



# Work Sharing (WS) Unemployment Insurance Plan Application

Mail: Employment Development Department Special Claims Office

PO Box 419076, Rancho Cordova, CA 95741-9076

Questions? 916-464-3343

1) Please select the box of the type of Work Sharing plan you would like to file:

<input type="checkbox"/> <b>New</b>	<input type="checkbox"/> <b>Renewal</b>	<input type="checkbox"/> <b>Expanded Coverage</b>
Requested plan start date (must be a Sunday): _____		

*Note: To renew a plan a new application must be received no later than 10 days after the expiration date of the prior plan. If renewing, how many additional Work Sharing Certifications, DE 4581WS do you need? \_\_\_\_\_*

2) Employer Information

Name/DBA: \_\_\_\_\_

Business Type: \_\_\_\_\_

Employer Account Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

3) Employer Contact Information

Primary Contact

Alternate Contact

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

4)  **Yes**  **No** Will the Work Sharing occur in a different location than the address provided above? If yes, please provide the alternate contact and location information below:

Name (if different): \_\_\_\_\_

Name (if different): \_\_\_\_\_

Phone Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

5)  **Yes**  **No** Is your business/organization a public entity? Please check the appropriate box below.

<input type="checkbox"/> <b>City</b>	<input type="checkbox"/> <b>County</b>	<input type="checkbox"/> <b>State</b>	<input type="checkbox"/> <b>Federal</b>	<input type="checkbox"/> <b>School District</b>	<input type="checkbox"/> <b>Other</b> (Specify) _____
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6)  **Yes**  **No** Your participation in the Work Sharing program is strictly confidential. Occasionally the Employment Development Department (EDD) receives requests for the names of companies that would be willing to share their experiences with this program. Are you willing to have your name and contact information released for this purpose?

7) Fill in the table for the full-time and part-time workforce who will be covered by the Work Sharing plan.

a) Department/ Unit Name	b) Number of employees in Dept/Unit	c) Number of employees in Dept/Unit who will participate in WS	d) Usual weekly hours of employees in affected Dept/Unit	e) Estimated % of weekly hours reduced
1.				
2.				
3.				

**Total:** \_\_\_\_\_

**Total:** \_\_\_\_\_

**Total:** \_\_\_\_\_

**Total:** \_\_\_\_\_

<b>EDD USE ONLY</b>				
First Contact Date: _____		Effective Date: _____		
WS EE: _____	%: _____	SIC: _____	Union (Y/N) _____	Layoff (Y/N) _____

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8) Check the box below with the appropriate pay period cycle:

<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>Bi-weekly</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Other</b> (Specify) _____
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If your pay period is weekly or bi-weekly, select the payroll ending day below:

<input type="checkbox"/> <b>Mon</b>	<input type="checkbox"/> <b>Tues</b>	<input type="checkbox"/> <b>Wed</b>	<input type="checkbox"/> <b>Thur</b>	<input type="checkbox"/> <b>Fri</b>	<input type="checkbox"/> <b>Sat</b>	<input type="checkbox"/> <b>Sun</b>
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9)  **Yes**  **No** If you were not approved to participate in the Work Sharing program, would your business lay off workers?

10) Estimate the number of employees who would need to be laid off if you were not participating in the Work Sharing program: \_\_\_\_\_

11) Describe the circumstances requiring your use of the Work Sharing program:

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12) How do you plan to notify your employees of the Work Sharing program?

<input type="checkbox"/> <b>Memo/Letter</b>	<input type="checkbox"/> <b>Email</b>	<input type="checkbox"/> <b>Staff Meeting</b>	<input type="checkbox"/> <b>Other</b> (Specify) _____
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13)  **Yes**  **No** Will advance notice be given to the affected employees?

If not, please explain why advance notice is not feasible:

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14)  **Yes**  **No** Are any participating employees covered by a union/collective bargaining agreement?

If yes, the below section(s) must be completed:

<b>Union Name:</b> _____	<b>Union Local Number:</b> _____	<b>Phone Number:</b> _____
<b>Name of Authorized Union Representative:</b> _____		<b>Position Title:</b> _____
<b>Authorized Union Representative Signature:</b> _____		<b>Date:</b> _____

<b>Union Name:</b> _____	<b>Union Local Number:</b> _____	<b>Phone Number:</b> _____
<b>Name of Authorized Union Representative:</b> _____		<b>Position Title:</b> _____
<b>Authorized Union Representative Signature:</b> _____		<b>Date:</b> _____

15) Does your Work Sharing plan involve:

a.  **Yes**  **No** At least two employees?

b.  **Yes**  **No** At least 10 percent of your workforce or work unit(s)?

c.  **Yes**  **No** At least a 10 percent reduction and no more than 60 percent in BOTH hours worked and wages each week?

