Notice - Injury Leave Benefits/Leave Election Letter (Version 3.1.17)

This letter is sent to employees who are absent for any time beyond seven days, after the claim is accepted. The *Work-Related Injury Leave Election* form should be attached to the letter.

Dear [EMPLOYEE]:

Your injury of [DATE] has been determined by Inservco Insurance Services, Inc. to be covered by the *Workers’ Compensation Law*. The *Notice to Employees Work-Related Injury Information*, sent to you with previous correspondence, explains the workers’ compensation benefits in detail. This letter explains the leave options available to you.

A *Work-Related Injury Leave Election* form is enclosed for your completion; **return it by [DATE 2 WEEKS FROM LETTER DATE].** Prior to making your election about leave usage, you should consider the options, the severity of your injury, and the potential retirement implications.

You may elect to use accrued sick or annual leave (referred to as paid injury leave) to supplement your workers’ compensation indemnity benefit or you may elect injury leave without pay with benefits. Should you elect to use accrued leave, one day of leave will be charged for each day used, and the supplement that will be received will approximately equal the difference between the workers’ compensation indemnity benefit and your net salary. Paid injury leave and injury leave without pay with benefits may be used for the duration of the absence or up to nine months (274 calendar days), whichever is less. If you have enough accumulated leave, it is possible to use it beyond nine months if needed, but only if no unpaid injury leave has been used. If you do not have accrued leave, you will be placed on injury leave without pay with benefits.

To assist in making your decision whether or not to use paid injury leave, the biweekly net amount of the paid injury leave supplement has been estimated on the attached *Election* form; it is based on your regular biweekly net salary at time of injury. This is a maximum amount and may be less (or zero) if you have voluntary deductions or if you earned extra compensation, such as overtime or shift differential pay that causes your workers’ compensation indemnity benefit to be higher than your regular net salary. The actual amount of the paid injury leave supplement will be calculated when the workers’ compensation indemnity benefits are paid.

**[INSERT FOR RETROACTIVE AWARDS**: Attached is a Retroactive Medical Coverage Election form for you to complete and return. If you did not have medical coverage while absent from work, you may elect to have medical benefits restored for this period. If you elect to have the medical benefits restored, you will be responsible for all applicable costs. If you had coverage through the PEBTF under COBRA, your premiums will be reimbursed and applicable costs will be deducted from your pay. If you do not return the form along with your leave election, your medical coverage will not be reinstated for this absence period.**]**

If you have received full pay to date, you will have been overpaid. This overpayment will equal approximately the amount of the workers’ compensation indemnity benefit. The Bureau of Commonwealth Payroll Operations will contact you regarding this overpayment.

The *Family and Medical Leave Act of 1993* (FMLA) requires the commonwealth to provide 12 weeks of leave with benefits for serious health conditions (most work-related injuries meet the definition of a serious health condition) provided the employee meets certain conditions. The *Notice* provides additional information about the FMLA and about your rights, benefits, and obligations while absent due to your injury. All paid and unpaid injury leave used is designated as leave under the provisions of FMLA.

I sincerely regret that you have been injured and hope that you will be able to return to work soon. **Remember, you are responsible for contacting your supervisor and your claims adjuster at Inservco as soon as your doctor certifies that you are able to return to work.** Also, if you become able to perform modified duties or are able to return to work on a reduced time basis (part-time), you should discuss these possibilities with your supervisor and your claims adjuster. We will work with you to assist in any way we can to help you return to your pre-injury lifestyle.

If you have any questions concerning this claim, please contact me at [ADDRESS AND/OR TELEPHONE].

Sincerely,

WC Coordinator

Enclosure:

Work-Related Injury Leave Election Form, Version – Nine Months 3.1.17

Retroactive Medical Coverage Election Form (if applicable)

cc: Supervisor

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.