Employee Election for Lost Time Benefits

State Employee Injury Compensation Trust Fund/SEICTF

Submit to Agency Personnel/Payroll Clerk and SEICTF when the employee will miss more than three (3) days of work.

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TO BE COMPLETED BY EMPLOYEE:

Your options for lost time benefits are:

A) **First three days off work due to occupational injury (waiting period). You should:**

1) Utilize available annual/sick leave, or
2) Take unpaid days.
3) File with your agency's payroll department only.

B) **After three day waiting period. You should:**

1) Take SEICTF benefit of two-thirds pay with no deductions, federal or state taxes, or retirement credit. Accrue leave at 2/3rds of regular leave rate, or
2) Take available annual/sick leave. Regular deductions and RSA contribution continue.
3) **FAX this form to SEICTF at 888-827-6753 or 334-223-6170 or submit via email SEICTF@finance.alabama.gov.**

Select the option on this form you wish to use. You may change the option you selected under (B) at the beginning of any regular pay period. This selection cannot be retroactive. **Elections must be made by the employee and received by SEICTF before any compensation benefits are paid.**

Employee Name _____ SSN _____ Date of Injury _____

Employing Agency _____ Division _____ Location _____

***** Payment Option Selected by Employee: **(A and B must be completed)** *****

Choose one from Section A:

A) ☐ 1. Annual/Sick leave for three-day waiting period. ☐ 2. Leave without pay for three-day waiting period.

Choose one from Section B:

B) ☐ 1. SEICTF Wage Replacement beyond three-day waiting period. ☐ 2. Annual/Sick leave beyond three-day waiting period.

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TO BE COMPLETED BY AGENCY: FORM 11 MUST ALSO BE COMPLETED AND SUBMITTED TO STATE PERSONNEL
NOTICE: REPORTING OF HOURS MUST BE SUBMITTED TO SEICTF BEFORE COMPENSATION BENEFITS ARE PAID

1) APOST Certification ☐ Yes ☐ No

2) Gross Salary at Time of Injury $ _____ Semi-Monthly $ _____ Hourly Rate

3) **First** three WORKING days or 24 working hours of work missed due to injury? **(Give exact dates)** _____

4) Employee status (check one) ☐ Full-Time ☐ Contract ☐ Part-Time Hire Date _____

5) Retirement Plan Info: ☐ ERS ☐ State Police ☐ Judicial ☐ TRS
☐ Tier I ☐ Tier II

6) Deduction for child support withholding?
(If yes, indicate amount and provide copy of order to SEICTF.) ☐ No ☐ Yes $ _____

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TO BE COMPLETED BY SEICTF:

RSA Adjusted Amount $ _____ Semi-Monthly _____ Employers %

Two-thirds Amount $ _____ Semi-Monthly _____ Employers %

Approved
Effective Date: _____ Signature _____ Date: _____

Disapproved
Effective Date: _____ Signature _____ Date: _____

EMPLOYEE MUST SIGN PAGE 2

HIPAA COMPLIANT
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

DISCLOSE TO: State Employee Injury Compensation Trust Fund (SEICTF), P.O. Box 1390, Montgomery, AL 36102-1390, including its agents and authorized representatives.

PURPOSE(S) OF DISCLOSURE: I am the claimant in an employee injury claim. SEICTF is the organization that is handling this claim. The purpose of the disclosure of these records is to allow SEICTF to evaluate my medical history and my damages and injuries in this case in the complete context of my medical history and to allow them a fair opportunity to use these records to determine any and all benefits for which I may be eligible as a result of this claim.

INFORMATION TO BE DISCLOSED: My intent is for you, the agency/healthcare provider listed below, to provide my complete record for all time periods to the above-named organization. Records to be provided may include but are not limited to: all records related to any worker's compensation claim by me, all payment records, all subrogation documents and letters, all documents, records, statements, first report of injury, physician reports and forms and all investigative notes and documents, all printouts on my health expense and payments and records, any documents showing whether your payments on my behalf completely resolve and/or satisfy the complete debt to a health care provider, all history and physical examinations; all progress note, physicians notes, and nurses notes; all lab reports; all x-ray reports, MRI reports, CT scans, Myelograms, EMG, and all other diagnostic procedure reports; all consultation reports and records; all emergency room records, all discharge reports; all after care plans; and all financial records. I specifically authorize the release of information relating to: all substance abuse records (including alcohol/drug abuse); all mental health, counseling, psychiatric, and psychological records.

RIGHT TO REVOKE: I understand that I may revoke this authorization by sending a signed, written notice to SEICTF and to the entity being authorized to disclose my health information pursuant to this document. However, I also understand that any revocation will be effective only to the extent that action has not already been taken in reliance of this authorization. **Unless specifically revoked in writing, this authorization shall remain in force until the settlement or final disposition of my employee injury claim**.

RECORDS TO BE DISCLOSED: ANY AND ALL RECORDS

I understand that SEICTF will not use these records for any other purposes than the purposes stated above. I understand that protected health information that is disclosed pursuant to this authorization may result in re-disclosure and may no longer be protected by federal law.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

Employee Signature	Home Phone & Employee Daytime Number	Date
Supervisor	Supervisor Phone Number	Date