MIDWESTERN UNIVERSITY
Office of Human Resources

Insurance Premium & Short Term Disability Payment (STD)
Recovery Authorization Form

Employee Name: _____

I acknowledge Midwestern University's right to recover the any STD payments and Flex time (exception: Flex time used during the 5-day waiting period) made to me while on STD under the following conditions:

- I fail to return from leave of absence at the expiration of the leave to which I am entitled.
- I fail to return to work for the same amount of time for which I was paid disability income.
    - If returning in a reduced FTE, an equivalent number of weeks subject to supervisor and HR approval.
- The reason I fail to return to work is not due to the continuation, recurrence, or onset of a serious health condition or due to transitioning to Long Term Disability.

In the event I do not return to work for at least the equivalent amount of time, based on my FTE status at the time I received the benefits, I agree to reimburse Midwestern University for the STD payments received, and any Flex time (except during the 5-day waiting period) I received during my leave. I understand that my available vacation leave accruals will first be applied towards this reimbursement.

I certify that I have read, understand and agree to the above policy.

Signature: _____Date:_____