STATE OF MARYLAND
DEPARTMENT OF LABOR
DIVISION OF UNEMPLOYMENT INSURANCE

REQUEST RECONSIDERATION OF OVERPAYMENT RECOUPMENT – WAIVER

The Request of Reconsideration of Overpayment Recoupment must be made within thirty (30) days from the date of the original overpayment notice, unless the claimant can show good cause for failure to meet the 30 day requirement.

The Department of Labor may waive recovery of an Unemployment Insurance (UI) overpayment when the claimant is found to be without fault and lacks the ability to pay now and in the foreseeable future or is a part of a household that is below the federal minimum poverty level and likely to remain there for the foreseeable future.

Current HHS Poverty Guidelines			
Persons in Family	**48 Contiguous States and D.C.**	**Alaska**	**Hawaii**
1	$12,490.00	$15,600.00	$14,380.00
2	$16,910.00	$21,130.00	$19,460.00
3	$21,330.00	$26,660.00	$24,540.00
4	$25,750.00	$32,190.00	$29,620.00
5	$30,170.00	$37,720.00	$34,700.00
6	$34,590.00	$43,250.00	$39,780.00
7	$39,010.00	$48,780.00	$44,860.00
8	$43,430.00	$54,310.00	$49,940.00
For each additional person above 8, add:	$4,420.00	$5,530.00	$5,080.00

If you meet the above criteria, please complete the following to request a waiver of your UI overpayment.

Claimant's Name	
S.S. No.	
Street Address	
City, State, Zip	
Telephone Number	
Email Address	

AFFIDAVIT OF CURRENT INCOME AND LIVING EXPENSES

Average Monthly Household Income

1. Your Current monthly gross income:_____
   Please provide copies of your two (2) most recent paystubs.

   Your highest level of education or vocational training completed:_____

2. Your spouse's current monthly gross income:_____
   Please provide copies of your spouse's two (2) most recent pay stubs.

   Spouse Name:_____

   Spouse Social Security Number:_____

3. List names, ages, and Social Security Numbers for all dependents residing in your home (attach additional pages as necessary):

   Name:_____ Age:_____

   SSN:_____ Monthly Gross Income:_____

   Name:_____ Age:_____

   SSN:_____ Monthly Gross Income:_____

   Name:_____ Age:_____

   SSN:_____ Monthly Gross Income:_____

   Name:_____ Age:_____

   SSN:_____ Monthly Gross Income:_____

Waiver Request

In order for the request for waiver to be approved, you must show lack of ability to pay now and in the foreseeable future. Please use the space provided below or an attached sheet to indicate what conditions exist that make you unable to repay your overpayment in the foreseeable future. If reason is due to medical complications, please enclose a medical statement.

Financial Statement

Other monthly gross income - *Please provide copies of your two (2) most recent paystubs for each:*

Social Security	
Pension and/or Retirement	
Severance	
Disability	
Unemployment Compensation	
Alimony	
Child Support	
TANF/Food Stamps	
Other Income (please list) _____ _____ _____	_____ _____ _____
TOTAL INCOME AND ASSETS	

Monthly Expenses – *Please provide supporting documentation for all monthly expenses listed below:*

Mortgage/Rent	
Second Mortgage	
Water	
Gas	
Electric	
Cable	
Internet	
Medical/Dental	
Telephone	
Transportation (Car Payment, fuel, bus, etc.)	
Food	
Child Care	

Student Loan(s)	
Credit Card(s)	
Home/Renter's Insurance	
Auto Insurance	
Health Insurance	
Life Insurance	
Court ordered support paid out	
Other (please specify) ____________________ ____________________ ____________________	____ ____ ____
TOTAL EXPENSES	

Bank Accounts - *Please attach any additional bank accounts on a separate page.*

Name of Bank / Financial Institution:____

Bank / Financial Institution Address:____

Type of Account: Checking Savings Certificate of Deposits Other:

Account Number:__________________________ Value of Account:________________________________

Name of Bank / Financial Institution:____

Bank / Financial Institution Address:____

Type of Account: Checking Savings Certificate of Deposits Other:

Account Number:__________________________ Value of Account:________________________________

Name of Bank / Financial Institution:____

Bank / Financial Institution Address:____

Type of Account: Checking Savings Certificate of Deposits Other:

Account Number:__________________________ Value of Account:________________________________

Name of Bank / Financial Institution:____

Bank / Financial Institution Address:____

Type of Account: Checking Savings Certificate of Deposits Other:

Account Number:__________________________ Value of Account:________________________________

CERTIFICATION AND SIGNATURE

I understand that failure to answer the questions on this form truthfully may be considered unemployment insurance fraud. I hereby certify that my answers to the questions on this form are true and correct.

I AFFIRM, UNDER THE PENALTIES OF PERJURY, THAT THE INCOME, EXPENSES, AND INFORMATION LISTED ON THIS FORM ARE ACCURATE AND CORRECT.

Claimant's Signature:_____ Date:_____

When you have completed this form, please mail it and all attachments you wish to present to the following address:

Department of Labor
ATTN: Benefit Payment Control
1100 North Eutaw Street, Room 206
Baltimore, MD 21201
(410) 767-2404

MAIL COMPLETED FORM TO THE ABOVE ADDRESS WITHIN 30 DAYS FROM THE DATE OF THE ORIGINAL OVERPAYMENT NOTICE.