

Company Payroll Company



1193 SE Port St Lucie Blvd, Suite 101, Port Saint Lucie, Florida 34952 · Phone: 800.742.8220 · Fax: 772.872.7284

Payroll Service Implementation Form

Mid-Year Implementation. (Please include All Year-To-Date Quarterly Reports, and monthly reports, as necessary. Questions? Call us.)

Company Name:		Date Established:	
Federal Employer ID Number (EIN):		Tax Type: <input type="checkbox"/> Assoc <input type="checkbox"/> C-Corp <input type="checkbox"/> Non-Profit <input type="checkbox"/> Partnership <input type="checkbox"/> S-Corp <input type="checkbox"/> Sole Proprietor	SIC Code:
Description Of Operations:			
Primary Corporate Officer's Name:		Primary Corporate Officer's Title:	
Address:		Suite No.:	
City:		State:	Zip Code:
Telephone:		E-Mail Address:	
Payroll Cycle: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly		First Payroll Date:	Default Payroll: <input type="checkbox"/> Yes <input type="checkbox"/> No
941 Reporting Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Weekly	State SUTA Acct No / Rate:	State SIT Acct No:	Worker's Comp Mod. Ratio:
Benefits Anniversary Date:	Benefit Pre-Tax: <input type="checkbox"/> Yes <input type="checkbox"/> No	Vacation Allowance:	Sick Hours Allowance:
401(k) Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No	401(k) Plan Match: <input type="checkbox"/> Yes <input type="checkbox"/> No	401(k) Match Explanation:	
Remarks/Comments:		Company Code: (Office Use Only)	Agent No: (Office Use Only)

TERMS AND CONDITIONS

- Company shall perform the payroll processing services and any statutory reporting requirements on behalf of Customer in a professional manner.
- Customer shall pay to Company, for the services performed under this letter, compensation in the amount provided on the attached price sheet.
- Company is and shall remain an independent Company at all times. Company shall be responsible for hiring any assistance needed in performing under this letter at no additional cost to Customer. Company shall indemnify Customer for any and all damages and liabilities caused by Company or Company's assistance in their performance.
- Services can be terminated by providing each party a written notice. All correspondence shall be sent or faxed to the Company's or Customer's business address, as appropriate.
- Services shall not be assigned, nor any performance hereunder delegated by Company or Customer, without the express written consent of the other, which consent shall not be unreasonably withheld.
- Additional Terms and Conditions:
 - Client is responsible for prompt and accurate submission of all time worked.
 - Client is responsible for prompt and accurate submission of all personnel changes.
 - Client is responsible for funding its payroll, and all associated expenses. Returned debited amounts will incur an additional \$75 fee.
 - Client is responsible for providing Company Representatives with proper access during benefits enrollment sessions.

I verify that the above information is correct to the best of my knowledge. If any information changes, during the term of the service agreement, I will immediately notify Company Payroll Company of such change. Changes must be submitted in writing via U.S. Mail to the address above, or via fax at (772) 872-7284.

Employer's Representative / Title
(All requests must be signed)

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Authorization Agreement for Use of Checking Account Information

I (we) hereby authorize **COMPANY PAYROLL COMPANY** to use the financial institution named below ("Bank") information for the processing of our company's payroll.

Company Name	Signer's Name	Bank Account Number		Bank Name
Bank Address	City	State	Zip Code	Bank Phone Number
ABA Transit / Routing Number (lower left corner of check)		Check Fraction	First Check Number to Use	
Attach Voided Check Here				

(___) I (we) hereby authorize **COMPANY PAYROLL COMPANY** to use the following signature when processing of our company's payroll checks and any associated reports.

This authorization is to remain in force until **COMPANY PAYROLL COMPANY** has received written notification of its termination.

