FORM 273 (SHEET 1 OF 3) 300M-6-46-18840 REV. 5-46

THE COMMONWEALTH OF MASSACHUSETTS
DIVISION OF EMPLOYMENT SECURITY

NOTICE TO EMPLOYER OF CLAIM FILED

RETURN TO:
DIVISION OF EMPLOYMENT SECURITY
227 MAIN STREET
HYANNIS, MASS.

SOCIAL SECURITY ACCOUNT NUMBER 012-07-8477

NAME William E. Kenny

ADDRESS 10 Johnson Street, Provincetown

DATE CLAIM FILED 10-4-48

LAST OCCUPATION

EMPLOYER Provincetown Cold Storage

ADDRESS Provincetown, Mass.

NOTICE MAILED
10-5-48
EFF. WK. NO.
27

DATE OF SEPARATION not seperated REASON FOR SEPARATION Still working-part time

YOU ARE HEREBY NOTIFIED THAT THE ABOVE NAMED INDIVIDUAL HAS FILED A CLAIM WITH THIS DIVISION FOR UNEMPLOYMENT BENEFITS AND HAS STATED THAT YOU WERE HIS EMPLOYER ON THE DATE OF SEPARATION SHOWN ABOVE.

IF YOU KNOW OF ANY MISREPRESENTATION OR OTHER REASON WHY PAYMENT OF BENEFITS SHOULD NOT BE MADE TO THIS CLAIMANT, YOU MUST UNDER THE LAW (G. L. 151A §38) COMPLETE THIS FORM AND RETURN IT TO THE OFFICE LOCATION SHOWN ABOVE WITHIN 7 DAYS FROM THE DATE APPEARING IN THE "NOTICE MAILED" BLOCK. THE LAW REQUIRES YOU TO STATE YOUR REASONS WHY PAYMENT OF BENEFITS SHOULD NOT BE MADE TO THIS CLAIMANT AND FAILURE TO DO SO WILL BAR YOU FROM FURTHER PROCEEDINGS RELATING TO THIS CLAIM.

IF YOU RETURN THIS FORM WITH YOUR REASONS WHY PAYMENT OF BENEFITS SHOULD NOT BE MADE TO THIS CLAIMANT, YOU WILL BE NOTIFIED IF BENEFITS ARE AWARDED TO THE CLAIMANT, AND YOU WILL HAVE THE RIGHT TO APPLY FOR A REVIEW OF THE DETERMINATION AT THAT TIME. IF BENEFITS ARE NOT AWARDED TO THE CLAIMANT, OR IF YOU FAIL TO STATE YOUR REASONS, YOU WILL RECEIVE NO FURTHER NOTICE.

PAYMENT OF BENEFITS TO THE INDIVIDUAL NAMED ABOVE MAY BE AFFECTED BY ANY ONE OF THE FOLLOWING REASONS:

LEFT VOLUNTARILY WITHOUT GOOD CAUSE ATTRIBUTABLE TO THE EMPLOYER OR HIS AGENT.
SICK OR UNAVAILABLE FOR WORK.
SUITABLE WORK NOW AVAILABLE.
CURRENTLY EMPLOYED.
DISCHARGED BECAUSE OF WILFUL MISCONDUCT.
UNEMPLOYED BECAUSE OF A LABOR DISPUTE.
RECEIVING WORKMEN'S COMPENSATION, DISMISSAL PAY, VACATION ALLOWANCE.

THESE OR OTHER REASONS AFFECTING THE CLAIM SHOULD BE DETAILED BELOW.

DIVISION OF EMPLOYMENT SECURITY
ROBERT E. MARSHALL, DIRECTOR

NAME OF EMPLOYER BY OFFICIAL TITLE

THE FOLLOWING PERSON IN OUR ORGANIZATION MAY BE CALLED FOR FURTHER INFORMATION, IF NECESSARY, RELATIVE TO THIS CLAIM.

NAME TELEPHONE NUMBER