pennsylvania
DEPARTMENT OF LABOR & INDUSTRY

OFFICE OF UNEMPLOYMENT COMPENSATION BENEFITS

SHARED–WORK PLAN
Biweekly Claim Form–Employer

Employer Name:		Plan Number:	
Street Address:			
City:		State:	Zip Code:
Phone Number:	Fax Number:		
Email:			

Refer to Instructions on Page 2 of this form.

WEEK 1: _____/_____/_____ MM DD YYYY	WEEK 2: _____/_____/_____ MM DD YYYY

Please complete this section for employees participating in the Shared–Work Plan. List the number of hours the employee was paid for each claim week. If the employee was paid for time off for any reason, **include** those hours. **Do not include** unpaid time off. If you need additional space, please complete additional copies of this form.

Social Security No.	Name	Hours Paid	
		Week 1	Week 2

Employer Signature

Date

Title

Instructions:

To file claims for Shared–Work UC for participating employees, complete this form (in black ink) after the second claim week ends. Once you have signed and dated this claim form, mail it to the office address shown below within seven days of the end of the second week.

You will file for two consecutive weeks on this form. A week begins on Sunday and ends on Saturday, regardless of your pay period schedule. Write the week-ending dates of the weeks for which you are filing in the WEEK 1 and WEEK 2 areas on the front of this form.

Below are examples showing when to mail the claim form.

Filing Two Consecutive Weeks		
Week 1 Ending Date	Week 2 Ending Date	Mail The Claim Form
7/16/2011	7/23/2011	7/24–7/30/2011

Office Address:

Office of UC Benefits
ATTN: Shared–Work
651 Boas St., Room 605
Harrisburg, PA 17121
877-785-1531

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