leave Without Pay status for the duration of authorized absence due to work-related disability. I understand that no voluntary deductions can be made from my workers' compensation wage replacement benefits, and I will be responsible for making direct payments to the respective payees.

Option 2: _____ **WC Benefits + Sick/Regular Pay = Regular Salary (100%)**

I elect to supplement my WC wage loss replacement benefits with available accrued sick leave credits. The total of my WC wage replacement benefits ***plus*** salary payments (supplemental sick leave credits and/or regular pay) shall equal my regular salary. I understand that my sick leave credits will used on a pro-rata basis. Do not use my available accrued vacation leave credits. If I do not have sufficient accrued sick leave credits to receive a sum equal to my full salary, I will receive an amount equal to workers' compensation benefits plus regular pay for any days worked plus available sick leave pay.

Option 3: _____ **WC Benefits + Sick/Vacation/Regular Pay = Regular Salary (100%)**

I elect to supplement my WC wage replacement benefits with available accrued sick and vacation leave credits. The total of my WC wage replacement benefits ***plus*** salary payments (supplemental sick and/or vacation leave credits and/or regular pay) shall equal my regular salary. I understand that my sick and/or vacation leave credits will be used on a pro-rata basis. I further understand that my vacation leave credits will ***only*** be used if my available accrued sick leave credit balance is insufficient *or* if my available accrued vacation leave credit balance will be in excess of the maximum year end accrued balance of 720 hours .

I understand that no deductions can be made from my WC benefit payments, other than for statutory ERS contributions as indicated below. All voluntary deductions and reductions shall be from my vacation/sick leave payments. As such, should my vacation/sick leave payments be insufficient to cover all voluntary deduction items, I shall make payments directly to the respective payees.

STATUTORY ERS DEDUCTION FROM WAGE LOSS REPLACEMENT BENEFITS: In accordance with HRS §78-25**,** I am a member of the **ERS Contributory/Hybrid retirement plan** and hereby acknowledge **_________ (initial)** that the Employer and/or TPA/IC are required to deduct the applicable statutory ERS contribution from my wage loss replacement benefits and appropriately deposit such amounts to the ERS.

I understand that I am responsible for timely notifying my department and the TPA/ IC of any changes to my mailing address. With my signature below, I hereby authorize the WC Coordinator of my college to process applicable On-Line Leave Request entry in compliance with my election as shown above. A photocopy of this form shall be considered as effective and valid as the original.

____ ________________
Signature of Employee-Claimant Date
(*Invalid without signature)*

Original: **First Insurance**
Copies: **WC Coordinator, UH Payroll (to be attached to first submission of UH Form 78) & Office of Risk Management**