STATE OF NEW JERSEY
DEPARTMENT OF LABOR
DIVISION OF
UNEMPLOYMENT AND DISABILITY INSURANCE

REQUEST FOR WAGE INFORMATION
FOR DEPENDENCY ALLOWANCE

<table>
<thead>
<tr>
<th>SS NO.</th>
<th>PROGRAM CODE</th>
<th>DATE OF CLAIM</th>
<th>NAME OF CLAIMANT</th>
<th>DATE OF MAILING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10</td>
<td>7/04/99</td>
<td></td>
<td>1/28/00</td>
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EMPLOYEE NAME:

EMPLOYEE SOCIAL SECURITY:

Wages for the calendar quarter ending 9/30/99 were reported by you on FORM WR-30, "EMPLOYER REPORT OF WAGES PAID", for the above named employee.

This individual has been listed as an unemployed dependent spouse or child on a claim for unemployment benefits filed by the above named claimant.

In accordance with N.J.S.A. 43:21-3(c) (2), in order for the claimant's benefits to be increased by dependency allowance, the claimant's spouse and claimed dependent children must be unemployed during the week in WHICH THE UNEMPLOYMENT CLAIM IS FILED.

NOTE: IF THE EMPLOYEE DID NOT EARN WAGES FROM YOU DURING THE CALENDAR WEEK LISTED BELOW, DO NOT RETURN THIS FORM.

If the above listed employee earned wages from you during the calendar week beginning 7/04/99 and ending 7/10/99:

1. WHAT WERE THE EMPLOYEE'S GROSS EARNING PER DAY FOR:
   
   Sun. _______  Mon. _______  Tues. _______  Wed. _______  
   Thur. _______  Fri. _______  Sat. _______

2. On what date did this employee start working for you? ____________
3. Is he/she still employed by you? YES____ NO____
4. Please sign and return this form to the address specified below.

RETURN THIS FORM TO:

BUREAU OF BENEFIT PAYMENT CONTROL
ATTN: DEPENDENCY VERIFICATION
PO Box 043
TRENTON, N.J. 08625-0043

SIGNATURE OF AUTHORIZED REPRESENTATIVE

NAME

TITLE

TELEPHONE_________________________ DATE_________________________