



STATE OF NEW YORK

NOTIFICATION AND CLAIM TO OWNER OF UNCASHED NEW YORK STATE PAYROLL CHECK(S)

September 20, 2024

EMPLOYEE NAME  
EMPLOYEE ADDRESS  
CITY, NY 00000-0000

Corrected Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NYSEMPID: N0XXXXXX

Payee:  
FIRST NAME, LAST NAME

Our records indicate the below referenced check(s) were issued by New York State to the payee noted above and have not been cashed. If you have these check(s) in your possession, please cash them immediately.

If you do not have these check(s) in your possession, complete steps 1 through 5 to request replacement check(s). If all steps are not completed, replacement checks may not be issued. Return this entire letter by October 18, 2024.

- 1. Is your address correct?  YES  NO If no, correct your address above.
- 2. Put an 'X' to the left of each payment for which you, or someone for whom you are authorized to make claim on behalf of, are entitled and would like a replacement check issued. If no checks are selected, all checks will be issued a replacement.

Check #	Issue Date	Amount	Check #	Issue Date	Amount
<input type="checkbox"/> XXXXXXXX	05/04/2023	4.66			
<input type="checkbox"/> XXXXXXXX	12/06/2023	2915.68			

- 3. Are you authorized and claiming these payment(s) on behalf of someone other than yourself?  YES  NO  
**IMPORTANT NOTE:** If you are claiming on behalf of someone who is deceased, you must enclose an original copy of the death certificate and completed Next of Kin Affidavit. ([https://www.osc.state.ny.us/files/state-agencies/payroll/pdf/ac934p\\_fillable.pdf](https://www.osc.state.ny.us/files/state-agencies/payroll/pdf/ac934p_fillable.pdf))
- 4. Sign the below attestation:

I hereby certify that the above described checks were not received or cashed by me. In consideration of the issuance of replacement checks payable as originally drawn, if I/we have not done so already, I/we agree to destroy the original checks should the original checks at any time hereafter come into my/our possession or control, and I/we further agree to reimburse the State of New York for any loss or damage by reason of the issuance of the replacements check for which application is made herein. I/We hereby affirm the above to be true under the penalties of perjury.

\_\_\_\_\_  
Signature of Payee(s) or Representative

\_\_\_\_\_  
Date

Contact Phone Number (Required): \_\_\_\_\_

- 5. Return this **ENTIRE** letter to: AGENCY NAME  
AGENCY STREET ADDRESS.  
CITY, NY ZIP CODE

If these check(s) are not cashed, they will be considered abandoned property and shall be turned over to the Office of Unclaimed Funds at the Office of the State Comptroller. After April 2025, you must contact the Office of Unclaimed Funds (<http://www.osc.state.ny.us/ouf/index.htm>) to claim these funds. For questions contact your agency payroll office.

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