Division of Labor Standards

Claim for Unpaid Wage Supplements

Answer all questions on both sides. Print clearly.
Send to: NYS Dept. of Labor,
Division of Labor Standards, Bldg. 12, Rm. 185C,
State Office Campus, Albany NY 12240

For office use only S

Identification number

Refer to wage claim ID 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: You must have asked for the supplements due before we can help you.

1. Your full name ☐ Ms. ☐ Mrs. ☐ Mr.
3. Social Security number
2. Your address | Apt. no. | City, town or village | County | Zip code
4. (Area code) phone number 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) phone number ( )
9. Names and addresses of responsible persons of firm
10. Kind of business firm engaged in
11. Is the firm still in business? ☐ Yes ☐ 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 who hired 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 ☐ I quit ☐ I was discharged ☐ I was temporarily laid off ☐ I am still employed
20. Reason for quitting, discharge, or layoff
21. Were you a member of any union when employed by this firm? ☐ Yes ☐ No
If "Yes," give name, local no., address, zip code and telephone no. of union
22. Have you asked your union for assistance? ☐ Yes ☐ 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? ☐ Yes ☐ No
26. Date of request
27. To whom was the request made?
28. Did the employer refuse to pay these benefits? ☐ Yes ☐ No
If "Yes," give employer's reason for refusal
29. Were any payments due you paid by checks returned not honored? ☐ Yes ☐ No If "Yes," submit photo copies of check(s)
30. How were wages paid? ☐ Cash ☐ Check ☐ 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.

Claimant's signature ______ Date ______

See Reverse

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31. Supplement claimed	32. Period involved	33. Date payments due and payable	34. Amount claimed
☐ Holiday pay			
☐ Vacation pay			
☐ Sick pay			
☐ Health insurance ☐ Hospital ☐ Medical - surgical			
☐ Bonus			
☐ Expenses			
☐ Other (specify)			
			35. Total amount claimed $

36. Did this employer previously pay this type of benefit to you? ☐ 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 upon a written document, attach a 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