Employment Security Department
WASHINGTON STATE

SharedWork
EMPLOYER PLAN APPLICATION

Submit this form by fax to 800-701-7754
or upload at SharedWork upload
Questions? Call 800-752-2500

Please print or type the following information.
Answer all questions and sign to complete.

1. Employment Security Department (ESD) number: _____
Find this number on your ESD tax statement.

2. Employer Name: _____ DBA: _____

3. Mailing Address: _____

City: _____ State: _____ ZIP code: _____ County: _____

Physical Location/Street Address (if different from mailing): _____

City: _____ State: _____ ZIP code: _____ County: _____

4. Employer representative: An employer must identify a representative to coordinate with SharedWork Program staff regarding the employer plan and eligible employee claims. Employer representatives must report changes and respond to written requests for information within 10 days. Representatives also must be easily available to program staff.

Primary employer representative:	Alternative employer representative:
Name: _____	Name: _____
Job title: _____	Job title: _____
Email: _____	Email: _____
Phone: _____ Ext.: _____	Phone: _____ Ext.: _____
Fax: _____	Fax: _____

5. Is your business experiencing an economic downturn? ☐ Yes ☐ Maybe

6. What date did you or will you reduce hours? _____
MM/DD/YYYY

7. How many employees are you submitting to participate in SharedWork?
(Complete the REQUIRED employer plan employee list.) _____

8. Estimate how many jobs will be saved by using the SharedWork Program? _____

9. How will you give advance notice to affected employees whose hours are or will be reduced?

☐ Email ☐ Memo or letter ☐ Staff meeting ☐ Other: _____

If advance notice is not possible, please state why: _____

_____

10. How did you hear about the SharedWork Program? ☐ Association ☐ Chamber of Commerce
☐ Conference ☐ Email Outreach ☐ Webinar ☐ local WorkSource business services team
☐ Other: _____

11. a) How many of your participating employee are union represented? _____ ☐ N/A

b) **Employer union affiliation information (if applicable):** The employer's SharedWork plan must be approved in writing by the collective bargaining agent for each affected collective bargaining agreement covering any affected employee. **Approval signature(s) are required to process this application.**

Union: _____ Local: _____	Union: _____ Local: _____
Phone: _____ Ext.: _____	Phone: _____ Ext.: _____
Authorized union representative name	Authorized union representative name
Print: _____ print name	Print: _____ print name
Signature: _____	Signature: _____

12. **Your signature certifies that:**

- You have at least two permanent employees enrolled in the SharedWork plan.
- Affected employees were hired on a permanent basis.
- Health benefits will continue to be provided under the same terms and conditions as when the affected employee worked their usual weekly hours, unless health benefits are changed for all your employees.
- Retirement benefits and contributions under defined plans will continue to be provided under the same terms and conditions as when the affected employees worked their usual weekly hours, unless retirement benefits are changed for all your employees.
- Paid vacation, holidays, and sick leave continue to be provided under the same terms and conditions as when the affected employees worked their usual weekly hours.
- You agree to furnish all reports and information necessary for proper administration of your SharedWork plan.
- Your participation is consistent with your obligations under federal and state law.
- If there are any changes to the information on this application or employee (*participant*) list, you will notify SharedWork program staff immediately.
- You agree not to use SharedWork to subsidize seasonal employees during the off season.

By signing below, I, _____ certify that I am authorized to sign this document
print name
on behalf of the employer and that all information provided on this application is true and correct.

Signature: _____ Title: _____ Date: _____
Owner, Proprietor, CEO, CFO, CO, GM, HR Manager, Payroll Manager — MM/DD/YYYY

NEXT Click here to complete the employer plan employee list. We can only process completed applications.