

# ABC<sup>®</sup> Payroll Services

## Employer Conversion Form

FEDERAL ID#: \_\_\_\_\_ FL SUTA #: \_\_\_\_\_ FL SUTA RATE: \_\_\_\_\_

Sole Proprietorship: \_\_\_\_\_ Partnership: \_\_\_\_\_ LLC: \_\_\_\_\_ C-Corp: \_\_\_\_\_ S-Corp: \_\_\_\_\_

### LEGAL NAME & ADDRESS

DIVISIONS: YES \_\_\_\_\_ NO \_\_\_\_\_

BUSINESS NAME: \_\_\_\_\_

D/B/A: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

### NAME & ADDRESS TO BE ON CHECKS

NAME: \_\_\_\_\_

D/B/A: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

### DELIVERY ADDRESS

NAME: \_\_\_\_\_

DELIVER TO THE ATTENTION OF: \_\_\_\_\_ RESIDENTIAL: YES \_\_\_\_\_ NO \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SPECIAL INSTRUCTIONS: \_\_\_\_\_

**PAY-AS-YOU-GO WC** YES \_\_\_\_\_ NO \_\_\_\_\_

WC CARRIER: \_\_\_\_\_

INSURANCE COMPANY & AGENT: \_\_\_\_\_

### PAYROLL

CHECK DAY: \_\_\_\_\_ CALL IN DAY: \_\_\_\_\_ PERIOD BEGIN DAY/DATE: \_\_\_\_\_

INPUT METHOD: PHONE \_\_\_\_\_ FAX \_\_\_\_\_ EMAIL \_\_\_\_\_ ONLINE \_\_\_\_\_

PAYROLL FREQUENCY: WEEKLY \_\_\_\_\_ BI-WEEKLY \_\_\_\_\_ SEMI-MONTHLY \_\_\_\_\_

FIRST CHECK DATE: \_\_\_\_\_ FED TAX FREQUENCY: MONTHLY \_\_\_\_\_ SEMI-WEEKLY \_\_\_\_\_

HAVE YOU PAID WAGES THROUGH THIS CORPORATION (EIN) THIS CALENDAR YEAR?: YES \_\_\_\_\_ NO \_\_\_\_\_

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

# ABCO Payroll Services®

Client's Legal Name: \_\_\_\_\_ Federal ID Number: \_\_\_\_\_

DBA: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## SERVICE AGREEMENT

The undersigned client hereby retains Infinisource Inc. DBA ABCO Payroll Services Inc. to provide the following services at the prevailing rates charged.

## PAYROLL PREPARATION

CLIENT will provide the information necessary to process payroll in a timely manner.

CLIENT is solely responsible, legally or otherwise, for the information that they submit to ABCO Payroll Services for processing. It is also understood and agreed by CLIENT that ABCO Payroll Services is not responsible for any tax liability for pay periods before this agreement went into effect, or any penalties or interest assessed on those taxes.

ABCO Payroll Services will prepare and supply to CLIENT the payroll checks and reports as mutually agreed, and

ABCO Payroll Services will be responsible to make payments and file reports as prescribed by the various tax agencies for all escrowed items that were timely received, and ABCO Payroll Services will pay any and all penalties and interest for any late filings that were the fault of ABCO Payroll Services' actions.

CLIENT will authorize payment of ABCO Payroll Services invoice either by Electronic Funds (ACH) or by Debit Check. The CLIENT as well as the SIGNER on behalf of the CLIENT hereto, does agree to be corporately and/or individually liable for any and all amounts owing including dishonored checks, debit check, ACH debits which ABCO Payroll Services receives from the CLIENT or the CLIENT'S agent. CLIENT and the individual SIGNER, hereof shall be individually and jointly liable to ABCO Payroll Services for the full amount of any dishonored items together with interest, court costs, attorney's fees, and penalties, including triple damages as provided by Florida law, Any litigation by CLIENT or ABCO Payroll Services, for any reason, is to be in Manatee County, Florida.

It is mutually agreed that ABCO Payroll Services will correspond only with the CLIENT/OWNER and/or the person authorized by the owner to handle any and all payroll information. At no time will ABCO Payroll Services communicate with any other employees of CLIENT.

## PRIVACY NOTICE

As your payroll provider, we receive and collect non-public personal information from various forms and statements that you provide. We do not disclose such information, except as instructed to do so by you. Access is restricted to subpoenas or, with your authorization, to those professionals who need such information to provide services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your non-public personal or business information.

