

Unemployment Insurance (UI) Application Form



| Organization Profile | | | | | | |
|---|--------------------------|------------------------|--------------------|--------------|----------------|------------|
| Organization Name | | | | | | |
| Physical Address | | City | S | state | Zip | |
| Contact | Title | | Website | | | |
| Telephone | Fax | | Email | | | |
| Operations Profile | | | | | | |
| Type of Entity 501c3 Government | Tribe Date Es | it. | When is your | fiscal year? | ? | |
| Description of Applicant's Operation | | | | | | |
| Current UI Funding Method: Paying State Unem | | State cct. No. | | FEIN | | |
| If taxpaying: | | If reimbursing | g: | | | |
| Have you paid unemployment taxes for at least two years? | 🗌 Yes 🗌 No | | management met | | ator 🗌 Grou | ıp Program |
| Are you currently in good standing with the state? | Yes No | | nistrator/program | | | |
| Employment Profile Plea | ase attach an additional | l sheet of paper, as r | needed, to more fu | lly answer t | he following q | uestions: |
| Number of Full-time Employees | Number of Part-time I | Employees | Number o | of W-2s fron | n Prior Year | |
| 1. Do you anticipate any loss or reduction in ov layoffs, and/or reduction in employees' hour | | | will result in | Yes | | No 🗌 |
| If yes, please explain and include estimate of affected employees and date(s) of action | | | | | | |
| 2. Do you anticipate any elimination or reduction that will result in layoffs, and/or reduction in | • | ., | | Yes | | No 🗌 |
| If yes, identify the source and provide an ex (include number of affected employees and action.) | | | | | | |
| Do you anticipate any restructuring within your reduction in employees' hours or wages with | | | d/or | Yes | | No 🗌 |
| If yes, please explain and include estimate of affected employees and date(s) of actio | | | | | | |
| 4. Have you experienced any layoffs/staff red months? | uctions, other than regu | llar seasonal during t | the last 12 | Yes | | No 🗌 |
| If yes, please explain. Include number of a employees and the dates on which layoffs or reductions took place. | | | | | | |
| 5. Do you anticipate an increase in the hiring o over the next 12 months? | f employees who will be | e affected by season | al layoffs | Yes | | No 🗌 |
| If yes, please explain. Include number of e and date(s) of action. | mployees | | | | | |

Unemployment Insurance

Employment Profile cont'd

6. Are you currently or have you, in the past 12 months, had employees whose wages are exempt Yes No

If yes, please explain. Include number of exempt employees and their term of employment.

- 7. How many of your employees are seasonal and when is their term of employment?
- 8. How many of your employees are employed in a Head Start program and when is their term of employment?

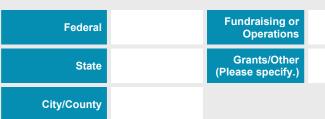
9. Please enter the following estimates:

| | Gross Wages | UI Benefit Charges (claims paid) | UI Tax Rate (if applicable) | Annual Operating Budget |
|--|-------------------------|-------------------------------------|-------------------------------------|-------------------------|
| Current YTD | | | | |
| Prior Year One | | | | |
| Prior Year Two | | | | |
| Prior Year Three | | | | |
| 10. Approximately how claims do you have ar | | | ately how many of are protested? | |
| | fan Oalan dan Maan 0004 | | | |

12. Estimated Wages for Calendar Year 2024:

Funding Profile

1. What percentage of your annual payroll is attributable to the following funding sources:



2. Are there any upcoming funding issues, not previously mentioned on this application, specific to your organization or your sector that might affect your employment levels?

 How did you hear about us?
 Please specify (i.e. Agency Name, Google, Webinar, etc.):

 Insurance Agency
 Nonprofit Association
 Website/Search Engine

 Advertisement
 Event
 Other

Signature

The information provided on this application form has been confirmed by all necessary parties within this organization to be true, accurate, and complete to the best of our knowledge. We acknowledge that any misrepresentation will result in immediate cancellation of any service or coverage pursuant to the terms of this product for which this application is submitted.

| Signature (No electronic signatures, please.) | Name |
|---|-------|
| | |
| | |
| Date | Title |
| | |

Email back to: mwhittey@firstnonprofit.com