American Payroll and Benefits I, LLC
PO Box 189 Ocala, FL 34478
Phone: 352-624-1999 Fax: 352-342-9356

EMPLOYEE CHANGE FORM

Employer/Client Name: _____

Section 1: Current Employee Information

Employee Name: _____

SSN: XXX – XX – _____ **Birthdate:** _____ (mm/dd/yyyy)

Section 2: Employee Change (list new information only)

PERSONAL INFORMATION Effective Date of Change: _____

☐ Name: _____
(A change of name requires a copy of the employee's new Social Security Card for verification and a new W-4)

☐ Address: _____

☐ Email: _____ ☐ Phone: _____

☐ Emergency Contact Name _____

Contact Relationship: _____ Contact Phone: _____

EMPLOYMENT Effective Date of Change: _____

☐ Pay Rate: _____ per ☐ hour ☐ pay period ☐ year

☐ Job Title: _____

☐ Department: _____

☐ Status: ☐ full-time ☐ part-time

OTHER Effective Date of Change: _____

Describe: _____

Section 3: Signature

Employer/Client Signature _____ Date _____

Employee Signature _____ Date _____
if required