



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:

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)

2. Street Address and Telephone Number of Main Office:

6. Ownership Information

Is business publicly held? Yes No
If yes, provide name and Federal Employer 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 _____
Address _____

% of Ownership _____

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

3a. E-Mail Address:

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

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

7a. Will gross payroll meet or exceed \$1500.00 in either 3rd or 4th 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
2002								
2003								
2004								
2005								
2006								

11. Check (✓) form of organization

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

11a. Date of Incorporation _____

COMPLETE REPORT ON REVERSE SIDE AND SIGN

12. NATURE AND LOCATION 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
Total	100.00	Total	100.00

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, address and telephone number of officer or representative to furnish payroll information.

15. Have you acquired the organization, trade or business, or substantially all the assets of another employing unit? **Yes** **No**
 If yes, provide the name and Federal Identification Number of the acquired entity.

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 authorized 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.