PAYROLL
MANAGEMENT, INC.

550 Center St.
PO Box 1837
Auburn, ME 04211-1837

Phone (207) 783-6880 * Toll Free (800) 734-6880 * Fax (207) 753-0484 * Toll Free Fax (800) 322-6880 * www.payrollmgt.com

NEW EMPLOYEE SET-UP INFORMATION

CLIENT NUMBER: _____ CLIENT NAME: _____ DATE: ___/___/____

****

PERSONAL INFORMATION

EMPLOYEE NUMBER: _____ LAST NAME: _____ FIRST: _____ MI: _____
(If no number is specified, PMI will use last four digits of SSN)

ADDRESS LINE 1: _____

ADDRESS LINE 2: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____ SEX (M or F): _____ DATE OF BIRTH: _____/_____/_____

ETHNICITY _____
(Hispanic or Latino/White/Black or African American/Native Hawaiian or Other Pacific Islander/Asian/American Indian or Alaska Native/Two or More Races)

E-MAIL ADDRESS: _____

HOME PHONE: (_____) _____ - _____ CELL PHONE: (_____) _____ - _____

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HIRING INFORMATION

DATE OF HIRE: _____/_____/_____ PART TIME: _____ FULL TIME: _____

HOURLY/SALARY: _____ (H or S) HOURLY RATE: _____ or SALARY PER PAY PERIOD $ _____

PAY FREQUENCY: _____ JOB CATEGORY _____
(weekly, bi-weekly, semi-monthly, monthly, etc.)

DIVISION: _____ DEPARTMENT: _____ WORKER'S COMP CODE: _____

Start vacation/sick/personal on this employee? _____ If yes, at what accrual rate: _____

****

TAX WITHHOLDING INFORMATION (from Form W-4):

Federal Filing Status (*): _____ Exemptions: _____ Additional FWT: _____ $ or %

State Filing Status (*): _____ Exemptions: _____ Additional SWT: _____ $ or %

*(S=Single/M=Married/MD=Married, but withholding at the higher Single rate/NRA=single Non-Resident Alien/NRM=married Non-Resident Alien)

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NEW EMPLOYEE SET-UP INFORMATION

CLIENT NUMBER: _____ **CLIENT NAME:** _____ **DATE:** ____/____/_____

EMPLOYEE NUMBER: _____ **LAST NAME:** _____ **FIRST:** _____ **MI:** _____

****

HEALTH INSURANCE INFORMATION:

Part-Time Employee (less than 30 hours per week)? _____ (If yes, skip rest of form)

Full-Time Employee (30 hours or more per week)? _____

Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

_____ Yes (Continue) If yes, did employee elect to enroll in coverage? _____ Yes _____ No
If the employee is not eligible today, including the result of a waiting or probationary period, when is the employee eligible for coverage?

_____ (mm/dd/yyyy) (Continue)
_____ No (Skip rest of form)

TELL US ABOUT THE HEALTH PLAN OFFERED BY THIS EMPLOYER

Does the employer offer a health plan that covers an employee's Spouse or Dependent?
_____ Yes, which people? _____ Spouse _____ Dependent(s)
_____ No

Does the employer offer a health plan that meets the minimum essential coverage standard?
_____ Yes
_____ No

How much would the employee have to pay in premiums for this plan? $ _____

How often? _____ Weekly _____ Every 2 weeks _____ Twice a month _____ Monthly _____ Other

****

DIRECT DEPOSIT INFORMATION:

1. Name of Bank or Savings Association: _____

Routing Number: _____ Account Number: _____

_____ Checking _____ Savings AMOUNT: _____

2. Name of Bank or Savings Association: _____

Routing Number: _____ Account Number: _____

_____ Checking _____ Savings AMOUNT: _____

*****PLEASE ATTACH A COPY OF A VOIDED CHECK FOR VERIFICATION*****