Reset Form

SUTA Account Termination or Transfer Request

State Form 46800 (R7 / 03-16)
INDIANA DEPARTMENT OF WORKFORCE DEVELOPMENT
10 N. Senate Ave RM SE 202
Indianapolis, IN 46204-2277
Confidential Record Pursuant To IC 4-1-6, IC 22-4-19-6

04680001

IMPORTANT: Employers are required to file quarterly reports until the Agency makes a determination to terminate, suspend, or transfer liability for their account. Failure to file required quarterly reports may create estimated liabilities as described in IC 22-4-11-4. Failure to timely report the cessation or transfer of a business may result in civil penalties as described in IC 22-4-11.5-9 being assessed to the Employer. Please go to www.in.gov/dwd/SUTA.htm for additional information or clarification.

SECTION ONE - IDENTIFICATION OF THE EMPLOYER

What is the SUTA number currently assigned to the business being terminated, suspended, or transferred?

What is the last day on which wages greater than zero were or will be paid by this employer? ___ / ___ / ___

IMPORTANT: You must accurately report the last payroll date for this organization in Indiana. A quarterly report with gross wages greater than zero for the quarter containing this date is required. If a liable report is not filed, wages will be estimated based on your certification of this date on this form. If a quarterly report is filed for a quarter after this date, the account termination, suspension, or transfer will be reversed and new liability will be established for the employer.

What is the name of this business as registered with IDWD?

Date registered with the Indiana Secretary of State? ___ / ___ / ___

If not required to register with the Indiana Secretary of State, what is the legal name of the business used to secure the EIN from the IRS?

What is the FEIN number of this employer as registered with IDWD?

To what address should final notices regarding this business be sent? ***Do not use a third party agent address.***

Street

City State

ZIP - ☐ US ☐ Canada ☐ Mexico ☐ Other

What is the telephone number for the business? ***Do not use a third party agent phone number.***

Phone - - Ext or Name

Please provide an email address where IDWD may contact a responsible party for the business. *Leave blank if not applicable.*

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SECTION TWO - BASIS FOR LIABILITY CHANGE

1. Are you submitting this form to report that you have transferred all or part of your existing business or workforce to a different business? Yes ☐ No ☐ ***If No, go to question 2.***

IMPORTANT: Indiana requires that a business disclose the transfer of assets, including the workforce, between businesses. Answering no to this question indicates that you did not in any way transfer operational control of all or part of an existing Indiana business including the workforce. Failure to disclose transfer of operational control of assets is considered a material misrepresentation under the Act. Please attach documentation which supports the type of transfer for evaluation under IC 22-4-10 and IC 22-4-11.5. For a bankruptcy, you must attach the specific Order approving the sale or transfer of the assets. If you disagree with the successorship determination of the Agency, you will have 15 days to protest the initial determination in writing per IC 22-4-32.

Select the type that best describes this transfer

Reorganization or FEIN Change ☐ Bankruptcy ☐ Sheriff's Sale/Foreclosure ☐

Purchase/Transfer Franchise ☐ PEO/Leasing Agreement ☐ Other purchase or transfer ☐

(a) To the best of your knowledge, what percent of the existing business transferred? ☐☐☐ . ☐☐ %

Please provide any known information regarding the identity of the Acquirer: FEIN ☐☐☐☐☐☐☐☐☐

SUTA # ☐☐☐☐☐☐ Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(b) What day did operational control transfer to the acquirer? ☐☐ / ☐☐ / ☐☐

Operational control transfers on the day that the acquirer has a legal right to direct the business operations, even if they do not immediately exercise the right.

If you answered Yes to Question 1, selected the type of transfer, have answered questions 1(a) and 1(b), and have identified the disposer to the best of your ability, please go to section 3 to complete the status change request.

2. Are you submitting this form to voluntarily terminate the account and transfer any experience balance associated to the account to the State? Yes ☐ No ☐ ***If No, go to question 3.***

An employer may voluntarily terminate an account under IC 22-4-9-2 if they have not had any employment in the current or prior calendar year. A request for account termination must be filed by January 31st of the year for which it is to be effective.

(a) Have you paid any wages as defined by IC 22-4-4 to anyone engaged in covered employment as defined by IC 22-4-8 during the current or prior calendar year? Yes ☐ No ☐

If you answered Yes to question 2 and to question 2a, go to section 3 to complete the status change. If you answered No to question 2a, you are not eligible to voluntarily terminate the account at this time. If you do not currently have wages or covered employment, but do not yet meet the requirement for voluntarily terminating your account, please answer question 2 No and complete section 3 to suspend the account.

3. Are you submitting this form to suspend liability and reporting on the account? Yes ☐ No ☐

If an employer ceases to have covered employment during a calendar year, but does not meet the requirement for voluntary termination or anticipates having covered employment in the future, the employer can request to suspend liability on the account. Once the account is suspended, the employer may resume reporting for up to four (4) years after the suspension.

Select the type that best describe this action

Permanent business closure ☐ Proprietorship / partnership operating without employees ☐

Reorganization or FEIN Change ☐ Corporation officers working without remuneration ☐

If you answered Yes to question 3 and have selected the appropriate closure description, go to section 3 to complete the status change.

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SECTION THREE - DISCLOSURES AND CERTIFICATION OF INFORMATION

Provide the name and contact information for the person who prepared this form for signature.

First Name | Last Name

Telephone - - Agent Employee

Preparer's Signature: _____ Date / /

Provide the name of the person who is the responsible party for registration of this entity. ***Do not identify a third party Agent.***

First Name | Last Name

Telephone - - Title

Responsible Party's Signature: _____ Date / /

IMPORTANT: By signing this form, you are certifying that the information contained herein is true and accurate to the best of your knowledge and belief. You further affirm that you are a person of sufficient authority with regard to the named entity to file this document and to bind the business by the information provided including all required attachments and disclosures as indicated.

Mail completed forms to: IDWD - Employer Status Reports
10 N Senate Ave Rm SE 202
Indianapolis, IN 46204-2277

Fax: (317) 233-2706
Questions: (800) 437-9136 (2)
Handbook: www.in.gov/dwd