Maryland
DEPARTMENT OF LABOR

DIVISION OF UNEMPLOYMENT INSURANCE
Reemployment and Trade Unit
1100 N. Eutaw Street, Room 500
Baltimore, MD 21201

APPLICATION FOR WORK SHARING UNEMPLOYMENT INSURANCE PLAN

☐ New Request ☐ Modification

I. Employer Information

1. Name: _____ Doing Business As: _____
2. MD Unemployment Insurance Contribution Tax ID Number: 00_____
3. Employer FEIN: _____
4. Mailing Address: _____
   State: _____ Zip Code: _____ Phone: _____
5. Location where Work Sharing will occur if not the same as above (indicate if employees work remotely here): _____
6. Industry: _____
7. Is your business (check all that apply): ☐ Minority-Owned ☐ Women-Owned ☐ Veteran-Owned
8. Total number of Maryland workers employed by your business: _____

II. Plan Information

1. Are you implementing a Work Sharing plan due to an economic downturn resulting from COVID-19?
   ☐ Yes ☐ No. If NO, what is your reason: _____
2. On what date do you want this plan to become effective? *Must be a Sunday that is 7 or more calendar days from the date this application is submitted.* _____
3. On what date do you want this plan to end? *Must be a Saturday. Cannot extend beyond 6 months (26 weeks) from the effective date.* _____
4. Is this reduction in work hours in lieu of layoffs? ☐ Yes ☐ No
5. Approximately how many Maryland employees would be laid off in the absence of this plan? _____
6. How did you hear about Work Sharing? _____
7. Are any employees who will participate in this plan covered by a Collective Bargaining Agreement?
   ☐ Yes ☐ No
   a. *If YES, the collective bargaining agent must complete and sign below.*
   b. *If NO, an employee participating in the Work Sharing plan must complete and sign below to confirm they are aware, as well as their colleagues, of this plan and that their hours will be reduced.*

Name of Collective Bargaining Agent or Employee Participant:_____

Phone:_____ Signature (*electronic signatures are permitted*): _____

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8. Did you notify your employees about your application for Work Sharing prior to submitting?

If YES, how? _____

If NO, why not? _____

9. Identification of affected unit(s). *An affected unit is a specified facility, department, shift, or other definable unit consisting of two or more employees.**

Affected Unit Name *(specific facility, department)*	**Number of Employees in Entire Unit**	**Number of Work Sharing Employees in Unit**	**Hours Reduction %** *(must be within range of 20%-50% in multiples of 5)*

**Attach additional pages if necessary*

10. Please complete the attached Work Sharing Participant list for all affected employees.

11. If all employees in the affected unit are not included in the plan, please provide a reasonable justification. _____

_____

12. Will benefits be affected if work hours of the affected employees are reduced to less than their normal weekly hours of work? *Please see policy #18 under section III.* ☐ Yes ☐ No

    a. If YES, how? _____

    _____

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III. Certification

We certify to the following:

1. The plan is effective for no more than six months (26 weeks). ☐

2. The plan includes an estimate of the number of layoffs that might occur absent participation in the Work Sharing program. ☐

3. The plan applies to and identifies the specified affected unit. ☐

4. Each employee in the plan was continuously employed by our company for the three months immediately prior to submission of this plan. Note that this requirement will be relaxed during the COVID-19 pandemic to allow employers to bring back any employee who was on the payroll on the date in which the employer was forced to shut down its operations as a direct result of COVID-19. ☐

5. The hours of work for each affected employee will be reduced by not less than twenty (20) percent and not more than fifty (50) percent. In the context of reopening our company, the employee hour reduction percentage is based off their regular schedule prior to being temporarily laid off or furloughed due to COVID-19. ☐

6. The plan applies to all employees in the affected unit and provides equal treatment to all employees of the group for all weeks of the plan, unless a reasonable good cause has been provided. ☐

7. The plan can be used for full-time, part-time, and salaried or exempt employees whose normal work schedule prior to reduction were between 20 to 40 hours. ☐

8. We have completed the Work Sharing Participant List and will include it when submitting this application. ☐

9. The plan shall not serve as a subsidy for seasonal, temporary part-time, or intermittent employment. ☐

10. The plan shall not be used during normal or expected fluctuations in economic activity that are an inherent part of an industry or occupation. ☐

11. The plan shall not be used by an employer as a payroll subsidy on a long-term basis for usual operations. ☐

12. It is strongly encouraged that the proposed plan or a summary has been made available to each affected employee or to the collective bargaining representative for inspection. A description of how the plan was made available has been provided or if notice of the plan was not feasible, an explanation of why advance notice was not given has been provided. ☐

13. We will furnish reports relating to proper conduct of the plan and agree to allow the authorized representatives access to all records necessary to verify the plan prior to approval and after approval, to monitor and evaluate the application of the plan. ☐

14. That if this plan is intended as a transition to a permanent staff reduction, notification will be provided to the Division of Unemployment Insurance for assistance in developing a Reemployment Assistance Plan. ☐

15. We understand that the plan may be revoked if there is conduct that tends to defeat the intent, there is a failure to comply, there is an unreasonable revision or any violation of the criterion on which the plan was approved. ☐

16. We will not hire new employees in, or transfer employees to, the affected unit while the plan is in effect. ☐

17. We are aware of the potential effects on our unemployment insurance account if benefits are paid. ☐

18. We understand that the health and retirement benefits of the affected employees will continue to be provided as though their work weeks had not been reduced. However, if the level of benefits for employees who are not in the Work Sharing unit are reduced, then the level of benefits for Work Sharing employees may be reduced by a like amount. ☐

19. Our company's unemployment tax contributions are current at the time of submission of this application. ☐

20. We agree that the terms and implementation of the Work Sharing plan are consistent with any obligation we have under federal and state laws. ☐

We hereby certify under penalties of perjury that the information submitted with this application for approval of a Work Sharing plan is true and correct to the best of our knowledge, information, and belief.

Authorized Employer Signature (*electronic signatures are permitted*): ___________________________

Name (*Type/Print*): ____ Date: ____________________

Contact Person: _____________________________ Contact Title: ____________________________

Contact Email: ______________________________Contact Phone: __________________________

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VI. For Division of Unemployment Insurance Office use ONLY

The Deputy Assistant Secretary of the Maryland Department of Labor will approve or deny this plan in writing within fifteen (15) calendar days. The decision of the Deputy Assistant Secretary is final. If this plan is approved, the Deputy Assistant Secretary may revoke this plan at any time for non-compliance with the terms of this agreement. If this plan is denied, you may submit another plan in fifteen (15) calendar days.

Date Received by the Work Sharing Unit: ______________

Recommendation by Reviewer: ☐ Approve ☐ Deny

Why: ____

Final Decision by Deputy Assistant Secretary: ☐ **Approve** ☐ **Deny**

Date of Final Decision:_____________

____
Deputy Assistant Secretary Signature