



Employment Information Questionnaire (EIQ)

Claimant Information

Last Name: _____ First Name: _____ MI: _____
 SSN: _____

Employer Information	
Employer Name: _____	Account Number: _____
Country: <i>(Check One)</i> <input type="checkbox"/> U.S. (Includes U.S. Territories) <input type="checkbox"/> Canada <input type="checkbox"/> Other: _____	
Address 1: _____	Address: (Apt., Floor, Suite, etc.) _____
City: _____	State: _____ Zip Code: _____
Province: _____	Postal Code: _____
Employer Contact Name: _____	Contact Title: _____
Primary Telephone Number: _____	Secondary Telephone Number: _____
Number of Workers: _____ Did the business close? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: / /	
Did company change its name?: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Former Business Name: _____	
Claimant Information	
Claimant Job Title: _____	Type of Service Performed: _____
Length of Employment: From: / / To: / /	
Ending Pay: _____ Per <i>(Check One)</i> <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> BiWeekly <input type="checkbox"/> Other: _____	
Hours Worked: _____ Per <i>(Check One)</i> <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Other: _____	
Work Location: _____	
Additional Comments	