

Multiple Week Application for SUBenefits

FORM SUB-2

ABOUT YOU

Participant's Name (First, Middle Initial, Last)				Participant's Social Security Number (SSN)				Plant CISCO Code			
WEEK 1				WEEK 2							
Month Day Year				Month Day Year							

UNEMPLOYMENT COMPENSATION

For WEEK 1 or WEEK 2, did you receive, or were you eligible to receive, any State or Federal Unemployment Compensation Benefit? (See mailing check list on reverse side for more information.) If yes, enter the total GROSS AMOUNT . WEEK 1 Yes WEEK 2 Yes No No Enclose proof of receipt of such benefit showing the gross amount and each week ending date. If no, review the reasons for ineligibility for each week below and circle the letter in the ineligibility column to the right. A. Exhausted /Insufficient wages to qualify C. Too much earned income B. State Waiting Week D. Other _____ Enclose a copy of any papers from the State or Federal Agency for proof of ineligibility.	WEEK 1		WEEK 2	
	UC BENEFIT RECEIVED	Reason for Ineligibility	UC BENEFIT RECEIVED	Reason for Ineligibility
	Gross Amount	A B C D	Gross Amount	A B C D
	\$		\$	

OFFICE	USE	ONLY	
FIRST WEEK	UC Amount	Week Date	Approver
SECOND WEEK	UC Amount	Week Date	Approver

EARNINGS

For any day in WEEK 1 or WEEK 2, did you receive any earnings from ANY employer, including self-employment? Did you receive or were you eligible for any Corporation HOLIDAY PAY for the week(s) you are claiming? Fill in the name and address of the employer. ENTER GROSS EARNINGS.	Earnings		Earnings	
	Gross Amount		Gross Amount	
	\$		\$	

WEEK 1	YES	NO	Earnings	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Name of Employer: _____											
Address: _____											
WEEK 2	YES	NO	Earnings	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Name of Employer: _____											
Address: _____											

OTHER BENEFITS

For any of the days in WEEK 1 or WEEK 2, did you receive, or were you eligible for, or claiming:	Sickness /accident Disability Benefits	Worker's Compensation Training Allowance	Disability Pension Corporation Pension
	Other: _____		

WEEK 1	YES	NO	Other Benefits	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Name of Payer: _____											
Type of Benefit: _____											
WEEK 2	YES	NO	Other Benefits	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Name of Payer: _____											
Type of Benefit: _____											

SIGNATURE AND DATE

I have read the "Certification Statement" on page two of this application and agree to be bound thereby.

_____ Signature _____ Date _____



You must sign and date this form so that your request can be processed.

INSTRUCTIONS

- Use black or blue ink.
- Leave WEEK 2 blank unless applying for two weeks of SUBenefits.
- Fill out all five parts of the application.
- Enclose a copy of the State or Federal Unemployment papers. (For example, Unemployment Compensation (UC), Trade Readjustment Allowance (TRA), UC Extended Benefits (EB), or Emergency Unemployment Compensation (EUC)).
- Mail completed form to:

GM Benefits & Services Center
P.O. Box 5078
Southfield, MI 48086-5078

INQUIRES

If you have any questions, call the GM Benefits & Services Center at 1-800-489-4646, Monday through Friday between 7:30 a.m. and 6:00 p.m. Eastern Time zone, to speak with a Customer Service Associate.

NOTICE TO EMPLOYEE

The filing of this application does not constitute assurance that a benefit will be paid. Any such payment is conditioned upon satisfactory fulfillment of other applicable requirements of the Plan. This application must be filed with the GM Benefits & Services Center within 60 calendar days after the week ending date shown. If you have no dependents on file with the corporation for other benefit purposes (e.g. if you waived health care), you must file Form SUB-DI to receive SUBenefits.

CERTIFICATION STATEMENT

I hereby represent that the information on this form is true and correct to the best of my information and belief.

I hereby authorize and direct any government agency to which I have made a claim for unemployment benefits (including UC, Extended UC, or TRA Benefits) for all or part of the period of layoff covered by this application, to make available to the Corporation, the GM Benefits & Services Center or its agents all records showing or related to, each claim and payment or denial thereof.

I hereby authorize and request the Plan Administrator, with the consent of the Corporation or its agents, to withhold and pay to the appropriate official any income tax or any other tax to which any payments made to me are subject pursuant to a law which provides for withholding.

If an overpayment results from benefits paid as a result of this application, I authorize recovery of the overpayment in accordance with the applicable provisions of the SUB Plan.

I am actively registered for work at the state employment office. I am able to work and available for work in accordance with State System requirements.

I understand the marital status and dependency information on file with the corporation will be used solely to determine my Weekly After-Tax Pay under the SUB Plan and will not be used for federal, state or local income tax withholding for payroll purposes.