COUNTY OF GLENN
Coordination of Benefits Authorization Form

1. EMPLOYEE INFORMATION:

Employee's Name: _____ DEPT: _____

___ I am requesting a Leave of Absence for my own serious health condition (including pregnancy)

___ I am requesting a Leave of Absence to provide care to a family member or to bond with a new child

***Special Note: All selected elections are final and may not be modified for the duration of the specified leave.**

2. PAY STATUS: At the Onset of This Leave of Absence, I Request the Following Pay Status

_____	I have not/will not apply for wage replacement benefits (State Disability): The leave banks I select below will be used for all my regular work shifts for the duration of my leave. (Required if not receiving wage replacement benefits or if disability benefits are waived)
_____	I request to coordinate my leave bank hours with wage replacement benefits (State Disability) up to 100% of base bi-weekly compensation: I understand that I cannot exceed my regular County wages when coordinating my leave banks with State Disability benefits
_____	Leave Without Pay (LWOP): This is a fully unpaid leave, no leave bank hours will be used for the duration of your leave. For example: Leave to care for a qualifying family member, or if an employee is receiving other wage replacement benefits such as State Disability. Seniority, leave accruals, eligibility for catastrophic leave, and other benefits may be affected. (See applicable MOU and Catastrophic Leave Policy for more information).

Employee Acknowledgment _____ (Employee Initials)	**If your FMLA/CFRA leave becomes unpaid, you will be responsible for submitting your share of the health benefit premium to the Department of Finance by the 10th day of the month preceding the coverage month. If your premium payment is not made in a timely fashion, your group health insurance will be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse. The same provisions apply to the premium requirements for group dental, vision, and supplemental life insurance plans.**

3. LEAVE INFORMATION: Leave Banks to be Coordinated During my Leave of Absence

Sick Leave Balance (Leave to care for a family member is limited to Family Sick Leave entitlements, 48 hours per year)	**Hours Available:**	**Order of Leave Bank Usage:**	**1**
Vacation Leave Balance	**Hours Available:**	**Order of Leave Bank Usage:**	**2**
Compensatory Time Off (CTO) Balance	**Hours Available:**	**Order of Leave Bank Usage:**	**3**
Annual Leave Balance	**Hours Available:**	**Order of Leave Bank Usage:**	

Employee Acknowledgement (signature indicates the foregoing statements are true and correct)**:**

Employee's Signature: _____Date_____

Department Head/Designee Acknowledgement: _____ Date: _____

Personnel Director or Designee: _____ Date: _____