VOLUNTARY TRANSITIONAL RETIREMENT PLAN (VTR)

Southern Nazarene University understands the difficulty in planning for retirement years. For this reason the Board of Trustees has approved the following transitional plan for retirement for those who qualify and would like to phase into full retirement over a three year period.

To qualify you must meet two criteria: reached your sixth-fifth (65) birthday and have completed fifteen (15) years of full time service to Southern Nazarene University. If approved, you can expect:

1. Work half time. (20 hours per week or half of a full teaching load plus)
2. No paid time off will be paid, i.e. vacation, sick leave, holidays, etc.
3. Health insurance will be paid by SNU subject to the following:
   • If you and your spouse have been on the SNU health insurance for the past twelve (12) months, SNU will pay for you and your spouse’s Medicare Plan A, B, and D and a Medicare supplement.
   • If your spouse is not eligible for Medicare, (s)he will be enrolled in the SNU Premier plan and you will pay the employee premium for single coverage.
4. Life/AD&D insurance will continue to be paid by SNU
5. Long term disability will continue to be paid by SNU
6. You will be able to continue participation in the Section 125 flexible spending plan.
7. You will be able to continue to contribute to the 403(b) retirement plan and SNU will continue to match 1 ½ times your contribution up to your 5% contribution.
8. As long as SNU pays retirement bonuses, it will be paid at the end of the VTR.
9. You will not be allowed to supplement your base compensation by additional duties on campus, such as other temporary jobs, adjunct teaching, etc.

At the end of your full-time employment, SNU will pay all unused vacation and personal holidays, if applicable.

Your request will be reviewed for approval/denial by a committee of Cabinet members. You can expect their decision in approximately thirty days.
FACULTY ELECTION FORM

VOLUNTARY TRANSITIONAL RETIREMENT

Effective with the academic year beginning in Fall ____________, I request to participate in the Voluntary Transitional Retirement Program.

I elect to begin participation in this program for ________ (one, two, or three) years and will retire on June 30, ________.

During my participation in the program, I will carry one half teaching load, I understand my salary will be reduced to 50% and will be spread over 12 months.

I understand the University will incur the cost of my health insurance.

I further understand that participation in this program may be limited based on student and/or faculty scheduling needs. I further understand that if I am not approved to participate in this program beginning in the above stated academic year, I may re-apply for the following academic year.

I further understand that once accepted in this Voluntary Transitional Retirement Program I will meet with the Human Resources department to discuss/finalize benefits.

____________________________________  ______________________  ______________
FACULTY SIGNATURE                  ID NUMBER                  DATE

____________________________________  ______________________
CHAIR’S SIGNATURE                   DATE

Dean’s Comments/Recommendations:

_____________________________________________________________________________

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____________________________________  ______________________
DEAN’S SIGNATURE                    DATE

This request has been          _____ Approved

                  _____ Not Approved

____________________________________  ______________________
PRESIDENT’S SIGNATURE              PROVOST’S SIGNATURE
STAFF ELECTION FORM

VOLUNTARY TRANSITIONAL RETIREMENT

Effective _________________________ I request to participate in the Voluntary Transitional Retirement Program. I elect to begin participation in this program on __________________ and continue for _________ (one, two, or three) year(s).

During my participation in the program, I will work 20 hours per week and my compensation will be based on time worked.

I understand the University will incur the cost of my health insurance. I further understand that I will be able to continue participating in the flexible spending account program, retirement matching and life insurance.

______________________________________________________________________________

Supervisor Comments/Recommendations: ____________________________________________

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VICE PRESIDENT’S SIGNATURE

DATE

____________________________________

PRESIDENT’S SIGNATURE

DATE

This request has been _____ Approved

_____ Not Approved

____________________________________

PRESDIDENT’S SIGNATURE

VICE PRESIDENT, BUSINESS AND FINANCIAL AFFAIRS