

STATE DISABILITY INSURANCE

Overpayment Refund and Return Form

1. Claimant Information

FULL NAME

SOCIAL SECURITY NUMBER (LAST 4 DIGITS) / CLAIMANT ID

MAILING ADDRESS

PHONE NUMBER

EMAIL ADDRESS

2. Overpayment and Refund Details

CLAIM NUMBER

OVERPAYMENT NOTICE DATE

TOTAL OVERPAYMENT AMOUNT (\$)

REFUND AMOUNT ENCLOSED (\$)

PAYMENT METHOD (CHECK / MONEY ORDER)

CHECK / MONEY ORDER NUMBER

3. Reason for Refund / Return

- ☐ RECEIVED BENEFITS FOR A PERIOD DURING WHICH I RETURNED TO WORK
- ☐ DUPLICATE PAYMENT RECEIVED FOR THE SAME BENEFIT PERIOD
- ☐ ADMINISTRATIVE/CLERICAL ERROR BY THE AGENCY
- ☐ RECEIVED WORKERS' COMPENSATION OR OTHER CONFLICTING BENEFITS
- ☐ OTHER (PLEASE SPECIFY BELOW)

Submission Instructions:

- Please make checks or money orders payable to the official State Disability Insurance department.
- Write your Claim Number and Social Security Number (last 4 digits) on the memo line of the check.
- Do not send cash through the mail.
- Mail this completed form along with your payment to the designated State Disability office address.

CLAIMANT SIGNATURE

DATE

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