

## CLAIMANT'S AFFIDAVIT OF FEDERAL CIVILIAN SERVICE, WAGES, AND REASON FOR SEPARATION - UCFE

### LIABLE STATE

Agent State FIPS \_\_\_\_\_ Local Office Number \_\_\_\_\_ Contact Phone NO. \_\_\_\_\_

Claimant's Name \_\_\_\_\_

Birth Date (MM/DD/YYYY) \_\_\_\_\_ SOC.SEC.NO. \_\_\_\_\_

Type of Claim (*check one*)    New    Additional    Date Filed (MM/DD/YYYY) \_\_\_\_\_

Effective Date of Claim (MM/DD/YYYY) \_\_\_\_\_

Employer (*Federal agency + 3-digit federal agency code*) \_\_\_\_\_

Employment Address (No., Street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

### DATES OF EMPLOYMENT (MM/DD/YYYY)

FROM	TO	FROM	TO	FROM	TO

### GROSS WAGE RECEIVED FROM THE ABOVE AGENCY FOR THE BASE PERIOD (Complete only if a **NEW** claim)

QUARTER ENDING	YEAR	GROSS WAGES	HOURS WORKED	WEEKS WORKED
<b>TOTAL GROSS WAGES</b>				

Documentary Evidence (*Submitted by claimant showing federal civilian employment*)

SF-50    W-2    Other \_\_\_\_\_

MAIL CLAIMANTS- Send in with this form all papers showing that you worked for the above federal agency. This includes SF-50, W-2 paystubs, payroll change slips, letters of authority or other official documentation.

**TERMINAL ANNUAL LEAVE OR SEVERANCE PAYMENT**

Did you receive or are you entitled to receive terminal annual leave or severance pay provided by any federal law or agency employer agreement?    Yes    No    If yes, complete the following information.

TYPE OF LEAVE	AMOUNT	DATE OF PAYMENT	WEEKS	AMOUNT OF LEAVE		PERIOD OF LEAVE/ SEVERANCE PAY (MM/DD/YYYY)	
				DAYS	HOURS	FROM	TO
Severance Annual							
Severance Annual							

Reason for Separation \_\_\_\_\_

I, THE CLAIMANT, UNDERSTAND that penalties are provided by law for an individual making false statements to obtain benefits; that any determination based on this affidavit is not final; that it is subject to correction upon receipt of wage and separation information from the federal agency for which I worked; that benefit payments made as a result of such a determination may have to be adjusted on the basis of information furnished by the federal agency; and that any amount overpaid may have to be repaid or offset against future benefits.

I, THE CLAIMANT, SWEAR OR AFFIRM that the above statements, to the best of my knowledge and belief, are true and correct.

Claimant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Local Office Representative's Signature \_\_\_\_\_ Date \_\_\_\_\_

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Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. Auxiliary aids and services are available upon request to individuals with disabilities. To request this document in alternative format or for further information about this policy, Contact the UI Tax Office at 602-771-6606; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request.