PAYCHEX

Office/Client Number _____

New Employee Packet

Employer Information: Choose your option for submitting employee information. For detailed instructions for these options, refer to the PEO New Employee Packet Employer Instructions.

☐ Option 1 - Spreadsheet Submission and Certification *(Complete **one** spreadsheet attachment per client code)*
(Requires Authorized Signature in Section A)

☐ Option 2 – NEP Submission: Complete B1 and B2

☐ Option 3 – Online payroll clients only: Print out online payroll summary information for applicable new employee in place of completing Section B1 (*Click here for sample online payroll summary.)*

A - EMPLOYEE INFORMATION SUBMISSION AND CERTIFICATION

As an authorized representative, I am electing to submit all required new employee information via the approved spreadsheet or through a printout of the online payroll summary information. I attest that I have accurately and completely provided all required information and understand that Paychex Business Solutions (PBS) is relying on the accuracy and completeness of the information provided. I further understand that this information will be the basis upon which PBS sets up each employee and I accept responsibility for any incorrect or inaccurate information provided to PBS.

Client Authorized Signature _____ _____ _____
Signature Title Date

B1 - CORPORATE INFORMATION COMPLETED BY MANAGER OR SUPERVISOR

Client Name _____ Department Name or Number _____

Employee Name _____ Last four digits of Social Security Number _____

Employee ID _____ Work Authorization Expiration (if applicable) ___/___/_____

Employee Worksite Location *(full address required)*

Address _____ City _____ State _____ Zip _____

Status ☐ Full-time ☐ Part-time

Rate of Pay 1 $ _____ ☐ per hour ☐ period *(select one)*

Rate of Pay 2 $ _____ ☐ per hour ☐ period *(select one)*

Rate of Pay 3 $ _____ ☐ per hour ☐ period *(select one)*

Gender ☐ Female ☐ Male Hire Date _____ Union Employee ☐ Yes ☐ No

Withholding State _____ State Unemployment Insurance State _____ Residence State _____

Job Title _____ Workers' Comp Class Code _____ Benefit Insurance Class Code _____

Location Name _____ Insurance Standard Hours _____

Job Category *(select one)*
☐ Executive/Senior Level Officials and Managers [1.1] ☐ First/Mid-Level Officials and Managers [1.2] ☐ Professionals [2]
☐ Technicians [3] ☐ Sales Workers [4] ☐ Office and Clerical [5] ☐ Craft Workers (skilled) [6] ☐ Operatives (semi-skilled) [7]
☐ Laborers (unskilled) [8] ☐ Service Workers [9]

Description of Duties (provide a short description of daily regular activities) _____

_____

☐ Work from remote office or location (note how often) _____

☐ Travel (note how often) _____

Supervisor, Manager, or
Authorized Signature _____ _____ _____
Signature Title Date

B2 - EQUAL EMPLOYMENT OPPORTUNITY INFORMATION*

We are subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights laws and regulations. In order to comply with these laws, you must complete the Job Category information. Although employees are invited to voluntarily self-identify their race and ethnicity, submission of this information is voluntary and refusal to provide it cannot and will not subject an employee to any adverse treatment. Because not all employees complete the requested information, you are being asked to do so by conducting a visual assessment of the employee's National Origin/Race.

*Verify Employer and Employee Sections' information and complete Section 3, if applicable.

Employee •Read Sections 1 and 2 •Complete and sign Employee Signature section •Complete Section 3

SECTION 1. EMPLOYEE ACKNOWLEDGEMENTS

For all employees:

I understand that my worksite employer ("Client") has entered into a Client Service Agreement ("Agreement") with Paychex Business Solutions or an affiliated company ("PBS") whereby PBS has agreed to co-employ individuals who are performing services for Client. I understand that I am a co-employee of PBS who will be assigned to perform services for the Client in connection with the Agreement. I understand this relationship may be terminated at will at anytime by me, Client, or PBS. I acknowledge that in the event Client does not pay PBS with respect to the services provided by me to Client for any particular pay period, PBS, where required by law, will pay me for such pay period, and where permitted by law, will pay me the then current minimum wage rate for that pay period and my applicable overtime pay based on such minimum wage rate for that pay period, or the minimum salary for that pay period. In the event that Client files a petition in bankruptcy at a time when monies are due to PBS from Client for wages paid to me, I hereby assign PBS any and all rights I have to assert a priority wage claim in the bankruptcy proceeding.

☐ **I understand that a mark in the foregoing box constitutes written notice that my worksite employer is providing my workers' compensation insurance benefits.** I understand that PBS is committed to compliance with any and all state and federal Workers' Compensation laws and requirements. I understand that any special rules and regulations required by my state and/or industry will be posted by Client on the company bulletin boards and/or are available from management for my information and review. I agree to comply with these rules and regulations and realize that failure to do so may affect the benefits provided to me. I understand that, as a newly hired employee of Client or PBS, where permitted by law, I will be subject to an Introductory/Probationary Period for purposes of unemployment insurance.

