(yellow form)

GREEN COUNTY TERMINATION REPORT

☐ HR
☐ Acctg

Department to Complete

Employee Name _____

Department & Position _____

Employee Number _____ SS# _____

Address _____

_____

Phone Number _____

Last Day Worked _____

Termination Date (if different) _____

Estimated Last Check _____

Reason for Termination _____

Signature of Department Head _____ Date: _____

Please Return To HR

Human Resources to Complete

HEALTH INSURANCE Date of Cancellation _____

VISION Date of Cancellation _____

DENTAL Date of Cancellation _____

LONG TERM DISABILITY Date of Cancellation _____

SHORT TERM DISABILITY Date of Cancellation _____

LIFE INSURANCE Date of Cancellation _____

Accounting to Complete

WRS Date of Cancellation _____
Additional EE Cont's?
FLEXIBLE BENEFITS Date of Cancellation _____

DEFERRED COMP/ROTH Date of Cancellation _____

VACATION EARNED PAY Amount _____

ACCRUED VACATION PAY Amount _____

SICK TIME PAY OUT Amount _____

OTHER PAY OUT Amount _____

Send copy back to HR once completed