SWS-39	Benefits Employer Sworn Written Statement

If you need more space to complete this Sworn Written Statement, attach additional pages and they will be incorporated into this document. Claimant, you must complete Section A before submitting the Sworn Written Statement to the employer.

A. CLAIMANT INFORMATION

Name:	Last	First	Middle Initial
Deepwater Horizon Settlement Program Claimant Number:	|___|___|___|___|___|___|___|___|___|		
Social Security Number: *or* **Individual Taxpayer Identification Number:**	|___|___|___| - |___|___| - |___|___|___|___|		
Current Address:	Street		
	City	State	Zip Code

B. EMPLOYER INFORMATION

Employer Name	Period of Claimant's Employment	
Street	From ____/____/____ to ____/____/____	
City	State	Zip Code
Parish/County	Telephone Number	
Employer Website *(if available)*	(___) ___ - ____	
Employer Identification Number (EIN) |___|___| - |___|___|___|___|___|___|___|		
Supervisor/Authorized Representative- Last Name	First Name	Middle Initial

C. EMPLOYER-RELATED HEALTH CARE BENEFITS LOSSES

Fill out all sections applicable to the claimant. If the claimant was offered and had accepted employment prior to April 20, 2010 to begin between April 21, 2010 and December 31, 2010, fill out the information to the best of your knowledge about the claimant's planned enrollment status.

1. Medical Coverage:	◯ **Claimant was enrolled, or planned to enroll, in Medical Coverage.** ◯ **Not Applicable to Claimant.** Go to C.2.
(a) Name of Plan	
(b) Date of Enrollment or Planned Enrollment	**___/___/20__**
(c) Type of Coverage or Planned Coverage	◯ **Individual Coverage** ◯ **Family Coverage**
(d) Periodic Premiums or Planned Periodic Premiums by the Employer: State the amount that you would have paid on behalf of the claimant if the Spill had not occurred from April 21, 2010 or the claimant's projected start date, through the earlier of the date that you would have continued to pay the premiums or December 31, 2011.	**A. Amount Paid $_____** **B. Frequency of Payments** ◯ **Annually** ◯ **Monthly** ◯ **Weekly** ◯ **Per Pay Period** **Number of days per Pay Period: _____**

(e) Periodic Premiums or Planned Periodic Premiums by the Claimant: If the claimant was enrolled as of April 20, 2010, provide the amount and frequency of Periodic Premiums paid by the claimant in April 2010. If the claimant was not enrolled as of April 20, 2010, provide the amount and frequency of Periodic Premiums that the claimant would have made as of the projected start date of employment.	**A. Amount Paid $**_____ **B. Frequency of Payments** ◯ **Annually** ◯ **Monthly** ◯ **Weekly** ◯ **Per Pay Period** **Number of days per Pay Period:** _____
(f) Effective Date of Termination or Withdraw of Benefits. If the claimant was enrolled as of April 20, 2010, state the date the Benefits terminated. If the claimant was not yet enrolled as of April 20, 2010, state the date that you notified the claimant that he or she would no longer be receiving Benefits. If the claimant's offer for employment was withdrawn, state the date of withdraw of the offer.	___/___/20__
(g) Reason for the Termination of Benefits for Claimants Enrolled as of April 20, 2010. If the claimant was enrolled as of April 20, 2010, check the box next to the reason why the claimant's Benefits were terminated.	◯ **Claimant's Benefits were terminated because he or she was terminated from employment.** ◯ **Claimant's Benefits were terminated because he or she experienced a change in employment status, or reduction in hours, that caused him or her to no longer be eligible for health care benefits.**
(h) If the termination in (g) was related to or due to the Spill, state how.	
(i) Reason for the Amended or Withdrawn Offer for Benefits for Claimants Who Were Not Enrolled as of April 20, 2010. If the claimant was not yet enrolled as of April 20, 2010, check the box next to the reason why the claimant's offer for Benefits was amended or withdrawn.	◯ **Claimant's Benefits were terminated because the claimant's offer for employment with my business was withdrawn.** ◯ **Claimant's Benefits were terminated because the claimant's employment offer was amended in a way that caused a change in employment status, or reduction in hours, that caused him or her to no longer be eligible for health care benefits.**
(j) If the reason for the amended or withdrawn offer in (i) was related to or due to the Spill, state how.	
2. Dental Coverage:	◯ **Claimant was enrolled, or planned to enroll, in Dental Coverage.** ◯ **Not Applicable to Claimant.** Go to C.3.
(a) Name of Plan	

(b) Date of Enrollment or Planned Enrollment	**___/___/20__**
(c) Type of Coverage or Planned Coverage	**◯ Individual Coverage** **◯ Family Coverage**
(d) Periodic Premiums or Planned Periodic Premiums: State the amount that you would have paid on behalf of the claimant if the Spill had not occurred from April 21, 2010 or the claimant's projected start date, through the earlier of the date that you would have continued to pay the premiums or December 31, 2011.	**A. Amount Paid $_____** **B. Frequency of Payments** **◯ Annually** **◯ Monthly** **◯ Weekly** **◯ Per Pay Period** **Number of days per Pay Period: _____**
(e) Periodic Premiums or Planned Periodic Premiums by the Claimant: If the claimant was enrolled as of April 20, 2010, provide the amount and frequency of Periodic Premiums paid by the claimant in April 2010. If the claimant was not enrolled as of April 20, 2010, provide the amount and frequency of Periodic Premiums that the claimant would have made as of the projected start date of employment.	**A. Amount Paid $_____** **B. Frequency of Payments** **◯ Annually** **◯ Monthly** **◯ Weekly** **◯ Per Pay Period** **Number of days per Pay Period: _____**
(f) Effective Date of Termination or Withdraw of Benefits. If the claimant was enrolled as of April 20, 2010, state the date the Benefits terminated. If the claimant was not yet enrolled as of April 20, 2010, state the date that you notified the claimant that he or she would no longer be receiving Benefits. If the claimant's offer for employment was withdrawn, state the date of withdraw of the offer.	**___/___/20__**
(g) Reason for the Termination of Benefits for Claimants Enrolled as of April 20, 2010. If the claimant was enrolled as of April 20, 2010, check the box next to the reason why the claimant's Benefits were terminated.	**◯ Claimant's Benefits were terminated because he or she was terminated from employment.** **◯ Claimant's Benefits were terminated because he or she experienced a change in employment status, or reduction in hours, that caused him or her to no longer be eligible for health care benefits.**
(h) If the termination in (g) was related to or due to the Spill, state how.	
(i) Reason for the Amended or Withdrawn Offer for Benefits for Claimants Who Were Not Enrolled as of April 20, 2010. If the claimant was not yet enrolled as of April 20, 2010, check the box next to the reason why the claimant's offer for Benefits was amended or withdrawn.	**◯ Claimant's Benefits were terminated because the claimant's offer for employment with my business was withdrawn.** **◯ Claimant's Benefits were terminated because the claimant's employment offer was amended in a way that caused a change in employment status, or reduction in hours, that caused him or her to no longer be eligible for health care benefits.**

(j) If the reason for the amended or withdrawn offer in (i) was related to or due to the Spill, state how.	
3. Vision Coverage:	◯ **Claimant was enrolled, or planned to enroll, in Vision Coverage.** ◯ **Not Applicable to Claimant.** Go to C.4.
(a) Name of Plan	
(b) Date of Enrollment or Planned Enrollment	**___/___/20__**
(c) Type of Coverage or Planned Coverage	◯ **Individual Coverage** ◯ **Family Coverage**
(d) Periodic Premiums or Planned Periodic Premiums: State the amount that you would have paid on behalf of the claimant if the Spill had not occurred from April 21, 2010 or the claimant's projected start date, through the earlier of the date that you would have continued to pay the premiums or December 31, 2011.	**A. Amount Paid $_____** **B. Frequency of Payments** ◯ **Annually** ◯ **Monthly** ◯ **Weekly** ◯ **Per Pay Period** **Number of days per Pay Period: _____**
(e) Periodic Premiums or Planned Periodic Premiums by the Claimant: If the claimant was enrolled as of April 20, 2010, provide the amount and frequency of Periodic Premiums paid by the claimant in April 2010. If the claimant was not enrolled as of April 20, 2010, provide the amount and frequency of Periodic Premiums that the claimant would have made as of the projected start date of employment.	**A. Amount Paid $_____** **B. Frequency of Payments** ◯ **Annually** ◯ **Monthly** ◯ **Weekly** ◯ **Per Pay Period** **Number of days per Pay Period: _____**
(f) Effective Date of Termination or Withdraw of Benefits. If the claimant was enrolled as of April 20, 2010, state the date the Benefits terminated. If the claimant was not yet enrolled as of April 20, 2010, state the date that you notified the claimant that he or she would no longer be receiving Benefits. If the claimant's offer for employment was withdrawn, state the date of withdraw of the offer.	**___/___/20__**
(g) Reason for the Termination of Benefits for Claimants Enrolled as of April 20, 2010. If the claimant was enrolled as of April 20, 2010, check the box next to the reason why the claimant's Benefits were terminated.	◯ **Claimant's Benefits were terminated because he or she was terminated from employment.** ◯ **Claimant's Benefits were terminated because he or she experienced a change in employment status, or reduction in hours, that caused him or her to no longer be eligible for health care benefits.**
(h) If the termination in (g) was related to or due to the Spill, state how.	

(i) Reason for the Amended or Withdrawn Offer for Benefits for Claimants Who Were Not Enrolled as of April 20, 2010. If the claimant was not yet enrolled as of April 20, 2010, check the box next to the reason why the claimant's offer for Benefits was amended or withdrawn.	◯ **Claimant's Benefits were terminated because the claimant's offer for employment with my business was withdrawn.** ◯ **Claimant's Benefits were terminated because the claimant's employment offer was amended in a way that caused a change in employment status, or reduction in hours, that caused him or her to no longer be eligible for health care benefits.**
(j) If the reason for the amended or withdrawn offer in (i) was related to or due to the Spill, state how.	
4. Prescription Drug Coverage:	◯ **Claimant was enrolled, or planned to enroll, in Prescription Drug Coverage.** ◯ **Not Applicable to Claimant.** Go to Section D.
(a) Name of Plan	
(b) Date of Enrollment or Planned Enrollment	**___/___/20__**
(c) Type of Coverage or Planned Coverage	◯ **Individual Coverage** ◯ **Family Coverage**
(d) Periodic Premiums or Planned Periodic Premiums: State the amount that you would have paid on behalf of the claimant if the Spill had not occurred from April 21,2010 or the claimant's projected start date, through the earlier of the date that you would have continued to pay the premiums or December 31, 2011.	**A. Amount Paid $_____** **B. Frequency of Payments** ◯ **Annually** ◯ **Monthly** ◯ **Weekly** ◯ **Per Pay Period** **Number of days per Pay Period: _____**
(e) Periodic Premiums or Planned Periodic Premiums by the Claimant: If the claimant was enrolled as of April 20, 2010, provide the amount and frequency of Periodic Premiums paid by the claimant in April 2010. If the claimant was not enrolled as of April 20, 2010, provide the amount and frequency of Periodic Premiums that the claimant would have made as of the projected start date of employment.	**A. Amount Paid $_____** **B. Frequency of Payments** ◯ **Annually** ◯ **Monthly** ◯ **Weekly** ◯ **Per Pay Period** **Number of days per Pay Period: _____**
(f) Effective Date of Termination or Withdraw of Benefits. If the claimant was enrolled as of April 20, 2010, state the date the Benefits terminated. If the claimant was not yet enrolled as of April 20, 2010, state the date that you notified the claimant that he or she would no longer be receiving Benefits. If the claimant's offer for employment was withdrawn, state the date of withdraw of the offer.	**___/___/20__**

(g) Reason for the Termination of Benefits for Claimants Enrolled as of April 20, 2010. If the claimant was enrolled as of April 20, 2010, check the box next to the reason why the claimant's Benefits were terminated.	◯ **Claimant's Benefits were terminated because he or she was terminated from employment.** ◯ **Claimant's Benefits were terminated because he or she experienced a change in employment status, or reduction in hours, that caused him or her to no longer be eligible for health care benefits.**
(h) If the termination in (g) was related to or due to the Spill, state how.	
(i) Reason for the Amended or Withdrawn Offer for Benefits for Claimants Who Were Not Enrolled as of April 20, 2010. If the claimant was not yet enrolled as of April 20, 2010, check the box next to the reason why the claimant's offer for Benefits was amended or withdrawn.	◯ **Claimant's Benefits were terminated because the claimant's offer for employment with my business was withdrawn.** ◯ **Claimant's Benefits were terminated because the claimant's employment offer was amended in a way that caused a change in employment status, or reduction in hours, that caused him or her to no longer be eligible for health care benefits.**
(j) If the reason for the amended or withdrawn offer in (i) was related to or due to the Spill, state how.	

D. EMPLOYER-RELATED RETIREMENT BENEFITS LOSSES

Fill out each section that is applicable to the claimant. If the claimant was offered and had accepted employment prior to April 20, 2010 to begin between April 21, 2010 and December 31, 2010, fill out the information to the best of your knowledge about the claimant's planned enrollment status. If claimant was enrolled in, or eligible for more than one type of Retirement Plan, photocopy this section and complete it for each type of Plan.

