

Shared Work Compensation Plan Application



Employment Security Department
WASHINGTON STATE

1. Company Information:

Name: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

Physical address location (if different from mailing address): _____

City: _____ State: _____ Zip code: _____

Phone: _____ Fax: _____

E-mail: _____ County: _____

2. Employment Security (ES) Tax Reference Number:

United Business Identifier (UBI) Number: _____

Type of Business: _____

3. Your company must designate an employer representative responsible for being the contact and coordinating with the Shared Work Administrative Unit. Please provide this information below.

Name: _____ Job title: _____ E-mail: _____

Phone: _____ Extension: _____ Fax: _____

4. Alternate Employer Representative information:

Name: _____ Job title: _____ E-mail: _____

Phone: _____ Extension: _____ Fax: _____

5. Have you ever had a previously approved Shared Work plan? Yes: No:

6. When do you anticipate reducing weekly work hours? _____

7. Employer Certification -- I certify to the following:

- We will identify all of the affected hourly employees working full-time 35 to 40 hours a week and the affected employees assigned work shift.
- We will continue to maintain health benefits while hours are reduced.
- We will furnish all reports and information necessary for the proper administration of the plan to the Shared Work Administrative Unit.

8. **Modification Statement:** Authorization to modify the Shared Work Plan allows an employer to adjust the reduction of weekly work hours for participating employees or add employees to an existing plan. Any changes must meet the requirements of the original approved plan.

Our business would like the flexibility to modify our plan? Yes: No:

9. Employer signature: _____

Title: _____ Date: _____

10. Collective Bargaining Agent Information (if applicable):

Name: _____ Union: _____

Signature: _____ Local: _____