**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**: