Iowa Department of
Inspections, Appeals & Licensing
321 E 12th Street
Des Moines, IA 50319
Phone: 515-631-8901
Fax: 515-242-6507

Wage Claim

Part 1 – Claimant Information

First Name:	**Last Name:**	**Date of Birth:**
Social Security Number:	**Phone Number:**	**Email Address:**
Address:		
City:	**State:**	**ZIP:**

Part 2 – Employer Information

Name of Business:		
Was work performed in Iowa? **Yes ☐ No ☐**	**Are you Union Contract Covered?** **Yes ☐ No ☐**	**Have you retained an Attorney?** **Yes ☐ No☐**

Part 3 – Reason of Claim

Explain the reason for filing your claim and the circumstances:	**Requested Claim Amount: $**

By signing below, I certify that the information on this form and the attachments (if any) is true and accurate to the best of my knowledge.

I assign in trust this claim and all penalties accruing of non-payment, and liens securing them, to the Iowa Department of Inspections, Appeals, and Licensing (DIAL) Director or Designee. This assignment shall become effective upon a determination by the DIAL Director or Designee that I have an enforceable claim. I authorize the DIAL Director or Designee to settle this claim. I authorize the DIAL Director or Designee to receive payment for this claim, and authorize such payment to be mailed to me unless I have made a different arrangement with the DIAL Director or Designee.

I understand that I must cooperate as required by the DIAL Director or Designee, and it is my responsibility to provide sufficient information to demonstrate the claim due. I understand that there is no guarantee that the DIAL Director or Designee will accept my claim and collect on it.

_____ _____

Signature **Date**