Employment Development Department
State of California

NEW EMPLOYEE REGISTRY BENEFIT AUDIT

REPLY IS REQUIRED BY LAW

Please return **ALL** Benefit Audit forms. This information could be the basis for administrative penalties assessed against a claimant and may impact your benefit charges. Accuracy is extremely important.

See enclosed instructions for step-by-step assistance. For additional clarification, **call 1-866-401-2849, or visit the EDD website at www.edd.ca.gov.**

Social Security No. (SSN):
Employee Name:

- If the **INDIVIDUAL WORKED** or had earnings, complete items 1 through 6.
- If earnings are zero for all of the weeks listed, CHECK HERE ☐ and complete only items 1, 2, 3 and 6.

1. Compare the SSN and Employee Name shown above with your records. If different, provide the information below:
SSN: _ _ _- _ _- _ _ _ _ Employee Name: _____ Employee Date of Birth: _____

2. The employee's Start-of-Work Date you previously provided:
If not correct, enter the **ACTUAL** Start-of-Work Date (**Not the Hire Date)**: _____

3. Is the employee still working for you? ☐ Yes ☐ No If No, enter the last day the employee **physically** worked: _____
Reason no longer working: ☐ Laid off/Lack of work ☐ Misconduct/Fired ☐ Voluntary Quit ☐ Other: _____

4. Pay Period: ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly Pay Period Start Date: _____ End date: _____
Rate of Pay: Hourly $_____ per hour Salary $_____ per _____ Other: _____

5. Type of earnings: REG=Regular/Overtime **V**=Vacation **H**=Holiday **SL**=Sick Leave
S=Severance **C**=Commissions **RES**=Residuals **O**=Other _____
If the employee is a school contract employee, attach a copy of the contract.

Week Begins	Provide the number of hours worked/earned for each day.							Week Ends	Provide the total weekly hours. (Explain if reporting no hours for a week)	Provide the gross earnings **when worked not paid**.	For **REG,V,H** or **SL** provide the total hours for each pay type below.				For **S,C,RES** or **O** place a check mark for each pay type below.			
	S	M	T	W	TH	F	S				REG	V	H	SL	S	C	RES	O

SAMPLE

6. I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

NAME: _____ SIGNATURE: _____ TITLE: _____

DATE: _____ PHONE NUMBER: _ _ _-_ _ _ -_ _ _ _ FAX NUMBER: _ _ _- _ _ _- _ _ _ _ EMAIL: _____

PLEASE RETURN ALL NEW EMPLOYEE REGISTRY BENEFIT AUDITS WITHIN 10 DAYS OF RECEIPT TO:
EMPLOYMENT DEVELOPMENT DEPARTMENT, PO BOX 2410, RANCHO CORDOVA, CA 95741-2410