LLC DOCTAL CERVICE										
U.S. POSTAL SERVICE REQUEST FOR WAIVER OF CLAIM FOR ERRONEOUS PAYMENT OF PAY (Submit in triplicate)										
PART I – To Be Completed By Claimant										
1. NAME OF CLAIMANT		2. SOCIAL SECURITY NO.		3. CLAIMANT'S STATUS Active Retirec Employee — Emplo	f Former					
4. CLAIMANT'S HOME ADDRESS (Include Apt. No.)		5. NAME AND LOCATION							
·	, ,									
6. PER. COV. BY ERRONEO			OSS AMOUNT REQUESTED	8. P.O. INVOICE	` '''					
FROM .	TO .	FOR \$	R WAIVER	DATE	NO.					
9. DESCRIBE THE NATURE OF TH	HE ERRONEOUS PAYMENT OF	l .	tach separate sheet if necess	:arv)						
9. DESCRIBE THE NATURE OF THE ERRONEOUS PAYMENT OF PAY (Attach separate sheet if necessary)										
10. DID YOU INQUIRE OF YOUR S	HIDERVISOR CONCERNING PO	SSIRI E	EDBUD IN VOLID DAV2 IE S	SO FUDNISH DETAILS						
10. DID 100 INQUINE OF 100K 3	OPERVISOR CONCERNING FO	SSIDLL	LKKOK IN TOOK FAT! II 3	OO, FURNISH DE TAILS						
11. STATE THE CIRCUMSTANCES	YOU FEEL JUSTIFY WAIVER C	OF THIS	CLAIM							
40. IF ANN DEDAYMENT HAD BEE	NAME LIGT ANGUNTO AND	DATEO (DEDAID							
12. IF ANY REPAYMENT HAS BEE	N MADE, LIST AMOUNTS AND L	DATEST	REPAID							
The collection of this information is a	#h-====d h.: 20 LICC 404 4002 an	4 F 1100	0220 This information will be		of alaims for					
The collection of this information is au erroneous payment of pay. As a routil										
law enforcement agency for investiga	tive or prosecutive purposes, to a	congress	sional office at your request, to	o OMB for review of private	relief legislation, to					
which the Postal Service is a party. C	ompletion of this form is voluntary,	, howeve	er, if this information is not pro	vided, you will not be grante	ed a waiver.					
I make the foregoing request for waiv					naking a false claim.					
(U.S. Code, Title 18, Section 287, pro										
APPLICATION FOR REFUND: If collection of all or part of the amoun			SIGNATURE OF CLAIMAN	Т	DATE					
in Item 7 is waived, I make application for refund of all, or the appropriate										
part of the amounts repaid which are	shown in Item 12.				Ì					

		o Be Completed By tain one copy. Forw							oyee
CLAIMA	NT, OR FACTS O\	ACTS OR CIRCUMS VERLOOKED OR IN MENT OCCURRED (CORRECTL	Y STATE	D BY THE	CLAIMANT ON TH			
Pay	Amount	Amount G	ROSS AMOI Pay	UNT OF CL Amo		D BY PAY PERIOD Amount	Pay	Amount	Amount
Period	Paid	Should Be	Period	Pai		Should Be	Period	Paid	Should Be
		dge and belief there					, or lack of	good faith on th	e part of the
SIGNATU		son having an intere	st in this re	quest for y		claim.			DATE
		PART III – To Be	Complete	d By The	Division	Field Director, H	uman Res	ources	
SIGNATURE			TITLE	TITLE				DATE	
	PART I	V – To Be Complet	ted By Dire	ector, Min	neapolis	Postal Data Cen	ter, Or His	Designee Only	1
GROSS AMT. CLAIMED \$			h CLAIM A	LLOWED					
GROSS	S AMT. WAIVED	\$							
SIGNATU	IRE OF APPROVING	G OFFICER		TITLE					DATE