

# Agency Payroll Employee Insurance Benefits Transfer Form

(To be completed by the employer to whom the member has been transferred.)

## SECTION A - PREVIOUS AGENCY INFORMATION

TRANSFERRED FROM: AGENCY NO.:	PAYROLL POS. NO.:	AGENCY NAME:
PAYROLL PERIOD BEGIN DATE FOR LAST INSURANCE DEDUCTION TAKEN AT PREVIOUS AGENCY:		PAYROLL PERIOD END DATE FOR LAST INSURANCE DEDUCTION TAKEN AT PREVIOUS AGENCY:
PAY FREQUENCY AT PREVIOUS AGENCY: <input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> 26	LAST DAY OF EMPLOYMENT AT PREVIOUS AGENCY:	LAST DAY OF INSURANCE COVERAGE AT PREVIOUS AGENCY:

## SECTION B - NEW AGENCY INFORMATION

TRANSFERRED TO: AGENCY NO.:	PAYROLL POS. NO.:	AGENCY NAME:
PAYROLL PERIOD BEGIN DATE FOR FIRST INSURANCE DEDUCTION TAKEN AT NEW AGENCY:		
PAY FREQUENCY AT NEW AGENCY: <input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> 26	FIRST DAY OF EMPLOYMENT AT NEW AGENCY:	FIRST DAY OF INSURANCE COVERAGE AT NEW AGENCY:

## SECTION C - EMPLOYEE INFORMATION

SOCIAL SECURITY NUMBER:	NAME: First	Initial	Last
DAYTIME PHONE: Area Code	Number		NIGHTTIME PHONE: Area Code
HOME ADDRESS: Street		City	State Zip
MAILING ADDRESS: Street		City	State Zip
EMPLOYMENT STATUS: <input type="checkbox"/> Seasonal <input type="checkbox"/> Regular (Full-time) <input type="checkbox"/> Part-time (Regular)		RETIREMENT SYSTEM: <input type="checkbox"/> OESC <input type="checkbox"/> OLERS <input type="checkbox"/> OPERS <input type="checkbox"/> Judicial <input type="checkbox"/> Teacher <input type="checkbox"/> Wildlife	

## SECTION D- AGENCY COMPARISON INFORMATION

Does employee show continuous insurance coverage?  
(Compare last day of coverage at previous agency to first day of coverage at new agency.)  Yes  No

Does first day of insurance coverage fall between period begin date and period end date in payroll?  Yes  No. If no, explain.

Supplemental Life coverage level \$ \_\_\_\_\_

Did pay frequency change?  Yes  No If yes, and the employee had any of the following SoonerChoice deductions, (Health Care Spending Account and/or Dependent Care Spending Account) please recompute and complete the appropriate line(s).

C ME \$ \_\_\_\_\_ (Health Care Spending Account)

C DA \$ \_\_\_\_\_ (Dependent Care Spending Account)

## SECTION E- RETIREMENT COORDINATION

Check here if employee is a member of Teacher's Retirement.   
Where appropriate, a copy of this OPM-30 will be sent to Teachers Retirement immediately upon receipt by OPM!

Check here if employee is a member of OPERS.   
Where appropriate, a copy of this OPM-30 will be sent to OPERS immediately upon receipt by OPM!

## SECTION F - PAYROLL COORDINATOR AUTHORIZATION

Please send form to Agency Payroll, Office of Personnel Management, 2101 North Lincoln Boulevard, Oklahoma City, OK 73105, (405) 521-6321

Signature	Date
Phone Number	E-Mail Address