

Please print or type the following information

1. Employer information:

Business name: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____ County: _____

Physical location address

(if different from mailing address): _____

City: _____ State: _____ Zip code: _____ County: _____

2. Employment Security Department (ESD) number: _____

3. Employer representative: An employer representative must be provided to coordinate with Shared-Work Program staff in all matters pertaining to the employer plan and eligible employee claims.

| Primary employer representative | Alternate employer representative |
|---------------------------------|-----------------------------------|
| Name: _____ | Name: _____ |
| Job title: _____ | Job title: _____ |
| Email: _____ | Email: _____ |
| Phone: _____ Extension: _____ | Phone: _____ Extension: _____ |
| Fax: _____ | Fax: _____ |

4. What date were/(or will) work hours (be) reduced? _____
(month/day/year)

5. Estimated number of layoffs that would have occurred if you did not participate in Shared Work? _____

6. What is your plan to give advance notice to affected employees whose hours are/will be reduced?

- Memo or letter Email Staff meeting Other: Explain below

If advance notice is not feasible, please explain why:

7. Employer union-affiliation(s) information (if applicable): The employer's Shared-Work plan must be approved by the collective bargaining agreement for each affected employee under a collective bargaining agreement.

| | |
|---|---|
| Union: _____ Local: _____ | Union: _____ Local: _____ |
| Phone: _____ Extension: _____ | Phone: _____ Extension: _____ |
| <u>Authorized union representative name</u> | <u>Authorized union representative name</u> |
| Print: _____ | Print: _____ |
| Signature: _____ | Signature: _____ |

8. By your signature, you are certifying the following:

- You have a minimum of at least two employees who are enrolled in the Shared-Work plan.
- Affected employees were hired on a permanent basis.
- Health benefits will continue to be provided under the same terms and conditions as when the affected employee worked his/her usual weekly hours, unless health benefits changed for all your employees.
- Retirement benefits under a defined benefit plan or contributions under a defined contribution plan will continue to be provided under the same terms and conditions as when the affected employee worked his/her usual weekly hours, unless retirement benefits changed for all your employees.
- Paid vacation, holidays, and sick leave continue to be provided under the same terms and conditions as when the affected employee worked his/her usual weekly hours of work.
- You agreed to furnish all reports and information necessary for proper administration of your Shared-Work plan.
- Your participation is consistent with your obligations under federal and state law.
- If there are any changes to the information on this plan application or the plan participant list, you will notify Shared-Work program staff immediately.
- All information provided on this application is true and correct.

Employer signature: _____
 Owner, Proprietor, CEO, CFO, Corporate Officer

Title: _____ Date: _____

Employer name: _____
 Please print

