Human Resources

Reset Form

New Employee Transfer of Benefits Form

To Be Completed by the Previous Employer

Employee Name (First, MI, Last):			
Name of Previous Employer:			
Type of Previous Employer: SC State Agency ☐ SC School District ☐ SC Higher Education ☐ SC Legislative/Court ☐ SC County Government ☐			
Hire Date:		Separation Date:	
Is the employee enrolled in SC PEBA Insurance? Yes☐ No ☐		SC PEBA BIN:	
Has SC PEBA been notified of the employee's transfer to UofSC (Group # H27)? Yes ☐ No ☐	SC PEBA Group #:	Effective Date of Insurance Termination with Previous Employer:	
Type of Position: Full-Time Equivalent ☐ Research Grant Position ☐Time Limited Position ☐ Temporary Position ☐			
State Service Date:		Annual Leave Accrual Date:	
Annual Leave Balance (hours):	Sick Leave Balance (hours):	YTD Family Sick Leave Hours Taken:	YTD FMLA Hours Taken:
Average Number of Hours Per Workday:		YTD Annual Leave Hours Taken:	Paid Military Leave Hours Taken (FFY):
Was annual leave paid out upon separation? Yes☐ No☐		Do all leave balances reported include all future leave accruals the employee is entitled to receive prior to separation? Yes ☐ No ☐	
What is the payroll deduction frequency for benefits?		Monthly☐ Semi- Monthly☐ Bi-weekly☐	
Is the employee enrolled in MoneyPlus accounts? Yes ☐ No ☐			
Health Savings Account	YTD Contributions: Include final paycheck? Yes ☐ No ☐	Annual Goal Amount:	
Limited-Use Spending Account	YTD Contributions: Include final paycheck? Yes ☐ No ☐	Annual Goal Amount:	
Medical Spending Account	YTD Contributions: Include final paycheck? Yes☐ No ☐	Annual Goal Amount:	
Dependent Care Spending Account	YTD Contributions: Include final paycheck? Yes ☐ No☐	Annual Goal Amount:	
Does the employee have a deferred compensation account?		Yes ☐ No ☐ * *If yes, please advise the employee that they must contact Empower.*	
Previous Employer's Contact Name:		Job Title:	
Email Address:			
Phone Number:		Date:	

***Please fax or email this competed form to BENEFITS@mailbox.sc.edu or 803.777.1584**

To Be Completed by UofSC Benefits Office	
To Be Reviewed by the UofSC Benefits Counselor:	**☐ Approved ☐ Denied**
Name of Approver:	**Date:**
To Be Reviewed by the UofSC Leave Administrator:	**☐Approved ☐Denied**
Name of Approver:	**Date:**
To Be Completed by UofSC Payroll Office	
Completed by:	**Date:**

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