

1

INSTRUCTIONS: Complete all information on this form. Sign, date, and return to the State agency (department/office) address shown at the bottom of this page. Prompt return of this **fully completed** form will prevent delays when processing payments. Information provided in this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information and Privacy Statement.
NOTE: Governmental entities, federal, State, and local (including school districts), are not required to submit this form.

2

PAYEE'S LEGAL BUSINESS NAME (Type or Print)
 United Parcel Service

SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.) **E-MAIL ADDRESS**
 United Parcel Service

MAILING ADDRESS Lock Box 577	BUSINESS ADDRESS 55 Glenlake Parkway NE
CITY, STATE, ZIP CODE Carol Stream IL 60132-0577	CITY, STATE, ZIP CODE Atlanta GA 30328

3

PAYEE ENTITY TYPE

CHECK ONE BOX ONLY

ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 3 | 6 | - | 2 | 4 | 0 | 7 | 3 | 8 | 1 |

PARTNERSHIP **CORPORATION:**

ESTATE OR TRUST **MEDICAL** (e.g., dentistry, psychotherapy, chiropractic, etc.)

INDIVIDUAL OR SOLE PROPRIETOR **LEGAL** (e.g., attorney services)

ENTER SOCIAL SECURITY NUMBER: **EXEMPT** (nonprofit)

ALL OTHERS

(SSN required by authority of California Revenue and Tax Code Section 18646)

NOTE:
 Payment will not be processed without an accompanying taxpayer I.D. number.

4

PAYEE RESIDENCY STATUS

California resident - Qualified to do business in California or maintains a permanent place of business in California.

California nonresident (see reverse side) - Payments to nonresidents for services may be subject to State income tax withholding.

No services performed in California.

Copy of Franchise Tax Board waiver of State withholding attached.

5

I hereby certify under penalty of perjury that the information provided on this document is true and correct. Should my residency status change, I will promptly notify the State agency below.

AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) Florence Matteo	TITLE Director of Enterprise Accounts
SIGNATURE <i>Florence Matteo</i>	DATE 6-28-11
TELEPHONE (602) 758-8654	

6

Please return completed form to:

Department/Office: _____

Unit/Section: _____

Mailing Address: _____

City/State/Zip: _____

Telephone: (____) _____ **Fax:** (____) _____

E-mail Address: _____