

**STATE OF RHODE ISLAND
DIVISION OF TAXATION - EMPLOYER TAX SECTION**

1 Capitol Hill - Suite 36
Providence, Rhode Island 02908
(401) 574-8700 (Option 2) or WWW.UITAX.RI.GOV

CLAIM FOR REFUND OF TEMPORARY DISABILITY INSURANCE TAX

IMPORTANT - Please read instructions before completing

1. Enter your Name, Social Security Number, and Address.

YOUR NAME (First, Middle Initial and Last)	SOCIAL SECURITY NUMBER
NO. AND STREET	- -
CITY	STATE ZIP CODE

2. Enter the calendar year for which a refund is being claimed, filing date, your signature, and telephone number.

I hereby apply for a refund of taxes paid in excess during the calendar year _____ to the R.I. Temporary Disability Insurance Fund. I certify that the facts presented including the attached W-2, are true to the best of my knowledge and belief.

Date: _____ Signature: _____ Telephone : _____

3. IMPORTANT - ATTACH A COPY OF FEDERAL FORM W-2 FOR EACH EMPLOYER LISTED

COMPANY TELEPHONE NUMBER:	COMPANY TELEPHONE NUMBER:
FIRM NAME OF EMPLOYER	FIRM NAME OF EMPLOYER
STREET & NUMBER	STREET & NUMBER
CITY STATE & ZIP WAGE \$ -	CITY STATE & ZIP WAGE \$ -
COMPANY TELEPHONE NUMBER:	COMPANY TELEPHONE NUMBER:
FIRM NAME OF EMPLOYER	FIRM NAME OF EMPLOYER
STREET & NUMBER	STREET & NUMBER
CITY STATE & ZIP WAGE \$ -	CITY STATE & ZIP WAGE \$ -
COMPANY TELEPHONE NUMBER:	COMPANY TELEPHONE NUMBER:
FIRM NAME OF EMPLOYER	FIRM NAME OF EMPLOYER
STREET & NUMBER	STREET & NUMBER
CITY STATE & ZIP WAGE \$ -	CITY STATE & ZIP WAGE \$ -