For employees who are not represented by a union:

I acknowledge receipt of the Employee Handbook and addenda (if applicable), and I understand that I am responsible for understanding and reviewing the policies contained in that booklet and any subsequent additions, revisions, and/or addenda.

I understand that Client may now have, or may establish, a drug-free workplace or a drug and/or alcohol testing program consistent with applicable federal, state, and local law. I agree to work under the conditions requiring a drug-free workplace, consistent with applicable federal, state, and local law. I also understand that all employees at the location, pursuant to Client's policy and federal, state, and local law, may be subject to urinalysis and/or blood screening or other medically recognized tests designed to detect the presence of alcohol or controlled drugs. I understand that the taking of such alcohol and/or drug tests is a condition of continual employment, and I agree to undergo alcohol and drug testing consistent with Client's policies and applicable federal, state, and local law.

I certify that all the information on this document, or any supporting documents is correct, and I understand that any misrepresentation or omission of any information may result in the immediate dismissal of employment.

I understand Client and PBS hire only individuals who are legally eligible to work in the United States.

If I will be assigned to a work site in Alabama, Montana, South Carolina, or Utah, I recognize that I must review and sign a state-specific Addendum to this New Employee Packet.

SECTION 2. ACKNOWLEDGEMENT OF GROUP BENEFITS (if applicable)

I understand that I may be eligible or become eligible for certain benefits under the group plans provided by Paychex Business Solutions (PBS). Furthermore, I understand in order for my benefits to be effective, I must complete my assigned benefit waiting period and submit the required enrollment forms/correspondence to PBS prior to my effective date of coverage. I acknowledge that it is my responsibility, and/or appropriate family member(s) to read and understand the various benefit plans presented to me in my benefit packet. I also understand that I should refer to the certificates of insurance and/or plan documents for detailed information regarding benefit provisions and that the provisions may be subject to change. I understand that if I enroll, my benefit choices must remain in effect until the following annual enrollment unless I experience a qualifying event as discussed below.

I understand that if I do not receive my benefit packet during my benefit waiting period, **I am responsible for notifying PBS' Benefits Department prior to my effective date of coverage.** If I am uncertain of my assigned benefit waiting period, I understand I am responsible for obtaining confirmation of my assigned benefit waiting period from my on-site contact or PBS' Benefits Department. Furthermore, I understand that if I do not return my signed enrollment form to PBS after I begin working as an eligible employee and before the date my coverage is to be effective, PBS will consider this a waiver of group coverage.

I understand that if I do not elect benefits at the time of my initial eligibility, I will not be permitted to enroll or make mid-year election changes unless a qualifying event occurs. I understand if I experience a qualifying event and would like to enroll, I must notify PBS and submit the required forms and documentation within 30 days of my qualifying event or I will not be permitted to make changes or enroll until the following annual enrollment. Furthermore, I understand if I request coverage for myself and eligible dependents as a late enrollee and am accepted, I will be required to furnish evidence of good health for each individual ("Certificates of Creditable Coverage"), or be subjected to the insurance policies pre-existing exclusion provisions.

I authorize deductions for required employee contributions toward group benefits. I understand that in the event my employment terminates in the middle of a month, the medical, dental and/or vision plan I elected will continue until the end of that month, and any Flexible Savings Account Plan, Short-Term Disability or Long-Term Disability plan elected will terminate concurrently with my termination from employment. I authorize PBS to deduct from my final paycheck, as authorized by state and federal law, the full employee contribution payments owed for the final month of the applicable group benefits. I understand that I must meet the eligibility requirements for coverage to be effective.

EMPLOYEE SIGNATURE

Name _____ Social Security Number _____-_____-_____

Address _____ City _____ State _____ Zip _____

Telephone Number (_____) _____ - _____ Birth Date _____

I have read and acknowledge all of the statements contained in Section 1 ("Employee Acknowledgements") and in Section 2 ("Acknowledgement of Group Benefits") of this New Employee Packet.

Signature _____ Date _____ **Continue to Section 3**

Employee •Read Sections 1 and 2 •Complete and sign Employee Signature section •Complete Section 3

Employee Name _____

SECTION 3. EQUAL EMPLOYMENT OPPORTUNITY INFORMATION

We are subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights laws and regulations. In order to comply with these laws, we invite you to voluntarily self-identify your race and ethnicity. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information will be kept confidential and will only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify specific individuals.

