Nebo SCHOOL DISTRICT

FTE/Hour Change Agreement

This agreement serves as notification to the employee of the changes that will come about as a result of their voluntarily changing from full benefited status to less than full benefited status in Nebo School District. The employee acknowledges the following adjustments will take place upon the execution of this agreement.

Employee Name:	Work Site:		Start Date:
Current Job:	Current FTE:	New FTE:	End Date:
Details:			

Please **initial** each of the following. Your initial designates that you both understand and agree with the terms outlined.

_____1. **Medical Insurance:** I recognize that my medical insurance may be impacted by this decision. For clarifications, I will contact the Benefits Secretary in Human Resources for details.

_____2. **Leave:** I recognize that my leave may be impacted by this decision. Details are found in Section 14 of the associated employee handbook. For clarifications, I will contact the Leave Secretary in Human Resources for details.

_____3. **Life and Disability Insurance:** I recognize that my life and disability insurance benefits may be impacted by this decision. For clarifications, I will contact the Benefits Secretary in Human Resources for details.

_____4. **Employment:** I recognize there is no guarantee that I will return to full-time employment. I also acknowledge that the Nebo School District has the discretion to require an increase of my employment to full time.

_____5. **Utah Retirement System:** I recognize that this decision may impact my URS benefits.

_____6. **Voluntary:** I have entered into this agreement voluntarily and of my own free will.

Please sign and date. Your signature designates that you understand this agreement and will abide by the stipulations as outlined.

A copy of the agreement should be kept at the work site. The original shall be placed in the employee's personnel file. This agreement is only valid once all parties have signed and dated below.

Employee Signature: _____ Date: _____

Principal/Supervisor Signature: _____ Date: _____

Director Signature: _____ Date: _____

Human Resource Director Signature: _____ Date: _____
(Verify with Benefits Secretary that they have communicated with her)