

## GROUP HEALTH INSURANCE TRANSFER REPORT

Wis. Stat. § 40.06

This form is to be completed by the employer when a state employee transfers to another state agency/group or when a local employee leaves active employment and starts employer paid annuitant status. Transactions such as changing HMOs or changing from single to family coverage require a new *Health Insurance Application* (ET-2301) and should not be submitted on this form.

Employee Name (Last, First, Middle Initial)		
Social Security Number	Sex (M/F)	Birthdate (MM/DD/CCYY)
Carrier Name		Carrier Suffix

### TRANSFER TO

Employer Name		Employer Number <b>69-036-</b>	Group Number
Enrollment Type	Employee Type	Coverage Code	
Event Date	Coverage Report Month	Coverage Begin Date	

### TRANSFER FROM

Employer Name		Employer Number <b>69-036-</b>	Group Number
Employee Type		Coverage Code	
Coverage Report Month		Coverage End Date	

Payroll Representative Signature	
Date Submitted (MM/DD/CCYY)	Telephone Number

*Please make 2 copies of this form.  
Send the original to ETF, send one copy to the Carrier, and retain one copy for your records.*