NEW JERSEY DEPARTMENT OF LABOR
UNEMPLOYMENT INSURANCE OFFICE 933
57 PARK ST
BLOOMFIELD NJ 07003-2598

NOTICE TO EMPLOYER OF MONETARY DETERMINATION AND REQUEST FOR SEPARATION INFORMATION

BC-3E (R-02-02)

1. SOCIAL SECURITY NO.	2. PROG. CODE	3. DATE OF CLAIM	4. DATE OF MAILING
	10	01/06/2002	03/22/2002

5. CLAIMANT'S NAME

7. NAME WORKED UNDER (IF DIFFERENT)

	BEGINS	ENDS
8. BASE YEAR	10/01/2000	09/30/2001
9. BENEFIT YEAR	01/06/2002	01/04/2003

10. EMPLOYER IDENTIFICATION NUMBER

6. MONETARY DETERMINATION

(a) MAXIMUM BENEFIT AMOUNT $12,350.00 (b) WEEKLY BENEFIT RATE $ 475.00

(c) MAXIMUM CHARGEABLE AMOUNT $ 5,668.53 (d) % OF WEEKLY BENEFIT AMOUNT CHARGEABLE TO YOUR ACCOUNT 45.899%

MAXIMUM CHARGEABLE AMOUNT IS THE TOTAL AMOUNT THAT MAY BE CHARGED TO YOUR ACCOUNT IF CLAIMANT IS OTHERWISE ELIGIBLE FOR BENEFITS.

(e) WEEKLY DEPENDENCY ALLOWANCE $ (f) NO. OF DEPENDENTS

THE WEEKLY BENEFIT RATE ABOVE INCLUDES THE DEPENDENCY ALLOWANCE

WAGES AS REPORTED	QUARTER ENDING 12/31/2000		QUARTER ENDING 3/31/2001		QUARTER ENDING 6/30/2001		QUARTER ENDING 9/30/2001		BASE YEAR TOTALS	
☐ BY THE EMPLOYER	BASE WEEKS	TOTAL WAGES	BASE WEEKS	TOTAL WAGES	BASE WEEKS	TOTAL WAGES	BASE WEEKS	TOTAL WAGES	BASE WEEKS	TOTAL WAGES
☒ BY CLAIMANT'S AFFIDAVIT			13	7800.00	13	7800.00	13	7800.00	39	23400.00

RIGHT OF APPEAL: If you disagree with this monetary determination, you must file an appeal in writing to the above address. The appeal must be received or postmarked within seven calendar days after delivery or within ten calendar days after the date of mailing of this notice as shown in item 4.

If you submit any information indicating that he/she may be ineligible or disqualified for benefits, you will receive a separate notice of determination indicating claimant's eligibility, or disqualification.

REQUEST FOR SEPARATION INFORMATION: Refer to Important Notice to Employer (Item A) on the reverse of this form to determine if you are required to complete this Request for Separation Information. If required, complete the items listed below, detach at perforation, and mail to the above office within ten calendar days after the date of mailing in Item 4. If you fail to comply, payments to the claimant and charges to your experience rating account will be processed based on available information.

DETACH HERE

NAME	FRD	SOC. SEC. NO.	PC	DATE OF CLAIM 933
	01/11/2002		10	01/06/2002

A. The claimant was separated for a reason other than lack of work

Claimant's Last Day of Work: _____ Last day of separation (if different): _____

The reason for separation is: _____

_____

_____

B. The claimant is receiving/has applied for a company pension, 401K, or other type of retirement benefit.

Did claimant contribute? ☐ Yes ☐ No Monthly Amount of Pension: $ _____

IF LUMP SUM payment is issued, please enter total amount: $ _____ Date LUMP SUM paid: _____

C. The claimant was paid for a period after his/her last day of work. Amount received: $ _____

Type of payment: ☐ Vacation Holiday ☐ Severance ☐ Payment in Lieu of Notice through _____ (Date) ☐ Continuation Pay through _____ (Date)

Was this payment part of a contractual agreement? ☐ Yes ☐ No

D. The separation is temporary. The claimant is scheduled to return to work on _____ (Date)

BC-3E.1 (R-02-02)

EMPLOYER IDENTIFICATION NUMBER

EMPLOYER

NUMBER
PO BOX 397
TRENTON NJ 08625-0397

I certify that the information submitted in this report is true and correct.

Signed _____ Official Position _____

Date _____ E-mail _____

Telephone No: _____ Ext: _____ FAX No: _____