Disability/Leave Benefits Form (DBF)

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| **PART I: DEPARTMENT ONLY** |
| Employee Name: | Enter Employee Name | Employee ID #: | Enter Employee ID# |
| Dept.: | Enter Department Name | Dept. Contact Phone #: | Enter Dept. Contact Phone |
| **PART II: DEPARTMENT ONLY** |
| Last Day Physically Worked: | Enter Last Day | # of Hours: | 20 | Hire Date: | Enter Hire Date |
| Last Day of Paid Sick Leave: | Enter Last Day | Empl. Regular Work Schedule: | e.g. M-F/8-5 | Empl. Appt. %: | E100nter % |
| Other Paid Leave Taken: | [ ]  Vacation  | [ ]  Catastrophic  | Possibility of Workers’ Compensation: | Choose an Item |
|  | [ ]  Holiday | [ ]  None | Leave Dates: |       Enter End Date ***thru*** Enter End Date |
| Last Day on UC Pay Status: | Enter Last Day | FML Eligible: | Choose an Item |
| **TYPE OF ABSENCE** |
| [ ]  | Disability | [ ]  | Pregnancy (PDL) | [ ]  | Workers’ Comp. (P&S) | [ ]  | Personal | [ ]  | Family Member |
| [ ]  | Furlough | [ ]  | Baby Bonding (CFRA) | [ ]  | Workers’ Comp. (HCF) | [ ]  | Lecturer Bridge Period | [ ]  | Military |
| **PART III: PAYROLL ONLY** |
| Insurance Direct Payment |
| Type | Plan | 1st – 12th weeks | 13th – 25th weeks | 26th week on | CFRA |
| Health |       | $0.00 | $0.00 | $0.00 | $0.00 |
| Dental |       | $0.00 | $0.00 | $0.00 | $0.00 |
| Vision |       | $0.00 | $0.00 | $0.00 | $0.00 |
| Legal |       | $0.00 | $0.00 | $0.00 | $0.00 |
| Life  |       | $0.00 | $0.00 | $0.00 | $0.00 |
| Dep. Life |       | $0.00 | $0.00 | $0.00 | $0.00 |
| AD&D |       | $0.00 | $0.00 | $0.00 | $0.00 |
| Supplemental Disability |       | $0.00 | $0.00 | $0.00 | $0.00 |
| TOTAL | $0.00 | $0.00 | $0.00 | $0.00 |
| DUE DATES |       |       |       |       |
|       |       |       |       |
| **Please Note**: A payment of the total in each column is due on every date shown in the corresponding column. |       |       |       |       |
|       |       |       |       |
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|       |       |       |       |
| TOTAL | $0.00 | $0.00 | $0.00 | $0.00 |
| * Employee is responsible for Employee contribution plans. Immediately upon return to work, re-enroll in any plans which may have lapsed during your leave. The re-enrollment period is 31 days beginning on the first day of return to work.
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| * *I understand it is my responsibility to continue my voluntary deductions (e.g., auto insurance, UC loan programs, etc.)*
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| * ***I understand it is my responsibility to pay for my benefit premiums or my benefits will be cancelled***
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| ***Employee Signature*** |  | ***Date*** |

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| **DISABILITY BENEFITS MATRIX** |
| **Leave Type** | Medical — Employee Contribution | Medical — UC Contribution | Dental/Vision | Health FSA |
| **Disability — FML Eligible(as long as employee remains disabled beyond 12 weeks)** | Employee pays up to 26 weeks | UC paid up to 26 weeks | UC paid up to 12 weeks | Employee must either suspend or cancel |
| **Disability - NOT FML Eligible (remains disabled > 12 weeks)** | Employee pays premium up to 26 weeks | UC paid up to 26 weeks | Employee pay/cancel | Employee must either suspend or cancel |
| **Family Member Leave - FML eligible** | Employee pays premium up to 12 weeks | UC paid 12 weeks  | UC paid 12 weeks | Employee must either suspend or cancel |
| **Pregnancy disability leave (PDL)\*** | Employee pays premium up to 17 1/3 weeks | UC paid up to 17 1/3 weeks | UC paid up to 17 1/3 weeks | Employee must either suspend or cancel |
| **Parental leave/Baby Bonding leave (CFRA)\*** | Employee pays premium up to 12 weeks | UC paid up to 12 weeks | UC paid up to 12 weeks | Employee must either suspend or cancel |
| **Furlough/Temp. Layoff** | Employee pays premium up to 16 weeks | UC paid up to 16 weeks | UC paid up to 16 weeks | Employee must either suspend or cancel |
| **LWOP/Personal/Family Member Leave (not FML)** | Employee pays | No UC contributions | Employee pays | Employee must either suspend or cancel |
| **Workers' Comp (WC) Permanent & Stationary (PS)** | Employee pays | No UC contributions | Employee pays | Employee must either suspend or cancel |
| **WC > 26 wks Temporary Disability (TD)Health Contingency Fund (HCF)** | UC paid | UC paid | Employee pays | Employee must either suspend or cancel |
| **Military Leave** | Contact Human Resources |  |  |  |
| * Continuation of the University’s contribution to healthcare coverage for Pregnancy Disability Leave (PDL) and California Family Rights Act (CFRA) includes medical, dental, and vision. Health benefits coverage could continue up to 29 1/3 weeks (17 1/3 weeks for PDL and 12 weeks for CFRA), assuming the employee is disabled by pregnancy for the maximum number of weeks (17 1/3) and then takes a twelve (12) week CFRA parental leave
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| Notes:* Life, DepCare Dependent Life, AD&D, Legal premiums: employee may pay or cancel
* If your FMLA leave period ends and you are still out on unpaid leave, you are responsible for both the employee and the UC contribution for your Dental and Vision coverage, and your Medical coverage unless you are receiving Short Term Disability benefits from Liberty Mutual (26 weeks maximum).
* First payment: Mail a signed copy of this form with your payment payable to “REGENTS – UC” to: University of California, Riverside, Attn: Payroll Office-002, Riverside, CA 92521. Second payment on: Mail just your payment to the address above.
* Contact the Payroll Office at (951) 827-1962 with questions regarding premium payments.
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