

#### Request for Waiver of Claim for Erroneous Payment of Pay

PART I. To Be Completed by Claimant			
1. Claimant's Name (Last, First, MI)	2. Employee	Identification Number (EIN)	3. Claimant's Status:
			☐ Active Employee
		T	☐ Former Employee
<ol> <li>Claimant's Home Address (Street, City, State, ZIP Cod If applicable)</li> </ol>	e™; include apt no.	5. Name and Location of Organ	nization to Which Assigned
6. Period Covered by Erroneous Payment of Pay (MM/Di	D/YYYY) From: _	To:	
7. Amount Requested for Waiver: \$ 8	3. P.O. Invoice Numb	er: Da	ate: (Attach copy)
9. Describe the nature of the erroneous payment for pay.	(Attach separate she	eet if necessary.)	
10. Did you ask your supervisor about the possible error	in your pay? If so, fur	nish details.	
11. State the circumstances you feel justify waiver of this	claim.		
12. If you have made any repayments, list amounts and o	dates repaid.		
<b>Privacy Act Statement:</b> Your information will be us 39 U.S.C. 401, 409, 410, 1001, 1003, 1004, 1005,			payment of pay. Collection is authorized by
Providing the information is voluntary, but if not profollows: in relevant legal proceedings; to law enforce	ement when the U.	S. Postal Service (USPS) or r	equesting agency becomes aware of a
violation of law; to a congressional office at your re- audits; to labor organizations as required by law; to			
Equal Employment Opportunity Commission; to the	Merit Systems Pro	otection Board or Office of Spe	ecial Counsel; the Selective Service System
records pertaining to supervisors and postmasters and to financial entities regarding financial transactions.		o supervisory and other mana	gerial organizations recognized by USPS;
		Application for Defendent	collection of all or part of the access to
I make the foregoing request for waiver of claim for payment of pay with full knowledge of the penalties			collection of all or part of the amount in plication for refund of all, or the appropriate
willfully making a false claim. (U.S.C., Title 18, Sec for a maximum fine of \$10,000 or imprisonment for		amounts repaid which are sh	nown in Item 12.
ioi a maximum ille oi \$10,000 oi imprisorment for	o years or bourt.)		
Signature of Claimant		Data Signed (MMM/DDAAAA)	
organization or organization		Date Signed (MM/DD/YYYY)	

# PART II. To Be Completed by Current Postmaster or Installation Head of the Active or Former Employee (Retain one copy. Forward original and one copy to Manager, Human Resources (District).

Provide all additional facts or circumstances that will clairfy and amplify the statement of facts made by the claimant on the claim form, including a descritpion of how the overpayment occurred. (Continue on separate sheet, if necessary)

		G	ross Amoun	t of Claim Listed by	Pay Periods			
Pay Period	Amount Paid	Amount Should Be	Pay Period	Amount Paid	Amount Should Be	Pay Period	Amount Paid	Amount Should Be
	\$	\$		\$	\$		\$	\$
	\$	\$		\$	\$		\$	\$
	\$	\$		\$	\$		¢	\$
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	est of my knowled			ation of fraud, misr	representation fault,	or lack of	good faith on the	
	pest of my knowled other person having	ge and belief there		ation of fraud, misr	1+	or lack of	good faith on the	

Review form for accuracy and completeness. Add any additional pertinent facts. (Continue on separate sheet, if necessary.)

Signature			Title		Da	ate (MM/DD/YYYY)
Printed Name  PART IV. To Be Completed by Manager, Eagan Account		Phone Number				
		Accounti	ng Services.			
Gross Amount Claimed	\$			Claim Allowed		
Gross Amount Waived	\$		Claim Denied			
Signature		Title		Date (MM/DD/YYY	ate (MM/DD/YYYY)	
Printed Name			Phone Number			

MAIL TO: ACCOUNTING SERVICES, 2825 LONE OAK PKWY, EAGAN MN 55121-9616



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Providing the information is voluntary, but if not pro- follows: in relevant legal proceedings; to law enfor- violation of law; to a congressional office at your re- audits; to labor organizations as required by law; to Equal Employment Opportunity Commission; to the records pertaining to supervisors and postmasters and to financial entities regarding financial transact	cement when the Usequest; to entities or of federal, state, locate Merit Systems Programmy be disclosed to	S. Postal Service (USPS) or individuals under contract w l or foreign government age otection Board or Office of Sp	requesting agency becomes aware of a ith USPS; to entities authorized to perform ncies regarding personnel matters; to the pecial Counsel; the Selective Service System
I make the foregoing request for waiver of claim for payment of pay with full knowledge of the penaltic willfully making a false claim. (U.S.C., Title 18, Se for a maximum fine of \$10,000 or imprisonment for	es involved for ection 287, provides		f collection of all or part of the amount in oplication for refund of all, or the appropriate shown in Item 12.
Signature of Claimant		Date Signed (MM/DD/YYYY)	

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	\$	\$		\$	\$		\$	\$
	\$	\$		\$	\$		\$	\$
To the be	est of my knowled	\$ ge and belief there g an interest in this		ation of fraud, misi		ult, or lack of	1 7	
To the be	est of my knowled ther person having	ge and belief there		ation of fraud, misi		ult, or lack of	1 7	
To the be	est of my knowled ther person having	ge and belief there		ation of fraud, misi waiver of claim.		ult, or lack of	1 7	part of the

Signature		Title		Date (MM/DD/YYYY)
Printed Name		Phone Number	Phone Number	
PART IV. To Be Completed	by Manager, Eagan <i>i</i>	Accounting Services.		
Gross Amount Claimed	\$		Claim Allowed	
Gross Amount Waived	\$		Claim Denied	
Signature	·	Title		Date (MM/DD/YYYY)
Printed Name		Phone Number	er	

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I make the foregoing request for waiver of claim of payment of pay with full knowledge of the penalti willfully making a false claim. (U.S.C., Title 18, Sofor a maximum fine of \$10,000 or imprisonment for the following statement of the foregoing statement of the f	es involved for ection 287, provides		f collection of all or part of the amount in pplication for refund of all, or the appropriate shown in Item 12.
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	\$	\$		\$	\$		\$	\$
	\$	\$		\$	\$		\$	\$
		ge and belief there g an interest in this			epresentation fault	, or lack of	good faith on the	part of the claima
	other person having				representation fault	, or lack of	good faith on the	part of the claimar
or any c	other person having			waiver of claim.		, or lack of	good faith on the	•

Signature	Signature			Date (MM/DD/YYYY)
Printed Name		Phone Number		
PART IV. To Be Completed	by Manager, Eagan Acco	unting Services.		
Gross Amount Claimed	\$		Claim Allowed	

Gross Amount Claimed \$ Claim Allowed

Gross Amount Waived \$ Claim Denied

Signature Title Date (MM/DD/YYYY)

Printed Name Phone Number

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