# Request For Waiver Of Overpayment Of Unemployment Benefits

**Name: _____ Claimant ID or S.S.N.:_____ Date of Claim: _____**

**In order to adjudicate your request for a waiver of debt under the provisions of the New Jersey Administrative Code, N.J.A.C. 12:17-14.2, please respond to the following questions. Your answers will assist us in determining fault and whether or not it would be patently contrary to the principles of equity and good conscience to require you to repay the overpayment on your claim. The Department of Labor and Workforce Development is required to take into account all potential income of the claimant and the claimant's family.**

1. At any time before or since you received the benefit payments that were determined to have been overpaid, did you:
   a. Know that you provided information that was inaccurate? ❒ Yes ❒ No
   b. Fail to provide information that was relevant to determining your eligibility? ❒ Yes ❒ No
   c. Allow another individual(s) to fail to provide information that was relevant to determining your eligibility? ❒ Yes ❒ No
   d. Know that you should not have been paid these benefits? ❒ Yes ❒ No
2. How many dependants do you claim on your Federal Income Tax Return? _____
3. If married or in a civil union, what is your spouse's/civil union partner's social security number? _____
4. Are you currently receiving any type of public/government assistance (food stamps, AFDC, etc.)?

   ❒ Yes $ _____ Amount per month ❒ No

   If "No," have you applied for public/government assistance (food stamps, AFDC, etc.)? ❒ Yes ❒ No
5. State the reason(s) why you feel you should not have to repay this overpayment. _____

   _____

   _____

I certify that the statements made on both sides of this form are true and accurate to the best of my knowledge. I understand that the law provides penalties for making false statements. These penalties include loss of benefits, fines, refunds, prosecution and imprisonment.

Claimant's Signature:_____Date: _____

In order to complete the processing of your request, it may be necessary to verify any and all of your financial data. Please print or type your name in the space provided below and sign and date where indicated to allow release of personal financial data from banks, credit agencies or other financial institutions and organizations to the New Jersey Department of Labor and Workforce Development.

_____ , do hereby authorize the release of all financial records, credit information, or any other data as required, to the New Jersey Department of Labor and Workforce Development.

Claimant's Signature:_____Date: _____

Complete both sides of this form and mail it along with any supporting documentation to:

**New Jersey Department of Labor and Workforce Development**
**Division of Unemployment Insurance**
**Bureau of Benefit Payment Control**
**Refund Processing Section**
**PO Box 951**
**Trenton, NJ 08625-0951**

**Name:** _____ **Claimant ID or S.S.N.:** _____ **Date of Claim:** _____

## INCOME

| | Claimant | | Spouse/Civil Union Partner | |
|---|---|---|---|---|
| | Last 12 Months | Next 12 Months | Last 12 Months | Next 12 Months |
| Wages | | | | |
| Self-Employment | | | | |
| Unemployment | | | | |
| Pensions | | | | |
| Interest | | | | |
| Dividends | | | | |
| Social Security | | | | |
| Child Support/Alimony | | | | |
| Other Income | | | | |
| Total Income | | | | |

## ASSETS (Claimant & Spouse/Civil Union Partner)

Checking Account Balance: _____
Bank Name/ Address:

Savings Account Balance: _____
Bank Name/Address:

Investment/Brokerage Account Balance: _____
Institution Name/Address:

Cash on Hand: _____

Current Value of all Stocks: _____

Current Value of all Bonds: _____

Cash in Value of all Insurance Policies: _____

## EXPENSES

| | Current Balance | Monthly Payment |
|---|---|---|
| Rent/Mortage | | |
| Property Taxes | | |
| Utilities | | |
| Food | | |
| Clothing | | |
| Medical | | |
| Auto Expenses/Gas | | |
| Auto Loan | | |
| Other Loans | | |
| Telephone | | |
| Cable/Satellite | | |
| Internet | | |
| Insurance | | |
| Child Support/ Alimony | | |
| Other | | |
| | | |
| | | |
| Total Expenses | | |

NOTE: If you have additional expenses or there are other factors that you wish to be considered, please attach additional sheet(s). Please complete both sides of this form. Sign and date both sides and any attachments.

Claimant's Signature_____Date:_____