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| logo122508.png | University of Texas at San Antonio1 UTSA CircleSan Antonio, Texas 78249 | P: 210.458.4250F: 210.458.7890benefits@utsa.edu |
|  |
| **TRANSFER OF RETIREMENT & INSURANCE RECORDS** |
| **Employee Name:**  |  | **EMPL ID:** |  | **Hire Date:** |  |
| **Texas Teacher Retirement System** | **[ ]  Yes** | **[ ]  No** |
| If yes, was employee ever offered ORP? | **[ ]  Yes** | **[ ]  No** |
| *If yes, attach a copy of the ORP Acknowledgement Form* |
| **Texas Optional Retirement Program** | **[ ]  Yes** | **[ ]  No** |
| *If yes, attach a copy of the TRS 28 (Notice of Election to Participate in ORP) & complete the following fields.* |
| Offer Date: |  | Election Date: |  |
| State Contribution Rate: | **[ ]  6.0%** | **[ ]  8.5%** |
| Vested: | **[ ]  Yes** | Vesting Date:  | **[ ]  No** |
| Name of Carrier: |  |
| **UTSaver Tax Shelter Annuity** | **[ ]  Yes** | **[ ]  No** |
| Name of Carrier: |  |
| Monthly Deduction: | **$** | Year to Date: | **$** |
| **UTSaver Deferred Compensation Program** | **[ ]  Yes** | **[ ]  No** |
| Name of Carrier: |  |
| Monthly Deduction: | **$** | Year to Date: | **$** |
| **MEDICAL Insurance** | **[ ]  Yes** | **[ ]  No** |
| If yes, Name of Carrier *(UT Select BCBS PPO)*: |  |
| Sub Only **[ ]**  | Sub/Spouse **[ ]**  | Sub/Child(ren) **[ ]**  | Sub/Family **[ ]**  |
| **DENTAL Insurance** | **[ ]  Yes** | **[ ]  No** |
| If yes, Name of Carrier *(Delta DHMO)*: |  |
| Sub Only **[ ]**  | Sub/Spouse **[ ]**  | Sub/Child(ren) **[ ]**  | Sub/Family **[ ]**  |
| **VISION Insurance** | **[ ]  Yes** | **[ ]  No** |
| If yes, Name of Carrier *(Superior)*: |  |
| Sub Only **[ ]**  | Sub/Spouse **[ ]**  | Sub/Child(ren) **[ ]**  | Sub/Family **[ ]**  |
| **LIFE Insurance** | **[ ]  Yes** | **[ ]  No** |
| If yes, Name of Carrier *(Dearborn National)*: |  |
| Employee Level |  | Family Coverage: |  |
| **AD&D Insurance** | **[ ]  Yes** | **[ ]  No** |
| If yes, Name of Carrier *(Dearborn National)*: |  |
| Employee Amount | **$** | Family Amount: | **$** |
| **LONG TERM DISABILITY Insurance** | **[ ]  Yes** | **[ ]  No** |
| If yes, Name of Carrier *(Dearborn National)*: |  |
| **SHORT TERM DISABILITY Insurance** | **[ ]  Yes** | **[ ]  No** |
| If yes, Name of Carrier *(Dearborn National)*: |  |
| **FLEXIBLE SPENDING ACCOUNTS** |  |  |
| Medical Reimbursement:  | **[ ]  Yes** **[ ]  No** | Monthly Amount: | **$** | Year to Date: | **$** |
| Dependent Day Care Reimbursement | **[ ]  Yes****[ ]  No** | Monthly Amount: | **$** | Year to Date: | **$** |
| **Employee’s Term Date:** |  |
| **Print Name & Title:**  |  | **Phone # :** |  |
| **Agency Name:** |  | **Date :** |  |