

Unemployment Insurance Request for Reconsideration

Please print clearly

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Claim Effective/Start Date: ____ / ____ / ____ Social Security number: XXX-XX- ____

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 any documentation that could be considered proof of employment and wages such as pay stubs, W-2s, 1099s, vouchers, checks, tips, bonuses, meals, lodging, commissions, vacation pay and records of employment and/or payment.
- Do not send originals; photocopy all supporting documentation onto 8½ x 11 single-sided paper.
- Write your name, the last four digits of your Social Security number and your phone number on each attachment.
- If you received worker's compensation, include a copy of your most recent Subsequent Report of Injury (SROI) filing.
- This completed form and all attachments must be received within the time frame noted above in the IMPORTANT! message.

Please print clearly.

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 ____ / ____ / ____ - ____ / ____ / ____ \$ _____

Quarter ____ / ____ / ____ - ____ / ____ / ____ \$ _____

Quarter ____ / ____ / ____ - ____ / ____ / ____ \$ _____

Quarter ____ / ____ / ____ - ____ / ____ / ____ \$ _____

Quarter ____ / ____ / ____ - ____ / ____ / ____ \$ _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

If work was performed outside New York State,
indicate state: _____

Quarter ____ / ____ / ____ - ____ / ____ / ____ \$ _____

Quarter ____ / ____ / ____ - ____ / ____ / ____ \$ _____

Quarter ____ / ____ / ____ - ____ / ____ / ____ \$ _____

Quarter ____ / ____ / ____ - ____ / ____ / ____ \$ _____

Quarter ____ / ____ / ____ - ____ / ____ / ____ \$ _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

If work was performed outside New York State,
indicate state: _____

Quarter ____ / ____ / ____ - ____ / ____ / ____ \$ _____

Quarter ____ / ____ / ____ - ____ / ____ / ____ \$ _____

Quarter ____ / ____ / ____ - ____ / ____ / ____ \$ _____

Quarter ____ / ____ / ____ - ____ / ____ / ____ \$ _____

Quarter ____ / ____ / ____ - ____ / ____ / ____ \$ _____

Certification

I certify that the above information is true to the best of my knowledge and I am aware that there are penalties for making false statements. I understand 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 time frame noted above in the IMPORTANT! message.

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

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

Claim weekly benefits at www.labor.ny.gov
or call Tel-Service at 888-581-5812.

For more information visit:
www.labor.ny.gov.

For help, see the claimant handbook at
www.labor.ny.gov/uihandbook.