Connecticut Department of Labor
Wage and Workplace Standards Division
200 Folly Brook Boulevard
Wethersfield, CT 06109

Tel.: 860-263-6790 www.ct.gov/dol

OFFICIAL USE ONLY:	
Unit:	Agent Initials:
Industry Code:	
Territory:	

STATEMENT OF CLAIM FOR WAGES

INSTRUCTIONS: Complete both sides of this form, and sign. Type or print legibly. Complete all items to the best of your knowledge. Failure to do so may result in delays. Enclose any copies of documentation that may be relevant to your claim. Please notify us immediately by mail if you have a change of address, phone number or have been paid.

EMPLOYEE INFORMATION

1. Your Name (Employee)	**4.** Date	**5.** Social Security Number	**5a.** Sex ☐ Male ☐ Female

2. Your Address (Number and Street)	(City or Town)	(State)	(Zip Code)

3. Your Telephone Number	**6.** Type of Work Done / Occupation / Title

7. I prefer to receive an acknowledgement letter by ☐ Regular Mail ☐ Email Email address:

EMPLOYMENT INFORMATION

8. Business Name (Employer)	**10.** Business Telephone No

9. Business Street Address *(not a P.O. Box)*	(City or Town)	(State)	(Zip Code)

11. Other Business Name(s) that might be used by employer

12. Name of Person in charge	**13.** Title (e.g.: owner, president, manager)

14. Did you work at the business address listed in item #8? ☐ Yes ☐ No Please provide location:

15. Number of Hours Per Week	Date Hired	First Wage Rate	Last Wage Rate	Quit / Layoff ☐ Discharged ☐ Still Employed ☐

16. Date of Separation	Reason for the Separation

17. Wages Claimed From (Date)	To (Date)	At the Rate of (Hour, Day, Week, etc.)	Total Amount Claimed

CLAIM DETAILS

18. Please check the reason(s) you are filing this claim:

☐ Final paycheck(s) not received or incorrect

☐ Commission(s) not received or incorrect (please provide detailed information and employment agreement if available)

☐ Bonus

☐ Vacation Pay upon termination (please provide written policy)

☐ Minimum Wage

☐ Overtime wages (time and one-half)

☐ Not paid for all hours worked

☐ Non-Payment of Prevailing Rate on Public Works Project (please provide project name(s) on back of this form)

☐ Improperly classified as an independent contractor

☐ Bounced paycheck

☐ Illegal deductions

☐ No paystub

Explain why you believe the employer owes you wages. List the dates and hours for which you believe wages are due.
Attach additional sheets if necessary.

19. Did you ask the employer for the money you believe is due?

☐ Yes Name and title of person you asked: ____

☐ No If No, why ____

►►IMPORTANT◄◄

PLEASE NOTE THE FOLLOWING :

1. This claim form will be returned to you if it is incomplete or illegible.
2. If you are complaining that you did not receive a **final paycheck**, <u>you must physically report to the normal place you are paid and attempt to obtain payment yourself. Making phone calls and/or sending friends or relatives to obtain payment are not sufficient. If you do not attempt to obtain payment yourself, we will not investigate your claim.</u>
3. This Division has jurisdiction over **wage issues only**. We cannot assist you in obtaining payment for time not worked (holiday pay, severance pay, etc.), or for expenses, tax issues, or pension plan issues. We <u>may</u> be able to assist you in obtaining payment for unused fringe benefits such as vacation pay, but only upon separation of employment.

In signing this form, I hereby attest to the following:

● That this is a true statement of wages due me to the best of my knowledge and belief. I hereby assign all wages and all penalties accruing because of their non-payment, and all liens securing them to the Labor Commissioner of the State of Connecticut to collect in accordance with the law.

● That I authorize the mailing at my own risk of any money paid on this claim.

● That I authorize the Labor Commissioner or any person authorized by the Labor Commissioner to approve a proposed compromise adjustment or settlement of this claim, unless I object in writing within ten days after notification to me at the address given by me to the Labor Commissioner. I understand my claim may be reassigned back to me to pursue in small claims court or through a private attorney.

● If I do not request in writing, subsequent to closure of this case, the return of any papers submitted by me in connection with this claim, I hereby authorize the Labor Commissioner to destroy them after three years.

20. I understand that this complaint form is subject to the Freedom of Information laws.

____ ______________________
Signature Date

____ ______________________
Signature of Parent or Guardian (*required if claimant is under 18 years old)* Date