

**CATHOLIC DIOCESE OF ROCKFORD**

*Short-Term Disability Program*

Reimbursement Claim Form

**Explanation of Program:**

Diocesan parishes, schools and agencies use this form for reimbursement of wages paid to full-time employees during the **Short-Term Disability Period**. The Short-Term Disability Period begins after 2 weeks (10 working days) of consecutive absence from work due to an illness or injury (not covered by workers' compensation). The Short-Term Disability Period ends 3 months after the first day of absence from work [see the separate Long-Term Disability Program for absences exceeding 3 months].

When employees cannot work due to illnesses or non-work injuries, the Short-Term Disability Program will reimburse Diocesan Employers 80% of regular wages (excluding overtime, commissions, or bonuses) plus the FICA/Medicare tax on those wages for a total reimbursement factor of .8612. Employees remain on their employer's payroll — the Short-Term Disability Program reimburses the employers (parish, school, or agency).

The first 2 weeks of each absence (10 working days) are the responsibility of the local employer. If, for example, an employee has 4 unused sick days and becomes disabled, that employee will receive no wages for 6 working days (the balance of the 10 working day waiting period for short-term disability benefits). If that employee remains disabled after the 10 working day waiting period, the employer begins paying 80% of that employee's regular wages — the Short-Term Disability Program will reimburse the employer the 80% (plus FICA/Medicare tax).

If an employee has more than 10 unused sick days, the employer should continue to pay 100% of regular pay until those days are fully exhausted. However, the Short-Term Disability Program will reimburse the employer 80% of the regular pay — the local employer pays the difference.

**To qualify for this reimbursement, claims must be filed no later than 60 days after employee returns to work.**

**Information about claim:**

Parish, school, or agency: \_\_\_\_\_ City: \_\_\_\_\_

Employee: \_\_\_\_\_

First day of absence due to this illness or injury: \_\_\_\_\_ Date employee returned to work: \_\_\_\_\_

If Maternity Leave - birthdate of baby: \_\_\_\_\_

Brief description of illness or injury: \_\_\_\_\_

*Include written substantiation from his/her physician - required before reimbursement will be made*

**Request for reimbursement:**

Regular wages during Short-Term Disability Period  
[Maximum period: 3 months minus first 2 weeks waiting period]

\$ \_\_\_\_\_

x .8612

= \_\_\_\_\_ ◀

\_\_\_\_\_  
Authorized signature of employer making claim for reimbursement

Send this claim form to:  
Attn: Deb Sheley, Benefits Coordinator  
PO Box 7044, Rockford, IL 61125

For inquiries regarding eligibility, call  
**Before** you begin to pay benefits,  
Deb Sheley at 815-399-4300, ext.338