

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:** _____