

PAYROLL CHANGE FORM

EMPLOYEE: Complete Name, Social Security Number, Effective Date and areas affected by change **ONLY**.

Must also be completed by Human Resources.

FOR HR AND PAYROLL USE - REQUIRED INFORMATION

EFFECTIVE DATE _____ **COMPLETED BY (HR)** _____

PROCESSED DATE _____ **ENTERED BY (Payroll)** _____

TYPE OF CHANGE NAME ADDRESS SALARY BONUS
 EMPLOYMENT STATUS TAX PAYROLL STATUS
 BENEFITS COST CENTER POSITION

NAME _____
LAST FIRST FULL MIDDLE NAME OTHER NAME USED

CURRENT ADDRESS _____
STREET APT.#
CITY STATE ZIP

HOME TELEPHONE NUMBER _(_____)_____-_____

CELL PHONE NUMBER _(_____)_____-_____

SOCIAL SECURITY NUMBER _____-_____-_____

DATE OF BIRTH ____/____/____ **COST CENTER** _____

JOB CODE / TITLE _____

PAYROLL STATUS

F - Full time P - Part time
 S - Salaried H - Hourly

EMPLOYMENT START DATE

____/____/____

CLASSIFICATION

Exempt Non-exempt

NUMBER OF EXEMPTION (W4)

W4 MARITAL STATUS

H - Married, withhold at higher single rate
 M - Married
 S - Single, Head of Household

EMPLOYMENT TYPE

- 40+ hours
- 30 - 40 hours
- less than 30 hours

MONTHLY SALARY OR HOURLY RATE
(monthly salary (salaried employees only) or hourly rate (hourly employees only) as noted on Change Documentation

CHECK DISPOSITION

- P - Physical
- D - Direct Deposit

HOURS PER WEEK _____

Enter the total number of hours the employee is scheduled to work per week.

BENEFITS:

	MEDICAL		DENTAL	VISION	TOTAL
	HSA	PPO			
EE Only					
EE + 1					
EE + 2					

HEALTH SAVINGS ACCOUNT	DEPENDENT CARE ACCOUNT	FLEXIBLE SPENDING ACCT
monthly contribution \$	monthly contribution \$	\$
bi-weekly contribution \$	bi-weekly contribution \$	\$