APPENDIX

Agreement

Related Policy: Non-Renewal Program for Academic Professional and Administrative Employees

(The terms of this program are explained within the policy.)

Your Benefit under This Program

Subject to verification of eligibility, you will be entitled to:

1. A cash payment equal to one week of pay per full year of continuous University service in an appointment of 75 percent time or greater, up to a maximum of 52 weeks of pay. Weeks of pay for this purpose are calculated using the pay rate in on the last day of employment. Based on a preliminary review of University records of your years of service, you have _____ full years of continuous service.
   AND
2. Continuation of the University contribution to your medical and dental coverage (as in effect on the last day of employment) for up to 18 months following termination of employment, but no later than the last day of the month in which you become covered under another group medical plan. Your contribution for this coverage will be the same as if you had remained employed. If you become eligible for Medicare before or during this subsidized period, you must apply for Medicare Part B, and Medicare becomes primary with the UPlan secondary for coverage.

Application

I wish to apply for benefits under the Nonrenewal Program that is available to eligible Professional & Administrative staff. I make this application voluntarily, and any questions I had regarding this Program have been answered to my satisfaction.

I understand that the University must approve my participation in this Program and the date on which I terminate my employment, and that University approval is not complete until signed below. I also understand that University approval of my participation is contingent upon my signing the attached **Release** on the last day of my employment, *and that I will not receive any benefits under this Program if I do not sign the **Release**.*

I elect to terminate my employment at 4:30 p.m. on _____ which is within sixty calendar days following the issue date of the non-renewal notice.

I understand that my resignation is irrevocable.

I understand that I may not be rehired at the University for the number of weeks that are covered by my lump sum payment.

I understand that if I am eligible for a University contribution to my medical and dental coverage, it will be based on my level of coverage (employee-only or tier of family coverage), work location, **and** permanent residence on my last day of employment at the University.

_____ _____

Date Signature

_____ _____

Employee ID Number Print Name

I have certified the eligibility of this employee and authorize payment of a severance benefit of $ _____.

Note: Temporary employees are not eligible.

_____ x _____ x _____

Years of Service Hourly Rate of Pay Hours in Regular Workweek (maximum of 40 hours)

_____

Department Contact Phone

Date	Department Head	Department
Date	Dean or Administrative Officer	
ACCEPTED:	Vice President	