Wyoming Unemployment Insurance Division
Benefit Payment Control
Fraud Reporting Form

Date ________________

Unemployment Insurance (UI) benefit fraud is any willful misrepresentation, omission or concealment of material facts by an individual to obtain or increase benefits.

Please complete as much of the following information as possible about the person (claimant) you believe is receiving UI benefits: Call (307) 235-3236 if you have questions or concerns.

Claimant’s Name: ________________________________________________

Social Security Number (if known): ________________________________

Address: Street ________________________________________________

City ____________________________________________ Zip ___________

Home Phone Number: _________________________ Cell Phone Number: __________

Mark an “X” for each issue that applies.

☐ Claimant is working and NOT reporting earnings
   Name of Employer: ____________________________________________
   Contact person at this business: _________________________________
   Employer’s Address: Street ____________________________________
   City __________________________ State __________ Zip ____________
   Employer’s Phone Number: _________________________________
   Did you see the claimant working? ________ When? __________
   Where? ___________________________________________________
   Amount of Salary/Earnings: _________________________________
   Hours Worked/Days Worked per Week: ________
   Date Claimant Started Working: ________ Is he/she still working? ___
   Claimants Job Title (or type of work performed for this employer):
   _________________________________________________________

☐ Claimant is self - employed
   Name of business __________________
   What type of business or work is it? __________________________
   Does the claimant advertise? _________________________________

☐ Claimant is NOT Actively Searching for work
   Has the claimant told you he/she is not looking for work? _________
   For what time period were they not seeking? ____________________

☐ Claimant has refused work
   For what business or individual? ________________________________
   Business or individual phone number or address __________________
   When? ________________________________
Claimant’s Name: ____________________________________________________________

☐ Claimant is NOT able to work or NOT Available for work
  If Illness or Medical Problem, what type? ____________________________________
    Since when _____________________________________________________________
  If Hospitalized, Where? _________________________________________________
    When? __________________________________________________________________
  Disabled - type of disability ______________________________________________
    Since When __________________________________________________________________
  Incarcerated (Jail/Prison) Where? __________________________________________
    Jail contact or phone number ____________________________________________
    Date incarcerated _______________________________________________________:
    Date released __________________________________________________________
  Vacationing or Pursuing Hobby (Hunting/Fishing trip, etc)
    Where? __________________________________________________________________
    When? ___________________________________________________________________

☐ No Transportation / Transportation Problems - When?: _______________________

☐ Full time caretaker (for child/parents, etc.) For Whom?: ______________________
   When? ___________________________________________________________________

☐ Other: __________________________________________________________________

________________________________________________________

Additioinal information/comments: ________________________________________________

________________________________________________________

________________________________________________________

OPTIONAL: You will remain anonymous. Please complete the following if we can contact
you for clarification or additional information.
  Your name ________________________________________________________________
  Your address _______________________________________________________________
  City _______________________________________________________________________
  State ______________________________________________________________________
  Your phone number _________________________________________________________

Submit by mailing to: Wyoming Department of Workforce Services
Unemployment Insurance Division - BPC
PO Box 2760
Casper WY  82602-2760

Or fax to: 307-235-3277   ATTN: BPC

Thank you for your assistance in enforcing Wyoming Unemployment Insurance Division’s laws
and protecting the integrity of the Wyoming Unemployment Insurance program.