

# SHARED WORK PLAN APPLICATION

K-BEN 101 (Rev. 4-13)

MAIL: Unemployment Contact Center  
P.O. Box 3539  
Topeka, KS 66601-3539  
FAX: (785) 296-1858  
EMAIL: sharedwork@dol.ks.gov

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? <input type="checkbox"/> YES <input type="checkbox"/> NO	Initials _____	Date: _____
Reduced weekly hours: _____	Normal weekly hours: _____	Payroll week ending: _____	
Determination: <input type="checkbox"/> Denied <input type="checkbox"/> Approved	Beginning date: _____	Ending date: _____	
Reason for denial: _____			
Examiner: _____	Date: _____	PLAN NO. _____	SUB PLAN NO. _____

