



New York State Department of Labor  
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

<b>For office use only</b>		<b>S</b>
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 <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> 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? <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 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 <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 the 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 photo copies 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.

\_\_\_\_\_  
Claimant's signature

\_\_\_\_\_  
Date

**See Reverse**

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"/> Hospital <input type="checkbox"/> Medical - surgical			
<input type="checkbox"/> Bonus			
<input type="checkbox"/> Expenses			
<input type="checkbox"/> 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