## POWER OF ATTORNEY

CLIENT hereby appoints Infinisource Inc. DBA ABCO Payroll Services Inc., FID# 38-2976613, 3800 26<sup>th</sup> St. W., Bradenton, FL 34205-3508 941-755-9511 as attorneys-in-fact to represent submit any and all payroll records to any insurance provider or government taxing agency. It is understood that in some tax agency matters a special power of attorney on special government forms may be required and CLIENT will immediately provide if so requested.

## SATISFACTION GUARANTEE

If at any time, for any reason, within 90 days of CLIENT'S first invoice date, CLIENT is dissatisfied with ABCO Payroll Services, CLIENT may cancel ABCO Payroll Services' services and receive a full refund of ABCO Payroll Services' payroll processing fee. Any dishonored bank items within the first 90 days of service make the satisfaction guarantee null and void.

It is mutually understood that this agreement can be terminated by either party by written notice. ABCO Payroll Services Inc. has the legal right to hold all CLIENT'S money in escrow until all payments made by ABCO Payroll Services Inc. on behalf of CLIENT have cleared the responsibility of ABCO Payroll Services Inc.

THEREFORE, THIS service agreement is dated \_\_\_\_\_ and agreed to by the following:

Print Signers NAME \_\_\_\_\_

ABCO Payroll Services Inc.

Signed by \_\_\_\_\_

\_\_\_\_\_  
Kenneth R. Reynolds, Director of Payroll

3800 26<sup>th</sup> Street West • Bradenton, Florida 34205-3508  
Voice: 941 755-9511 • FAX: 941 755-9055

# ABC Payroll Services®

## CLIENT AUTHORIZATION AGREEMENT FOR DEBIT CHECK/ACH TRANSACTIONS

As a Client of Infinisource Inc. DBA ABC Payroll Services Inc., I hereby agree and authorize the following:

1. ABC Payroll Services to initiate debit or credit entries to my DDA account listed below for the applicable charges related to the services provided by ABC Payroll Services.
2. CLIENT will have available on deposit in clients DDA account with BANK sufficient amounts to honor the Debit Check or Electronic Funds Transfer initiated by ABC Payroll Services.
3. CLIENT understands that the processing dates for payments accepted for EFT will be in accordance with ACH rules in force at the time initiated.
4. CLIENT agrees that their BANKS treatment of any charge and the BANKS right to respect it, shall be the same as if the entry were initiated personally by the CLIENT. If any charge is dishonored, whether with or without cause, BANK nor ABC Payroll Services, will be under any liability whatsoever.
5. Payments will be accepted by Electronic Funds Transfer (National Automated Clearing House). If EFT is not available, non-signed paper items will be accepted.

Bank Name \_\_\_\_\_ Bank Contact \_\_\_\_\_ Phone# ( ) -  
Bank Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Client Name \_\_\_\_\_  
Bank# (TRANSIT/ABA) \_\_\_\_\_ DDA Account # \_\_\_\_\_

This authority is to remain in full force and effect until BANK has received written notification from me of its termination in such time and in such manner as to afford BANK and ABC Payroll Services, a reasonable opportunity to act on it.

CLIENT Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
**IMPORTANT:** Must be authorized signer on bank account listed above.

Print Clients Name \_\_\_\_\_

**IMPORTANT: SEND A VOIDED CHECK**

3800 26<sup>th</sup> Street West  
Bradenton, Florida 34205-3508

# Reporting Agent Authorization

## Taxpayer

<b>1a</b> Name of taxpayer (as distinguished from trade name)	<b>2</b> Employer identification number (EIN)
<b>1b</b> Trade name, if any	<b>4</b> If you are a seasonal employer, check here <input type="checkbox"/>
<b>3</b> Address (number, street, and room or suite no.)	<b>5</b> Other identification number
City or town, state, and ZIP code	
<b>6</b> Contact person	<b>7</b> Daytime telephone number ( )
	<b>8</b> Fax number ( )

## Reporting Agent

<b>9</b> Name (enter company name or name of business) <b>Infinisource, Inc</b>	<b>10</b> Employer identification number (EIN) <b>38 2976613</b>
<b>11</b> Address (number, street, and room or suite no.) <b>15 E Washington St</b>	
City or town, state, and ZIP code <b>Coldwater, MI 49036</b>	
<b>12</b> Contact person <b>Laura Burlingame</b>	<b>13</b> Daytime telephone number ( 800 ) 796-7915
	<b>14</b> Fax number ( 888 ) 773-4208

## Authorization of Reporting Agent To Sign and File Returns

**15** Use the entry lines below to indicate the tax return(s) to be filed by the reporting agent. Enter the beginning year of annual tax returns or beginning quarter of quarterly tax returns. See the instructions for how to enter the quarter and year. Once this authority is granted, it is effective until revoked by the taxpayer or reporting agent.

