Salary & Benefits Checklist

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Hire: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Weekly Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Starting Salary: \_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per \_\_\_\_\_\_\_\_\_\_\_\_

**Benefit Entitlements:**

**Benefit information and forms located at http://<COMPANY INTRANET SITE>**

|  |  |
| --- | --- |
| **BENEFIT** | **EFFECTIVE DATE** |
| Medical Coverage |  |
| Dental Coverage |  |
| Life/Accidental Death Insurance |  |
| Vision Coverage |  |
| Short-Term/Long-Term Disability |  |

|  |  |
| --- | --- |
| **BENEFIT** | **ELIGIBLILITY** |
| Vacation Accrual: \_\_\_\_ weeks/year |  |
| Sick Accrual |  |
| Holidays |  |
| 401K |  |
| Flexible Spending Account |  |
| Employee Assistance Program |  |
| OTHER: <Benefit Name> |  |
| OTHER: <Benefit Name> |  |
| OTHER: <Benefit Name> |  |

Your signature below acknowledges that a representative of the Human Resources Department has reviewed the above items with you.

*Employee Date*

*Human Resources Representative Date*