University of Wisconsin Madison
Office of Human Resources 21 N Park Street, Suite 5101 Madison, WI 53715

CONFIDENTIAL REQUEST FOR RESTORATION OF 500 HOURS OF SICK LEAVE UNDER THE SUPPLEMENTAL HEALTH INSURANCE CONVERSION CREDIT PROGRAM

Under the provisions of the Supplemental Health Insurance Conversion Credit (SHICC) program, certain employees may be eligible to have a maximum of 500 hours of used sick leave restored for purposes of conversion to health insurance credits upon retirement to pay for health insurance premiums. The conditions for this restoration are that (1) the employee must have used 500 hours or more of accrued sick leave in the three years immediately preceding the effective date of the employee's retirement/disability (2) the employee used the 500 or more hours for the same single personal injury or illness (3) the employee is eligible for SHICC which requires they have 15 full years of adjusted continuous service with the state when they end state employment.

EMPLOYEE NAME (Last, First, MI)	**SOCIAL SECURITY NUMBER** (Last Four Digits) **xxx-xx-**
DEPARTMENT	**RETIREMENT DATE (mm/dd/yy)**

1. State the nature of the illness or injury for which at least 500 hours of sick leave was used for.

2. On what date did the injury originally occur or the illness begin? (mm/dd/yy)

3. Using the retirement date above as a starting point, identify all instances within three years prior to that date for which sick leave was approved and used relative to the illness or injury indicated in #1 above. The date of each absence and the amount of sick leave approved and used must be included. This information may be provided on a separate sheet, if needed.

Date(s) of Absence				**Sick Leave Hours Approved and Used**
From		**Through**		
From		**Through**		
From		**Through**		
From		**Through**		
From		**Through**		
From		**Through**		

If medical documents are available that may help in the processing of this request, you may wish to inform the employer at this time. I have medical documents relating to this request

☐ Yes ☐ No ☐ Unsure

Medical Practitioner (s) Name who can document the above medical information.

Address	Telephone Number

Your signature is required to begin processing this request. Your signature also attests that the information provided is accurate and truthful, to the best of your knowledge.

Your signature will also give an authorized representative of the appointing authority permission to contact the above-named medical practitioner(s) for verification of the illness or injury identified above and its duration. The medical practitioner(s) will only be contacted if the information provided on this request form is not sufficient to determine your eligibility for the restoration of the 500 hours of used sick leave.

Date (mm/dd/yy)	**Employee Signature**