940 _____	941 _____	940-PR _____	941-PR _____	941-SS _____	943 _____
943-PR _____	944 _____	944-PR _____	944-SS _____	945 _____	1042 _____
CT-1 _____					

## Authorization of Reporting Agent To Make Deposits and Payments

**16** Use the entry lines below to enter the starting date (the first month and year) of any tax return(s) for which the reporting agent is authorized to make deposits or payments. See the instructions for how to enter the month and year. Once this authority is granted, it is effective until revoked by the taxpayer or reporting agent.

940 _____	941 _____	943 _____	944 _____	945 _____	720 _____
1041 _____	1042 _____	1120 _____	CT-1 _____	990-PF _____	990-T _____

## Disclosure of Information to Reporting Agents

**17a** Check here to authorize the reporting agent to receive or request copies of tax information and other communications from the IRS related to the authorization granted on line 15 and/or line 16

**b** Check here if the reporting agent also wants to receive copies of notices from the IRS

## Form W-2 Series or Form 1099 Series Disclosure Authorization

**18a** The reporting agent is authorized to receive otherwise confidential taxpayer information from the IRS to assist in responding to certain IRS notices relating to the Form W-2 series information returns. This authority is effective for calendar year forms beginning \_\_\_\_\_.

**b** The reporting agent is authorized to receive otherwise confidential taxpayer information from the IRS to assist in responding to certain IRS notices relating to the Form 1099 series information returns. This authority is effective for calendar year forms beginning \_\_\_\_\_.

## State or Local Authorization

**19** Check here to authorize the reporting agent to sign and file state or local returns related to the authorization granted on line 15 and/or line 16

## Authorization Agreement

I understand that this agreement does not relieve me, as the taxpayer, of the responsibility to ensure that all tax returns are filed and that all deposits and payments are made. If line 15 is completed, the reporting agent named above is authorized to sign and file the return indicated, beginning with the quarter or year indicated. If any starting dates on line 16 are completed, the reporting agent named above is authorized to make deposits and payments beginning with the period indicated. Any authorization granted remains in effect until it is revoked by the taxpayer or reporting agent. I am authorizing the IRS to disclose otherwise confidential tax information to the reporting agent relating to the authority granted on line 15 and/or line 16, including disclosures required to process Form 8655. Disclosure authority is effective upon signature of taxpayer and IRS receipt of Form 8655. The authority granted on Form 8655 will not revoke any Power of Attorney (Form 2848) or Tax Information Authorization (Form 8821) in effect.

<b>Sign Here</b>	I certify I have the authority to execute this form and authorize disclosure of otherwise confidential information on behalf of the taxpayer.		
	▶ _____ Signature of taxpayer	▶ _____ Title	▶ _____ Date



**Florida Department of Revenue  
POWER OF ATTORNEY  
and Declaration of Representative**

**DR-835  
R. 09/09**

Rule 12-6.0015  
Florida Administrative Code  
Effective 06/10

**See Instructions for additional information.**

**PART I - POWER OF ATTORNEY**

**Section 1. Taxpayer Information.** Taxpayer(s) must sign and date this form on Page 2, Part I, Section 8.

Taxpayer name(s) and address(es)	Federal ID no(s). (SSN*, FEIN, etc.)	Florida Tax Registration Number(s) (Business Part. No., Sales Tax No., U.T. Acct No., etc.)
	Contact person	Telephone number (        ) Fax number (        )

The Taxpayer(s) hereby appoint(s) the following representative(s) as attorney(s)-in-fact:

**Section 2. Representative(s).** Each representative must be listed individually, and must sign and date this form on Page 2, Part II.

Name and address (include name of firm if applicable) <b>Infinisource, Inc PO Box 369 Coldwater, MI 49036 Carol Bucklin, Aif</b>	Telephone number ( <b>800</b> ) <b>796-7915</b>
	Fax number ( <b>888</b> ) <b>773-4208</b>
	Cell phone number (        )
Name and address (include name of firm if applicable)	Telephone number (        )
	Fax number (        )
	Cell phone number (        )
Name and address (include name of firm if applicable)	Telephone number (        )
	Fax number (        )
	Cell phone number (        )

To represent the taxpayer(s) before the Florida Department of Revenue in the following tax matters:

**Section 3. Tax Matters.** Do not complete this section if completing Section 4.

Type of Tax (Corporate, Sales, Unemployment, etc.)	Year(s) / Period(s)	Tax Matter(s) (Tax Audits, Protests, Refunds, etc.)

