Work Sharing (WS) Unemployment Insurance Plan Application

Mail: Employment Development Department Work Sharing Program
PO Box 989060, West Sacramento, CA 95798-9007
Questions? 916-464-3343

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

☐ **New** ☐ **Renewal** ☐ **Expanded Coverage**
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.

☐ **City** ☐ **County** ☐ **State** ☐ **Federal** ☐ **School District** ☐ **Other** (Specify) _____

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:** _____

EDD USE ONLY

First Contact Date: _____ Effective Date: _____

WS EE: _____ %: _____ SIC: _____ Union (Y/N) _____ Layoff (Y/N) _____

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

☐ **Weekly** ☐ **Bi-weekly** ☐ **Monthly** ☐ **Other** (Specify) _____

If your pay period is weekly or bi-weekly, select the payroll ending day below:

☐ **Mon** ☐ **Tues** ☐ **Wed** ☐ **Thur** ☐ **Fri** ☐ **Sat** ☐ **Sun**

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:

_____

_____

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

☐ **Memo/Letter** ☐ **Email** ☐ **Staff Meeting** ☐ **Other** (Specify) _____

13) ☐ **Yes** ☐ **No** Will advance notice be given to the affected employees?
If not, please explain why advance notice is not feasible:

_____

_____

14) ☐ **Yes** ☐ **No** Are any participating employees covered by a union/collective bargaining agreement?
If yes, the below section(s) must be completed:

Union Name: _____ **Union Local Number:** _____ **Phone Number:** _____
Name of Authorized Union Representative: _____ **Position Title:** _____
Authorized Union Representative Signature: _____ **Date:** _____

Union Name: _____ **Union Local Number:** _____ **Phone Number:** _____
Name of Authorized Union Representative: _____ **Position Title:** _____
Authorized Union Representative Signature: _____ **Date:** _____

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)?

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.

Employment Development Department
State of California

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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	☐	☐	
New Year's Day (Observed)	☐	☐	
Martin Luther King Jr. Day	☐	☐	
Lincoln's Birthday	☐	☐	
Washington's Birthday	☐	☐	
President's Day	☐	☐	
Cesar Chavez Day	☐	☐	
Good Friday	☐	☐	
Memorial Day	☐	☐	
July 4th	☐	☐	
Labor Day	☐	☐	
Columbus Day	☐	☐	
Veterans Day	☐	☐	
Thanksgiving	☐	☐	
Day After Thanksgiving	☐	☐	
Christmas Eve	☐	☐	
Christmas Day (Observed)	☐	☐	
Other Holidays: Please list below	☐	☐	
	☐	☐	
	☐	☐	

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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State of California

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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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8.				
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10.				
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26.				
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.