☐ A visual assessment of the employee's National Origin/Race has been made as the employee has not voluntarily provided this information.

Gender ☐ Female ☐ Male

National Origin ***(if you meet the definition of Hispanic or Latino, check the box below.)***

☐ Hispanic or Latino *(All persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.)*

Race ***(check the appropriate box)***

☐ White *(Not of Hispanic or Latino origin. All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.)*

☐ Black or African American *(Not of Hispanic or Latino origin. All persons having origins in any of the Black racial groups of Africa.)*

☐ Asian *(Not of Hispanic or Latino origin. All persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent.)*

☐ Native Hawaiian or Other Pacific Islander *(Not of Hispanic or Latino origin. All persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)*

☐ American Indian or Alaskan Native *(Not of Hispanic or Latino origin. All persons having origins in any of the original peoples of North and South America, and who maintains tribal affiliation or community attachment.)*

☐ Two or More Races *(Not of Hispanic or Latino origin. All persons who identify with more than one of the five races listed.)*

Employee's Personal Email Address _____ Employee's Work Email Address _____

Mail or fax to:

970 Lake Carillon Drive, Suite 400
St. Petersburg, FL 33716

Fax: 1-800-668-7296

Internal Use Only

Underwriting Audit Updates

Workers' Comp Class Code _____

Benefit Insurance Class Code _____

Audit completed by _____

Payroll Audit _____

Form W-4 (2016)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E** _____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	**G** _____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2016

1 Your first name and middle initial	Last name	**2 Your social security number**
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	**4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**
6	Additional amount, if any, you want withheld from each paycheck	**6** $
7	I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►	**7**

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ► **Date** ►

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2016 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or are a qualifying widow(er); $285,350 if you are head of household; $259,400 if you are single and not head of household or a qualifying widow(er); or $155,650 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,300 if head of household; $6,300 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2016 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2016 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2016. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2016. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $9,000	0
6,001 - 14,000	1	9,001 - 17,000	1
14,001 - 25,000	2	17,001 - 26,000	2
25,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 75,000	5
44,001 - 55,000	6	75,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

PAYCHEX

Direct Deposit Enrollment/Change Form

Company Name_____ **Client Number**_____

Employee/Worker Name_____ **Employee/Worker Number**_____

EMPLOYEE/WORKER: Retain a copy of this form for your records. Return the original to your employer.

EMPLOYERS: Return this form to your local Paychex office. For clients using on-line services, please retain a copy of this document for your records.

COMPLETE TO ENROLL / ADD / CHANGE BANK ACCOUNTS – *PLEASE PRINT IN BLACK/BLUE INK ONLY*

Type of Account	Routing/Transit Number	Checking/Savings Account Number*	Financial Institution ("Bank") Name	I wish to deposit (check one):
☐ Checking ☐ Savings				☐ _____ % of Net ☐ Specific Dollar Amount $_____ .00 ☐ Remainder of Net Pay
☐ Checking ☐ Savings				☐ _____ % of Net ☐ Specific Dollar Amount $_____ .00 ☐ Remainder of Net Pay

One of the following is required to process this enrollment (check one):

☐ Voided check with name imprinted (no starter checks)

☐ Deposit slip (only accepted if the verbiage "ACH R/T" appears before the routing number)

☐ Bank letter or specification sheet (the signature of your local bank representative MUST be included)

☐ Other Bank Documentation from your Financial Institution – If this box is checked the employer must sign this confirmation:

I confirm that the above named employee/worker has added or changed a bank account for direct deposit transactions processed by Paychex, Inc.

Employer Signature:_____ **Date** _____

***Certain accounts may have restrictions on deposits and withdrawals. Check with your bank for more information specific to your account.**

COMPLETE IF CHANGING EXISTING DEPOSIT AMOUNTS – *PLEASE PRINT IN BLACK/BLUE INK ONLY*

Routing/Transit Number	Checking/Savings Account Number*	Financial Institution ("Bank") Name	Change My Deposit Amount to:
			☐ From _____% to____% of Net ☐ From $ _____.00 To $_____.00 ☐ Remainder of Net Pay
			☐ From _____% to____% of Net ☐ From $ _____.00 To $_____.00 ☐ Remainder of Net Pay

EMPLOYEE/WORKER CONFIRMATION STATEMENT

PLEASE SIGN IN BLACK/BLUE INK ONLY

I authorize my employer to deposit my wages/salary into the bank accounts specified above. I agree that direct deposit transactions I authorize comply with all applicable law. My signature below indicates that I am agreeing that I am either the accountholder or have the authority of the accountholder to authorize my employer to make direct deposits into the named account.

Employee/Worker Signature _____ **Date** _____

Note: Digital or Electronic Signatures are **not** acceptable.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid–year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.