Catholic Diocese of Columbus

Department for Education
614 · 221 · 5829
Fax 614 · 221 · 2563

SEPARATION BONUS PROGRAM

Acceptance Notification

Name of Teacher:_____

School:_____

Verified Number of Full Years of Full-Time Teaching in the Diocese:_____

(a) Separation Bonus Program (SBP) benefits have been approved for the following option, beginning _____ , _____ :

___ Plan A (health care)

___ Plan B (payments upon immediate retirement)

___ Plan C (payments without retirement)

For Plan B or Plan C election, the total payment will be $_____ , which shall be paid over _____ years, such that the proportionate annual amount will be paid in equal installments on the school's normal payroll dates during the respective year.

(b) SBP benefits have not been approved. Specify reason:

_____

_____

Completed by:_____ _____
Principal Signature Date

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Application Form

Teacher: **This form must be completed and submitted to your principal no later than March 15 of the current school year.**

Name of Teacher:_____

School:_____

Verified Number of Full Years of Full-Time Teaching in the Diocese:_____

I hereby apply for and request Separation Bonus Program (SBP) benefits, commencing at the start of the school year beginning in the Fall after the submission of this application. I understand that acceptance of this application by the school constitutes my voluntary resignation, the termination of my employment, and acceptance of the other terms of the SBP program as set forth in the COACE agreement.

I elect the following SBP option **[Select one]:**

___ Plan A - Continuation of Health Care Benefits (5 years)

___ Plan B - Payments Upon Immediate Retirement

___ Plan C - Payments Without Retirement

I understand that the respective payment schedule for a Plan B or Plan C election will be no less than 3 years and no more than 5 years, at the discretion and designation of the school.

Submitted by:_____ _____
Teacher Signature Date

_____
Print Teacher Name

Received by:_____ _____
Principal Signature Date

The teacher is to submit the original to the principal, and retain a copy for his/her records.

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Option Election

To be completed by the teacher if approved for SBP benefits:

Name of Teacher:_____

School:_____

In the event of my death, any remaining SBP payments due to me are to be paid to:

_____ my spouse

_____ my estate

_____ other (specify)

_____ _____
Teacher Signature Date

The teacher must return the original of this form, signed, to the principal no later than 5 working days from receipt. The teacher should keep a copy for his/her record. The original remains in the teacher's file at the school. The principal is to send a copy to the Diocesan Office of Catholic Schools Personnel Office.