DEPARTMENT OF REVENUE SERVICES

AUDIT DIVISION
25 SIGOURNEY STREET
HARTFORD, CONNECTICUT 06106

ASSIGNMENT OF RETAILER'S RIGHTS FOR REFUND

NAME OF CLAIMANT **(BUSINESS ENTITY OR INDIVIDUAL CLAIMING REFUND)**	**CT SALES TAX I.D.#**
COMPLETE NAME OF RETAILER	**CT SALES TAX I.D.#**
STREET ADDRESS, CITY OR TOWN, **STATE, AND ZIP CODE**	

INVOICE DATE	INVOICE NUMBER	GROSS AMOUNT OF SALES EXCLUDING TAX	PORTION OF SALE SUBJECT TO REFUND CLAIM	TAX COLLECTED AND PAID ON PORTION SUBJECT TO REFUND CLAIM	ITEM SOLD AND **REASON FOR REFUND**

ATTACH ADDITIONAL WORKSHEETS AS NEEDED.

DECLARATION BY RETAILER

I am the authorized representative of the retailer listed above. I declare under penalty of false statement that the figures above are true and correct for the sales indicated; that the sales tax shown was collected from this claimant and was remitted to the Department of Revenue Services; and that this retailer disclaims any interest in these sales taxes remitted to the Department of Revenue Services for the period / / through / / . Any refunds due are assigned to the claimant. The retailer understands that by signing this declaration it does not necessarily agree with the refund claim. (The penalty for false statement is imprisonment not to exceed one year or a fine not to exceed two thousand dollars, or both.)

NAME OF RETAILER (PLEASE PRINT)

SIGNATURE OF AUTHORIZED REPRESENTATIVE

DATE

NAME OF AUTHORIZED REPRESENTATIVE (PLEASE PRINT)

TITLE (PLEASE PRINT)

THIS SCHEDULE SHALL BE ATTACHED AND MADE A PART OF THE SALES TAX CLAIM OF CLAIMANT.