(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	e B Complete and Return Within 4 Workdays
	erance Pay Information
YesNo If "Yes", or if currently enti Amount of payment: \$ Dat d. Did this person receive or is he/she entitled agreement?YesNo If "yes," comp	al leave on or after the effective date of claim shown in item 5? itled to such a payment, complete the following information: te of payment:// Number of days of Leave: to receive severance pay provided by Federal law or agency employee plete the following information: Beginning date:// Ending Date://
	Title:
Print Name:	Telephone: ()Date/
ETA-931A (Revised 1/2003)	

OMB No.: 1205-0179 OMB Expiration Date: 10/31/2015 Estimated Average Response Time: 5 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.