
APPLICATION FOR APPROVAL OF WORK SHARING UNEMPLOYMENT INSURANCE PLAN

___ New Request ___ Modification

I. Employer Information

1. Name: _____ Doing Business As: _____

2. Mailing Address: _____

State: _____ Zip Code _____ 3. Telephone No.: _____

4. MD Employer Number: 00 _____

Location where Work Sharing will occur if not the same as above

1. Name: _____ Doing Business As: _____

2. Address: _____

II. Plan Information

1. On what date (must be a Sunday) do you want this plan to become effective? _____

2. On what date (must be a Saturday) do you want this plan to end? up to 6 months _____

3. What is the percentage reduction in hours of work? minimum 20% maximum 50% _____%

4. Do you anticipate a reduction of more than 50% of the Normal Work Hours of any Unit? __ Yes __ No

5. Is this reduction in work hours in lieu of layoffs? ___ Yes ___ No

6. How many employees will be laid off in the absence of this plan? _____

7. What is the reason for the reduction? _____

8. Are any employees who will participate in this plan covered by a Collective Bargaining Agreement? ___ Yes ___ No

a. If Yes – the collective bargaining agent must complete and sign in Section IV

b. If No – a representative of the employees or employee’s association must complete and sign Section IV.

9. Identification of affected units-attach additional page if necessary



Table with 4 columns: Affected Unit (Name of Specific Plant, Dept. Unit), Bargaining Agent, Number of Employees in Unit, Number of Work Sharing Employees. Rows a, b, c.

10. Will benefits be affected if work hours of the affected employees are reduced to less than their normal weekly hours of work? Yes No If Yes, how? :

11. Did you notify your employees about your application for Work Sharing? If, yes how
If no, why

We hereby certify under penalties of perjury that the information submitted with this application for approval of a Work Sharing Unemployment Plan is true and correct to the best of our knowledge, information and belief.

Employer Signature: Contact Person:
Name (Type or Print): Telephone Number
Title: Date:

IV. Representative of Employee's Association or Collective Bargaining Agent

1. Name: 2. Name:
Telephone Number: Telephone number:
Signature: Signature:

The Deputy Assistant Secretary of the MD Department of Labor will approve or disapprove this plan in writing within fifteen (15) days. The decision of the Deputy Assistant Secretary is final. If this plan is approved, the Deputy Assistant Secretary may revoke this plan at any time for non-compliance with the terms of this agreement. If this plan is disapproved, you may submit another plan fifteen (15) days after the disapproval.

Date received in the Office of the Deputy Assistant Secretary:
Recommendation: Approved Disapproved
Why: Final: Approved Disapproved
, Deputy Assistant Secretary

III. Certification

We certify to the following:

- The Plan applies to and identifies the specified affected group and each employee on the plan was continuously employed by our company for the three months immediately prior to submission of this plan
- This plan is effective for no more than 6 months
- The Plan includes an estimate of the number of layoffs that might occur absent participation in the Work Sharing program
- The hours of work for each affected employee will be reduced by not less than twenty (20) percent and not more than fifty (50) percent
- The Plan applies to all employees in the affected group and provides equal treatment to all employees of the group for all weeks of the plan
- The Plan shall not serve as a subsidy for seasonal, temporary part-time or intermittent employment
- The Plan shall not be used during normal or expected fluctuations in economic activity that are an inherent part of an industry or occupation
- The Plan shall not be used by an employer as a payroll subsidy on a long-term basis for usual operations
- The proposed plan or a summary has been made available to each affected employee or to the collective bargaining representative for inspection. A description of how the plan was made available has been provided or if notice of the plan was not feasible, an explanation of why advance notice was not feasible has been provided
- That we will furnish reports relating to proper conduct of the plan and agree to allow the authorized representatives access to all records necessary to verify the plan prior to approval and after approval, to monitor and evaluate application of the plan
- That if this plan is intended as a transition to a permanent staff reduction, notification will be provided to the Division of Unemployment Insurance for assistance in developing a Reemployment Assistance Plan
- That we understand that the plan may be revoked if there is conduct that tends to defeat the intent, there is a failure to comply, there is an unreasonable revision or any violation of the criterion on which the plan was approved
- That we will not hire new employees in, or transfer employees to, the affected unit while the plan is in effect
- That we are aware of the potential effects on our UI Account if benefits are paid
- That we understand that the health and retirement benefits of the affected employees will continue to be provided as though their work weeks had not been reduced. However, if the level of benefits for employees who are not in the Work Sharing group are reduced then the level of benefits for Work Sharing Employees may be reduced by a like amount
- On the most recent computation date preceding the date of the submission of the Work Sharing Plan for approval, the total of all contributions paid on the employing unit's own behalf and credited to its account for all previous periods are current
- That we agree that the terms and implementation of the Work Sharing Plan are consistent with any obligation I have under federal and state laws