

NEW YORK STATE DEPARTMENT OF LABOR
 Unemployment Insurance Division
 Gov. W. Averell Harriman
 State Office Building Campus
 Albany, N.Y. 12240
 Phone: (518) 457-5806

SHARED WORK PLAN APPLICATION

TYPE or PRINT in black ink

Complete both sides

1. EMPLOYER NAME	2. UI EMPLOYER ACCOUNT NO. <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:15%; text-align:center;"> </td> <td style="width:15%; text-align:center;"> </td> <td style="width:15%; text-align:center;"> </td> <td style="width:15%; text-align:center;"> </td> <td style="width:15%; text-align:center;"> </td> <td style="width:15%; text-align:center;"> </td> </tr> </table>							
3. BUSINESS NAME (<i>Enter "same as No. 1"</i>)	4. LOCATION CODE, IF ANY <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:15%; text-align:center;">9</td> <td style="width:15%; text-align:center;">8</td> <td style="width:15%; text-align:center;"> </td> <td style="width:15%; text-align:center;"> </td> <td style="width:15%; text-align:center;"> </td> <td style="width:15%; text-align:center;"> </td> </tr> </table>		9	8				
9	8							
5. MAILING ADDRESS (<i>No., Street or P.O. Box, City, State, ZIP</i>)								
6. NAME OF CONTACT PERSON	7. TITLE	8. BUSINESS PHONE NUMBER						

9. This is A NEW PLAN A MODIFICATION OF AN EXISTING PLAN
10. PLAN START DATE: On what date (*must be a Monday date*) do you want this plan to become effective? _____
11. PLAN END DATE: On what date (*must be a Sunday date*) do you want this plan to end? _____
12. How many individuals do you employ on a full-time basis in New York State? _____
13. Please estimate how many people would have been laid off, if not for the Shared Work Program. _____
14. What is your specific type of business? _____
15. Are any employees who will participate in this plan covered by a collective bargaining agreement? Yes No
 (Each applicable collective bargaining agent must complete and sign a collective bargaining concurrence statement - see reverse.)
16. Are any employees who will participate in this plan paid wages derived from piece work? Yes No
 If yes, please provide details regarding piece work arrangements such as copies of any agreements, or descriptions of how such employees are paid.

17. Identification of Affected Units.

Affected Unit	Bargaining Agent	Number of Full Time Employees in Unit	Number Work Sharing Employees
A. _____	_____	_____	_____
B. _____	_____	_____	_____
C. _____	_____	_____	_____
D. _____	_____	_____	_____

FOR DEPARTMENT USE ONLY - DO NOT COMPLETE BELOW THIS LINE

DETERMINATION: Approval Disapproval. Reason(s): _____

BY: _____ DATE: _____

18. Please describe briefly the circumstances requiring your company's use of the Shared Work Program to avoid layoff:

19. EMPLOYER CERTIFICATION

We certify to the following:

- A. If not for this Shared Work program, there would have been a layoff to a degree equivalent to the total number of working hours proposed to be reduced or restricted for all employees included in this Shared Work program.
- B. Health insurance, medical insurance or any other fringe benefits provided to the employees immediately prior to the application will not be eliminated or diminished for the duration of the plan.
- C. Additional full-time or part-time employees will not be hired for the affected group for the duration of the plan.
- D. The purpose of the plan is to stabilize the work force during a period of temporary business decline, and it will not be used to subsidize employers who have traditionally used part-time employees.
- E. I understand that Shared Work benefit payments may be charged to my unemployment insurance account (experience rated or reimbursable).
- F. Reports necessary for the proper administration of the plan will be furnished to the Commissioner upon request, and access permitted to all records necessary to verify the plan before approval and to evaluate the application of the plan after approval.

EMPLOYER NAME (Type or Print) _____ TITLE _____

SIGNATURE _____ DATE _____

Signature must be of a corporate officer, sole proprietor or general partner.

20. COLLECTIVE BARGAINING AGENT(S) CONCURRENCE

1. Union Name: _____ 2. Union Name: _____

Local Number: _____ Local Number: _____

Telephone:() _____ Telephone:() _____

Signature: _____ Signature: _____

Name (Type or Print): _____ Name (Type or Print): _____

Title: _____ Title: _____

3. Union Name: _____ 4. Union Name: _____

Local Number: _____ Local Number: _____

Telephone:() _____ Telephone:() _____

Signature: _____ Signature: _____

Name (Type or Print): _____ Name (Type or Print): _____

Title: _____ Title: _____

IF YOU WISH TO PARTICIPATE IN THIS PROGRAM, RETURN THIS APPLICATION TO:

New York State Department of Labor
Unemployment Insurance Division
Liability and Determination Section
Gov. W. Averell Harriman
State Office Building Campus
Albany, N. Y. 12240
FAX: (518)485-6172

NEW YORK STATE DEPARTMENT OF LABOR - UNEMPLOYMENT INSURANCE DIVISION

SHARED WORK PLAN PARTICIPANT LISTING

Employer (Company Name) and Work Site Address			U.I. Employer Account No. (or Location Code)		Date	
Employee Name	Employee Social Security Number	Normal Full-Time Hours <u>/1</u>	Proposed Hours	Proposed Percent Reduction <u>/2</u>	Union Member Yes or No <u>/3</u>	Piece Workers Yes or No
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/1 Must be at least 35 but not more than 40 hours per week.

/2 Can be no less than 20% and no more than 60%.

/3 If yes, the collective bargaining agent(s) must concur (item 21 of form SW 2.1).