**Section 4. To Appoint an Unemployment Tax Agent Only.** Do not complete Sections 3 and 6 if completing Section 4.

By completing this section, an employer (taxpayer) appoints a representative to act as its Florida unemployment tax agent before the Florida Department of Revenue on a continuing basis and to receive confidential information with respect to mailings, filings, and other tax matters related to the Florida unemployment compensation law. All other sections of this form (except Sections 3 and 6) must also be completed. **Do not complete Section 4 unless you wish to appoint an unemployment tax agent on a continuing basis.**

Agent name <b>Carol Bucklin, Aif</b>	Agent number (required)
Firm name <b>Infinisource, Inc</b>	Federal I.D. No. (required) <b>38-2976613</b>
Address (if different from above)	Telephone number ( <b>800</b> ) <b>796-7915</b>

Mail Type: See Instructions for explanations. Check one box only.  1 (Primary)  2 (Reporting)  3 (Rate)  4 (Claim)

**Section 5. Acts Authorized.**

The representative(s) are authorized to receive and inspect confidential tax information and to perform any and all acts that I (we) can perform with respect to the tax matters described in Section 3 and Section 4 (for example, the authority to sign any agreements, consents, or other documents). Except as otherwise provided, the authority specifically includes the power to execute waivers of restrictions on assessment or collection of deficiencies in tax, to execute consents extending the statutory period for assessment or claims for refund of taxes, and to execute closing agreements under section 213.21, Florida Statutes. This authority does not include the power to endorse or cash warrants, or the power to sign certain returns.

If you want to authorize a representative named in Section 2 to receive (but not to endorse or cash) refund warrants, write the name of the representative on this line and check the box

List any specific limitations or deletions to the acts otherwise authorized in this Power of Attorney.



Florida Tax Registration Number:

Taxpayer Name(s):

Federal Identification Number:

- Taxpayer(s) must complete Page 1 of this Power of Attorney or it will not be processed.

**Section 6. Notices and Communication.** Do not complete Section 6 if completing Section 4.

- Notices and other written communications will be sent to the first representative listed in Part I, Section 2, unless the taxpayer selects one of the options below. Receipt by either the representative or the taxpayer will be considered receipt by both.
  - If you want notices and communications sent to both you and your representative, check this box
  - If you want notices or communications sent to you and not your representative, check this box

Certain computer-generated notices and other written communications cannot be issued in duplicate due to current system constraints. Therefore, we will send these communications to only the taxpayer at his or her tax registration address.

**Section 7. Retention / Nonrevocation of Prior Power(s) of Attorney.**

The filing of this Power of Attorney will not revoke earlier Power(s) of Attorney on file with the Florida Department of Revenue, even for the same tax matters and years or periods covered by this document. If you want to revoke a prior Power of

Attorney, check this box

**You must attach a copy of any Power of Attorney you wish to revoke.**

**Section 8. Signature of Taxpayer(s).**

If a tax matter concerns a joint return, **both** husband and wife must sign if joint representation is requested. If signed by a corporate officer, partner, member/managing member, guardian, tax matters partner/person, executor, receiver, administrator, trustee, or fiduciary on behalf of the taxpayer, I declare under penalties of perjury that I have the authority to execute this form on behalf of the taxpayer.

**Under penalties of perjury, I (we) declare that I (we) have read the foregoing document, and the facts stated in it are true.**

**If this Power of Attorney is not signed and dated, it will be returned.**

_____ Signature	_____ Date	_____ Title (if applicable)
_____ Print name		
_____ Signature	_____ Date	_____ Title (if applicable)
_____ Print name		

