

**KANSAS STATE UNIVERSITY
VOLUNTARY LIMITED RETIREMENT HEALTH CARE BRIDGE PROGRAM
FOR FACULTY/UNCLASSIFIED PROFESSIONAL**

TRANSMITTAL FORM

TO: _____, Provost or 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: _____ .

The Limited Health Care Bridge Program provides a mechanism through which the University may contribute to the cost of health insurance to assist unclassified employees wanting to retire before qualifying for Medicare coverage. The intent is to provide support to employees who would not otherwise be able to retire without this support. The program is used only when in the best interest of the University and the employee. This decision will be made on a case-by-case basis taking the employee's appointment or job responsibilities, the timing of the request and other pertinent factors into consideration.

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]

DEPARTMENT OR UNIT IS RESPONSIBLE FOR FUNDING THE LIMITED HEALTHCARE BRIDGE COST

The undersigned have reviewed and recommend approval of this proposal:

Department Head/Director

Date

Dean/Vice President

Date

APPROVED:

Provost or Vice President

Date

Please forward with employee's request letter to Human Capital Services - Benefits, 103 Edwards Hall.