16)  **Yes**  **No** Will a reduction in *health* benefits be scheduled to occur during the duration of the WS plan? If yes, answer the following question.

a.  **Yes**  **No** If so, will those reductions be applied equally to all employees (including those who are not participating in the WS plan)?

17)  **Yes**  **No** Will a reduction in *retirement* benefits be scheduled to occur during the duration of the WS plan? If yes, answer the following question.

a.  **Yes**  **No** If so, will those reductions be applied equally to all employees (including those who are not participating in the WS plan)?

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**By signing this application, we understand and certify the following is true and correct:**

1. We understand that by participating in the WS program our reserve account will be charged in the usual manner or may have an adverse effect on our tax rate.
2. We understand that if we are a participating reimbursable employer, we will be billed quarterly for the cost of benefits paid.
3. We understand that we are not to utilize the WS program for total layoffs during the holiday weeks.
4. We understand that a holiday cannot be used as a WS day unless the employee(s) in the same position performed services (and was paid for those services) as a part of a regular work week, during the 12 months prior to the employer's participation in the WS program.
5. We understand that any employee on the WS program must have worked at least one normal work week with no reductions prior to the issuance of certification forms for benefit payments.
6. We understand that if employees are attached to a school district and/or non-profit entity that we will provide dates the employee(s) are between successive academic terms/recess periods.
7. We understand that the plan approved by the EDD shall expire 12 months after its effective date.
8. We understand that we must continue to provide health and retirement benefits under the same terms and conditions as when the affected employees worked his/her usual weekly hours, unless health/retirement benefits change for all employees (including employees not participating in the WS plan).
9. We understand that we must provide the weekly percentage of reductions in hours and wages for each participating employee, and we must furnish all reports and information as requested by the EDD to monitor and review our WS plan.
10. We understand that we must notify the EDD immediately if there are any changes to the information on this plan application, and that we must submit the specific changes in writing for review and approval.
11. We understand that leased or temporary service employees that are provided by another employer or that we provide to other employers, cannot be covered under the WS plan.
12. We understand that participating in the WS program is consistent with the employer's obligation under applicable federal and state laws.



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### Work Sharing Employer's Holiday Schedule

A holiday schedule is necessary to process employee's WS payments. Please indicate which holidays your company was open/closed during the 12 months prior to the start of your WS plan.

**Employer Account Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

HOLIDAY	OPEN	CLOSED	COMMENTS
New Year's Eve	<input type="checkbox"/>	<input type="checkbox"/>	
New Year's Day (Observed)	<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 Day	<input type="checkbox"/>	<input type="checkbox"/>	
Good Friday	<input type="checkbox"/>	<input type="checkbox"/>	
Memorial Day	<input type="checkbox"/>	<input type="checkbox"/>	
July 4 <sup>th</sup>	<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 Day (Observed)	<input type="checkbox"/>	<input type="checkbox"/>	
Other Holidays: Please list below			
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	

I have provided the information on this form so that our employees may participate in the Work Sharing Unemployment Insurance program. I understand failure to provide correct information, in accordance with this certification and in accordance with the provisions of the California Unemployment Insurance Code (CUIC), could result in a denial or cancellation of this plan. I certify that I agree to all Work Sharing terms per **Section 1279.5 of the CUIC**. If signing this form electronically, I understand and acknowledge that this electronic signature has the same meaning and validity as my handwritten signature. I further attest that I have signature authority with the named employer.

\*If a private business, below signature must be of corporate officer, sole proprietor, or general partner.

\*If a public entity, below signature must be of executive officer or person with authorization.

**Authorized Signature:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please complete the WS Employee Participant Roster on page 5 and ensure the number of employees listed matches the total number of employees listed on page 1, question 7c.**

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### Work Sharing Employee Participant Roster

\*Employee Participant Roster must match the number indicated on Question #7c on page 1 of 5.

Employer Account Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employee's Full Name	Employee's Full SSN	Department/ Work Unit Name	Indicate if WS employee is a Corporate Officer or Sole or Major stockholder ( Yes / No )	If applicable, enter title/role of Corporate Officer or Sole or Major stockholder
1.				
2.				
3.				
4.				
5.				
6.				
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10.				
11.				
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25.				
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27.				
28.				
29.				
30.				

**NOTE: A complete list of employees participating must be included with your application. Copy this page if additional space is needed. The WS plan cannot be approved without a WS Employee Participant Roster.**