Office of HUMAN RESOURCES

New Employee Benefits Transfer Form

To be completed by previous employer

Employee Name (First, MI, Last):		
Name of Previous Employer:		
Previous Employer: ☐ SC State Agency ☐ SC School District ☐ SC Higher Education Agency Code:_____		
Previous Employer Hire Date:	Previous Employer Separation Date:	
Is the employee enrolled in PEBA Insurance? Yes ☐ No ☐	PEBA BIN:	
Type of Position: ☐ Full-Time Equivalent Position ☐ Temporary- Time Limited Position		
State Service Date:	Annual Leave Accrual Date:	
Annual leave hours to transfer:	Sick leave hours to transfer:	
Is the employee enrolled in MoneyPlus accounts? Yes ☐ No ☐		
Health Savings Account	YTD Contributions: Include final paycheck? Yes ☐ No ☐	Annual Election Amount:
Limited-Use Spending Account	YTD Contributions: Include final paycheck? Yes ☐ No ☐	Annual Election Amount:
Medical Spending Account	YTD Contributions: Include final paycheck? Yes ☐ No ☐	Annual Election Amount:
Dependent Care Spending Account	YTD Contributions: Include final paycheck? Yes ☐ No ☐	Annual Election Amount:
Does the employee have a SC Deferred Compensation account?		* *If yes, please advise the employee that they must contact Empower. Yes* ☐ *No* ☐
Previous Employer's Contact Name:		Job Title:
Phone Number:		
Email Address:		Date:

***Please email to empins@clemson.edu or fax to 864.656.4672**