COMPANY NAME

NEW EMPLOYEE PAYROLL INFORMATION

LAST NAME: _____

FIRST NAME: _____ MIDDLE INITIAL: _____

ADDRESS: _____

_____

CITY: _____ STATE: _____ ZIP CODE: _____

SOCIAL SECURITY NUMBER: _____ EMPLOYEE NUMBER: _____

MARITAL STATUS:

FEDERAL	M☐ S☐
STATE	M☐ S☐

EXEMPTIONS:

FEDERAL	STATE

EXTRA FED WH: _____ EXTRA STATE WH: _____

HOURLY OR SALARY EMPLOYEE: H☐ S☐ RATE OF PAY OR SALARY: _____

FULL TIME OR PART TIME: F☐ P☐ DEPARTMENT: _____

HIRE DATE: _____ START DATE FOR PTO HOURS: _____

BIRTH DATE: _____ START DATE FOR VACATION: _____

THE EMPLOYER MUST KEEP ALL PAYROLL FORMS IN AN EMPLOYEE FILE FOR THEIR RECORDS.

PAYROLL FORMS COMPLETED

- ☐ W-4
- ☐ STATE W-4
- ☐ I-9
- ☐ VERIFY DOCUMENTS FOR I-9 & SIGN FORM

FORMS SUBMITTED

- ☐ STATE W-4 SUBMITTED TO PROPER AGENCY
- ☐ THIS FORM COMPLETED AND SENT TO:

KRAMER & ASSOCIATES LLC

FAX: (712) 276-6619

E-MAIL: KIMHASSLER@KRAMERCPASLLC.COM

**** BEFORE A CHECK CAN BE CREATED, THIS FORM MUST BE COMPLETED AND SENT TO KRAMER & ASSOCIATES LLC ****

PLEASE COMPLETE REVERSE SIDE ⇨

ADDITIONAL PAPERWORK - IF APPLICABLE

☐ **DIRECT DEPOSIT** IF APPLICABLE, SEND FORMS AND COPY OF CHECK TO KRAMER & ASSOCIATES LLC

HEALTH INSURANCE AMOUNT PER PAY PERIOD _____

PRETAX AFTER TAX (CIRCLE ONE) ANNUAL AMOUNT _____ EFFECTIVE DATE _____

FLEX-MEDICAL AMOUNT PER PAY PERIOD _____

(SEC 125) ANNUAL AMOUNT _____ EFFECTIVE DATE _____

FLEX-DAY CARE AMOUNT PER PAY PERIOD _____

(SEC 125) ANNUAL AMOUNT _____ EFFECTIVE DATE _____

DENTAL INSURANCE AMOUNT PER PAY PERIOD _____

PRETAX AFTER TAX (CIRCLE ONE) ANNUAL AMOUNT _____ EFFECTIVE DATE _____

401 K / SIMPLE IRA PERCENTAGE _____ EFFECTIVE DATE _____

OR

ANNUAL AMOUNT _____

LIFE INSURANCE AMOUNT PER PAY PERIOD _____

ANNUAL AMOUNT _____ EFFECTIVE DATE _____

LONG-TERM DISABILITY AMOUNT PER PAY PERIOD _____

ANNUAL AMOUNT _____ EFFECTIVE DATE _____

NOTES: _____

PERMANENT PAYROLL CHANGES

NUMBER	NAME	FIELD	FROM	TO