

State of Hawaii  
Department of Labor and Industrial Relations  
Unemployment Insurance Division

**VERIFICATION OF PARTIAL UNEMPLOYMENT STATUS**

Employer Name:

Address:

City, State, and Zip Code:

Mail Date:

Claimant's Name:

SSN: XXX-XX-

The above claimant has filed a partial claim for unemployment benefits because of temporary reduced work hours. Please complete and return this form within five working days from the mail date above. Payments may be held or delayed pending your compliance with this form. If the form is not returned, the claimant will have to change his/her status to totally unemployed, register for work and follow their union's job call rules for other work, or make three job contacts every week. Please call the local office shown below for questions or assistance in completing this form.

1. Prior to the reduction in work hours, was the claimant a full-time worker? Yes \_\_\_ No \_\_\_ (*If "No," stop here and return the form.*)
2. Reason the claimant is not working full-time hours presently? Not enough work \_\_\_ Other \_\_\_  
If other, explain: \_\_\_\_\_
3. Will the claimant be regularly scheduled/offered reduced hours each week? Yes \_\_\_ No \_\_\_
4. Is the employer: (a) paying for medical insurance; or (b) maintaining the claimant's sick leave or vacation credits? Yes \_\_\_ No \_\_\_ (*Check "No" if the vacation credits or medical insurance is being maintained through a labor union.*)
  - a) If "Yes," provide the date, if any, the employer will end medical coverage or stop maintaining the claimant's sick leave or vacation credits. \_\_\_\_\_ (mm/dd/yy)
5. If "No" to questions 3 and 4, do you plan to call the claimant back to work soon? Yes \_\_\_ No \_\_\_
  - a) If "Yes," "Definite Return to Work Date" \_\_\_\_/\_\_\_\_/\_\_\_\_; or,
  - b) If not definite, the expected time period or number of weeks before he/she returns to work \_\_\_\_\_ (*Note: The claimant must be converted from partial to totally unemployed claim status if there is no definite or expected return to work date.*)

I certify that the above information is true and correct to the best of my knowledge.

Employer/Representative Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Return form to:

**UNEMPLOYMENT INSURANCE DIVISION**  
Local Claims Office Information

**Oahu**

**Honolulu Claims Office**

830 Punchbowl St. Rm 110  
Honolulu, HI 96813-5080  
Ph: (808) 586-8970 or 586-8971, Fax: (808) 586-8980  
Email: [dlir.ui.honolulu@hawaii.gov](mailto:dlir.ui.honolulu@hawaii.gov)

**Kauai**

**Kauai Claims Office**

4370 Kukui Grove St., Ste 3-214  
Lihue, HI 96766  
Ph: (808) 274-3043, Fax: (808) 274-3046  
Email: [dlir.ui.kauai@hawaii.gov](mailto:dlir.ui.kauai@hawaii.gov)

**Waipahu Claims Office**

94-275 Mokuola St. Rm. 301  
Waipahu, HI 96797-3369  
Ph: (808) 675-0030, Fax: (808) 675-0025  
Email: [dlir.ui.waipahu@hawaii.gov](mailto:dlir.ui.waipahu@hawaii.gov)

**Hawaii**

**Hilo Claims Office**

1990 Kinoole St, Rm 101  
Hilo, HI 96720-5293  
Ph: (808) 974-4086, Fax: (808) 974-4085  
Email: [dlir.ui.hilo@hawaii.gov](mailto:dlir.ui.hilo@hawaii.gov)

**Kona Claims Office**

81-990 Halekii St, Rm 2090  
PO Box 167, Kealahou, HI 96750-0167  
Ph: (808) 322-4822, Fax: (808) 322-4828  
Email: [dlir.ui.kona@hawaii.gov](mailto:dlir.ui.kona@hawaii.gov)

**Maui**

**Maui Claims Office**

54 South High St, Rm. 201  
Wailuku, HI 96793-2198  
Ph: (808) 984-8400, Fax: (808) 984-8444  
Email: [dlir.ui.maui@hawaii.gov](mailto:dlir.ui.maui@hawaii.gov)

**Molokai Claims Office**

55 Makaena St, Rm. 4  
PO Box 1858  
Kaunakakai, HI 96748-1858  
Ph: (808) 553-1750, Fax: (808) 553-1753  
Email: [dlir.ui.maui@hawaii.gov](mailto:dlir.ui.maui@hawaii.gov)

**Liable Interstate Unit**

830 Punchbowl St. Rm 110  
Honolulu, HI 96813-5080  
Ph: (808) 586-8960, Fax: (808) 586-8980  
Email: [dlir.ui.honolulu@hawaii.gov](mailto:dlir.ui.honolulu@hawaii.gov)