

**CITY OF AUSTIN**  
**SICK LEAVE PAYOUT REQUEST FOR INSURANCE DEDUCTIBLE**  
**AUTHORIZATION PAYMENT FORM**

DATE: \_\_\_\_\_

EMPLOYEE NAME: \_\_\_\_\_

EMPLOYEE NUMBER: \_\_\_\_\_ DEPARTMENT: \_\_\_\_\_

BALANCE OF SICK LEAVE ACCOUNT: \_\_\_\_\_

AMOUNT OF REQUEST: \$ \_\_\_\_\_

**(Please attach a copy of your insurance verification information, which in most cases would be your EOB accumulator information, maximum total reimbursement of \$750 per calendar year)**

I hereby request the use of sick leave for the purpose of meeting a portion of my health insurance deductible. By making this request, I understand that my current year sick leave hours will be reduced in an amount equivalent to that of my request.

I also understand that I must have a sufficient sick leave balance to cover my request. If I do not have a sufficient balance, my request will be reduced to the maximum amount available (up to \$750 maximum amount allowed).

I certify that these expenses are not reimbursable under any other plan, including a plan of another employer that covers me, my spouse, or another member of my family and that I will not seek reimbursement for such expenses from another plan unless specifically permitted by that plan.

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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Finance Department Use Only:

Dollar Value of Accrued Sick Leave: \_\_\_\_\_

Number of Sick Leave Hours Adjustment Necessary: \_\_\_\_\_

Amount Paid to Employee: \_\_\_\_\_

Date of Sick Leave Hours Adjustment: \_\_\_\_\_

W/E Payroll Date Payment was Made: \_\_\_\_\_

Payroll Check Number Including Payment: \_\_\_\_\_

Sick Leave Hours Adjusted by: \_\_\_\_\_