



NEW YORK STATE
DEPARTMENT OF LABOR
PO Box 15130
ALBANY, NY 12212-5130

UNEMPLOYMENT INSURANCE Request for Reconsideration

IMPORTANT!

Response must be received within (30) thirty days from the Date Mailed of your last Monetary Benefit Determination.

Complete the following information

NAME: _____ SOCIAL SECURITY #: _____ - _____ - _____
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIP CODE: _____
 CLAIM EFFECTIVE / START DATE: ____ / ____ / ____ BENEFIT YEAR ENDING DATE: ____ / ____ / ____

Form requirements

To correct wages and/or add wages not reflected on your Monetary Benefit Determination, follow the instructions below.



- | Complete the employer and quarterly wage information below using black or blue ink;
- | Include proof of wages, (wages include the monetary value of tips, bonuses, meals and lodging, as well as commissions and vacation pay). Requests submitted without proof of wages will be rejected;
- | Photocopy all supporting documentation onto 8 x 11 single-sided paper. Do not send originals;
- | Write your Name, Social Security Number and Telephone Number on each attachment;
- | If you received Worker's Compensation include a copy of your most recent C8 Form;
- | This completed notice and all attachments must be received within the timeframe noted above in the IMPORTANT! message.

Employer Information

Please Print Clearly. Attach an additional page if you have information for more than (3) three employers.

EMPLOYER: _____
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 If work was performed outside New York State, indicate State: _____

Basic or Alternate Base Period Total Quarterly Gross Wages

Write in the total quarterly gross wages for each employer / quarter indicated. Refer to your most recent Monetary Benefit Determination for assistance.

QUARTER	MM	DD	YYYY	-	MM	DD	YYYY	\$										
_____	__	__	____	-	__	__	____	\$										
_____	__	__	____	-	__	__	____	\$										
_____	__	__	____	-	__	__	____	\$										
_____	__	__	____	-	__	__	____	\$										

EMPLOYER: _____
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 If work was performed outside New York State, indicate State: _____

_____	__	__	____	-	__	__	____	\$										
_____	__	__	____	-	__	__	____	\$										
_____	__	__	____	-	__	__	____	\$										
_____	__	__	____	-	__	__	____	\$										

EMPLOYER: _____
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 If work was performed outside New York State, indicate State: _____

_____	__	__	____	-	__	__	____	\$										
_____	__	__	____	-	__	__	____	\$										
_____	__	__	____	-	__	__	____	\$										
_____	__	__	____	-	__	__	____	\$										

Acknowledgment

I certify that the above information is correct and I understand that I will be notified of the results of my request.

Signature Required _____

Date _____

Area Code _____

Telephone Number _____

Return Instructions

This notice and all attachments must be received within the timeframe noted above in the IMPORTANT! message.



FAX: 518-457-9378
 This notice is your cover page.
 Indicate total # of pages _____

OR



MAIL: New York State Department of Labor
 P.O. Box 15130
 Albany, NY 12212-5130



Claim your weekly benefits on the web or by calling Tel-Service.



For additional information visit our website: www.labor.state.ny.us



For assistance, review your Claimant Handbook