OVERPAYMENT WAIVER REQUEST

State Form 52986 (R4 / 7-25)

INDIANA DEPARTMENT OF WORKFORCE DEVELOPMENT

Name

Last 4 digits of Social Security Number
X X X - X X - ☐ ☐ ☐ ☐

Street Address | Apt | City | State | ZIP

Telephone Number | Marital Status | Date of Birth (month, day, year)

E-mail Address

If you are overpaid unemployment benefits, the Department of Workforce Development ("DWD") is required to collect that overpayment. However, Indiana Code 22-4-13-1(i) provides that your overpayment amount may be waived if you meet the criteria below. Note that the overpayment cannot be waived if you worked for an employer who elected to make payments instead of contributions.

Your overpayment may be waived if:

1. Payment of the benefits was without fault of the individual, regardless of intent; AND
2. Repayment would be contrary to equity and good conscience.

The waiver process does not include looking at the decision that caused the overpayment. The waiver process is to determine whether you qualify to have your overpayment waived.

Please complete this form and return it to DWD within 15 days of the date the decision creating the overpayment becomes final. If the issue that caused the overpayment has been appealed, wait until after you receive an appeal decision. We will not review any waiver request if the issue that has caused the overpayment is under appeal.

To be considered, waiver requests must be:

- Submitted within 15 days of the date the decision creating the overpayment becomes final.
- Entirely filled out;
- Filled out clearly so it can be read; and
- Include all required documents.

Note that we will not consider your form if you have not previously verified your identity.

Your waiver request may be denied if you do not provide documents that are requested below.

DWD will review the waiver request and send you a decision. DWD may need to contact you to gather more information. Please verify your contact information is up to date at https://uplink.in.gov/CSS/CSSLogon.

STATEMENT OF ECONOMIC HARDSHIP & FAULT

1. List all people that live in your household, and their relationship to you:

Name	Age	Relationship	Does this person rely on you for financial support?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

2. Provide your employment information:

Employer's Name (write "self" if self-employed)	Hours Worked Per Week	Most Recent Date of Hire (month, day, year)

3. If you are currently receiving Unemployment Benefits, provide your weekly benefit amount: _____

4. Provide your Household Income:

- Be sure to show **MONTHLY** gross amounts below. If paid weekly, multiply by 4.33 (4 1/3) to figure monthly pay. If paid every two (2) weeks, multiply by 2.166 (2 1/6). Do **NOT** include Unemployment Benefits below.
- If claimant is self-employed, claimant must provide supporting income documentation.

Income From Employment and Other Household Income	Yours	Spouse's / Partner's	Other Household Members
GROSS Pay			
Social Security Benefits (including SSDI)			
Pension(s) (VA, Military, Civil Service, Railroad, etc.)			
Worker's Compensation			
Rental Income (minus ordinary / necessary expenses)			
Alimony			
Other Income			
TOTALS	$ 0.00	$ 0.00	$ 0.00

Total Monthly Household Income: $ 0.00

5. Provide any additional information you would like DWD to consider in this matter, including why you believe the overpayment was not your fault:

Please provide any other information you would like the DWD to consider in this matter on **additional sheets of paper attached to this form**. The DWD has the following options based on the information supplied: (1) approve the waiver of recovery of the remaining amount of your overpayment; (2) approve the waiver of a specific portion of your overpayment, with the balance not waived to be collected in accordance with the standard collection procedures of the DWD; or (3) deny the waiver of recovery of the entire overpayment and require repayment in accordance with the standard collection practices of the DWD.

I hereby certify that the information I have provided in this form is a true, accurate and complete disclosure and representation of the material facts pertaining to my request for a waiver of an overpayment of unemployment benefits. This certification is based on my personal knowledge and belief.

Claimant's Signature

Date (Month, day, year)

Printed Name of Claimant

Please mail or fax this application to the following:
Indiana Department of Workforce Development
10 N. Senate Ave.
Indianapolis, IN 46204
FAX: (317) 633-7206