(STATE AGENCY IDENTIFICATION)

REQUEST FOR WAGE AND SEPARATION INFORMATION- UCFE

1. State Agency Address:	2. Name of Federal Agency, 3 Digit Agency Code, and Address:

3. Local Office/Call Center ID: 4. Date of Request: 5. Date claim taken: 6. Effective Date of Claim:

7. Name (Last, First, Middle Initial)	8. Social Security Number

Complete and Return Within 4 Workdays

9. Location of Official Duty Station. If outside U.S., enter Country: _____

10. Did this person perform Federal Civilian Service, as defined for UCFE purposes, for your agency at any time on or after the base period begin date shown in Item 11a below?

Yes __No

If No, Complete Items a – e below.

a. Under what legal authority was the individual hired?_____

b. What funding Source was used for salary payments? _____

c. Were payroll deductions made for Federal and State taxes?

Yes __No

d. Was Employee eligible for:

(1) Annual and Sick leave?

__Yes __No

(2) Health and Life insurance?

__Yes __No

(3) Civil Service or FERS retirement?

__Yes __No

e. Did the Federal agency provide direction and control?

Yes __No

11. Are base period wages provided electronically? __Yes __No

If "Yes," go to Item 12. If "no," report all Wages from base period begin date to separation date.

a. Base period beginning date_____

b. Report wages for quarters ending after date in "a" above.

Qtr. Ending	# of Weeks Worked	# of Hours Worked	Gross Wages
_____	____	_____	$_____
_____	____	_____	$_____
_____	____	_____	$_____
_____	_ ___	_____	$_____
_____	____	_____	$_____
_____	____	_____	$_____
_____	____	_____	$_____
_____	____	_____	$_____
_____	____	_____	$_____

12. Separation, Lump Sum Annual Leave, and Severance Pay Information

a. Did this person receive payment for annual leave on or after the date of separation?

__Yes __No

If ,"Yes" or if currently entitled to such a payment, enter below:

Amt of payment : $_____ Date of payment: __/__/__

Number of days of Leave: ___

b. Date of Separation __/__/__

c. Reason for separation:_____

_____

_____

_____

_____

d. Did this person receive or is he/she entitled to receive severance pay provided by Federal law or agency employee agreement?

__Yes __No

If "yes," complete the following information:

	Total Amount: $_____ Beginning date: ___/___/____Ending Date: ___/___/____
Print Name_____ Signature_____ ETA- 931 (Revised 1/2003)	Title_____ Telephone Number (_____) _____ Date____/___/____

OMB No.: 1205-0179 **OMB Expiration Date:** 08/31/2012 **Estimated Average Response Time:** 5 Minutes

Important Notice

If a completed Form ETA-931 is not received by the 12th calendar day from the "date of request," the State agency is authorized by the Department of Labor's Regulation, published at 20 CFR 609.6(e)(2), to pay benefits to the ex-federal civilian employee based on his/her affidavit. Any benefit payments made to the claimant will be charged to the Federal employing agency(ies) in accordance with Section 1023, PL 96-499, Omnibus Reconciliation Act of 1980 (94 Stat. 2599).

INSTRUCTIONS TO FEDERAL AGENCY

As an alternative to completing this form, attaching a computer printout that contains all of the information requested is acceptable if the layout of the print out is cleared with the U.S. Department of Labor, Washington, DC 20210.

Item 9. Enter the name of the state where the ex-federal civilian employee's official duty station is located. If it is outside of the U.S., enter the name of the country.

Item 10. If the federal agency's response is "No" to this question, provide the information requested in questions 10 a - e.

Item 11. The state agency will provide the beginning date of the base period for the unemployment compensation claim filed by the ex-federal civilian employee. All employment and wages from the base period beginning date through the date of separation are reportable in response to this request. Enter the number of weeks worked, number of hours worked and gross wages for the current calendar quarter and all other calendar quarters ending after the base period begin date. **Include as wages** the amount of any lump sum annual leave payment. **Do not include** severance pay as wages (Refer to 5 USC 5595).

Item 12. Agency findings are available from SF 50. If payroll office records are incomplete or inadequate, or if information on SF-50 is not sufficient, check with personnel for additional information and add as part of separation information.

Signature of Official. Form is not complete unless it (or attached computer printout) is signed and dated; also enter signer's title and telephone number.

