Smyrna School District
Notification of Intent to Apply for Short Term Disability

YOU MUST CALL The Hartford Insurance Company at 1-866-945-7781 by the 15th day if you need to be out more than 30 consecutive calendar days (20-22 working days). Please complete this form if you intend to apply for Short Term Disability.

Employee Name: ___________________________ Empl ID: _______________

Phone number where you can be reached during this time: ___________________

Building: _________________________________ Position: ___________________

Current balance - sick leave: ________

Current balance - vacation leave: ________
(where applicable)

First day Out: ______________

Projected date of return: ________________

If approved for a Short Term Disability by The Hartford Ins. Company:

Do you want to use your accumulated sick/vacation time in ¼ day increments to bring your salary to 100% while on short-term disability?

YES: ☐ (If yes, how many days do you wish to use) __________

NO: ☐

If not approved for a Short Term Disability by The Hartford, my time will continue to be charged to my sick/vacation balance.

____
Employee signature

____
Supervisor / Principal Signature

____
Date

- -

To be completed by District Office:

Verified: Sick days _____ Vacation days _____ Date to begin STD __________

Date rec'd at Smyrna District Office: ______________

The Smyrna School District does not discriminate in employment, educational programs, services or activities based on race, color, marital status, creed, religion, national origin, gender, age, genetic information, sexual orientation, gender identity, disability or any other protected category or status in accordance with state and federal laws.
Inquiries should be directed to the District Superintendent.