# Termination Checklist For State Employees

Wisconsin Department
of Employee Trust Funds
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Fax 608-267-4549
etf.wi.gov

Use this checklist for terminating employees who are under minimum retirement age (50 for protective category or 55 for all other employment categories). **Please provide a copy of this checklist to the employee along with any forms *before* their termination date.** ETF does not need a copy.

**NOTE:** If the employee has met the minimum retirement age, please use the *Termination Checklist For Retiring State Employees* (ET-2500).

Employers may either print or provide links to forms online or order hard copies here.

| **Employee Information** | |
|---|---|
| Name | |
| ETF ID | Termination date (MM/DD/YYYY) |

**Step 1: Wisconsin Retirement System Benefits**
See *Chapter 9 – Periodic Employee Transaction Reporting* and *Chapter 14 – Termination Rule and Reporting* of the WRS Administration Manual for details.

| **WRS Termination Reporting** | **Date Completed** |
|---|---|
| **STAR Agencies:** Enter the termination in PeopleSoft/Star. Make sure the employee's current address is correct. | Date<br>or N/A ☐ |
| **Non-STAR Agencies:** Submit a *P001 Termination – Employment or Retirement* transaction using the ***WRS Account Update*** application on the ETF Web Applications for Employers page. Make sure the employee's current address is included. | Date<br>or N/A ☐ |
| **Employee Forms and Notices** | **Date Employee Notified** |
| WRS Notices:<br>• See the Leaving WRS Employment webpage to learn about account options after you terminate.<br>• Contact ETF directly if your address or phone number changes.<br>• Contact ETF with questions at 1-877-533-5020 | Date<br>or N/A ☐ |

**Step 2: Wisconsin Deferred Compensation (WDC) Benefits**
See the *WDC Employer Guide* for details.

| **WDC Termination Reporting**<br>☐ Check here if the employee is not a WDC participant | **Date Completed** |
|---|---|
| Report termination in the Empower Retirement Plan Service Center (PSC) system. | Date<br>or N/A ☐ |
| **Employee Forms and Notices** | **Date Employee Notified** |
| Refer the employee to the Distribution Options brochure, the WDC website (www.wdc457.org), and provide the customer service number (1-877-457-9327) for information about their account. | Date<br>or N/A ☐ |

**Step 3: Health Insurance and Sick Leave Benefits**
See *Chapter 8 – Cancellation and Termination of Coverage* and *Chapter 12 – Accumulated Sick Leave Conversion Credits* in the State Agency Health Insurance Employer Manual (ET-1118) for details.

| **Health Insurance Termination Reporting**<br>☐ Check here if the employee is not a State health insurance subscriber | **Date Completed** |
|---|---|
| Enter a Termination of Coverage transaction. | Date<br>or N/A ☐ |
| **Active Employee Coverage End Date:** Date<br>**Health Plan Name:** ☐ Single ☐ Family | |
| **Sick Leave**<br>☐ Check here if the employee does not qualify for sick leave preservation | |
| Employers must certify sick leave through the AcSL system **within 30 days of the termination date** for the following employees:<br>• any employee with at least 20 years of WRS creditable service<br>• any employee applying for a disability benefit<br>• state constitutional officer<br>• a member or an officer of the legislature<br>• the head of a state department or agency who was appointed by the governor with senate confirmation<br>***Reminder:*** *If the employee has met the minimum retirement age, please use the Termination Checklist For Retiring State Employees (ET-2500)* | |
| **Employee Forms and Notices** | **Date Employee Notified** |
| Provide a *Continuation-Conversion Notice* (ET-2311) form with the employer sections completed along with a *Health Insurance Application/Change* (ET-2301). | Date<br>or N/A ☐ |
| Health Insurance and Sick Leave Notices:<br>• Health insurance coverage ends at the end of the month in which your employment ends.<br>• You and your qualified beneficiaries have the right to continue group coverage or convert to individual coverage for up to 18 months under COBRA.<br>  ○ You must complete the *Continuation-Conversion Notice (ET-2311)* and the *Health Insurance Application/Change (ET-2301)* forms and send to ETF within 60 days of the date your active coverage ends.<br>  ○ If you have 20 years of WRS creditable service, see options D and E in the *Qualified Beneficiary* section of the ET-2311.<br>  *Note: If you select option E, you must submit your paperwork to ETF by the date your active coverage ends.*<br>  ○ If you elect coverage under COBRA, the health plan will bill you directly.<br>• Contact ETF if your address or phone number changes.<br>• Contact ETF with questions at 1-877-533-5020 | Date<br>or N/A ☐ |
| Provide *eligible employees* with sick leave credit estimate from AcSL<br>*See Chapter 12, Subchapter 1209 in the employer manual for instructions.* | Date<br>or N/A ☐ |
| Refer *eligible employees* to the *Sick Leave Credit Conversion Program* (ET-4132) brochure | Date<br>or N/A ☐ |

**Step 4: Life Insurance Benefits**
See *Chapter 15 – Maintaining Coverage After Termination of Employment* in the WPE Group Life Insurance Program Administration Manual (ET-1117) for details.

| **Life Insurance Termination Reporting**<br>☐ Check here if the employee is not a state life insurance subscriber<br>☐ Check here if the employee qualifies for continuation of coverage | **Date Completed** |
|---|---|
| Identify when last premium payment is due and refund overpayments. | Date<br>or N/A ☐ |
| **Coverage Paid Thru:** Date<br>☐ Basic ☐ 100% Supplemental ☐ Additional 1 ☐ Additional 2 ☐ Additional 3<br>☐ Spouse & Dependent ☐ Unit I ☐ Units I and II | |
| **Employee Forms and Notices** | **Date Employee Notified** |
| Life Insurance Notices:<br>• Your coverage ends on the last calendar day of the month in which your employment ends.<br>• If you qualify for continuation of coverage, you must submit a *Group Life Insurance Continuation Application* (ET-2154) form to ETF within 31 days of coverage ending. You will be billed directly by Securian. | Date<br>or N/A ☐ |
| Provide qualified employees with the *Group Life Insurance Continuation Application* (ET-2154) form and refer them to the *WPE Group Life Insurance Program (ET-2101)* brochure | |

