

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

1. Enter the following information as shown on the most recent *Quarterly Contribution Return and Report of Wages, DE 9*, or the *Quarterly Contribution Return for School Employers, DE 9423*:

Employer Name: _____ Telephone Number: (____) _____

Mailing Address: _____

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

2. Enter specific type of business:

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

4. Location(s) where Work Sharing 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 Work Sharing Plan (New or Renewal) you are requesting:
____ / ____ / ____

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) _____ Layoff (Y or N) _____

8. Are the employees who will participate in the Work Sharing Plan part of the employer's permanent regular full-time or part-time workforce? Yes No

If not, specify the number of employees who are leased, temporary, seasonal, or intermittent.

A. Work unit(s) participating in WS	B. Number of employees in unit(s)	C. Number of leased, temporary, seasonal, or intermittent employees in unit(s) in WS
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
	TOTAL: _____	TOTAL: _____

9. Please provide the information on your regular full-time and part-time workforce who will be covered by the Work Sharing Plan by filling in the blanks below (Use additional paper if necessary).

A. Work unit(s) names participating in WS	B. Number of employees in unit(s)	C. Number of employees participating in WS (Number of participants must match your roster on page 5)	D. Usual weekly hours for employees in the affected unit	E. Specific % of hours reduced or to be reduced
1. _____	1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____	2. _____
3. _____	3. _____	3. _____	3. _____	3. _____
	TOTAL: _____	TOTAL: _____	TOTAL: _____	TOTAL: _____

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

- A. Pay 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 Work Sharing Plan being used to prevent layoffs or closure of your business? Estimate the number of employees who would have been laid off in the absence of participating in the Work Sharing Plan.

Yes No

If yes, provide the number of employees who would need to be laid off: _____

12. Briefly describe the circumstances requiring your use of the Work Sharing program:

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 on the holidays 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 July 2014, the 12 month period would be July 2013 through June 2014.

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"/>	
Veterans 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: _____

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

Contact Person: _____ Phone Number: (____) _____

Position or Title: _____

Work Sharing Employee Roster

(Copy this page if additional space is needed.)

#	Full Employee Name	Full Employee SSN	Hire Date	Work Unit Name
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				

Note: Number of employees on roster must match what is requested on the plan.

In accordance with Section 621(2) of the CUIC, are any of the names above corporate officers or the sole or major stockholder(s) who are deemed to have significant investment in company facilities? Yes No

A. If yes, please list the names:

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 7 and agree that their membership may participate in the Work Sharing program. 1279.5 (p)

<i>Please print or type the following information.</i>	<i>Please print or type the following information.</i>
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	Authorized Union Representative Signature
_____	_____
Date: _____ / _____ / _____	Date: _____ / _____ / _____

<i>Please print or type the following information.</i>	<i>Please print or type the following information.</i>
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	Authorized Union Representative Signature
_____	_____
Date: _____ / _____ / _____	Date: _____ / _____ / _____

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. [Section 1279.5(m) of the California Unemployment Insurance Code (CUIC)].
2. We understand that if we 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. [Section 1279.5(m) of the CUIC].
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 12 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(c)(3) of the CUIC].
4. We will provide the Employment Development Department with the weekly percentage of reduction in hours and wages for each participating employee as a result of this Work Sharing program. [California Code of Regulations, Title 22, Section 1279.5-5,(a)(7)(11)].
5. We understand that we are not to utilize the Work Sharing program only for total layoffs during holiday weeks as this is in conflict with state law, which limits participation in the Work Sharing program to those employers who plan to reduce employees' hours of work, in lieu of layoff, to stabilize the work force by a sharing of the remaining work. [Section 1279.5 (c)(3) of the CUIC].
6. 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. [Section 1279.5(a) of the CUIC].
7. 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. [Section 1253.3 of the CUIC].
8. We understand that a plan approved by the Employment Development Department shall expire 12 months after its effective date. Expanded coverage approved to add other work unit(s) shall expire on the same date as the originally approved 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 or within 10 days from the expiration date. [Section 1279.5(e) of the CUIC].
9. We understand that health benefits must be maintained at the same level as prior to the reduction in hours and wages or to the same extent as employees not participating in the plan unless the reduction in health benefits is applied equally to employees not participating in the Work Sharing program during the duration of the plan. [Section 1279.5 (c)(4) of the CUIC].
10. We understand that retirement benefits must be maintained at the same level as prior to the reduction in hours and wages or to the same extent as employees not participating in the plan unless the reduction in retirement benefits is applied equally to employees not participating in the Work Sharing program during the duration of the plan as required. [Section 1279.5 (c)(4) of the CUIC].
11. We understand that we must agree to furnish reports as requested by the Employment Development Department; allow the Department to access all records necessary to approve or disapprove the Work Sharing Plan; and allow the Department to periodically monitor and evaluate the Work Sharing Plan after it is approved. [Section 1279.5 (c)(6)(A-D) of the CUIC].
12. We understand that if we have any modifications during the approved plan period, we must submit the specifics of the changes in writing to the Employment Development Department promptly. The Employment Development Department will review the modifications and will approve or disapprove the plan pursuant to the Work Sharing laws governing plan approvals. [Section 1279.5(g) of the CUIC].
13. We understand and certify that participation in the Work Sharing Plan is consistent with the employer's obligation under applicable federal and state laws. [Section 1279.5(c)(7) of the CUIC].

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. I certify that I agree to these terms.

Employer Signature: _____ Date: ____/____/____

Private Business: Is the signature above of a corporate officer, sole proprietor, or general partner?

Yes No (If No, this *Work Sharing Unemployment Insurance Plan Application*, 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, this *Work Sharing Unemployment Insurance Plan Application*, 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 6 MUST BE COMPLETED

Return this application to: Employment Development Department Special Claims Office P. O. Box 419076 Rancho Cordova, CA 95741-9076	To order <i>Work Sharing Certifications</i> , DE 4581WS, call: 916-464-3323. For further information, call the Special Claims Office at: 916-464-3343 or FAX 916-464-2616.
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THANK YOU FOR CHOOSING WORK SHARING!