Authorized Customer's Signature Date

Printed Name / Title

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EMPLOYEE DATA SHEET

SECTION I – To be completed by Employee

NAME (Last, First Middle Initial)		SSN	
GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	HOME PHONE	CELL PHONE (Required)
E-MAIL ADDRESS (Required)			
ADDRESS			
CITY		STATE	ZIP CODE
W4 FORM TAX STATUS <input type="checkbox"/> SINGLE/MARRIED FILING SEPARATELY <input type="checkbox"/> MARRIED FILING JOINTLY <input type="checkbox"/> HEAD OF HOUSEHOLD	BOX STEP 2: <input type="checkbox"/> Do You Have Another Job? <input type="checkbox"/> Do You File Married AND Your Spouse Works?	CLAIM DEPENDENTS - Age 16 & Under: _____ x \$2,000 = _____ - Age 17 & Over: _____ x \$500 = _____	OTHER INCOME: DEDUCTIONS: EXTRA WITHHOLDING:
DIRECT DEPOSIT INFORMATION <input type="checkbox"/> SAVINGS <input type="checkbox"/> CHECKING	BANK NAME	ROUTING ACH NUMBER	ACCOUNT NUMBER

This authority is to remain in full force and effect until Company Payroll Company has received written notification from me of its termination in such time and manner as to afford Company Payroll Company and the financial institution reasonable opportunity to act on it. I understand that Basic Business Solutions shall not be held responsible for any bank charges that may be attached to my account.

Employee's Signature / Date

(All requests must be signed)

SECTION II – To be completed by Employer

TYPE OF REQUEST <input type="checkbox"/> New Hire <input type="checkbox"/> Change <input type="checkbox"/> Termination	EFFECTIVE DATE	STATUS <input type="checkbox"/> Active <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Terminated	
COMPANY CODE	COMPANY NAME		
HIRE DATE	EMPLOYEE TYPE <input type="checkbox"/> SALARY <input type="checkbox"/> HOURLY	SALARY/HOURLY RATE	
JOB TITLE	WORKERS COMP CODE	DEPARTMENT	
I-9 FORM EXPIRATION DATE			

EMPLOYER: In addition to this form, you need to collect the following forms from you new employee: A completed and signed IRS **Form W-4**, and a completed and signed **I-9 Form**.

Employer's Representative Signature

(All requests must be signed)

FAX COMPLETED FORM TO (772) 872-7284

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SUBCONTRACTOR DATA SHEET

SECTION I – To be completed by Subcontractor

COMPANY NAME		DATE ESTABLISHED	
FEDERAL TAX ID NUMBER (TIN)	TAX TYPE: <input type="checkbox"/> Assoc <input type="checkbox"/> C-Corp <input type="checkbox"/> Non-Profit <input type="checkbox"/> Partnership <input type="checkbox"/> S-Corp <input type="checkbox"/> Sole Proprietor		SIC CODE
DESCRIPTION OF OPERATIONS			
PRIMARY CORPORATE OFFICER'S NAME		PRIMARY CORPORATE OFFICER'S TITLE	
GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	BUSINESS' PHONE	CELL PHONE <i>(Required)</i>
E-MAIL ADDRESS <i>(Required)</i>			
ADDRESS			
CITY		STATE	ZIP CODE
DIRECT DEPOSIT INFORMATION <input type="checkbox"/> SAVINGS <input type="checkbox"/> CHECKING	BANK NAME	ROUTING ACH NUMBER	ACCOUNT NUMBER

This authority is to remain in full force and effect until Basic Business Solutions has received written notification from me of its termination in such time and manner as to afford Basic Business Solutions and the financial institution reasonable opportunity to act on it. I understand that Basic Business Solutions shall not be held responsible for any bank charges that may be attached to my account.

Subcontractor's Signature / Date
(All requests must be signed)

SECTION II – To be completed by Client

COMPANY NAME	START DATE
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In addition to this form, remember to collect the following forms from you new subcontractor:

- Certificate of Insurance for General Liability
- Certificate of Insurance for Workers Compensation.

Client's Representative Signature
(All requests must be signed)

FAX COMPLETED FORM TO (772) 872-7284