



Work Share Plan Application

Please print or type the following information

1. Employer Information

Business Name:

Mailing Address: City: State: Zip Code:

Physical Address (If different from mailing): City: State: Zip Code:

2. Business Identification Number (BIN):

3. Employer Representative: An employer representative must be provided to coordinate with Work Share Program staff in all matters pertaining to the employer plan and eligible employee claims.

Primary Employer Representative:		Alternate Employer Representative:	
Name:		Name:	
Job Title:		Job Title:	
Email:		Email:	
Phone:	Ext:	Phone:	Ext:
Fax:		Fax:	

4. Requested plan start date (Must be a Sunday date): (month/day/year) Plans expire after one year.

5. Estimated number of employees affected: **6. How many layoffs will you avoid?**

7. Health or retirement benefits will not be affected if work hours are reduced to less than normal weekly hours. Please @

8. Provide a description of how the Work Share program will be implemented:

9. How do you plan to notify your employees of the Work Share plan?

10. Employer union-affiliation(s) information (if applicable): The employer's Work Share plan must be approved by the collective bargaining agent for each affected employee under a collective bargaining agreement.

Union: Local: Authorized Union Rep. Name: Phone: Ext: By signing below I approve the named employer applying for a Work Share Plan. I further attest that I have signature authority with the named union. If I am signing this form electronically, I understand and acknowledge that this electronic signature has the same meaning and validity as my handwritten signature. Signature: Date:	Union: Local: Authorized Union Rep. Name: Phone: Ext: By signing below I approve the named employer applying for a Work Share Plan. I further attest that I have signature authority with the named union. If I am signing this form electronically, I understand and acknowledge that this electronic signature has the same meaning and validity as my handwritten signature. Signature: Date:
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Please check each box to show you are certifying the following:

1. I have at least three employees participating in the program.
2. I continuously employed each employee affected by this agreement for at least six months on a full time basis or at least one year on a part time basis, (and not on a seasonal, temporary or intermittent basis) prior to the start of the plan.
3. The employees' normal weekly work hours will be reduced by at least 20% but no more than 40%, with a corresponding reduction in wages.
4. I am aware that participation in the Work Share program may have an adverse effect on my Unemployment Insurance tax rate.
5. I will continue to provide health benefits under the same terms and conditions as when the affected employee worked his/her usual weekly hours, unless health benefits change for all my employees.
6. I will continue to provide retirement benefits under a defined benefit plan or contributions under a defined contribution plan under the same terms and conditions as when the affected employee worked his/her usual weekly hours, unless retirement benefits change for all my employees.
7. I will provide paid vacation, holidays, and sick leave under the same terms and conditions as when the affected employee worked his/her usual weekly hours of work.
8. I agree to furnish all reports and information necessary for proper administration of my Work Share plan.
9. I have provided all employees participating in my Work Share plan with the Initial Claim application (included in the Work Share Application Packet).
10. I will notify the Employment Department immediately if there are any changes to the information on this plan application or the plan participant list.

By clicking the Submit button below, I agree to abide by all state and federal unemployment laws and attest that all information provided on this application is true and correct.

By 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.

Authorized Signature:

Title:

Print Name:

Date:

NOTE: You must include a list of employee participants with your application. Your plan cannot be approved without the Participant List. Once you have attached the application to the email, by clicking the button below, you must attach the Participant List to the same email.

**Oregon Employment Department • Attn: UI Special Programs Center • 875 Union St. NE • Salem • Oregon • 97311 •
Fax: (503) 947-1833 • www.OregonWorkShare.com • Email: oed_workshare@oregon.gov**

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Disclaimer: If you send this form via email, it may not be secure. If you do not utilize email encryption software we advise you contact the UI Special Program Center at (503) 947-1800 or (800) 436-6191 to sign up with our secure email server. By clicking the submit button you acknowledge that you are responsible for ensuring the protection of the personally identifiable information included in this email.