RESET

CO	RECORD	DIST	CASE LOAD

DATE OF DISCOVERY	DATE OF NOTICE

WORKER NAME

TELEPHONE NUMBER	FAX NUMBER

REQUEST FOR EMPLOYMENT/EARNINGS INFORMATION

PLEASE FAX OR RETURN TO ADDRESS SHOWN BELOW

IMPORTANT

62 PS 487 (B) REQUIRES, **UNDER PENALTY OF LAW,*** THAT YOU COMPLETE THIS FORM UPON REQUEST AND RETURN IT **WITHIN 30 DAYS TO THE ADDRESS ABOVE.** EVERY EMPLOYER IS REQUIRED, WHEN REQUESTED IN WRITING FROM THE DEPARTMENT, TO DISCLOSE ANY MONEY IN SALARY, WAGES, COMPENSATION, AND THE AMOUNTS AND DATES OF SUCH SALARY. THE DEPARTMENT CERTIFIES THAT THE EMPLOYEE BELOW IS APPLYING FOR, RECEIVING OR DID RECEIVE PUBLIC ASSISTANCE, OR IS A LEGALLY RESPONSIBLE RELATIVE OF THE EMPLOYEE.

* A FINE NOT TO EXCEED $1,000

SUBJECT OF INQUIRY

EMPLOYEE'S NAME	SOCIAL SECURITY NUMBER
COMMENT	LAST KNOWN ADDRESS

EMPLOYER PAYROLL INFORMATION

COMPLETE THE INFORMATION REQUESTED BELOW AND ON THE BACK OF THIS FORM IF THE PERSON IS OR WAS EVER IN YOUR EMPLOY (PLEASE PRINT OR TYPE).

EMPLOYEE TELEPHONE NUMBER	EARNED INCOME CREDIT (EIC) RECEIVED
( )	☐ YES ☐ NO

IS INDIVIDUAL CURRENTLY EMPLOYED? ☐ YES ☐ NO IF NO, REASON FOR TERMINATION

EMPLOYER MEDICAL INFORMATION

MEDICAL INSURANCE COMPANY		MEDICAL INSURANCE COMPANY ADDRESS	
DATES OF COVERAGE FROM TO	TYPE OF COVERAGE	POLICY / CONTRACT NUMBER	GROUP NAME / NUMBER

Please provide earnings information by DATE of PAY as indicated ON REVERSE SIDE

PROVIDE EARNINGS INFORMATION BY DATE OF PAY FROM _____ TO PRESENT. PLEASE DO NOT USE QUARTERLY OR YEARLY AMOUNTS. A COMPUTER PRINTOUT OF THE EARNINGS DATA MAY BE SUBSTITUTED IF IT CONTAINS ALL OF THE REQUESTED INFORMATION. ACTUAL DATES OF PAY MUST BE INCLUDED, NOT MERELY "PAY PERIOD ENDING" OR "WEEK ENDING" INFORMATION. PLEASE PRINT OR TYPE AND SIGN YOUR NAME BELOW.

DATE OF PAY	GROSS AMOUNT	REGULAR HOURS	OVERTIME HOURS	TOTAL TAXES
PAY RATE:				

EMPLOYER'S REPRESENTATIVE (PLEASE PRINT) _____ TITLE _____ SIGNATURE _____ PHONE NUMBER _____ DATE _____

USE THIS SPACE FOR ADDITIONAL COMMENTS: