KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

SHARED WORK PLAN APPLICATION

K-BEN 101 (Rev. 7-16)

MAIL: Unemployment Contact Center
P.O. Box 3539
Topeka, KS 66601-3539
FAX: (785) 296-1858

Return this completed application as directed above. A determination of your company's eligibility to participate in the Shared Work Program will be made and you will be notified by letter.

A EMPLOYER INFORMATION

Company name: ______________________ Employer Serial number: ____________

Mailing address: ______________________

City: ______________ State: ________ ZIP: __________ Phone: (______) ____________

Affected unit: ______________ Number of workers: ________ Number of affected workers: ________

Regular work hours per week: __________ Plan to reduce hours from: ________ % to ________ %

Will reduction in hours affect participating employees' fringe benefits? ☐ YES ☐ NO If YES, explain: ______________

____

____

B EMPLOYER CERTIFICATION (To be completed by the person authorizing the implementation of the program)

I certify that the implementation of this Shared Work Plan and the resulting reduction in work hours is in lieu of temporary layoffs that affect at least 10% of the affected unit. I have provided a list identifying the affected employees by name and Social Security number. I understand that during the time the Shared Work Plan is in effect, the Kansas Department of Labor (KDOL) will submit a list of those employees in the affected unit to me weekly. I am responsible for completing the form and submitting it directly to KDOL every week hours are reduced. By submitting this form electronically, I certify I am responsible for the information.

Printed name: ______________________ Title: ______________________

Employer or representative signature: ______________________

Date (mm/dd/yyyy): ______________ Email: ______________________

C COLLECTIVE BARGAINING INFORMATION (If there is such an agreement, to be completed by bargaining unit)

Union name: ______________________ Local number: __________

Union official: ______________________ Title of official: ______________________

Signature: ______________________ Date (mm/dd/yyyy): ______________

FOR AGENCY USE ONLY

Application received: __________ Employer current? ☐ YES ☐ NO Initials ______ Date: ________

Reduced weekly hours: ________ Normal weekly hours: __________ Payroll week ending: __________

Determination: ☐ Denied ☐ Approved Beginning date: __________ Ending date: __________

Reason for denial: ______________________

Examiner: ______________________ Date: ________ **PLAN NO.** ________ **SUB PLAN NO.** ________

D IDENTIFICATION OF AFFECTED EMPLOYEES

EMPLOYEE NAME	SOCIAL SECURITY NUMBER

KANSAS UNEMPLOYMENT CONTACT CENTER – SHARED WORK PROGRAM
P.O. Box 3539, Topeka, KS 66601-3539 • Phone (785) 291-6132 • Fax (785) 296-1858