



Reduction in Force Disclosure and Election Form

Pursuant to [Policy and Procedure 41.015](#) for Administrative Employees and Classified Staff

This Reduction in Force Agreement is hereby entered into by _____, an Ohio University employee, in connection with the receipt of Reduction in Force Benefits pursuant to [Policy and Procedure 41.015](#).

I understand that my current employment at Ohio University will end on _____ due to a reduction in force. In accordance with Policy and Procedure 41.015, I will receive a total of _____ (number of months) of severance pay at my current rate of compensation to be issued:

bi-weekly semi-monthly (check one) for _____ (number) consecutive pay cycles following my separation.

I choose to continue to receive health benefits and life insurance for a period of six months after my separation from the university. I understand that I will be responsible for co-payment of premiums at the same rate applicable to university employees.

I am currently enrolled as a student at Ohio University in the College of _____.

I am not currently enrolled in a college at Ohio University.

_____, an eligible member of my family, is currently enrolled as a student at Ohio University in the College of _____.

I do not have an eligible family member currently enrolled at Ohio University in any college.

I understand that I or my family member will continue to receive tuition assistance (100% of instructional fees) for the number of years needed to obtain the degree currently in progress, not to exceed three continuous years at the undergraduate level or one year at the graduate level.

I understand and agree that it is my responsibility to inform the Office of Human Resources in writing if I accept an offer of employment, whether it be internal to the University or external, or if I begin receiving OPERS/STRS benefits during the period in which I am receiving severance pay or a continuation of health benefits or life insurance. I understand that upon accepting new employment or retirement benefits, my entitlement to receive severance pay and a continuation of health benefits or life insurance will cease.

Employee Signature: _____ **Date:** _____

Supervisor Name: _____

Supervisor Signature: _____ **Date:** _____

Pc: HR Records
Payroll