County of San Bernardino
Perfect Attendance Benefit Election Form
(Calendar Year 2021 / Pay Periods 01/21 – 26/21)

Employee ID	Last Name, First Name
Department	Work Phone Number

Please indicate your Perfect Attendance Benefit selection below:

❑ **Perfect Attendance Leave (PAL)** – Employees selecting this option will receive up to sixteen (16) hours* of Perfect Attendance Leave (PAL) time. Employees may take PAL time at their discretion, provided the minimum time used on a single day does not result in overtime. PAL time must be used before **December 16, 2022** (end of Pay Period 26/22). Employees who do not use PAL time before **December 16, 2022**, will forfeit all unused time. There is NO cash-out provision for unused PAL time.

❑ **Health Club Membership Reimbursement** – Employees selecting this option can request to be reimbursed up to $299 * for a one-year paid, ***employee-only*** membership in a health club of their choice. Employees selecting this option must also complete the enclosed *Perfect Attendance Health Club Membership Reimbursement* form.

NOTE: Employees who do not submit a *Perfect Attendance Benefit Election Form* to the Employee Benefits and Services Division (EBSD) by August 29, 2022, will receive up to sixteen (16) hours of PAL time as a default selection.

*** For employees in the Nurses Bargaining Unit or in a General Teamsters Bargaining Unit, Perfect Attendance benefits are prorated for employees scheduled less than eighty (80) hours per pay period. For example, an employee who is regularly scheduled 72 hours per pay period would be eligible for $269 health club reimbursement or 14.4 hours of perfect attendance leave.**

By signing below, I acknowledge and understand that, in accordance with IRS regulations, these benefits are TAXABLE. Should I select the PAL time option, I will be taxed in the same manner as for sick or vacation leave. If I select the Health Club Membership Reimbursement option, I will be taxed on the dollar amount paid/reimbursed for the membership. The benefit value will be added to my taxable W-2 wages in the year in which I receive my reimbursement. Additionally, I understand that I am responsible for all taxes.

Signature: _____ **Date:** _____

Please return this completed form to the EBSD:

- **Via email at mhm@hr.sbcounty.gov, or**
- **Via inter-office mail code EBSD (0440) Attention: PAL**