

Workers' Compensation Commission

NOTICE OF RESIGNATION

Name _____ SSN (LAST 4 DIGITS) _____

Department _____

I wish to resign my position for the following reason(s):

- | | |
|---|---|
| <input type="checkbox"/> Other Employment | <input type="checkbox"/> Disability Retirement |
| <input type="checkbox"/> Personal Reasons | <input type="checkbox"/> Relocation |
| <input type="checkbox"/> Regular Retirement | <input type="checkbox"/> Other (specify): _____ |

The effective date of my resignation will be _____, 20__ at _____ AM/PM.

- ☐ I request that I be paid for annual leave.
- ☐ I request that my annual and sick leave be transferred to the following agency:

☐ I request that my sick leave be transferred to the following school district:

☐ I wish to withdraw my retirement contributions. Attached is a completed Form (4101), **South Carolina Retirement Systems Refund Request** and a legible copy of my Driver's License or Special Identification Card issued by the SC Department of Public Safety.

☐ If eligible, I wish to convert Basic Life, Optional Life, Dependent Life/Spouse and/or Dependent Life/child coverage to an individual policy with MetLife. Please list which policies you wish to convert: _____

☐ I do not wish to withdraw my retirement contributions at this time.

If relocating, please provide new mailing address:

Street City State Zip Code

Employee Signature

Date