EMPLOYEE CHANGE FORM

Employer______________________________Date____________________________

Employee ______________________________SSN ____________________________

Please Change My: (fill in the changed information)

Name ____

Address____

City, State, ZIP ____

Leave of Absence: (please fill in all that apply)

Sick/Disability ______

Worker's Comp ______

Personal ______

Other ______

Date leave began: ____/_____/_____
Last reduction made: ____/_____/_____
Amount of last reduction: $_____________
Date returned from leave: ___/_____/_____
Reductions resumed on: ____/_____/_____
Amount of reduction: $______________

Notification of Termination of Employee

Last Reduction Made on: ____/_____/_____

Amount of Last Reduction: $______________

Last Pay Period (includes reduction): From _____________ To ______________

Last Day Worked: ____/_____/_____

All changes must be submitted promptly to OFG Financial Services in order for accurate record keeping to be maintained. Your cooperation is greatly appreciated in expediting notification of changes of an employee's status.

________________________________ ________________________

Employee Representative Signature Date

Sept 2007