SHORT TERM DISABILITY
DEDUCTION AUTHORIZATION
Lee County Board of County Commissioners

Name (Last, First, MI): _____ SS#: XXX-XX-_____

Effective Date of Coverage: _____ Dept. / Entity: _____

Payroll Deduction Authorization

I authorize my Short Term Disability premium to be deducted from my paycheck each month. I understand I can only terminate this benefit during Annual Open Enrollment.

By signing this agreement, I understand all aspects of this plan as presented and agree to all terms of this policy.

If my salary and/or age should change at any time during the plan year, my premium amount will be adjusted accordingly.

I am responsible for initiating my own application for this benefit by contacting the current plan carrier.

The waiting period for this plan is seven (7) calendar days. I will use one workweek of accumulated sick or vacation leave for this waiting period. The benefit will begin payment on day eight (8).

The use of this benefit in place of sick and vacation time **after a one-month period will constitute a break in service with the Florida Retirement System.**

I have the choice to use accumulated sick and vacation time, OR short-term disability, I may NOT utilize both of these benefits at the same time.

If I should DROP this plan, I will be required to submit an Evidence of Insurability (EOI) form, to the current plan carrier in order to re-enroll.

Signature: _____ Date: _____