

SHARED WORK PLAN - INDIVIDUAL PARTICIPANT

K-BEN 103 (Rev. 4-22)

Complete and submit this form to your employer. **All fields are required.** Any questions you have should be asked to your employer, not the Department of Labor, since your employer will be handling your claim. This information is used by the Department of Labor to confirm your identity and create your claim.

Personal Information	Employment Information
First name: _____	Number of hours you regularly work each week for this employer: _____
Middle name: _____	Do you work for any other employer(s)? <input type="checkbox"/> YES <input type="checkbox"/> NO
Last name: _____	Number of hours you regularly work for all other employers each week: _____
Social Security number: _____	Entitlement Questions
Mother's maiden name: _____	In the past 18 months, have you:
Date of birth: _____	• Served in the Armed Forces? <input type="checkbox"/> YES <input type="checkbox"/> NO
Driver's license number: _____	If YES, discharge date: _____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	• Worked for the federal government? <input type="checkbox"/> YES <input type="checkbox"/> NO
Mailing address: _____	• Worked in a state other than Kansas? <input type="checkbox"/> YES <input type="checkbox"/> NO
City: _____	State(s) you worked in: _____
State: _____ ZIP: _____	Do you wish to combine wages you earned in those state(s) for a Combined Wage Claim? <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you a U.S. citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO	• Filed a claim for or have received unemployment benefits? <input type="checkbox"/> YES <input type="checkbox"/> NO
In the last 18 months, have you gone by or used any other names and/or Social Security numbers? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, list them: _____ _____ _____	Do you receive any type of pension other than Social Security? <input type="checkbox"/> YES <input type="checkbox"/> NO

Tax Withholding Elections

Benefits paid under this program are taxable income that must be reported on your federal and state income tax filings. If you would like to have these taxes withheld from your benefits, indicate below.

- I want 10 percent of my weekly benefit amount withheld to go toward my federal income tax obligation.
 I want 3.5 percent of my weekly benefit amount withheld to go toward my state income tax obligation.

Certification

I certify that the information I have provided on this form is true and complete, and I understand that a willful or intentional misrepresentation or failure to disclose a material fact is fraudulent and punishable under the Kansas Employment Security Law. I further understand that each week I must tell my employer how many hours, if any, I am working for any other employers. By signing, I give the Kansas Department of Labor permission to file an initial claim for benefits if needed to participate in the Shared Work Plan.

Employee signature: _____ Date: _____

Phone: _____ Email: _____

OFFICE USE ONLY

Plan No. _____ Sub Plan No.: _____ Employer Serial No. _____

Plan information: Kansas Federal Military Claim type: New Additional