

**KERRVILLE ISD**  
**FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION**  
**(OFFSET)**

---

Name \_\_\_\_\_ Department/Campus \_\_\_\_\_

Position \_\_\_\_\_

This employee is absent from duty because of a job-related illness or injury beginning on *(date of first absence attributable to illness or injury)*. If eligible, workers' compensation insurance may begin paying a percentage of the employee's current wages on the eighth day of absence from duty if an extended absence is required.

\_\_\_\_\_  
District authorized signature

\_\_\_\_\_  
Date

---

**Employee choice:**

I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I also understand that the district will continue to pay its contribution toward the cost of my group health insurance coverage (if applicable) as long as I am on paid leave and/or family and medical leave (FMLA). I further understand that I will be responsible for paying all health insurance premiums if I am on **unpaid** leave that is not FMLA leave. I choose the following option:

- I choose to use only \_\_\_\_\_ days of available paid leave at this time.
  
- I choose to use all available paid leave. During the first seven days my leave will be used in full-day increments. I understand that once I begin to receive workers' compensation weekly income benefits my leave will be used in partial-day increments to supplement workers' compensation income benefits.
  
- I choose **not** to use any available paid leave at this time. I understand that I will not receive any regular salary payments from KERRVILLE ISD while receiving weekly income benefits under workers' compensation. No available paid leave will be deducted from my leave balance. I further understand that by selecting this option, I will receive only workers' compensation income benefits for any absences resulting from my work-related illness or injury, unless and until I communicate to the district a change in my decision.

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
Date

***For Claims Reporting Purposes Only:***

*For all employees:*

Amount of leave paid to employee: \$ \_\_\_\_\_.

Daily rate: \$ \_\_\_\_\_

Period of payment: from \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_  
for \_\_\_\_\_ days or \_\_\_\_\_ weeks

*For hourly employees only:*

Hourly rate: \$ \_\_\_\_\_.

Number of hours paid: \_\_\_\_\_