**Step 5: Income Continuation Insurance (ICI) Benefits**
See *Chapter 6 – Termination of Coverage in the Income Continuation Insurance Administration Manual (ET-1119)* for details.

| **ICI Termination Reporting**<br>☐ Check here if the employee is not a State ICI subscriber | |
|---|---|
| **Coverage Paid Thru:** Date | |
| **Employee Forms and Notices** | **Date Employee Notified** |
| ICI coverage ends when you terminate your employment. | Date<br>or N/A ☐ |

**Step 6: Supplemental Benefits**
See *Chapter X – Cancellation/Termination* in the *Supplemental Benefit Plans Administration Manual (ET-1158)* for details.

| **Supplemental Benefit Termination Reporting** | | **Coverage End Date** |
|---|---|---|
| **Commuter Fringe Benefit Accounts (Optum)**<br>*Coverage ends on the date of termination.* | Parking Account | Date<br>or N/A ☐ |
| | Transit Account | Date<br>or N/A ☐ |
| **Employee Reimbursement Accounts (Optum)**<br>*Coverage ends the last day of the month following final contribution. Dependent Day Care Account coverage ends December 31 of the plan year.* | Health Care Flexible Spending Account (HCFSA) | Date<br>or N/A ☐ |
| | Limited Purpose Flexible Spending Account (LPFSA) | Date<br>or N/A ☐ |
| | Dependent Day Care Account | Date<br>or N/A ☐ |
| **Securian Accident Plan**<br>☐ Employee ☐ Employee + spouse ☐ Employee + child(ren) ☐ Employee + family | | Date<br>or N/A ☐ |
| **Delta Dental of Wisconsin**<br>☐ PPO - Select Plan ☐ PPO Plus Premier - Select Plus Plan<br>☐ Employee ☐ Employee + spouse ☐ Employee + child(ren) ☐ Employee + family<br>☐ PPO Plus Premier-Preventive Plan<br>☐ Single ☐ Family | | Date<br>or N/A ☐ |
| **DeltaVision Vision Care**<br>**Coverage Paid Thru:** Date<br>☐ Employee ☐ Employee + spouse ☐ Employee + child(ren) ☐ Employee + family | | |

| **Employee Forms and Notices** | **Date Employee Notified** |
|---|---|
| If you have a FSA, you are eligible for COBRA through the end of the plan year by completing the *FSA Continuation Election Form (ET-1518)*<br>• If you choose not to continue coverage, medical expenses incurred after the coverage end date listed above will not be eligible for reimbursement.<br>• Any funds remaining after all valid claims have been paid will be forfeited. | Date<br>or N/A ☐ |
| Commuter Fringe Benefit Notices (Optum):<br>• Payment card will be deactivated upon termination. Reimbursement requests must be submitted online through your portal account or mobile app.<br>• You have until March 31, the last day of the run-out period, to submit reimbursement request(s) or resolve any outstanding claims for expenses incurred during the coverage period. | Date<br>or N/A ☐ |
| Health Savings Account (HSA) Notices (Optum):<br>• Your HSA contributions from both payroll deduction and employer contribution will end upon termination.<br>• You will continue to have access to your HSA after termination.<br>• There is a $1.32/month administrative fee that will begin the first of the month following termination. This fee will be deducted from your HSA account balance. | Date<br>or N/A ☐ |

| | |
|---|---|
| For questions about benefits administered by Optum, please see the Optum landing page or call their customer service number at 1-833-881-8158. | Date<br>or N/A ☐ |
| Delta Dental of Wisconsin Supplemental Coverage Notices:<br>• You may continue existing supplemental coverage up to 18 months if:<br>○ You choose "continuant" on the Delta Dental Retiree/Continuation form, *and*<br>○ You send the form to Delta Dental within 30 days of your termination date.<br>• If you choose to continue coverage, you will be billed directly by Delta Dental.<br>• Contact Delta Dental at 1-844-337-8383 with questions. | Date<br>or N/A ☐ |
| DeltaVision Vision Care Coverage Notices:<br>• You may continue existing supplemental coverage up to 18 months if:<br>○ You choose "continuant" on the Supplemental Vision Retiree/Continuant Change Form<br>○ You send the form to Delta Vision within 30 days of your termination date.<br>• If you choose to continue coverage, you will be billed directly by Delta Vision.<br>• For information regarding DeltaVision Vision Care benefits, visit their website or call 1-844-337-8383 | Date<br>or N/A ☐ |
| The Securian Accident benefit is portable and can be maintained up to age 70. You must contact Securian at 1-866-295-8690 or madisonbranch@securian.com within 30 days of your termination date to maintain coverage. | Date<br>or N/A ☐ |

**Employers and employees should contact ETF with any questions. Visit etf.wi.gov for ETF-administered benefits information, forms, brochures, benefit calculators, educational offerings and other resources.**

| **Signature** | |
|---|---|
| This signature acknowledges that both parties have reviewed this checklist before the employee's last day due to termination of employment, and that everything applicable to this employee has been completed as noted above. | |
| Employee Signature | Date (MM/DD/YYYY) |
| Employer Signature | Date (MM/DD/YYYY) |