

Payroll/Status Change Notice

Please Print

Routing Payroll _____ _____
 Effective Date of Change ____/____/____ New Hire Change Separation
 Employee Name _____
 Social Security # _____ Last _____ First _____ Middle _____
 Employee/Payroll # _____ Dept. _____

New Hire Information

Address _____ Street _____ City _____ State _____ Zip Code _____
 Telephone # (____) _____ Date of Birth (for administrative use only) ____/____/____
 Status: Full-Time Part-Time Full-Time Temporary Part-Time Temporary Other _____
 Job Title _____ Exempt Non-Exempt Hourly W-4 attached? Yes No

Change(s) for Current Employee

Type	From	To	Comments
<input type="checkbox"/> Address Change			
<input type="checkbox"/> Demotion			
<input type="checkbox"/> Department			
<input type="checkbox"/> 401(k)/403(b) Contribution			
<input type="checkbox"/> Insurance Eligibility			
<input type="checkbox"/> Job Title			
<input type="checkbox"/> Change of Insurance			
<input type="checkbox"/> Layoff			
<input type="checkbox"/> Length of Service Increase			
<input type="checkbox"/> Merit Increase			
<input type="checkbox"/> End of Introductory Period			
<input type="checkbox"/> Promotion			
<input type="checkbox"/> Re-evaluation of Current Job			
<input type="checkbox"/> Rehire			
<input type="checkbox"/> Resignation			
<input type="checkbox"/> Retirement			
<input type="checkbox"/> Salary/Wage			
<input type="checkbox"/> Separation			
<input type="checkbox"/> Shift Change			
<input type="checkbox"/> Transfer			
<input type="checkbox"/> Union Scale			
<input type="checkbox"/> Other _____			

Leave of Absence Begin Leave ____/____/____ Return from Leave ____/____/____
 Educational Personal Family/Medical Leave (Including Pregnancy)
 Short-Term Disability Long-Term Disability Other _____

Separation Separation Date ____/____/____ Last Day Worked ____/____/____ Last Day Paid ____/____/____
 Voluntary Separation Involuntary Separation Notice of COBRA Rights provided on ____/____/____
 Election of COBRA Yes No Start date of coverage ____/____/____
 If yes, describe type of coverage elected _____

Additional Comments _____

Employee Signature (Optional) _____ Name and Title _____ Date ____/____/____
 Supervisor/Designated Manager Signature _____ Name and Title _____ Date ____/____/____
 Human Resources/Payroll Manager Signature _____ Name and Title _____ Date ____/____/____