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: ___/___/____

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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: ________________

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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*****