



**New York State Department of Labor**  
**Division of Labor Standards**

**Claim for Unpaid Wage Supplements**

Please answer all questions on both sides - Please Print Clearly

For office use only

S

Identification Number

Refer to wage claim I.D. No. (if any)

Taken By

Section 198-c (3) of the New York State Labor Law excludes from wage supplement coverage those persons in an administrative, executive or professional capacity whose earnings exceed \$900 gross per week

**Note: It is necessary for you to have asked for the supplements due before we can assist you.**

1. Your Full Name <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Mr.			3. Social Security No.		
2. Your Address Apt. No. City, Town or Village County Zip Code			4. (Area Code) Telephone No. Day ( ) Evening ( )		
5. Claim against (Trade Name of employer)			6. Corporation Name, if any		
7. Address of main office or headquarters of firm City, Town or Village County Zip Code			8. (Area Code) Telephone No. ( )		
9. Names and addresses of responsible persons of firm					Their positions
10. Kind of business firm engaged in					11. Is firm still in business? <input type="checkbox"/> Yes <input type="checkbox"/> No
12. What was your work or occupation with this firm?			13. Address where you worked Zip Code		
14. Date hired	15. Name and position of person hiring you		16. Name of superintendent, manager or foreman		
17. Latest agreed rate of pay (per hour per week, per day)	18. Last day worked	19. Status with firm <input type="checkbox"/> I quit <input type="checkbox"/> I was discharged <input type="checkbox"/> I was temporarily laid off <input type="checkbox"/> I am still employed		20. Reason for quitting, discharge or layoff	
21. Were you a member of any union when employed by this firm? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "yes", give name, local no., address, zip code and telephone no. of union			
22. Have you asked your union for assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes", what action has the union taken?			

**Before answering question 24, first fill out the back of this form to help you figure payments due**

23. Name and address of employer's bank Zip Code		24. Total amount of payment due \$
25. Did you request these benefits? <input type="checkbox"/> YES <input type="checkbox"/> NO	26. Date of Request	27. To whom was the request made?
28. Did employer refuse to pay these benefits? <input type="checkbox"/> YES <input type="checkbox"/> NO		If "yes", give employer's reason for refusal
29. Were any payments due you paid by checks returned not honored? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", submit photocopies of check(s)		30. How were wages paid? <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Other (Explain)

**Any false statements knowingly made are punishable as a Class A misdemeanor (Section 210.45, the New York State Penal Law). I affirm that the above statements are true.**

**I authorize the Commissioner of Labor, deputies or agents to receive, endorse my name on, and deposit in the account of the Commissioner of Labor any checks or money orders made out to me as payment on this claim.**

\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
Date

31. Supplement Claimed	32. Period Involved	33. Date Payments Due and Payable	34. Amount Claimed
<input type="checkbox"/> Holiday Pay			
<input type="checkbox"/> Vacation Pay			
<input type="checkbox"/> Sick Pay			
<input type="checkbox"/> Health Insurance	<input type="checkbox"/> Hosp.	<input type="checkbox"/> Medic. - Surg.	
<input type="checkbox"/> Bonus			
<input type="checkbox"/> Expenses			
<input type="checkbox"/> Other (Specify)			
			35. Total Amount \$ Claimed

36. Were you ever previously paid this kind of benefit by this employer?     Yes     No

A. For what period? \_\_\_\_\_ Amount \$ \_\_\_\_\_

B. Who paid the benefits?:     Employer     Union     Other (Explain E.G. Blue Cross, HIP)

37. What kind of agreement covers this benefit? If based on a written document, please attach copy

- Company Policy     Oral     Written (specify, e.g. employee handbook, letter)
- Union Contract     Other (Explain)

38. What are the terms of agreement (eligibility requirements) for this benefit?

39. Include any additional information below: