

STC Application

~~NEBRASKA~~

DEPARTMENT OF LABOR

Employer Information

Are you the employer? Yes No

Employer Name:

State Unemployment Tax Number:

Work Site Location(s) by City:

STC Contact Person:

Title:

E-mail Address:

Phone Number:

Address:

City:

State:

Zip:

Country:

Narrative (Limit 1,000 characters):

Plan Information

Name of Affected Unit	Total Number of Employees in Affected Unit	Reduction of Usual Work Hours by Percentage

Proposed Effective Date of Plan:

End Date of Plan:

Estimated Number of Layoffs Avoided:

Please report the hours for any week that you are regularly closed due to a Holiday or Plant Shutdown.

Week of (Sun. - Sat.)	Hours Not Worked Due to Holiday/Shutdown	Usual Hours Worked	Paid/Unpaid Leave?	Comments

Description of How Employees in the Affected Unit will be Notified:

Employer Certification

I certify that this plan is in compliance with all requirements for the Short-Time Compensation (STC) plan (under Neb. Rev. Stat. §§48-672 to 48-683) and with all employer obligations under applicable federal and state laws and additionally certify:

- The affected unit(s) in which the STC plan will be implemented and the names, social security numbers and usual weekly hours (exclusive of overtime hours) of the employees have been specified.
- All employees of an affected unit will have their usual hours worked reduced by the same percentage.
- Any health and retirement benefits provided to any employee whose usual weekly hours of work are reduced under the STC program shall continue to be provided under the same terms and conditions as though the weekly hours of the employee have not been reduced or to the same extent as other employees not participating in the STC program.
- For defined benefit retirement plans, hours reduced under the STC plan shall be credited for purposes of participation, vesting, and accrual of benefits as though the usual weekly hours of work had not been reduced. The dollar amount of employer contributions to a defined contribution plan that are based on a percentage of compensation may be less due to the reduction in the employee's compensation.
- Reduction in health and retirement benefits scheduled to occur during the duration of the STC plan will be applied consistently to employees who are not participating in the STC program and to those employees who are participating.
- The aggregate reduction in work hours is in lieu of layoffs (temporary, permanent or both).
- The STC plan shall not serve as a subsidy to seasonal employment during the off-season, nor as a subsidy to temporary part-time or intermittent employment.
- The effective date and duration of the STC plan does not extend beyond the end of the twelfth full calendar month after the effective date.
- I will post notice of termination of the plan in a conspicuous location visible to all affected employees.
- I have obtained written approval of any applicable collective bargaining unit representative and have notified all affected employees who are not in a collective bargaining unit of the proposed STC plan.
- I will not hire additional part-time or full-time employees in the affected unit(s) while the STC plan is in effect.
- I will allow the Commissioner of Labor access to all records necessary to approve or disapprove the plan application.
- After approval of a plan, I will allow the commissioner access to monitor and evaluate the plan, and I will follow any directives the commissioner deems necessary for the Department of Labor to implement the plan and which are consistent with the requirements for STC plan applications.
- I will provide a weekly certification that contains the information requested by the commissioner for the duration of the STC plan.
- If there are any changes to the information on this plan application or the plan participant list, I will notify the Department of Labor.
- My participation is consistent with my obligations under federal and state law.

I hereby certify that I understand the above requirements and that the information provided in the application is true and correct to the best of my knowledge.

Contact Name: _____ Title: _____

Signature: _____ Date: _____