Department of Labor
PO Box 15130
Albany, NY 12212-5130
www.labor.ny.gov

IMPORTANT!
This form must be received within 30 calendar days from the Date Mailed of your last Monetary Benefit Determination. **Please print clearly. If you do not, we cannot process this form.**

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. **If you do not, we cannot process this form.**

Employer Information Please print clearly. Attach an additional page if you have information for more than (3) three employers.	**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.
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:___/___/______ - ___/___/______ $___ ___ ___ , ___ ___ ___ . ___ ___
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.