Fort Belknap Insurance Co.

Fort Belknap Agency 281 Chippewa Ave. P.O. Box 146 Harlem, Montana 59526
Phone: (406) 353-4181 / Fax: (406) 353-4934 / E-mail: fbinsur4@itstriangle.com

UNEMPLOYMENT COMPENSATION APPLICATION

Name: _____ Position: _____

Address: _____ Program: _____

_____ Supervisor: _____

Social Security: _____

Dates of Employment: From: _____ to: _____

Reason for Termination/Layoff:

Reduction in Force: _____ Date: _____

Lack of work: _____ Date: _____

Job Complete: _____ Date: _____

Lack of Funds: _____ Date: _____

Resigned: _____ Date: _____

Fired: _____ Date: _____

Other: _____ Date: _____

If one or more of the last three reasons were checked, please write explanation below:

_____

_____

_____

Do you owe child support? _____ If so, How much $_____

Court Order Attached: _____

I declare, to the best of my knowledge and belief, that these statements are true and correct.

_____ _____

Client's Signature Date

FORT BELKNAP EMPLOYEE'S INSURANCE COMPANY
UNEMPLOYMENT COMPENSATION INSURANCE CLAIM

FORT BELKNAP INDIAN RESERVATION
FORT BELKNAP, MONTANA

INITIAL CLAIM FOR BENEFITS/REQUEST FOR DETERMINATION OF STATUS

Name:_____ Social Security #:_____

Address:_____ Phone Number: _____

Sex: ( ) Female ( ) Male

Date of Birth:_____ Education: _____

Other last names used while working:_____

Are you an enrolled member of Fort Belknap ( ) Yes ( ) No

If yes, enrollment Number:_____

In the last 18 months, have you had any of the following?

Military Employment	_____Yes	_____ No	If, "Yes" please attach a copy of your DD214
Federal Civilian Employment	_____Yes	_____ No	
Employment elsewhere	_____Yes	_____ No	
Worker's Compensation	_____Yes	_____ No,	If yes, date claim began_____

Are you receiving or will you receive payments representing:

Severance Pay	_____ Yes	_____ No	Amount: $_____# weeks worked
Pension	_____ Yes	_____ No	Amount: $_____
Other Pay	_____ Yes	_____ No	Amount: $_____

Explain What Kind_____

_____

Are you attending school? _____ Yes _____ No

Are you a Union Member? _____ Yes _____ No

Are you a Veteran? _____ Yes _____ No

Are you self-employed? _____ Yes _____ No

EMPLOYMENT INFORMATION

(Give the name of your last employer)

Business Name: _____

Address: _____

Dates of Employment: From: _____ To: _____ (Both days inclusive)

Reason for Leaving: (Place an "X" in the appropriate space to indicate why you are no longer working for this employer)

_____ Lack of Work _____ Quit _____ Fired _____ Strike or Lockout _____ Still Working

Explain: _____

WORK SEARCH INFORMATION

(To be completed by the Claimant)

1. Is there any reason you cannot accept immediate employment? (Transportation, child care, medical etc)
   _____Yes _____No, If "Yes" why? _____
2. Are there any hours or days you are not willing to work?
   _____ Yes_____ No, If "Yes", what are they? _____
3. Did you work these hours or days for your last employer or within you normal occupation?
   _____Yes _____ No
4. I will concentrate my work search in the following occupations:

   A. _____ B. _____
5. I hereby certify, under penalty of perjury, that I am a Citizen or National of the United States of America.
   _____ Yes _____ No

   If "No" give Alien Registration Number: _____

TO BE COMPLETED BY THE CLAIMTAKER

1. _____ I must make a minimum of one employee contact each week.
   (This does not apply if you are Union or Job attached.)
2. _____ My work search is waived for the following:

   _____ A. I am a Union member in good standing and must apply for work according to my union rules. I may be required to provide a signed statement from my business agent.

