

**WORK SHARING (WS)
UNEMPLOYMENT INSURANCE PLAN APPLICATION**

1. Enter the following information as shown on the most recent DE 3DP/DE 9423, Quarterly Returns:

Employer Name: _____ Telephone Number: (____) _____

Mailing Address: _____

California Employer Account Number (Eight Digits): _____ - _____ - _____ - _____ - _____ - _____

2. Enter specific type of business:

3. Enter the employer name that will be used on WS Certifications:

4. Location(s) where WS will occur, if different from Section 1:

Employer Name: _____ Employer Name: _____

Address: _____ Address: _____

Telephone Number: (____) _____ Telephone Number: (____) _____

5. Is your business/organization a public entity? Yes No

If Yes, please enter an "X" in the box next to the type of public entity that best describes your organization:

City County State Federal School District Other (Specify) _____

6. Enter effective date of WS Plan (New or Renewal):

____/____/____

Note: The earliest effective date for a *new* WS Plan is the Sunday prior to the "first contact date" shown below in the "FOR EDD USE ONLY" box. The effective date for a *renewed* WS Plan is the day after the prior plan expires, providing the plan application is submitted no more than 10 days after the prior plan has expired.

A. If you are renewing your plan, how many additional Work Sharing Certifications, (DE 4581WS), do you need? _____

7. If you are adding employee(s) or work unit(s) to your existing plan, enter the effective date of the expanded coverage.

____/____/____

Note: The effective date is the Sunday prior to the date the expanded coverage will occur.

FOR EDD USE ONLY

First Contact Date ____/____/____ EFF. Date ____/____/____

New WS Plan Renewal Expanded WS Coverage

WS EE: _____ %: _____ SIC: _____ Union (Y or N) _____ Status (T or P) _____

8. Enter the estimated weekly percentage reduction in hours and wages of employees participating in the WS Plan: _____%

9. Please fill in the blanks (use additional paper if necessary):

<u>A. Work Unit(s) participating in WS</u>	<u>B. Number of employees in unit(s)</u>	<u>C. Number of employees participating in WS</u>
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
TOTAL: _____		TOTAL: _____

10. Please enter an "X" in the box next to the appropriate response:

A. Payroll periods are: Weekly Bi-Weekly Monthly Other (Specify) _____

B. If pay periods are weekly or bi-weekly, the payroll ending day is:

Mon Tues Wed Thur Fri Sat Sun

11. Is this WS Plan part of a transition to a permanent layoff or closure?

Yes No

12. Briefly describe the circumstances requiring your use of the WS program to avoid layoffs:

13. Are any participating employees covered by a union/collective bargaining agreement?

Yes No (If Yes, page 5 must be completed)

14. Your participation in the Work Sharing program is confidential. Occasionally the Employment Development Department receives requests for the names of companies that would be willing to share their experiences in this program. Are you willing to have your name released for this purpose?

Yes No

15. Please answer the following:

Does your WS Plan involve:

A. At least two employees? Yes No

B. At least 10% of your workforce or work unit(s)? Yes No

C. At least a 10% reduction in BOTH hours worked and wages? Yes No

THANK YOU FOR CHOOSING WORK SHARING!

WORK SHARING EMPLOYER'S HOLIDAY SCHEDULE

This schedule is a required part of the Work Sharing Unemployment Insurance Plan Application

This information is necessary to process your employees' Work Sharing (WS) payments. Work Sharing regulations state that a holiday cannot be used as a WS day unless an employee in the same position performed compensated services as part of an employee's regular paid work week during the 12 months prior to the employer's participation in the WS Program.

Indicate whether your company was open or closed due to holidays on the days listed below during the 12 months prior to the effective date of your WS Unemployment Insurance Plan Application. For example, if your WS Unemployment Insurance Plan is effective in January 2003, the 12 month period would be January 2002 through December 2002.

HOLIDAY	OPEN	CLOSED	COMMENTS
New Year's Eve	<input type="checkbox"/>	<input type="checkbox"/>	
New Year's Day	<input type="checkbox"/>	<input type="checkbox"/>	
Martin Luther King Jr. Day	<input type="checkbox"/>	<input type="checkbox"/>	
Lincoln's Birthday	<input type="checkbox"/>	<input type="checkbox"/>	
Washington's Birthday	<input type="checkbox"/>	<input type="checkbox"/>	
President's Day	<input type="checkbox"/>	<input type="checkbox"/>	
Cesar Chavez	<input type="checkbox"/>	<input type="checkbox"/>	
Good Friday	<input type="checkbox"/>	<input type="checkbox"/>	
Memorial Day	<input type="checkbox"/>	<input type="checkbox"/>	
July 4 th	<input type="checkbox"/>	<input type="checkbox"/>	
Labor Day	<input type="checkbox"/>	<input type="checkbox"/>	
Columbus Day	<input type="checkbox"/>	<input type="checkbox"/>	
Veteran's Day	<input type="checkbox"/>	<input type="checkbox"/>	
Thanksgiving	<input type="checkbox"/>	<input type="checkbox"/>	
Day After Thanksgiving	<input type="checkbox"/>	<input type="checkbox"/>	
Christmas Eve	<input type="checkbox"/>	<input type="checkbox"/>	
Christmas	<input type="checkbox"/>	<input type="checkbox"/>	
Other Holidays: Please list below			
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	

