



This report is to be filled in and returned to this office within 10 days of its receipt whether or not you are liable for assessments under Part III, Title 19, Delaware Code.

**REPORT TO DETERMINE LIABILITY  
AND IF LIABLE  
APPLICATION FOR  
EMPLOYER ACCOUNT NUMBER**

**(DO NOT FILL IN THIS SPACE)**

Employer Number \_\_\_\_\_  
Ind. Code and Area \_\_\_\_\_  
Effective Date of Liability \_\_\_\_\_  
Assessment Rate \_\_\_\_\_  
Status Date \_\_\_\_\_

**FILL IN WITH TYPEWRITER OR PRINT IN INK - ALL QUESTIONS MUST BE ANSWERED**

1. Name of Employer and Trade Name, if any.

1a. Federal Employer's Identification Number

2. Street Address and Telephone Number of Main Office

3. Address to which employer's report forms and mail are to be sent. Outside representative must file a power of attorney.

3a. E-Mail Address:

4. Have you previously filed an application for a Delaware U.I. Account number? Yes  No

5. Have you:

- 1. Started a new business
- 2. Purchased a going business (Attach Explanation)
- 3. Just begun having employment
- 4. Reorganized (Attach Explanation)
- 5. Other (Attach Explanation)

**6. Ownership Information**

Is business publicly held? Yes  No

If yes, provide name and Federal Identification Number of controlling entity:

If no, complete ownership information below. If more than one owner, attach additional information. percentage of ownership must total 100%

Name \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Addresses \_\_\_\_\_

% of Ownership

7. On what date did you first employ any workers in Delaware?

Will Gross Payroll meet or exceed \$1,500.00 in either the 3<sup>rd</sup> or 4<sup>th</sup> Quarter? Yes  No

8. Are you liable as an employer under the Unemployment Compensation Laws in any other State?

Yes  No

9. Do you own or control any other employing unit in Delaware?

No

Yes  Account # \_\_\_\_\_

10. State total number of workers in covered employment in Delaware and total payroll by calendar quarter. If unknown, you may estimate these numbers.

**Effective 1/1/96, wages of all corporate officers are reportable.**

	MARCH		JUNE		SEPT.		DEC.	
	Employees	Payroll	Employees	Payroll	Employees	Payroll	Employees	Payroll
2001								
2002								
2003								
2004								
2005								

11. Check (✓) form of organization

- Individual
- Partnership
- Delaware Corporation
- Out-Of-State Corporation
- Non-Profit
- Estate or Trust
- LLC (attach # Form 8832)

11a. Date of Incorporation \_\_\_\_\_

**COMPLETE REPORT ON REVERSE SIDE AND SIGN**

**12. NATURE AND PLACE OF BUSINESS IN DELAWARE** (Indicate in sections a,b,c,d, and e).

(a) Street Address (Number & Name)

(b) City/County

(c) Zip Code

(d) Principal Types of Activity (Manufacturer Wood Furniture, Food Super Market, Truck Rental Etc.) EXPLAIN FULLY	Percent of Total	(e) Principal Products or Services (Leather Gloves, Electric Motors, TV Repairs, etc.) EXPLAIN FULLY	Percent of Total
<b>Total</b>	<b>100.00</b>	<b>Total</b>	<b>100.00</b>

**13.** Will any employee work primarily in Delaware? Yes  No

If yes, skip 13(a). Go to #14

If no, complete 13(a) before going to #14.

**13(a)** Will any employee perform **some** work in Delaware? Yes  No

If no, go to #14

If yes, attach explanation. For each employee who does not work primarily in Delaware, list all States where work is performed, the State where the base of operations is located, the State from which work is directed, and the employee's State of residence.

**14.** Name, title, addresses and telephone number of officer or representative to furnish payroll information.

**15.** Have you acquired the organization, trade or business, or substantially all of the assets of another employing unit? Yes  No

If yes, provide the name and Federal Identification Number of the acquired entity.

If yes, do you wish to apply for a transfer of employment experience? Yes  No  **Application attached:**

If yes, the Department will send you form UC-411 for you to complete and return.

**16.** If you have reorganized has the ownership and management remained substantially the same? Yes  No

**THIS REPORT MUST BE SIGNED HERE BY THE OWNER OR DULY AUTHORIZED REPRESENTATIVE**

It is hereby certified that the information in this report and in any attached sheets is true and correct, to the best of my knowledge, and is submitted with the full knowledge that there are penalties prescribed by law for misstatements. **Application will not be processed without an original signature.**

(Original Signature Required)

Title \_\_\_\_\_

Date \_\_\_\_\_

(Business Name)

**NON-PROFIT EMPLOYERS ONLY**

**17. (a).** Please submit the following documents:

- (1) Copy of charter or articles on incorporation and by-laws
- (2) Copy of Internal Revenue Status under IRS Code (Sec. 501-a)

(b). Do you have in your employ four (4) or more employees? Yes  No

(c). Do you elect the reimbursement method in lieu of paying assessments? Yes  No

If yes, the department will send you form COM-4069

(d). Do you wish to make reimbursement payments with another employer and establish a group account? Yes  No

If answer is yes, list the names and addresses of all employers in the group and the name and address of the group Representative who will act as the agent responsible for the disbursement of timely payments to the State of Delaware.