# ADMINISTRATOR SHORT TERM DISABILITY PAY ELECTION FORM

**SECTION ONE: (Please Print)**

Employee Name: _____ T-_____

Office Number: _____ Mobile Phone Number:_____

Union Designation: _____ Personal Email Address: _____

**SECTION TWO:**

STD Leave Start Date: _____ Anticipated Return Date: _____

I acknowledge that I must continue to pay my share of health insurance premiums during my leave. If necessary,