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 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 500 hours must have been used in the three years preceding the effective date of the employee's retirement/disability and (2) the 500 hours must have been related to a single injury or illness. Employees are only eligible for the 500-hour restoration if they have 15 years of adjusted continuous service and are eligible for SHICC.

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 the 500 hours of sick leave were used.

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**