Sample Salary Continuation Plan Resolution

The undersigned secretary of _____ , does hereby certify that:

A special meeting of the Board of Directors of _____ , was held at the office of the Corporation at _____, on _____, 20____ at ____ o'clock for the purpose of acting upon a proposal that the Corporation establish a Salary Continuation Plan for certain employees of the firm.

_____ was Chairperson of the meeting and _____ acted as Secretary.

The meeting was called to order by the Chairperson and minutes were recorded by the Secretary. A waiver of notice of the meeting, duly executed and dated _____, 20____ was presented. A quorum of Directors was present.

The Chairperson stated that the purpose of the meeting was to authorize and direct that the necessary steps be taken to place in operation a Salary Continuation Plan for certain valuable employees. Discussion followed, and thereafter, upon motion duly made and seconded, the following resolution was adopted by unanimous vote.

> RESOLVED, that the Corporation establish a Salary Continuation Plan to pay the following benefits to the following eligible employees:
>
> Group I Employees: [list employee names]
>
> The Corporation will pay all employees in Group I full (100%) salary for the initial____ weeks/ months of total disability and three-fourths (75%) salary for the next _____ weeks/months of continuing total disability and one-half (50%) salary for the next _____ weeks/months of continuing total disability.
>
> Group II Employees: [list employee names]
>
> The Corporation will pay all employees in Group II full (100%) salary for the initial ____ weeks/ months of total disability and one-half (50%) salary for the next ____ weeks/months of continuing total disability.
>
> Group III Employees: [list employee names]
>
> The Corporation will pay all employees in Group III full (100%) salary for the initial _____ weeks/ months of total disability and _____ % salary for the next _____ weeks/months of continuing total disability.

Dated _____ , 20__ Secretary_____

On this date I have read and understand the above plan and the benefits provided for me.

Dated _____, 20____ Employee_____

Sample Letter

Date:

Name
Address
City, State, ZIP

Dear _____:

This letter will serve as notification of the disability salary continuation plan in effect for <*Business Name*>. The Plan's effective date is _____ , 20_____.

Under this Plan, <*Business Name*> will continue your full salary for _____ weeks in the event your sickness or accident causes you to become disabled as defined in the policies issued under the Plan.

Documentation of this sickness by a medical practitioner will be at my discretion. Disabilities lasting longer than _____ weeks will not be compensated by the continuance of salary. After _____weeks and for the continuation of your disability <*Business Name*> will pay no continuing salary. After _____ days of total disability as determined by , policy # _____, disability benefits will be paid according to the terms of the policy. Those benefits are defined in the policy and subject to any exclusions in the policy. To the extent the insured portion of this plan is an employee-benefit plan under ERISA, your policy will serve as a summary plan description.

Premiums for this disability policy will be paid by <*Business Name*> until further notice. Should you terminate your employment with <*Business Name*>, you have the right to continue the payment of premiums on this policy on your own.

We are pleased to provide this Salary Continuation Plan for you.

_____ _____
Owner Date

Received :_____ _____
Employee Date