ETA 931 (Revised 1/2003)

(STATE AGENCY IDENTIFICATION)

REQUEST FOR SEPARATION INFORMATION - ADDITIONAL CLAIM

1. State Agency Address:	2. Federal Agency Name, 3 Digit Agency Code, and Address:	
3. Local Office/Call Center:	4. Date of Request:	5. Effective Date:
6. Claimant's Name (Last, First, Middle Initial)	7. Social Security Number	

Federal Agency Response B Complete and Return Within 4 Workdays

8. Separation, Lump Sum Annual Leave, and Severance Pay Information

a. Date of Separation ____/____/_____

b. Reason for separation:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

c. Did this person receive payment for annual leave on or after the effective date of claim shown in item 5? __Yes __No If "Yes", or if currently entitled to such a payment, complete the following information:

Amount of payment: $_____ Date of payment: ____/____/_____ Number of days of Leave: _____

d. Did this person receive or is he/she entitled to receive severance pay provided by Federal law or agency employee agreement? __Yes __No If "yes," complete the following information:

Total Amount of payment: $_____ Beginning date: ____/____/_____ Ending Date: _____/____/_____

9. Signature of Official _____ **Title:** _____

Print Name: _____**Telephone: ( )**_____**Date**____/____/_____

ETA-931A (Revised 1/2003)

OMB No.: 1205-0179 **OMB Expiration Date:** 08/31/2012 **Estimated Average Response Time:** 5 Minutes

required to obtain or retain benefits under SSA 303(a)(6). Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workforce Security, Room S-4231, 200 Constitution Ave., NW, Washington, DC, 20210.

(STATE AGENCY IDENTIFICATION)
REQUEST FOR ADDITIONAL INFORMATION

1. State Agency Address:	**2. Federal Agency Name, 3 Digit Agency Code, and Address:**

3. Local Office/Call Center ID: **4. Date of Request:** **5. Effective Date:** **6. Separation Date:**

7. Claimant=s Name (Last, First, Middle Initial)	**8. Social Security Number**

9. State Agency Statement or Questions of Federal Agency:

10. Federal Agency Response:

11. Signature of Official _____ **Title:** _____

Print Name: _____ **Telephone: (____)**_____**Date:**_____/____/_____

ETA-934 (Revised 1/2003)

OMB No.: 1205-0179 **OMB Expiration Date:** 08/31/2012 **Estimated Average Response Time:** 4 Minutes
O M B Burden Statement: These reporting instructions have been approved under the Paperwork reduction Act of 1995. Persons are not required to respond to this collection of information unless it displays a valid OMB control number. Public reporting burden for this collection of information includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Submission is

required to obtain or retain benefits under SSA 303(a)(6). Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workforce Security, Room S-4231, 200 Constitution Ave., NW, Washington, DC, 20210.

ETA-935

(STATE AGENCY IDENTIFICATION)
CLAIMANT'S AFFIDAVIT OF FEDERAL CIVILIAN SERVICE, WAGES AND REASON FOR SEPARATION, ETA-935

1. State Agency Address:	2. Claimant's Name and Mailing Address:

3. Local Office/Call Center ID:	4. Date of Request:	5. Effective Date of Claim:	6. Separation Date

7. Federal Agency Name and Address:	8. Social Security Number

Instructions: Complete and Return Immediately

9. Affidavit of Federal Wage and Separation Information/Documentary Evidence

a. Enter the location of your Official Duty Station: (City, State)

b. Enter your wages with the above named employer below. Show wages by quarter starting with the wages that you earned after (base period begin date) up to the date you separated from this employer. Under Documentary Evidence, enter the source of the information provided and attach a copy. If additional space is needed to explain reason for separation, attach your signed explanation.

Quarter Ending	Year	Gross Wages	Documentary Evidence

c. Severance Pay. Did you receive or are you entitled to receive severance pay provided by Federal law or agency employee agreement? ___ Yes ___ No If "Yes" complete the following information: Total Entitlement: $_____.

Severance Pay Period Begin date: __/__/__ Ending Date: __/__/__

d. Pension: Are you entitled to receive a pension from any branch of the Federal Government? ___ Yes ___ No

Enter Gross Monthly Pension $_____.

e. Reason for Separation:

I, the claimant, understand that penalties are provided by law for an individual making false statements to obtain benefits and that determinations based on an affidavit are not final: that determinations are subject to correction upon receipt of wage and separation information from the Federal agency, that benefit payments made as a result of such determination may have to be adjusted on the basis of information from the Federal agency, and that any amount overpaid will have to be repaid or offset against future benefits. I, the claimant, swear or affirm, that the above statements, to the best of my knowledge, are true and correct.

10. Signature of Claimant: _____	Date: _____/_____/_____

ETA-935

OMB No.: 1205-0179 **OMB Expiration Date:** 08/31/2012 **Estimated Average Response Time:** 9 Minutes