

Employer Information Sheet

Employer Name and Tax No.

Notice to Employer:

Please fill out completely and return to:

EMPLOYEE INFORMATION

Full name of employee:

Address:

SSN#:

Date of Birth:

Number of dependents:

Date employed:

Job Title:

Rate of pay: \$ per

Average number of hours per week:

How often paid (check one): Weekly Bi-weekly Monthly Semi-monthly

If paid Weekly/Bi-weekly, state day of the week paid:

Date last paid:

If paid Semi-monthly, state dates paid:

Date last paid:

If paid Monthly, state date paid:

Date last paid:

Worksite address:

Date Terminated: If terminated, list the termination reason and the name and address of the new employer, if known:

Complete the Information below for the last four Pay Periods

Date Paid	Gross Wages	Bonus/ Commission	Federal Tax	State Tax	FICA	Retirement	Net Wages

MEDICAL INSURANCE INFORMATION FOR MINOR CHILDREN

Available as of _____ (Date) Not Available

Will be Available as of _____

Insurance Company Name:

Insurance Company Address :

Insurance Company Telephone Number:

Policy Number:

Employee certificate/ID#: _____

Type of Coverage:

Amount of Deductible: \$ _____

Cost to employee to cover self/dependents: \$ _____

Individuals covered/effective date: _____

Completed by:

Title:

Date:

When complete, return to the address shown below. **Employer Telephone Number:**