



Job Loss Protection Program

Request for Involuntary Unemployment
Protection Activation

Job Loss benefits Administrator
Attn: IU Claims Department
2555 Severn Avenue, Suite 100, Metairie, LA 70002
PHONE : 1-800-411-9222; FAX: 1-504-456-7324
Email: activations@fingrp.com

AFTER 30 CONSECUTIVE DAYS OF UNEMPLOYMENT

1. Read the Eligibility Notice in the box to the right.
2. Complete Section II – Claimant’s Statement.
3. Have the **Former Employer** complete Section I – Statement of Employer. Not applicable to self employed borrowers. If your former Employer is no longer in business proof that the business is closed is required.
4. Attach a copy of your state unemployment check or computer printout of benefits received. **If self employed** see requirements in your Certificate of Protection.
5. Submit this completed form and your proof of Involuntary Unemployment to the IU Claims Department shown in the top right portion of this form.

ELIGIBILITY NOTICE

To qualify for Involuntary Unemployment protection, you must have worked full time, thirty (30) hours per week minimum, on the same job continuously for the ninety (90) day period immediately prior to the date of your unemployment. You must be ready, willing and able to work.

I. STATEMENT OF EMPLOYER:

Our employee, _____, whose original date of employment was, _____ was involuntary released as of _____. The reason for involuntary release was _____.

Was this employee working at least 30 hrs per week? _____. Was this employee an independent contractor or self-employed? _____.

Did this employee receive severance payment upon termination? _____. If so, for how many weeks did the severance cover? _____. This employee was first made aware of his/her termination of employment on _____.

Were you required to give advance notice of the termination under the Worker Adjustment and Retraining Notification (WARN) Act of 1988? _____

I certify to the best of my knowledge the information provided is true and correct.

_____ Employer (Print Name of Company)	_____ Phone Number	_____ Address of Employer
_____ Signature of Employer or its Representative	_____ Date	_____ City/State/Zip Code

II. CLAIMANT’S STATEMENT

Name: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: (____) _____ Date Hired: _____ Last Day Worked: _____

Reason for Involuntary Release: _____

Former Employer: _____

If self employed have you filed for bankruptcy? _____ If so please provide the case number: _____

Have you applied for Disability benefits? _____ Are you physically able and available for work? _____

I was notified of my termination on _____. The amount of severance benefits I received as a result of my termination was \$ _____ for _____ weeks from the date of my unemployment. Are you eligible for state involuntary unemployment benefits? _____. If no, please explain why: _____

III. CLAIMANT’S STATEMENT OF AUTHORIZATION

I certify that the above information is true and correct. I authorize any employer, other person or other organization having any records, data, or information concerning this activation to furnish such records, data or information to the Administrator named above or its authorized representative as requested. I understand that in executing this authorization, I waive the right for such information to be privileged. I agree any statement made on this form found to be false may result in denial of benefits. A photocopy of this authorization shall be considered as effective and valid as the original.

Date: _____ Claimant’s Signature: _____

An incomplete form will be returned to you and not processed.