

## PERSONNEL TRANSFER RECORD

- TRANSFER
- TERMINATION
- RETIREMENT
- BENEFITTED LTE

When an employee transfers to another state agency, complete this form on his/her last day of employment. Send one copy immediately to the personnel/HR officer of the agency to which the employee is transferring. When an employee is terminating, place a completed copy of this form in the employee's personnel file ("P File").

TO: AGENCY NAME/SECONDARY LEVEL NAME/ADDRESS	NUMBER	FROM: AGENCY NAME/SECONDARY LEVEL NAME/ADDRESS	NUMBER
PERSON COMPLETING FORM		TELEPHONE	DATE

### 1. EMPLOYEE DATA

NAME OF TRANSFERRING EMPLOYEE	SOCIAL SECURITY NO.	BIRTHDATE	SEX	ETHNIC	DISABILITY	VET STATUS
PRESENT CLASSIFICATION	CLASS CODE	SCHEDULE & RANGE & EEO	PRESENT SALARY	LAST DAY ON PAYROLL		
STARTING DATE CONTINUOUS SERVICE	ADJUSTED DATE	PAYROLL SYSTEM <input type="checkbox"/> CENTRAL PAYROLL <input type="checkbox"/> UW <input type="checkbox"/> LEGISLATIVE				

### 2. EMPLOYEE PAYROLL DEDUCTIONS TAKEN BY SENDING AGENCY

TYPE OF DEDUCTION	MONTHLY DEDUCTION AMOUNT	MONTH PAID THROUGH
HEALTH INSURANCE – PLAN NAME & PAYROLL CODES (TYPE OF COVERAGE) <input type="checkbox"/> PRE TAX <input type="checkbox"/> POST TAX	\$	
LIFE INSURANCE <input type="checkbox"/> BASIC <input type="checkbox"/> +50% <input type="checkbox"/> +100% <input type="checkbox"/> ADD'L <input type="checkbox"/> PRETAX <input type="checkbox"/> SPOUSE AND/OR DEPENDENT COVERAGE <input type="checkbox"/> WAIVED BASIC AMOUNT _____ AGE _____ <input type="checkbox"/> POSTTAX <input type="checkbox"/> 1 UNIT/SCHEDULE <input type="checkbox"/> 2 UNITS/SCHEDULES		
INCOME CONTINUATION INSURANCE – INDICATE CATEGORY, ELIMINATION PERIOD		
DENTAL INSURANCE PLAN NAME & COVERAGE TYPE SINGLE TWO-PARTY FAMILY		
EPIC CATASTROPHIC INSURANCE – COVERAGE TYPE <input type="checkbox"/> SINGLE <input type="checkbox"/> TWO-PARTY <input type="checkbox"/> FAMILY		
OTHER INSURANCE – PLAN NAME & COVERAGE TYPE (E.G., CNA AD&D)		
UNION DUES – LOCAL NUMBER & ADDRESS		
RETIREMENT WRS ENROLLMENT DATE IF LESS THAN 6 MOS. _____	<b>BIWEEKLY DEDUCTION AMOUNT</b>	<b>IF LAID OFF, EFFECTIVE DATE OF LAYOFF –</b> _____
RETIREMENT PLAN & CODE _____ ADDITIONAL \$ _____		
CREDIT UNION – NAME & ADDRESS – DEDUCTION AUTHORIZATION		
STATE EMPLOYEES COMBINED CAMPAIGN <input type="checkbox"/> DANE CO. <input type="checkbox"/> MILWAUKEE CO. COMMUNITY HEALTH CHARITIES <input type="checkbox"/> PLEDGE BALANCE \$ _____		SOCIAL SECURITY EARNINGS PAID BY STATE THIS CALENDAR YEAR THROUGH LAST DATE ON PAYROLL OF SENDING AGENCY  \$ _____  (MUST BE COMPLETED WHEN MOVEMENT IS BETWEEN UW AND DOA CENTRAL PAYROLL AGENCY.)
DEFERRED COMPENSATION PARTICIPANT / TSA PARTICIPANT		
ERA <input type="checkbox"/> MEDICAL ANNUAL AMOUNT _____ YEAR TO DATE _____ <input type="checkbox"/> DEPENDENT CARE ANNUAL AMOUNT _____ YEAR TO DATE _____		
U.S. SAVINGS BOND DENOMINATION _____		
OTHER (PARKING, VAN POOL, WAGE ASSIGN, ETC.)		

### 3. LEAVE DATA (INDICATE HOURS & MINUTES) IF LESS THAN FULL-TIME, INDICATE PERCENTAGE \_\_\_\_\_ %

TRANSACTIONS PROCESSED THRU _____	SICK LEAVE	HOURS	OTHER	VACATION HOURS	PERSONAL HOLIDAY HOURS	SATURDAY/LEGAL HOLIDAY HOURS
TERMINATION/SABBATICAL LEAVE BALANCE AS OF LAST DAY ON PAYROLL  _____ HOURS	BALANCE AS OF EMPLOYEE'S LAST DAY ON PAYROLL		BALANCE CARRIED OVER FROM PREVIOUS YEAR			
	EARNED THIS CALENDAR YEAR THRU LAST DAY ON PAYROLL		ELIGIBLE THIS YEAR			
	USED THIS CALENDAR YEAR TO LAST DATE ON PAYROLL		USED THROUGH LAST DATE ON PAYROLL			
	USED PREVIOUS CALENDAR YEAR		BALANCE REMAINING AS OF LAST DAY ON PAYROLL			
	BALANCE CARRIED OVER FROM PREVIOUS YEAR					