

STATE OF NEW JERSEY DEPARTMENT OF LABOR DIVISION OF UNEMPLOYMENT AND DISABILITY INSURANCE			REQUEST FOR WAGE INFORMATION FOR DEPENDENCY ALLOWANCE	
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SS NO.	PROGRAM CODE	DATE OF CLAIM	NAME OF CLAIMANT	DATE OF MAILING
	10	7/04/99		1/28/00

SAMPLE

EMPLOYEE NAME:

EMPLOYEE SOCIAL SECURITY:

Wages for the calendar quarter ending 9/30/99 were reported by you on FORM WR-30, "EMPLOYER REPORT OF WAGES PAID", for the above named employee.

This individual has been listed as an unemployed dependent spouse or child on a claim for unemployment benefits filed by the above named claimant.

In accordance with N.J.S.A. 43:21-3(c) (2), in order for the claimant's benefits to be increased by dependency allowance, the claimant's spouse and claimed dependent children must be unemployed during the week in WHICH THE UNEMPLOYMENT CLAIM IS FILED.

NOTE: IF THE EMPLOYEE DID NOT EARN WAGES FROM YOU DURING THE CALANDAR WEEK LISTED BELOW, DO NOT RETURN THIS FORM.

If the above listed employee earned wages from you during the calendar week beginning 7/04/99 and ending 7/10/99:

1. WHAT WERE THE EMPLOYEE'S GROSS EARNING PER DAY FOR:

Sun. _____ Mon. _____ Tues. _____ Wed. _____
 Thur. _____ Fri. _____ Sat. _____

2. On what date did this employee start working for you ? _____

3. Is he/she still employed by you? YES _____ NO _____

4. Please sign and return this form to the address specified below.

RETURN THIS FORM TO:

BUREAU OF BENEFIT PAYMENT CONTROL
ATTN: DEPENDENCY VERIFICATION
PO Box 043
TRENTON, N.J. 08625-0043

SIGNATURE OF AUTHORIZED REPRESENTATIVE	
NAME	
TITLE	
TELEPHONE _____	DATE _____