

**COUNTY OF SACRAMENTO
WORKERS' COMPENSATION OFFICE
BENEFIT ELECTION FORM**

Phone Number: 876-5251

Fax Number: 876-5157

Background Regular employees who are temporarily disabled because of an on-the-job injury, may elect to integrate their temporary disability benefits with their accrued leave balances. This option is also available to all individuals who have exhausted their benefits pursuant to Labor Code Section 4850.

Mandatory election It is mandatory that you *make an election prior to receiving your first temporary disability benefit check*. Once your election is made and your first temporary disability check has been issued, *the election cannot be changed*.

Option A You may elect to have your accrued sick leave, vacation, CTO and holiday-in-lieu time integrated with temporary disability benefits. The monetary value of the temporary disability and the monetary value of the leave balance usage when added together represent the full gross pay. The number of leave balances used will vary per employee, but will never be more than one-half of the number of hours the employee is absent from work during the pay period due to the work-incurred injury or illness. During integration you will receive a partial paycheck from your department representing your accruals and a check for temporary disability benefits from the Workers' Compensation Office until all your accrued leave is exhausted. Thereafter, you will receive **ONLY** temporary disability benefits from the Workers' Compensation Office.

Option B You may elect to use a full day of your accrued sick leave, vacation, CTO, and holiday-in-lieu time for each full day that you are absent from work due to a work related injury or illness AND receive temporary disability benefits from the Workers' Compensation Office at the same time. You will then receive BOTH your full salary and temporary disability benefits until all accrued leave time is exhausted. Thereafter, you will receive **ONLY** temporary disability benefits from the Workers' Compensation Office.

Election Please elect one of the following by placing an "X" on the line next to your choice.

_____ Option A (Partial Leave balance usage)

_____ Option B (Full leave balance usage)

Signature of Injured Worker

_____-_____-_____
Social Security Number

Date

**Please forward the completed form to the Workers' Compensation Office
PO Box 276130
Sacramento, CA 95827
Mail Code 58-600**