

**Pro SERVICE**  
Outsourcing Solutions

**STATUS CHANGE FORM**

Client Name: \_\_\_\_\_

Employee Name (+SS# if needed): \_\_\_\_\_

**CHANGE (Please Check):**

**TO:**

**EFFECTIVE:**

Address		_____	_____
Telephone #		_____	_____
Federal Tax W/H		_____	_____
State Tax W/H		_____	_____
Additional Fed. Tax		_____	_____
Add. State Tax		_____	_____
Hourly Wage		_____	_____
Job Title		_____	_____
Department/Division		_____	_____
Salary		_____	_____
Worker's Comp Code		_____	_____
Other:		_____	_____

**INSURANCE (Please Check):**

**ENROLL TERM**

**EMPLOYEE OR DEPENDENT ONLY?**

**EFFECTIVE:**

Medical (HealthComp/Kaiser)			_____	_____
Dental (PPO/HMO)			_____	_____
Vision (Safeguard)			_____	_____
Other:			_____	_____

**All insurance enrollments must be accompanied by proper benefit enrollment forms**

**EMPLOYMENT CHANGE:**

**LAYOFF OR QUIT?**

**LAST DAY WORKED:**

Leave of Absence		_____	_____
Terminate Employment		_____	_____

(Please give reason if termination was for other than lack of hours)

Reason for Termination: \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Management Signature: \_\_\_\_\_