

OFFICE OF UNEMPLOYMENT COMPENSATION BENEFITS

SHARED-WORK PLAN Application for Shared-Work Plan (Employer)

PART A: Employer Information

Employer Name:			Employer Account No.	
Street Address:				
Dity:			State:	Zip Code:
Phone Number:	Fax Number:			
Email:				
PART B: Plan Information				
Affected Unit Name:				
No. of weeks the plan will be in effect:(maximum 52 consecutive weeks) ¹		Reduction Percentage:percent (minimum 20 percent-maximum 40 percent)		
Percentage of normal work hours that each employee will work: Calculation of work hours: For weeks during the effective period of the Shared-Work Plan, each employee will work the number of hours determined by the following formula: employee's normal weekly hours of work x (100 percent–reduction percentage).				
Are any participating employees covered by a collective bargaining agreement (CBA)? YES NO If yes, Part D of this application must be executed by the authorized collective bargaining representative(s).				

¹The effective period of a Shared–Work Plan combined with effective periods of the participating employer's other Shared–Work Plan may not equal more than 104 weeks out of a 156–week period.

Will there be any weeks during the effective period of the plan when participating employees' hours will be reduced by more than the reduction percentage due to holidays, designated vacation periods, equipment maintenance or other similar circumstances?
□ YES □ NO
If yes, indicate all dates that apply.

PART C: Participating employees in the affected unit (minimum of 2, determined without regard to participating employees who are corporate officers)²

Social Security No.	Name	Normal Work Hours	Work Hours Under Shared-Work Plan

- a. An employee who has been employed in the affected unit for less than 3 months prior to the date the employer applies for approval of the Shared-Work Plan.
- b. An employee who works 40 or more hours per week after his or her hours are reduced by the reduction percentage.

² All employees in the affected unit MUST be participating employees, except the following, who cannot participate:

Part D: Collective Bargaining Representative(s) Consent

The authorized collective bargaining representatives certify that they approve the Shared–Work Plan set forth in this application.

Union Name:	Union Name:
Union Local Number:	Union Local Number:
Telephone Number: ()	Telephone Number: ()
Name of Authorized Union Representative	Name of Authorized Union Representative
Position Title	Position Title
Authorized Union Representative Signature Date://	Authorized Union Representative Signature Date://
11 · N	
Union Name:	Union Name:
Union Name: Union Local Number:	Union Name: Union Local Number:
Union Local Number:	Union Local Number:
Union Local Number: Telephone Number:	Union Local Number: Telephone Number:
Union Local Number: Telephone Number: Name of Authorized Union Representative	Union Local Number: Telephone Number: Name of Authorized Union Representative
Union Local Number: Telephone Number: Name of Authorized Union Representative Position Title	Union Local Number: Telephone Number: Name of Authorized Union Representative Position Title

Part E: Assurances and Certifications

The employer makes the following assurances and certifications, all of which are material elements of this application:

- 1.) The employer will provide reports to the department relating to the operation of its Shared–Work Plan at the times and in the manner prescribed by the department and containing all information required by the department.
- 2.) The employer will not hire new employees in, or transfer employees to, the affected unit during the effective period of the Shared–Work Plan.
- 3.) The employer will not lay off participating employees during the effective period of the Shared–Work Plan or reduce participating employees' hours of work by more than the reduction percentage during the effective period of the Shared-Work Plan, except in cases of holidays, designated vacation periods, equipment maintenance or similar circumstances, as disclosed in Part B of this application.
- 4.) As a result of the decrease in the number of hours worked by each participating employee, there is a corresponding reduction in wages.
- 5.) The plan does not affect the fringe benefits of any participating employee not covered by a collective bargaining agreement.
- 6.) Implementation of this Shared–Work Plan is in lieu of temporary layoffs that would affect at least 10 percent of the employees in the affected unit.
- 7.) The reduction percentage is the same for all participating employees.
- 8.) The reduction percentage will not change during the period of the Shared–Work Plan unless a modified plan is approved by the department.
- 9.) The employer will abide by all terms & conditions of Article 13 of the Pennsylvania Unemployment Compensation Law.

Please sign and return your completed application to the Office of UC Benefits, ATTN: Shared–Work, 651 Boas St., Room 605, Harrisburg, PA 17121. If you have any questions regarding the application process, call 877-785-1531.

Employer Signature	Date	
Title	_	

FOR DEPARTMENT USE ONLY

DEPARTMENT SIGNATURE :		
DATE:	TITLE:	
PLAN NUMBER:		

Auxiliary aids and services are available upon request to individuals with disabilities. Equal Opportunity Employer/Program