**KANSAS STATE UNIVERSITY**

**VOLUNTARY LIMITED RETIREMENT HEALTH CARE BRIDGE PROGRAM**

**FOR FACULTY/UNCLASSIFIED PROFESSIONAL**

**TRANSMITTAL FORM**

**TO:** April C. Mason, Provost and Senior Vice President

**RE:** Limited Retirement Health Care Bridge Request

Attached is a request for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to participate in the Voluntary Limited

 name faculty/unclassified professional

Retirement Health Care Bridge Program.

Years of full-time service to Kansas State University: \_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please attach the request to retire and to participate in this program. Date of submission:\_\_\_\_\_\_\_\_\_\_\_\_.

Current coverage for: \_\_\_ Employee \_\_\_ Emp. & Spouse \_\_\_ Emp. & Children \_\_\_\_ Emp. & Family

Effective date of the HCB Agreement: \_\_\_\_\_\_\_\_\_\_\_\_\_.

Number of months HCB is to be funded\*: \_\_\_\_\_\_\_\_\_. The actual retirement date is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\*[Maximum 36 months, or up to the date the employee becomes eligible for Medicare]

The undersigned have reviewed and recommend approval of this proposal:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department Head/Director Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dean/ Vice President Date

**APROVED:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provost and Senior Vice President Date

**Documentation must include the *unsigned* proposed Agreement.**

***Please forward with Request Letter to the Office of Academic Personnel, 204 Anderson Hall.***