

ESTE DOCUMENTO AFECTA SU ELEGIBILIDAD PARA SEGURO POR DESEMPLEO. SI USTED NO LEE INGLES COMUNIQUESE
CON SU OFICINA LOCAL.

Date:

Claim NBR:

You previously filed an unemployment insurance claim beginning _____ In order to qualify
for your new claim, A.R.S. 23-771(A) (7) provides that you must have worked and earned \$
(8 times the new weekly benefit amount), between the beginning date of your prior claim and the
beginning date of your new claim.

Wages you have earned for services performed as an employee may be used to meet the above
requirement. Earnings from self employment; or payments for worker's compensation, severance,
vacation, holiday, or sick pay may not be used. On the table on the reverse side of this form enter any
work performed between _____ and _____

It is your responsibility to provide proof that you have earned the requalifying wages. Check stubs, pay
slips, W-2 forms, or other documents may be used to establish proof of earnings.

Mail the completed listing and proof of earnings to the address shown above as soon as possible,
but no later than 30 days from the date of this form.

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and
the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age
Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or
employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a
reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example,
this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair
accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action
that allows you to take part in and understand a program or activity, including making reasonable changes to an activity.
If you believe that you will not be able to understand or take part in a program or activity because of your disability,
please let us know of your disability needs in advance if at all possible. To request this document in alternative format or
for further information about this policy, contact you local office manager; TTY/TDD Services: 7-1-1.

DATES WORKED		EMPLOYER'S NAME	EMPLOYER'S ADDRESS (No., Street, City, State, ZIP)	GROSS WAGES BEFORE DEDUCTIONS	LOCAL OFFICE USE ONLY	
From	To				VER	TYPE OF PROOF
				\$		
				\$		
				\$		
				\$		
				\$		
				\$		
TOTAL				\$		

I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE AND BELIEF, I WORKED AND EARNED WAGES FROM THE EMPLOYERS DURING THE PERIODS SHOWN ABOVE.

CLAIMANT'S SIGNATURE	DATE
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LOCAL OFFICE USE ONLY					
TOTAL VERIFIED: \$			VALID CLAIM - COMPLETE <input type="checkbox"/> A3		
INVALID CLAIM - COMPLETE <input type="checkbox"/> C1 <input type="checkbox"/> C2 <input type="checkbox"/> C4		SOCIAL SECURITY NUMBER		CLAIMANT'S NAME CHECK	
ISSUE CODE 67	DEPUTY ID	PROGRAM	ISSUE STATUS	RESOLUTION CODE 67	COUNT N
(RE)DETERMINATION REASON (C2)		DISQUALIFICATION START		DISQUALIFICATION END	
STATEMENT NO. 1		STATEMENT NO. 2			