

Employee/Contractor Information Form

Please TYPE ALL data and sign form

COMPANY NAME: _____ **DATE:** _____
(THE COMPANY)

EMPLOYEE **CONTRACTOR**
NEW **CHANGE/UPDATE** **TERMINATION** **TERMINATION DATE:** _____

BASICS
Name: _____ **TIN,EIN or SSN:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Hire Date: _____ **Date of Birth:** _____ **Email:** _____

PAY (EMPLOYEES ONLY)
Hourly **Hourly Rate 1: \$** _____ **/hour** **Hourly Rate 2: \$** _____ **/hour**
Salary **Annual: \$** _____ **Monthly: \$** _____ **Weekly: \$** _____
Commission Only: \$ _____
Health Benefits Deduction per Payroll **Medical \$** _____ **Vision \$** _____ **Dental \$** _____
(For Health Benefits, provide worksheet showing employee's premium for each type per payroll)
#Vacation Days/Yr: _____ **#Sick Days/Yr:** _____

DIRECT DEPOSIT (Provide check copy if applicable)
Bank Routing Number: _____ **Bank Account Number:** _____ **Checking** **Savings**
Partial Amount: \$ _____ ***** **or** **Entire Paycheck**
***Balance of Pay to:**
Paper Check **Account information below (Split payments are not available for Contractors)**
Bank Routing Number: _____ **Bank Account Number:** _____ **Checking** **Savings**

AGREEMENT
 By signing this form I authorize THE COMPANY, named on this form, to deposit my pay automatically to the bank account(s) indicated on this form and, if necessary, to adjust or reverse a deposit for any payroll entry made to my account in error. This authorization will remain in effect until I cancel it in writing and in such time as to afford THE COMPANY a reasonable opportunity to act on it.

FILING STATUS AND WITHHOLDING ALLOWANCES (EMPLOYEES MUST FILL OUT FEDERAL/STATE WITHHOLDING FORM)
FEDERAL (obtain from W4)
 Single Married Head of Household Allowances: _____ Additional Withholdings: \$ _____
STATE (obtain from withholding form) **STATE NAME (if applicable):** _____
 Single Married Married Filing Separately Head of Household
 Allowances: _____ Additional Withholdings: \$ _____

PLEASE ATTACH: (Company Use Only)
CHECK COPY
FEDERAL WITHHOLDING FORM
STATE WITHHOLDING FORM
HEALTH BENEFITS WORKSHEET

Employee/Contractor Signature _____ **Date** _____

Manager Name _____ **Manager Signature** _____