**Notice - Termination of Benefits Due to Work-Related Injury**

This letter is sent to employees to notify them that commonwealth benefits will be terminated after one year of absence. It should be sent at least six weeks in advance of the expiration of leave with benefits.

Dear [EMPLOYEE]:

Injury leave (paid or unpaid) with benefits is available for the period of your absence, or up to one year’s absence from work, whichever is less. Your period of eligibility will cease on [DATE] because one year of injury leave will be exhausted. **Your workers’ compensation indemnity benefits are not affected by the termination of injury leave with benefits.**

We are notifying you, six weeks in advance, so that you have sufficient time to decide and choose one of the options listed below.

RETURN TO WORK. You may return to work if medically able to do so. Upon return to work, you must provide medical documentation releasing you to return to full, unrestricted duties. If modified duties are temporarily necessary, we will work with you to make appropriate arrangements for a specified period of time. The concurrence of the treating doctor must be secured prior to your return.

CONTINUED ABSENCE. If your absence continues and you receive workers’ compensation indemnity benefits, you may elect to remain on injury leave without pay until the absence ceases; but it cannot extend beyond three years from the date of injury. This leave will be approved in increments of as much as six months. In accordance with the Affordable Care Act, health benefits eligibility will continue for absences of 91 consecutive days or less after the one cumulative year has been met. Your entitlement to health care benefits will expire at midnight [1 YEAR WITH BENEFITS PLUS 91 DAYS].

RETIREMENT. If your absence appears to be long-term and if you meet the eligibility requirements, you may wish to apply for a disability or regular retirement. Accumulated, unused annual and personal leave and a portion of sick leave, if you qualify, will be paid if you choose this option. To determine if you are eligible to retire, contact the State Employees’ Retirement System at 800-633-5461. **Please note that any application for disability retirement must be made prior to separation from employment.**

RESIGNATION. You may resign your position. In addition to the return of retirement contributions (if you are not eligible for retirement benefits), you will be paid for accumulated, unused annual and personal leave.

APPLY FOR OTHER COMMONWEALTH EMPLOYMENT. You may apply for other commonwealth employment with job duties within your current medical restrictions. You should contact the Bureau of Talent Management at 717.787.5703 or the Civil Service Commission at 717.787.7811 or visit, [www.employment.state.pa.us](http://www.employment.state.pa.us) for more information. If this option is selected, and other employment is not obtained before the expiration of injury leave, you should choose one of the above options too.

APPLY FOR AN ACCOMMODATION. You may explore the possibility of an accommodation for a disability so that you are able to return to work. If you check this option, you will be referred to the disability services coordinator. This option does not indicate, and should not be interpreted to indicate that you are regarded by the commonwealth as having a disability as defined by the Americans with Disabilities Act (ADA).

If you have questions or wish to discuss the advantages and disadvantages of the above options, you may contact [PERSON]. As you consider the above options, keep in mind that you have a right to return to your job or an equivalent job for up to three years from the date of your injury. This guarantee does not apply if you are not fully capable of performing the duties of the job. This guarantee expires if your absence ceases and you do not return to work immediately; if you retire or resign your employment; if you are furloughed; or if workers’ compensation is terminated and you do not return to work immediately.

On the enclosed duplicate copy of this letter, please check the option you have selected. Upon receipt of your option election, we will send you any forms that may be required and contact you for counseling. Please complete the telephone number and signature space that is provided and return the signed copy within ten working days. If you do not respond to this letter by [DATE], we will assume that you are selecting the continued absence option.

If you have any questions, please contact me at [ADDRESS AND/OR TELEPHONE]. PA Relay Service for the deaf or hard of hearing is available at 711 or 1.800.654.5988.

Sincerely,

WC Coordinator

Enclosure:

Duplicate Copy of Letter

cc: Supervisor

Employee Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number (including area code) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note: This work-related injury does not indicate and should not be interpreted to indicate that you are regarded by the commonwealth as having a disability as defined by the ADA.