## **Change in Status Report**

Please Type or Print in Black Ink or File Online in NCSUITS

NC Dept. of Commerce Division of Employment Security Post Office Box 26504 Raleigh, N.C. 27611-6504

DES Employer Account Number:	
Employer Name:	_
Address:	

## Section 1 - Reason for Changes

What updates or changes are you requesting?

Was there a change to the legal or trade name, addresses, phone numbers, fax number, and/or email address?

Yes No (If yes, go to section 2 and complete the changes that pertain to the business)

Was there a change or update to the owners, officers, partners or fiduciaries?

Yes No (If yes, go to section 3 and complete the changes that pertain to the business)

Was an addition, change or update needed to the contact person?

Yes No (If yes, go to section 4 and complete the changes that pertain to the business)

Did you contract with a PEO (Professional Employer Organization), begin operating without employees, convert from a C-corporation to S-corporation, have a change in partnership, or cease operations in North Carolina? Did you change the business status such as incorporate or convert to a (LLC) Limited Liability Company. Do you need to report a change in the (FEIN) Federal Employer Identification number from the Internal Revenue Service?

Yes No (If yes, go to section 5 and complete the changes that pertain to the business)

Did the business resume employment in North Carolina?

Yes No (If yes, go to section 6 and complete the changes that pertain to business)

Did you sell, merge, or transfer all or part of the North Carolina business?

Yes No (If yes, go to section 7 and complete the changes that pertain to the business)

## Section 2 - Change to the Legal or Trade Name, Addresses, Phone Numbers, Fax Number, and/or Email Address

**Business Legal Name:** 

primary employee)"

Trade or Doing Business As Name:

Address Change Type (Check all that apply to address change provided) (If additional changes are required attach a list with the address type and address change):

Mailing Legal Physical Claims Rate Notice/Reimbursement Statement Billing

Address Line 1:

Address Line 2:

City: State: Zip Code: 
County: Country:

Physical Location Address must be an NC address (If no physical business location in NC, enter physical location of the

Check here if physical address is the address of an employee

Phone Number: (B)	-	Cell	Home	Office
Business Fax Number: (	) -	Email ac	ddress:	
Section 3 — Change or u	pdate to the ow	ners, officers, par	tners or fidu	ciaries (For additional changes attach another page
Provide changes for Parer Fiduciaries (Attach a list for	· ·	· ·		rtners, Principal Corporate Officers, Members or
Add Remove	Update			
First, Middle and Last Nam	ne or Business N	ame		
SSN/FEIN:	Title:			Percentage of Ownership:
Is owner compensated for	r their services:	Yes No		
Date of Ownership:		End Date	of Ownersh	ip:
Address Line 1:				
Address Line 2:				
City:	5	State:		Zip Code: -
County:		Cour	ntry:	
Email Address:				
Phone Number: ( )	-	Cell	Home	Office Fax Number:( ) -
Alternate Phone Number 1	1:( ) -	Cell	Home	Office
Alternate Phone Number 2	2: ( ) -	Cell	Home	Office
Add Remove	Update			
First, Middle and Last Nan	ne or Business N	ame		
SSN/FEIN:	Title:			Percentage of Ownership:
Is owner compensated for	r their services:	Yes N	No	
Date of Ownership:		End Date o	f Ownership	):
Address Line 1:				
Address Line 2:				
City:	Ç	State:		Zip Code:
County:		Coun	try:	
Email Address:				
Phone Number:( )	-	Cell	Home	Office Fax Number:( ) -
Alternate Phone Number 2	1: ( ) -	. Cell	Home	Office
Alternate Phone Number 2	2: ( ) -	- Cell	Home	Office

Section 4 — Addition, Change or Update Needed to the Contact Person (For Additional Changes Attach Another Page)

Add	Remove	Update							
Contact Fi	rst Name:				Contact Last Na	ame:			
Contact Ty	/pe:				Title:				
Address Li	ne 1:								
Address Li	ne 2:								
City:			State:			Zip Code:	-		
County:				Country	<b>/</b> :				
Phone Nur	mber: ( )	-	Cell	Home	Office				
Fax Numb	er: ( )	-	Email Addr	ess:					
Add	Remove	Update							
Contact Fir	rst Name:				Contact Last Na	ame:			
Contact Ty	/pe:				Title:				
Address Li	ne 1:								
Address Li	ne 2:								
City:			State:			Zip Code:	-		
County:				Coun	try:				
Phone Nur	mber: ( )	-	Cell	Home	Office				
Fax Numb	er:( )	-	Email Add	ress:					
Section 5	– Change ir	n Business Sta	atus (Inactivatio	on):					
Opera	ating business	without emp	oloyees			Date:			
Are th	he employees	being report	ed by a PEO (P	Profession	al Employer O	rganization)?	Yes	No	
Provi	de name of th	e PEO that yo	ou have contra	acted with	n:				
Chan	ged from C-Co	rporation to	S-Corporation			Date:			
Chang	ge in partnersh	nip				Date:			
Cease	ed operations	in North Card	olina, No Succe	essor		Date:			
The f	following thre	e changes in	business stat	us requir	e a new emplo	yer account. Pl	ease, regis	ster at des.r	c.gov.
*Inco	rporated busir	ness or conve	erted business	to a LLC		Date:			
*Char	nge in busines	s organizatio	n from one tax	entity ty	pe to another	Date:			
*Rece	eived a new Fe	deral Employ	yer Identificati	on Numb	er from the IRS	Date:			

Section 6	- Resumed NC Emplo	oyment					
Resumed Er	mployment in NC:	Yes 1	No	Date:			
Section 7	<ul> <li>Sold, Merged, or T</li> </ul>	ransferred a	ll or part of the No	orth Carolina busine	ss:		
Sold or transfe	rred all or part of the	e North Card	olina business to:		Date of Acc	quisition:	
Employer	Name:				Emp	loyer ID:	
Employer	FEIN:		Employer Pho	ne:( ) -			
Employer	Address:						
Was all or	part of the NC busin	ess sold or t	ransferred: all	part , if part v	what percentag	ge %	
Is there co	mmon ownership, n	nanagement	, or control betwe	en the two entities	? Yes	No	
How many	employees were tr	ansferred to	/rehired by the So	uccessor during the	acquisition?		
How many	, employees were re	tained by th	e Predecessor aft	er the acquisition?			
Does the f	ormer owner/opera	tor continue	to have payroll o	r employees in Nor	th Carolina?	Yes	No
Was there	a buy/sell agreeme	nt? Yes	No				
Was the b	usiness in bankrupto	y at the tim	e the business wa	s sold? Yes	No		
Section 8	- Certification						

## Be Sure That All Applicable Items are Completed Before Signing

I certify that the information entered on this form is true and accurate, and that I am authorized by the named employing unit to complete this report for determining unemployment tax liability.

Must Be Signed By One of the Following: Proprietor, Partner, President, Vice President, Corporate Secretary, Treasurer, CEO, CFO, COO, Member, Executive Director, Fiduciary

Signature:

Printed Name:

Email:

Date:

Title:

Phone:( ) -