



# SARPY COUNTY NOTICE OF RETIREMENT

**If you would like to talk to someone in the Human Resources Department before completing this form, please call 402-593-4486**

## EMPLOYEE INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Department: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Job Title: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Primary Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

## RETIREMENT INFORMATION

Date of Retirement: \_\_\_\_\_  
Employee Group:  AFSCME/Local 251  Employee's Association  
 F.O.P.  F.O.P: Communications  Non-Union

**If you currently have Group Health Insurance and have met the applicable employment requirements as a Retiree, please elect the following:**

I wish to continue coverage at the following level (if coverage is elected, you will be responsible for your portion of the premium and failure to remit such payment shall result in loss of coverage):  
 Employee Only  Employee/Spouse  Employee/Child(ren)  Family  
 I wish to decline coverage

## AUTHORIZATION

By signing this notice, you acknowledge that you have read and certify that this notice is accurately executed.

\_\_\_\_\_  
Employee Signature Date

## OFFICIAL/DEPT HEAD ACKNOWLEDGEMENT

\_\_\_\_\_  
Signature Date

## HUMAN RESOURCES

\_\_\_\_\_  
Signature Date