

REQUEST FOR EMPLOYMENT/EARNINGS INFORMATION

CO	RECORD	DIST	CASE LOAD
CAO DISC		DATE OF NOTICE	
WORKER NAME			
TELEPHONE NUMBER		FAX NUMBER	

PLEASE FAX OR RETURN TO ADDRESS SHOWN ON BACK OF THIS FORM



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 ON THE BACK OF THIS FORM.** 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 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 TAX CREDIT (EIC) RECEIVED <input type="checkbox"/> YES <input type="checkbox"/> NO	
IS INDIVIDUAL CURRENTLY EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> 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

