

SHORT-TIME COMPENSATION PLAN - APPLICATION FORM "A"

1. EMPLOYER/COMPANY NAME AND MAILING ADDRESS		2. UNIT NAME & WORK LOCATION	
		E-MAIL ADDRESS	
3. U.I. EMPLOYER ACCOUNT #	4. NAME & PHONE NUMBER OF EMPLOYER CONTACT PERSON		FAX NUMBER
5. APPLICATION TYPE ▷	Original Application <input type="checkbox"/>	Modification of Approved Plan by: <input type="checkbox"/> Adding Participants <input type="checkbox"/> Deleting Participants <input type="checkbox"/> Changing Work Hour Reductions	

PLAN DATA

6. Total number of full-time and regular part-time employees in unit?																			
7. Number of employees that would otherwise be totally laid off?																			
8. For employees included in Item 7, enter the number who regularly work the following hours per week, the total weekly hours for each category AND THEN ENTER ON THIS LINE THE SUM OF ALL THE CATEGORIES.	Enter total hours for all employees here. Hours																		
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;">EMPLOYEES:</td> <td style="width:15%; border: 1px solid black; padding: 2px;">No. _____</td> <td style="width:15%; border: 1px solid black; padding: 2px;">No. _____</td> <td style="width:15%; border: 1px solid black; padding: 2px;">No. _____</td> <td style="width:15%; border: 1px solid black; padding: 2px;">No. _____</td> <td style="width:15%; padding: 2px;">= _____ (Equals Item 7)</td> </tr> <tr> <td>HOURS/WEEK:</td> <td style="border: 1px solid black; padding: 2px;">x ____ Hours</td> <td style="border: 1px solid black; padding: 2px;">x ____ Hours</td> <td style="border: 1px solid black; padding: 2px;">x ____ Hours</td> <td style="border: 1px solid black; padding: 2px;">x Hours</td> <td style="padding: 2px;">(Grand Total Hours Per Week) ▷ ▷ ▷</td> </tr> <tr> <td>TOTAL HRS/WEEK:</td> <td style="border: 1px solid black; padding: 2px;">= _____</td> <td style="padding: 2px;">= _____</td> </tr> </table>	EMPLOYEES:	No. _____	No. _____	No. _____	No. _____	= _____ (Equals Item 7)	HOURS/WEEK:	x ____ Hours	x ____ Hours	x ____ Hours	x Hours	(Grand Total Hours Per Week) ▷ ▷ ▷	TOTAL HRS/WEEK:	= _____	= _____	= _____	= _____	= _____	
EMPLOYEES:	No. _____	No. _____	No. _____	No. _____	= _____ (Equals Item 7)														
HOURS/WEEK:	x ____ Hours	x ____ Hours	x ____ Hours	x Hours	(Grand Total Hours Per Week) ▷ ▷ ▷														
TOTAL HRS/WEEK:	= _____	= _____	= _____	= _____	= _____														
9. Number of weeks that employees in Item 7 would otherwise be totally laid off? <i>(if indefinite, please use 26 weeks.)</i>	Weeks																		
10. Multiply total hours for all employees in Item 8 times Item 9	Hours																		
11. Number of employees in unit you plan to have working reduced hours? <i>(Must be 10% or more of Item 6)</i>																			
12. COMPLETE APPLICATION FORM B, then enter the total of Form B column 9 on this line.	Hours																		
13. Divide Item 10 by Item 12 to obtain the number of weeks you plan or can project to work these employees on reduced hours. <i>(Round to the nearest full week and note that it must not exceed 26 weeks)</i>	Weeks																		
14. On what date (must be a Sunday) do you want this plan or modification to start?																			
15. On what date (must be a Saturday) do you want this plan to end? <i>(Plan duration not more than six (6) months)</i>																			
16. Describe how participants will be notified of plan and how you plan to work with them to implement it.																			
17. <input type="checkbox"/> I certify that I am not going to reduce fringe benefits, including health insurance, retirement benefits, paid vacations and holidays, sick leave, and similar benefits to any employee whose work week is affected by this plan. <input type="checkbox"/> If a reduction occurs, I certify that the change applies equally to all employees, including non-participating employees. Describe in detail, changes made to fringe benefits. Attach additional pages if necessary.																			
18. Does your business customarily have periods of employment where part-time or intermittent workers are used? Yes <input type="checkbox"/> No <input type="checkbox"/>																			
19. Do you consider your business seasonal? Yes <input type="checkbox"/> No <input type="checkbox"/>																			
20. Will this plan subsidize your off season? Yes <input type="checkbox"/> No <input type="checkbox"/>																			
21. Please describe the type of business/services you provide:																			
22. What specific type of work does the unit in which you have applied for STC perform?																			
23. Do you currently have any employees working for the company that are being paid by a temporary agency? Yes <input type="checkbox"/> No <input type="checkbox"/>																			
24. What are your plans for the temporary workers, should the STC plan be approved?																			

