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**: _____
_____
_____