1. Type of Retirement Plan. Check the box next to the plan that the claimant was enrolled in as of April 20, 2010. Name the Plan. If the claimant was not yet enrolled as of April 20, 2010 in the Retirement Plan, check the box next to the plan that the claimant would have been eligible for enrollment. Name the Plan.

◯ **Employer Pension Payments**	**Name of Plan:** _____
◯ **Employer Contributions to 401(k)**	**Name of Plan:** _____
◯ **Employer Contributions to 403(b)**	**Name of Plan:** _____
◯ **Employer Contributions to Profit Sharing**	**Name of Plan:** _____
◯ **Employer Contributions to Other Type of Account**	**Name of Plan:** _____

2. If you selected "Employer Contributions to Other Type of Account," describe the type of Plan and details.	
3. Date of Claimant's Enrollment, or Planned Enrollment, in Retirement Plan. State the start date of the claimant's enrollment in the Retirement Plan. If the claimant was not yet enrolled as of April 20, 2010, state the date the claimant was expected to become enrolled.	**___/___/20__**
4. Post-Spill Status of Plan. Check the box to indicate if the Benefits, or offer for Benefits, was terminated, or the Benefits were reduced.	◯ **The Plan Benefits were terminated, or the employee was terminated.** ◯ **The Plan Benefits were reduced.**
5. Effective Date of Termination or Reduction in Retirement Benefits. State the date that the claimant's Retirement Benefits were reduced or terminated. If the claimant was not yet enrolled, provide the date the Benefits were reduced or withdrawn.	**___/___/20__**
6. Amount and Frequency of the Vested Pre-Spill Employer Contribution to the Plan. If the claimant was enrolled as of April 20, 2010, state the amount and frequency of employer contributions between the earlier of May 1, 2009, or the claimant's start date, and the reduction or termination of Benefits. If the claimant was not yet enrolled in the Benefits Plan as of April 20, 2010, state the amount and frequency of planned employer contributions to the claimant's Retirement Plan.	**A. Amount Per Payment $_____** **B. Frequency of Payments:** ◯ **Annually** ◯ **Monthly** ◯ **Weekly** ◯ **Per Pay Period** **Number of days per Pay Period: _____**
7. If the Plan was Reduced Rather than Terminated, State the Amount and Frequency of Vested Post-Spill Employer Contribution to the Plan. If the claimant was still eligible for employer contribution after April 20, 2010, state the amount and frequency of the employer's post-Spill contributions until the earlier of the claimant's departure from employment or December 31, 2011.	**A. Amount Per Payment $_____** **B. Frequency of Contributions** ◯ **Annually** ◯ **Monthly** ◯ **Weekly** ◯ **Per Pay Period** **Number of days per Pay Period: _____**
8. Describe the Vesting Schedule, or Planned Vesting Schedule. Attach the Vesting Schedule to this Form. Describe the terms of the vesting schedule, including if the employer's contributions were contingent on the claimant's contribution and the any changes to the vesting schedule after the Spill.	
9. Reason for the Termination or Reduction of Benefits for Claimants Who Were Enrolled as of April 20, 2010. If the claimant was enrolled as of April 20, 2010, state the reason why the Benefits were reduced or terminated, including any Spill-Related reasons.	

10. Reason for the Amended or Withdrawn Offer for Benefits for Claimants Who Were Not Enrolled as of April 20, 2010. If the claimant was not yet enrolled in Retirement Benefits, state the reason for the amended or withdrawn offer of employment, including any Spill-related reasons.	

E. SIGNATURE

I certify and declare under penalty of perjury pursuant to 28 U.S.C. Section 1746 that all the information I have provided in this Statement (and in any pages I have attached to or submitted with this Statement to provide additional information requested in this Statement) is true and accurate to the best of my knowledge, and that supporting documents attached to or submitted with this Statement and the information contained therein are true, accurate, and complete to the best of my knowledge, and I understand that false statements or claims made in connection with this Statement may result in fines, imprisonment, and/or any other remedy available by law to the Federal Government, and that suspicious claims will be forwarded to federal, state, and local law enforcement agencies for possible investigation and prosecution.

Date Signed:	_____/_____/_____ (Month/Day/Year)	_____ Employer Signature _____ Name (Printed or Typed)