25. Please attach a narrative summary to describe what is occurring in your business or industry that has initiated the need for Short-Time Compensation and what steps, in addition to Short-Time Compensation, are being utilized to overcome this situation.

26. By signature below, I certify the information provided on Application Form A and B is correct and as follows:

- a. The employees in Items 6, 7 and 11 normal work hours do not exceed 40 (excluding overtime) regular pay hours per week.
- b. The hours shown in Item 8 exclude overtime pay hours and any in excess of 40 hours per week.
- c. This plan has been agreed on by all collective bargaining agents representing all employee participants shown on the attached Application Form "B".
- d. Each employee listed on Application Form "B" is a full-time or regular part-time employee of the employer.
- e. The plan is in lieu of a layoff of one or more workers for an indefinite period expected to last for more than two months, but not more than six months. **During the plan, none of the participants in the "Affected Unit" will be laid off.**
- f. The planned reduction in weekly hours for the employees listed on Application Form "B" is instead of layoffs that would result in at least as large a reduction in total work hours.
- g. The normal weekly hours for the employees will be reduced in accordance with the data shown on Application Form "B" with a corresponding reduction in wages.
- h. We understand that the short-time compensation benefits paid under this plan will be charged to our experience rating period (or if a reimbursable employer, we will be assessed for those payments).
- i. We understand that participation in the Short-Time Compensation Program will not affect our current unemployment tax rate, but that it could cause increases in our future rates.
- j. We understand that this plan is subject to review and can be revoked due to non-compliance with program rules and requirements.
- k. We certify that the Plan is consistent with employer obligations under applicable State and Federal Laws.

Signed: _____

Date: _____

Title: _____

B-148 STC (6/14)

Completing and Submitting an Application for a Short-Time Compensation Plan

GENERAL COMMENTS:

The STC application consists of two parts. Form A is a description of how the employer wants to implement the plan. Form B is a list of the employees that the employer expects to have involved in the plan.

Because there are certain percentages that must be met in the plan, we recommend the completion of Form B before Form A. By doing so, you will find it easier to comply with the percentage and avoid unnecessary changes to Form A. Keep in mind that the following requirements must be met by the plan you submit:

1. The unit must consist of at least five full-time or regular part-time employees who normally work no more than 40 hours per week. A "Sole Proprietor" of the business may not be included as one of the five participant employees of a qualifying unit.
2. The normal total hours of work for the unit cannot include any overtime nor any more than 40 hours for any of the employees in the unit.
3. The reduction percentage **must be equal** for all the employees listed on Form B and must be between 20% and 50%. Actual hours worked by plan participants must be substantially the same each week of the plan, with all participants working the reduced schedule. The identified workweek reduction must be applied consistently throughout the duration of the plan. Failure to implement your program consistently in accordance with the plan may result in the plan being revoked by the Commissioner.
4. All participants listed on Form B must be monetarily eligible for regular unemployment benefits. It should be noted that approval of any STC plan is subject to revocation if any participant is later found to be ineligible.
5. At least 10% of the employees or a minimum of 5 employees (whichever is greater) in the unit must participate in the plan.
6. The STC plan presented and approved is the plan that will be used. Substantial changes in work hours, even on a temporary basis, could be cause for the plan being revoked by the Commissioner. Layoff of the STC participating workers or other employees in the company who may not be participating in the STC plan may result in the plan being revoked by the Commissioner. You are required to notify your STC representative immediately should any layoffs occur during the course of an approved plan.
7. The STC plan cannot subsidize seasonal workers during the off season; nor can it subsidize periods of intermittent employment where part-time or intermittent workers have traditionally been used. "Seasonal employment" means employment with an employer who experiences at least a 20-percent difference between its highest level of employment during the off-season in each of the previous three years as reported to the Department with an employer on a temporary basis during a particular season.
8. Your plan must be "balanced", meaning it works mathematically. The number of hours needing to be saved (line 9 on Application A form) should equal the total number of hours workers will not work (line 12 on Application B form). The total hours needing to be saved must be able to be accomplished within the plan duration.

We **recommend** that you make a photocopy of your complete application to retain in your files.

Send the original of the completed application forms (Forms A and B) to the STC Unit, Vermont Department of Labor, P.O. Box 189, Montpelier, VT 05601-0189 or by fax to 802-828-9191.

As you begin thinking about the feasibility of this program, please build in a minimum of 30 days between the date you submit your application and the proposed start date of your plan, as the approval process may take up to 30 days.

If your plan is rejected, we will indicate the reasons in our letter of rejection. You are welcome to make any necessary corrections and resubmit a plan. Please be advised the department may take up to 30 days for the approval process on re-submission.

Please note all plans are subject to at least one compliance review by this department during the first three months of the plan. If that review indicates that an employer is not abiding by the terms of the approved plan and the statutory requirements for each plan, the Commissioner may revoke approval of the plan by notifying the employer in writing.

Also note that any approved plan will automatically be terminated on the effective date of any transfer of ownership of the legal business entity.

If you have questions or need assistance, please email us at UICCGeneral@labor.state.vt.us