Please print or type the following information:

Date: ____/____/____

Employer Name: _____

California Employer Account Number (Eight Digits): ____ -- ____ - ____

Contact Person: _____

Position or Title: _____

CERTIFYING INFORMATION

1. We understand that if we are a participating employer using the tax rate method, our reserve account will be charged in the usual manner for benefits paid under this program. In addition, these charges may increase the employer's unemployment insurance contribution rate in future years.
2. We understand that if you are a participating reimbursable employer, we will be billed quarterly for the cost of benefits paid in the same manner as they are currently billed for other unemployment insurance benefits.
3. We understand that a holiday cannot be used as a Work Sharing day unless the employee(s), in the same position, performed compensated services as part of the employee(s) normal weekly hours of work on that holiday, during the twelve month period prior to the employer's participation in the Work Sharing program. Furthermore, we understand that we are not to issue certification forms to employees that contain a holiday as the only Work Sharing day. (Section 1279.5 of the California Unemployment Insurance Code).
4. We will provide the Employment Development Department with the weekly percent of reduction in hours and wages for each participating employee as a result of this Work Sharing program.
5. We understand that in order to be eligible, any employee must have worked at least one normal work week with no reductions prior to issuance of certification forms for benefit payment.
6. We understand that if any employee is working for a school district and/or non-profit entity providing services to a school district, we must provide the Employment Development Department with the dates individual employees are between successive academic terms and/or in a recess period. Furthermore, we understand that we are not to issue certification forms to employees for those weeks the employee is between successive terms or in a recess period, where there is reasonable assurance that the employee will return to work. (Section 1253.3 of the California Unemployment Insurance Code).
7. We understand that a plan approved by the Employment Development Department shall expire six months after its effective date. Expanded coverage approved to add other work unit(s) shall expire on the same date as the plan. A new plan may be approved immediately following the expiration of the previous plan if the employer submits the new plan prior to the expiration of the previous plan and the employer finds it necessary to provide employees with continuous coverage under this program.

We have provided the information on this form so that our employees may participate in the Work Sharing Unemployment Insurance program, in lieu of layoffs. We understand that failure to provide correct information, in accordance with this certification and in accordance with the provisions of the California Unemployment Insurance Code, could result in a denial or cancellation of this plan.

Employer Signature: _____ Date: ____/____/____

Private Business: Is the signature above of a corporate officer, sole proprietor or general partner? Yes No
If No is checked, this WS Plan Application will be returned for the appropriate signature.

Yes No (If No, this DE 8686 form will be returned for the appropriate signature)

Public Entity: Is the signature above of an executive officer or person with authorization, substantiated in writing, to sign?
 Yes No (If No is checked, this DE 8686 form will be returned for the appropriate signature.)

Please print or type the following information:

Name of person signing above: _____ Position or Title: _____

Contact Person: _____ Telephone Number: (____) _____

**IF THERE IS A UNION/COLLECTIVE BARGAINING AGREEMENT
PAGE FIVE MUST BE COMPLETED**

UNION/COLLECTIVE BARGAINING UNIT(S) CONCURRENCE

This page may be duplicated if additional signatures are required

The authorized union representatives certify that they have read and understand the "Certifying Information" on page four and agree that their membership may participate in the WS program.

<p><i>Please print or type the following information</i></p> <p>Union Name: _____</p> <p>Union Local Number: _____</p> <p>Telephone Number: (____) _____</p> <p>_____</p> <p>Name of Authorized Union Representative</p> <p>_____</p> <p>Position Title</p> <p>_____</p> <p>Authorized Union Representative Signature</p> <p>Date: ____/____/____</p>	<p><i>Please print or type the following information</i></p> <p>Union Name: _____</p> <p>Union Local Number: _____</p> <p>Telephone Number: (____) _____</p> <p>_____</p> <p>Name of Authorized Union Representative</p> <p>_____</p> <p>Position Title</p> <p>_____</p> <p>Authorized Union Representative Signature</p> <p>Date: ____/____/____</p>
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<p><i>Please print or type the following information</i></p> <p>Union Name: _____</p> <p>Union Local Number: _____</p> <p>Telephone Number: (____) _____</p> <p>_____</p> <p>Name of Authorized Union Representative</p> <p>_____</p> <p>Position Title</p> <p>_____</p> <p>Authorized Union Representative Signature</p> <p>Date: ____/____/____</p>	<p><i>Please print or type the following information</i></p> <p>Union Name: _____</p> <p>Union Local Number: _____</p> <p>Telephone Number: (____) _____</p> <p>_____</p> <p>Name of Authorized Union Representative</p> <p>_____</p> <p>Position Title</p> <p>_____</p> <p>Authorized Union Representative Signature</p> <p>Date: ____/____/____</p>
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<p>Return this application to:</p> <p>Employment Development Department Special Claims Office P. O. Box 419076 Rancho Cordova, CA 95741-9076</p>	<p>To order Work Sharing Certifications, DE 4581WS, call: (916) 464-3323</p> <p>For further information, call the Special Claims Office at: (916) 464-3343 or FAX (916) 464-2616</p>
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