**PART II - DECLARATION OF REPRESENTATIVE**

**Under penalties of perjury, I declare that:**

- I am familiar with the mandatory standards of conduct governing representation before the Department of Revenue, including Rules 12-6.006 and 28-106.107 of the Florida Administrative Code, as amended.
- I am familiar with the law and facts related to this matter and am qualified to represent the taxpayer(s) in this matter.
- I am authorized to represent the taxpayer(s) identified in Part I for the tax matter(s) specified therein, and to receive and inspect confidential taxpayer information.
- I am one of the following:
  - Attorney - a member in good standing of the bar of the highest court of the jurisdiction shown below.
  - Certified Public Accountant - duly qualified to practice as a certified public accountant in the jurisdiction shown below.
  - Enrolled Agent - enrolled as an agent pursuant to the requirements of Treasury Department Circular Number 230.
  - Former Department of Revenue Employee. As a representative, I cannot accept representation in a matter upon which I had direct involvement while I was a public employee.
  - Unemployment Tax Agent authorized in Section 4 of this form.
  - Other Qualified Representative.
- **I have read the foregoing Declaration of Representative and the facts stated in it are true.**

**If this Declaration of Representative is not signed and dated, it will not be processed.**

Designation - Insert Letter from Above (a -f)	Jurisdiction (State) and Enrollment Card No. (if any)	Signature	Date

# ABC Payroll Services®

Simple, accurate, affordable payroll service

## Child Support Electronic Funds Transfer Authorization

### Authorization Agreement

I hereby authorize **ABC Payroll Services, Inc.** to provide the information required for enrollment and to make payment of court ordered child support via electronic funds transfer. My company's information may be provided to any state's child support disbursement unit and any bank(s) necessary to make the required transaction(s).

I understand that the return policy for child support funds submitted in error may be different in each state and that once payment is made to the recipient, funds may not be able to be returned.

This agreement will remain in effect until **ABC Payroll Services, Inc.** receives a written notice of cancellation.

### Account Information

EIN #: \_\_\_\_\_

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Signature

Print name: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Electronic child support processing fee \$2.00 each

# **ABCO** Payroll Services <sup>®</sup>

## **ABCO PAYROLL SERVICES WORKERS' COMPENSATION DEBIT PLAN**

**ABCO PAYROLL SERVICES** offers clients that have workers' compensation insurance with \_\_\_\_\_ (carrier), the opportunity to have the calculated workers' compensation premium billed and debited from their bank account each pay period. **ABCO PAYROLL SERVICES** uses information supplied by the client, the agent, and the insurance carrier, to calculate the premium due based upon actual adjusted gross payroll.

By signing this agreement, you are authorizing **ABCO PAYROLL SERVICES** to calculate the workers' compensation premium, debit the calculated premium from your bank account and provide (to the workers' compensation carrier and/or agent) payroll and workers' compensation premium calculation information as needed or required.

It is further understood that **ABCO PAYROLL SERVICES** calculates your premium based on the information we have been provided. Collection of calculated premium amounts by **ABCO PAYROLL SERVICES** does not in itself assure that your policy is in force. **ABCO PAYROLL SERVICES** takes no responsibility for the accuracy of rates, workers' compensation codes or any other discrepancies that may occur between **ABCO PAYROLL SERVICES'** premium calculations and those of your carrier.

You also agree that in the event there are insufficient funds available from your bank account on the payroll debit date for workers' compensation premiums, **ABCO PAYROLL SERVICES** and your carrier may terminate your company from direct billing of workers' compensation premiums, effective immediately. Your carrier will be notified within 24 hours of bank notification of insufficient funds, and this may result in a cancellation of your workers' compensation coverage.

Client acknowledges that **ABCO PAYROLL SERVICES** does not receive information concerning your policy directly from your insurance company (for example cancellation, pending cancellation or change in rates). It is the client's responsibility to forward correspondence from your insurance agent or insurance company which affects your policy.

**ABCO PAYROLL SERVICES** provides a workers' compensation report each pay period to enable the client to verify the employees' workers' compensation code assignments, workers' compensation rates and subject wages.

**AGENCY:** \_\_\_\_\_ **AGENT:** \_\_\_\_\_

**CLIENT NAME:** \_\_\_\_\_ **EIN#:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**INS COMPANY:** \_\_\_\_\_ **POLICY #:** \_\_\_\_\_

**EXEMPT OFFICERS:** \_\_\_\_\_

**NAME OF AUTHORIZING OFFICER:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

# ABC*CO* Payroll Services Inc.

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## Laser Check Signature Form

Client ID Number: \_\_\_\_\_

DATE: \_\_\_\_\_

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

### **PLEASE SIGN WITHIN THE BOUNDARIES WITHOUT TOUCHING LINES**

With double signatures, please be sure that **BOTH** signatures are written in all 3 boxes. To be assured of a clear signature, please sign as neatly as possible.

**Use boxes below when ONLY  
ONE signature is required**

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**Use boxes below when  
TWO signature are required**


