CASE NO. : XXXXX-XXXXXXXXXXX

UC 2203
(Revised 04/14)

CONNECTICUT LABOR DEPARTMENT

WAIVER QUESTIONNAIRE

IMPORTANTE
TENGO ESTO TRADUCIDO INMEDIATAMENTE

NAME: _____

S.S. No.: _____

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Amount Overpaid: $ _____

Two times the WBA: $ _____

(at the time the overpayment occurred)

Please complete all of the following information. Answers to questions should be complete and contain documentation where applicable. The decision rendered will be influenced by your responses to the questions. This form must be completed and submitted prior to your hearing, and **should not be discarded. Do not complete shaded areas.**

(1) Do you have a mental or physical condition, poor health or other circumstances, which will greatly reduce your chances of obtaining future employment? Yes _____ No _____
If yes, explain on a separate piece of paper and provide any medical documentation to support such condition.

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(2) Were you overpaid as a result of gross administrative error either by the Unemployment Compensation Department or the Employment Security Appeals Division? Yes _____ No _____

If yes, explain on a separate piece of paper and provide any documentation to support such error.

[**Note**: An overpayment created by the Appeals Division decision by itself does not constitute a finding of gross administrative error.]

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(3) Did you not apply for public welfare benefits (for which you would have been entitled) because you received unemployment benefits? Yes _____ No _____

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(4) An overpayment may be waived in the event of death. As the administrator of the deceased claimant's estate, are you providing a copy of the death certificate? Yes ____ No____

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(5) An overpayment may be canceled in a case of bankruptcy. If you filed for bankruptcy protection naming the Department of Labor as a creditor, are you providing a copy of the court bankruptcy filing? Yes _____ No _____

(6) Were you overpaid because the employer failed to provide the Department of Labor information during your hearing before the administrator that resulted in a denial of unemployment insurance benefits? Yes _____ No _____
[**Note**: There might have been information on this in a recent decision from the Appeals Division regarding your claim.]

(CONTINUED ON REVERSE SIDE)

Name: XXXXXX XXXXXXXX S.S.#: XXX-XX-XXXX

(7) Please complete. **All income reported below is for the 6 month period prior to the date you have completed this form. (Documentation must be provided)**

(a) Claimant's gross income (includes any wages, disability payments, welfare benefits, pensions, Social Security benefits, and cash contributions from any other source). $_____

(b) Spouse's gross income $_____

Spouse's Social Security No.

(c) Cash contributions from other family members; whether or not residing in the household. $_____

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(d) Claimant's unemployment compensation (less the amount overpaid) $_____

(e) Spouse's unemployment compensation $_____

(f) Add lines (a) through (e): $_____

(g) Multiply line (f) times 2: $_____

(h) 150 % of poverty level for stated family size: $_____

(i) Extraordinary medical expenses including dental, not covered by insurance (Documentation required) $_____

(j) Family size _____. Complete the information below. Attach a separate sheet, if needed.

ENTER FIRST AND LAST NAMES OF FAMILY MEMBERS WHO LIVE WITH YOU, AND/OR ARE FINANCIALLY DEPENDENT UPON YOU	**RELATIONSHIP**	**SOCIAL SECURITY NO.**

CERTIFICATION

I certify that the information contained herein is true and correct to the best of my knowledge and belief. I understand that the law provides penalties for making false statements or representations.

_____ _____ _____

Signature of Claimant **Date Completed** **Phone Number**

Interviewer Remarks:

_____

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