(blue form)

GREEN COUNTY NEW EMPLOYEE REPORT

☐ *HR*
☐ *Acctg*

Payroll checks cannot be issued without all necessary information and forms.
Use for New Hires, Change of Job, Position Or Department

HIRING DEPARTMENT _____ **Dept #** _____ **PR Acct #** _____

Employee to Complete

NAME: _____ _____
(As it appears on Social Security Card) Social Security Number

ADDRESS: _____ _____
Former Name (if applicable)

_____

DATE OF BIRTH: _____

Primary Phone # _____ **Alternate Phone #** ( ) _____
Cell: Yes/No Can Receive Text: Yes/No

Driver's License number, if county owned vehicles will be operated: _____

Has Employee been employed by Green County before? _____ Dates: _____

Has Employee participated in Wisconsin Retirement before? _____

If yes, previous employer: _____ Dates: _____

Is Employee currently active military? _____ No
(Including reserves & national guard)

Email Address (optional) _____

Emergency Contacts: _____
Name Phone

_____
Name Phone

Department to Complete

DATE EMPLOYMENT BEGAN: _____ **JOB TITLE:** _____

Employee Status: Full Time ☐ Part Time ☐ Pool ☐ Hours/week _____ Temporary ☐

Payroll Group: _____ **Grade:** _____ **Step:** _____ **Starting Rate:** _____ **Shift Diff:** _____
Hourly or **Salary**

INFORMATION REQUIRED:

Health Insurance	☐	Wisconsin Retirement	☐	Life	☐	Personal Time:
LT Disability Ins	☐	Flex Benefits	☐	Deferred Comp	☐	
ST Disability Ins	☐	Dental	☐	Vision	☐	

SHERIFF DEPT ONLY: Union employee Y N — Union Dues Y N
PEPP Contributions $10 $25

Department Head Signature: _____ **Date:** _____

Human Resources to Complete

Employee # _____ **FT** **PT** **NT** **LT** Ret Class _____ W/Comp Class _____ EEOC _____

Health Insurance: Single _____ Family _____ Ineligible _____ Decline _____
Amount: _____ _____ Effective Date: _____

Opt Life Insurance Single _____ Family _____ Ineligible _____ Decline _____
Amount: _____ _____ Effective Date: _____

Flex Benefits Ineligible _____ Decline _____ Effective Date: _____
Enrolled _____ Child FSA _____ Medical FSA _____

LT Disability Ineligible _____ Decline _____ Amount: _____ Effective Date: _____

ST Disability Ineligible _____ Decline _____ Amount: _____ Effective Date: _____

Vision Ineligible _____ Decline _____ Amount: _____ Effective Date: _____

Dental Ineligible _____ Decline _____ Amount: _____ Effective Date: _____

Union Dues Amount: _____ Effective Date: _____ No Contributions _____
PEPP Amount: _____ Effective Date: _____ **Block Sick Time?** _____

3/15/19