Request to Waive Overpayment Collection

I am requesting that collection of the unemployment benefits that were paid to me be waived for all of the following reasons indicated by the checked boxes below:

☑ **Unemployment Insurance Agency Error** (MCL 421.62(a)(iii)): The overpayment was because of an administrative or clerical error made by the UIA.

[See the following for the **completed Section 1 of UIA Form 1795**]

☑ **Financial Hardship** (MCL 421.62(a)(ii)): Imposing collections would cause a financial burden on me and my household.

[See the following for the **fully completed UIA Form 1795**]

☐ **Inaccurate Wage information** (MCL 421.62(a)(i)): Benefits were overpaid because I mistakenly provided inaccurate wage information and my employer provided inaccurate wage information or did not respond to provided inaccurate wage information.

[See the following for the **completed Section 1 of UIA Form 1795**]

UIA 1795
(Rev. 04-19)

Authorized by
MCL 421.1 et seq.

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LABOR AND ECONOMIC OPPORTUNITY
UNEMPLOYMENT INSURANCE AGENCY

SUSAN R.CORBIN
DIRECTOR

REQUEST TO WAIVE REPAYMENT OF BENEFIT OVERPAYMENT BALANCE

STATEMENT OF FINANCIAL CONDITION

Completion of this form is a request to waive repayment of your benefit overpayment balance. You can file your application online through your Michigan Web Account Manager (MiWAM) or return this completed form to the following address or fax number: Unemployment Insurance Agency, P.O. Box 169, Grand Rapids, MI 49501-0169, or fax to 1-517-636-0427.

Answer each question honestly and accurately. All items on this form must be completed in order to process your request for waiver of repayment. Write "N/A" or draw a line through any items that do not apply to you.

The Unemployment Insurance Agency (UIA) will notify you of your eligibility once your application has been reviewed. If approved, only the balance due as of the date of the application will be waived. If denied you must wait six months to reapply. If your overpayment was established based on fraud, you are not entitled to request a waiver and your application will be denied.

This information is confidential and will be used only to process this request. If you have any questions on completing this form, call Customer Service at 1-866-500-0017. TTY service is available at 1-866-366-0004.

1. Name: Claimant (Last Name) Christie (First name)

   Social Security Number: 555-55-5555

   Address: 123 Legal St. (Street address) / Lansing (City) / MI (State) / 55555 (Zip code)

   Telephone Number: (517) 555-5555 (Home/cell) / (517) 777-7777 (Work)

2. Are you employed? ☒ Yes ☐ No If "Yes", is work ☐ Full Time ☒ Part Time Hours per week 20

   If "No", list your last day worked: N/A (Month) / N/A (Day) / N/A (Year)

   Last employer: Employment Industries (Name)

   Address: 5678 Employment Rd. (Street address) / Lansing (City) / MI (State) / 55555 (Zip code)

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If not currently employed, do you have a date which you will return to work with any employer?

~~☐ Yes ☐ No~~ If "Yes", on what date? N/A (Month) / N/A (Day) / N/A (Year)

To evaluate your eligibility for a waiver, the average net income and assets for your household is compared to the annual poverty guidelines as published by the United States Department of Health and Human Services.

HOUSEHOLD

3. Are you legally married? ☐ Yes ☒ No

Spouse's name: N/A
Last name First name

Spouse's Social Security Number: N/A

Spouse's employer: N/A
Name

Spouse's Address: (If different) N/A / N/A / N/A / N/A
Street Address City State Zip Code

4. Do you have any dependents? ☒ Yes ☐ No

Allowable dependents are: spouse; natural child, stepchild, adopted child, grandchild under 18 or a full-time student under 22; parent over 65 or permanently disabled; sibling under 18 or full-time student under age 22. A dependent is allowed if you have provided more than half the cost of their support for at least six months before completing this form. In the case of a spouse or a child, if the relationship is less than six months, support must have been provided for the length of the relationship. Enter all dependents, including yourself, in the space provided below.

NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP TO YOU	ADDRESS (IF DIFFERENT)	AGE OF DEPENDENT
Christie Claimant	555-55-5555	Me	123 Legal St., Lansing MI 55555	43
Quincy Claimant	777-77-7777	Child	N/A	18
Kylie Claimant	888-88-8888	Child	N/A	16
N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A

NET INCOME

5. Have you had any income in the last 6 months? ☒ Yes ☐ No

Types of income may include: Wages, unemployment benefits, strike benefits, Social Security benefits, rental income, Worker's Disability Compensation, school aid, scholarships, grants, self-employment profits, etc. Do not include food stamps and welfare benefits as income. Disposable income is the amount remaining after deductions of any amounts required by law to be withheld such as state and federal taxes or child support. Enter the disposable household income from all sources for the six completed months before the date on which you completed this form. If possible, include copies of documents that verify these amounts. An example of the six completed months: If you received this form on April 26th of this year but do not complete and sign it until May 7th, the six months listed must be November of last year through April of this year.

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Previous Six Months Month / Year	A. Yourself Amount / Source	B. Dependent Amount / Source
January / 2025	$ 1,800 / wages	$ 2,200 / wages, scholarship
February / 2025	$ 1,800 / wages	$ 2,200 / wages, scholarship
March / 2025	$ 1,800 / wages	$ 2,200 / wages, scholarship
April / 2025	$ 1,800 / wages	$ 2,200 / wages, scholarship
May / 2025	$ 1,800 / wages	$ 2,200 / wages, scholarship
June / 2025	$ 1,800 / wages	$ 2,200 / wages, scholarship
TOTALS	$ 10,800	$ 13,200

Add the totals of A and B $ 24,000 **then Divide by 6 = $** 4,000 **Average Monthly Income**

If additional space is needed for other dependents, please add a separate sheet.

Do you or your dependent have a checking account?
☑ **Yes** ☐ **No**
Balance of all checking accounts: $ 1000

Do you or your dependent have a savings account?
☑ **Yes** ☐ **No**
Balance of all savings accounts: $ 2000

Certification: I certify that the information I have reported is true and correct. I understand that if I intentionally make a false statement, misrepresent facts or conceal material information to obtain benefits, I may be required to repay benefits, charged penalties and could be subject to criminal prosecution.

/s/Christie Claimant
Signature

07/01/2025
Date

(517) 555-5555
Telephone Number

Christie Claimant
Print Name

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