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|  | **NEW HAMPSHIRE EMPLOYMENT SECURITY  DECISION OF COMMISSIONER** |
| JFS-84400 |  |

Claimant's Name Social Security Number

\*\*\*-\*\*XXXX

Date Issued: Determination No:

XX/XX/XXXX

Business Unit:

|  |  |
| --- | --- |
|  | BENEFIT PAYMENT CONTROL 45 SOUTH FRUIT STREET CONCORD NH 03301-4857  Phone: (603) 228-4071  Fax: (603) 229-4390 |

**FINDING OF FACT:**

You filed and received Unemployment Compensation in the amount of $ for the weeks ending XX/XX/XXXX and XX/XX/XXXX telling the Department you neither worked nor earned wages during these weeks.

Information and documentation provided to the Department by of shows you worked and earned wages during these weeks.

(See attached summary)

**ISSUE(S) OF LAW INVOLVED:**

RSA 282-A:164

Complete law/rule reference can be viewed at [www.nhes.nh.gov](http://www.nhes.nh.gov) by using the NH LAW & RULE link on the left side of the page, or at any NH Employment Security Office.

**RIGHTS AND OBLIGATIONS:**

Your rights and obligations under Unemployment Compensation Law were provided to you when you filed your claim for Unemployment Insurance benefits.

**CONCLUSION:**

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You knowingly failed to report your work and earnings with for weeks ending XX/XX/XXXX and XX/XX/XXXX. You knowingly failed to report this activity for the purpose of obtaining or increasing unemployment benefits for the weeks covered above. The weeks at issue are denied.

You are disqualified for benefits for weeks ending **XX/XX/XXXX and XX/XX/XXXX**. You are also ineligible to receive benefits for a period of **X** weeks commencing **XX/XX/XXXX** and ending **XX/XX/XXXX**. In addition to any overpayment caused by this denial, a penalty equal to 20 percent of the overpaid benefits shall be ordered by the Commissioner or his or her representative.

The account of the following most recent employer(s) will be relieved of any charges associated with the weeks addressed in this determination. If such employer is a reimbursable employer, the account will be relieved upon recovery.

Si usted no puede leer esto, llame por favor a 1-800-266-2252 para una traduccion.

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**REPAYMENT OF OVERPAYMENT:**

You are overpaid benefits in the amount of **$** plus a 20 percent penalty of **$** for a total overpayment of **$**  and restitution is required. You should make a check or money order payable to "New Hampshire UCB Account" and mail to New Hampshire Employment Security, Attn: Cashier, 45 South Fruit Street, Concord, NH 03301 or you may call 1-800-852-3400, Ext or 1-603-229-4391 to discuss payment plan arrangements.

**APPEAL RIGHTS**: You may appeal this determination and have the opportunity for a hearing. To file an appeal, complete an **on-line** form at the NHES website at <http://www.nhes.nh.gov/forms/index.htm;> **mail** a form or letter to NHES Appeal Tribunal Unit, PO Box 2009, Concord, NH 03302-2009 or **fax** to (603) 223-6141; send an **email** to [appeals@nhes.nh.gov](mailto:appeals@nhes.nh.gov); or go **in person** at an NHES office. Include the determination ID number, your name, the last four digits of the claimant's social security number and any additional facts and/or documentation to support the appeal. An appeal must be postmarked or received in an NHES office **within 14 days from the determination mail date**, unless the Commissioner finds sufficient grounds to justify or excuse a delay in filing the appeal. If the 14th day is not a Department business day, the Commissioner has already extended the deadline. **A timely appeal must be filed no later than XX/XX/XXXX**. If the appeal is filed after this date include a statement with: (1) the date you received the determination; and (2) the reason for filing late. If unemployed, claimants should continue to file weekly benefit claims while the determination is under appeal.

CLAIMANT: Upon conclusion of the appeals process, you may request a compromise to forgive some or all of an overpayment debt. If shown to be in the best interests of the state, the Commissioner may waive certain costs and/or settle any overpayment debt with approval of the Attorney General. Send a written explanation of why the Commissioner should compromise the debt to **Commissioner, 45 South Fruit Street, Concord, NH 03301**. RSA 282-A: 29 and EMP 408.

Determination by:

For Office Use Only -

DTM:

FAC DTM:

LO #:

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| Claimant's Name: |  | Social Security #: | \*\*\*-\*\*-XXXX |
| Claimant's Address: |  | Summary by: |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Type of  Claim** | **Claim Week Ending Date** | **Benefits  Paid** | **Earnings  Reported by  you** | **Total  Earnings  Reported by  Employer(s)** | **Total Hours  Worked for  Employer(s)** | Employer Name | Dates  Wages  Paid | Gross  Earnings  Reported by  Employer | Hours  Worked  for  Employer |
| **Total** |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |  |  |  |
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|  | **TOTALS:** |  |  |  |  |  |  |  |  |

Comments:

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| --- | --- |
|  | **NEW HAMPSHIRE EMPLOYMENT SECURITY  SUMMARY OF OVERPAID WEEKS** |
| JFS-84400 |  |

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