   _____ B. I am "Job Attached" and will be returning to work within____weeks. I may be required to provide a signed statement from my employer.
   Business Name: _____
   Phone Number: _____
   Anticipation Return Date: _____

   _____ C. Other: (Specify) _____

FORT BELKNAP INSURANCE COMPANY
WORK SEARCH REQUIREMENTS.

To meet the active work-search requirements of the law, you must meet the work-search requirements on this form. The following rules apply to that work-search:

1. Work contacts must be for work you are willing and qualified to do, in a location you are willing to work.

2. You are required to make a minimum of one work search contact each week. The work search contact shall be in person unless the normal method of application is by mail or phone, or unless the employer contacted is more than 20 miles from the claimant's residence. The work search requirement may be waived if you are union attached or job attached. If you have questions or you're union attached or approved training status changes, notify your Employment Office.

3. All contacts must be made with a person who has hiring authority and written applications must be filed where accepted.

4. Required contacts must be within the week for which benefits are being claimed and on the days of the week when hiring is normally done.

5. The same employer(s) may not be used for required contacts in any two consecutive weeks unless requested by the employer.

Although the information on this form is confidential, other Federal or State Agencies have access to this information according to Section 1137 (a) (6) of the Social Security Act.

If there is a change in my union, job attachment, or approved training status, I will immediately begin making one employment contact each week. I will inform the Fort Belknap Insurance Company on any change relating to unemployment benefits.

In applying for unemployment benefits, I have received the **"Guide to Your Rights and Responsibilities"** booklet and understand that I am required to read it. I understand that I must be fully or partially employed, able and available to work. I understand that I have to aggressively seek work through the Bureau of Indian Affairs and Indian Health Service and that I have to be registered with the Fort Belknap TERO Office and the Tribal Personnel Office.

I have read and understand the requirements of this application.

I understand that I am required to keep a written record of my work searches.

If I fail to meet the work search requirements or make false or misleading statements, or withhold information in order to obtain benefits of which I was not entitled to will be a collected immediately through reduction in present or future unemployment benefits, lease income, wages and any other means.

If I am employed, I hereby authorize payments be withheld from my wages on a bi-weekly basis beginning the next pay-period upon discovery to repay benefits not entitled to me. These deductions are to be paid to: UNEMPLOYMENT FUND, The Fort Belknap Insurance Company, P.O. Box 146, Harlem, Montana 59526. I am also in agreement to sign a wage agreement authorizing deductions from my wages for the overpayment of benefits inadvertently paid to me or benefits of which I was not entitled to receive until paid in full.

_____ _____

Claimant's Signature *Date*

_____ _____

Claim taker's Signature *Date*

RELEASE OF CONFIDENTIAL INFORMATION FORM

Release of Confidential Information Authorization to the Fort Belknap Insurance Company to obtain personal/medical information for the purpose of processing a claim.

Claimant's Name:_____

Address:_____
(Street) (City) (State) (Zip)

I authorize the Individual Company, or Agency shown below to disclose to the **FORT BELKNAP INSURANCE COMPANY,** the information specified below which relates to my obtaining a claim for insurance benefits. I understand that any information obtained will be kept in strict confidence and will be used only for purposes directly related to the decision of obtaining benefits. I further understand that any information obtained may be released to a proper government/tribal agency or Court of Law for purpose of legal and investigative actions concerning fraud.

INFORMATION SOURCE: Employers, Doctors, Hospitals, Employees, Third Parties, Fort Belknap Indian Community.

INFORMATION REQUESTED: Doctor's reports, Employer/Employee Reports, Third Party Reports.

_____ _____
Client's Signature Date

NOTARY PUBLIC

State of: _____)

County of: _____)

BE IT REMEMBERED, that on the _____day of _____, A.D. 20_____, I the undersigned, a NOTARY PUBLIC, in and for the State and County aforementioned did personally appear before me, _____, and is personally known to me to be the identical person who executed the within instrument of writing.

IN TESTIMONY WHEREOF, I have hereunto subscribed my name and affixed my seal on the day and year last hereinabove written.

SEAL

_____
(Name)

_____
(Title)

My Commission Expires: _____