Rick Scott
GOVERNOR

FLORIDA DEPARTMENT of ECONOMIC OPPORTUNITY

Cissy Proctor
EXECUTIVE DIRECTOR

**VOLUNTARY PAYROLL DEDUCTION REQUEST**
Date: TODAY

Employer: _____

Address: _____

EMPLOYER - Florida Statute 443, Reemployment Assistance Law, requires that all overpayments of reemployment assistance benefits must be repaid. The employee named below is requesting your assistance in meeting his/her monetary overpayment obligation to the State of Florida through payroll deduction. This is a voluntary program for both you and your employee. You will not be held liable by the Department in the event that a payroll-deducted amount is not received by the Florida Dept of Economic Opportunity through lost mail or other problems. Your employee is personally responsible for meeting this monetary obligation to the State of Florida.

CLAIMANT - This voluntary program between you and your employer is being offered to assist you in meeting your monetary obligation to the State of Florida. Your employer is under no obligation to participate in this payroll deduction plan. In the event your employer elects to assist you through payroll deduction, you must inform them of the total amount to be withheld from each pay period. If the amount is not received by the Department for whatever reason, you are still personally responsible for meeting this obligation. You must notify your employer when you have satisfied your overpayment to prevent a credit from occurring.

Claimant's (employee's) name: **NME_CLMT** TOTAL OVERPAYMENT DUE: $TOT_OP_BAL

Social Security Number: **SSN_CLMT** MONTHLY MINIMUM DUE: **$MIN_AMT_DUE**

A. **Payroll Deduction Frequency** (circle one) WEEKLY BIWEEKLY MONTHLY OTHER (PLEASE SPECIFY) _____

B. **Amount:** _____ per pay period

C. **Effective Dates**: This voluntary payroll deduction will commence the first pay period after the employer receives this signed and completed form and will remain in effect until the employer receives notice from the employee that the overpayment has been satisfied.

Claimant (employee) signature: _____ Date _____

All payroll deduction checks should be made payable to the REEMPLOYMENT ASSISTANCE TRUST FUND and should include the employee's name and Social Security Number. Checks should be mailed to:

Florida Department of Economic Opportunity
Reemployment Assistance Services
Benefit Payment Control
P.O. Drawer 5050
Tallahassee, FL 32314-5050

D. **Acknowledgement**: The above employer has agreed to participate in this payroll deduction request.

Payroll Section contact's name (PLEASE PRINT): _____

Telephone number: ( ) _____

Please retain the original and return one signed copy to the above Department address with the first payment.





DEOI Form UCO-408 (Rev. 01/2013)