APPLICATION FOR REIMBURSEMENT FOR SALARY CONTINUANCE COSTS FOR UNIFOR & TMG EMPLOYEES

PURPOSE:

This form constitutes an application for reimbursement of salary costs for UNIFOR & TMG employees only who are ill for periods longer than 20 consecutive working days. Departments will be eligible for reimbursement of the total salary and benefit costs for an employee's absence **excluding the initial 20 working days**. Please note that the reimbursement will be processed 4 to 6 weeks after the employee's salary continuance leave ends.

ELIGIBILITY REQUIREMENTS:

Employees must:

- be eligible to participate in the LTD plan
- provide satisfactory medical documentation of illness to Employee Health Services, Human Resources Services
- be off work for at least 20 consecutive working days

Departments must participate in return to work initiatives in order to qualify.

PROCESS:

- Send this form to your Employee Health Services contact via **Fax: 905-540-9085 or e-mail** (e-mail address available at: http://www.workingatmcmaster.ca/ehs/contacts/**)**
- Please notify the appropriate accounting office regarding salary commitments and expected reimbursements to department accounts.
- Reimbursement will be made in a lump sum payment, upon the employee's return to work, or LTD approval, whichever occurs first.

As a supervisor, it is your responsibility to keep accurate records of employee illness, and to inform your employee that satisfactory medical documentation must be provided to Employee Health Services to support an absence of 10 days or greater due to illness/injury. The supervisor that approves this reimbursement form will be advised via e-mail of the journal entry number once the reimbursement is completed.

Name of Employee: ______________________________ **ID #:** ________________________

Department: ____

Univ/Health Sci – Non Research Acct ☐ ***Univ Research Acct*** ☐ ***Health Sci Research Acct*** ☐

Salary Chartfield String #: ____

Benefit Chartfield String #: ____

Sick Leave Start Date: ____

Anticipated Sick Leave End Date (if known): ______________________________________

Name of Supervisor: ____

Supervisor Signature: ____________________________ **Date**: ______________________

Dept. Administrator Signature: ____