

CLIFFS NATURAL RESOURCES
 SUPPLEMENTAL UNEMPLOYMENT BENEFIT PLAN
APPLICATION FOR WEEKLY BENEFITS

MAG

SECTION TO BE COMPLETED BY APPLICANT IN INK – PLEASE PRINT				Social Security No.			
Employee No. ()		NAME		Work Location		No. Dependents (Including Employee) ()	
Address (Street and No.)		City		State	Zip	Date Last Worked (Month, Day, Year)	
Benefit Year Beginning (Month, Day, Year)		Application for S.U.B. Week Ending Week Ending No. 1		Week Ending No. 2		Check Applicable Block <input type="checkbox"/> Initial S.U.B. Claim <input type="checkbox"/> Continued S.U.B. Claim	
Information from State Unemployment Compensation Check Amount of Check _____ Date of Check _____						If you are not eligible for state unemployment benefits for the weeks shown above due to appeal or protest of state U.C. Benefit, Check this block <input type="checkbox"/>	
ATTACH PROOF – COPY OF CLAIMANT PAYMENT STUB AND EXPLANATION						If you are not eligible due to disability, Check this block <input type="checkbox"/>	

Did you earn any other income including Self Employment in the Above Weeks?

If you checked "Yes", enter gross amount	NO YES	Week ending No. 1	NO YES	Week ending No. 2
		\$		\$

CERTIFICATION FOR APPLICATION OF WEEKLY BENEFITS

- A. I certify that during the week covered by this application I was LAID OFF and have registered to work with my state employment service.
- B. Did you, during the week covered by this application, earn wages or remuneration other than that shown above? Yes No
- C. Are you eligible for and claiming any accident, sickness, or total disability benefit or a pension or retirement benefit? Yes No
- D. Did you receive or are you eligible for any unemployment benefit from another employer? Yes No
- E. Were you unable to work or unavailable for full-time work at any time during this week? Yes No

If answer is yes complete the following:

Date disability began _____
 Name of Doctor _____
 Date last visited Doctor _____
 Describe disability _____

- F. Have you refused any referral or offer of suitable work this week? Yes No
- G. Did you voluntarily leave any other employment during the week indicated above? Yes No
- H. Have you failed to report to your State Employment Office with respect to the week indicated hereon? Yes No
- I. Are you on or scheduled to be on a paid vacation this week? Yes No

NOTE: If you answered "Yes" to any of the questions (B) through (I) above, attach explanation.

J. I hereby authorize the release to the company by State unemployment compensation authorities of any information pertaining to my State Unemployment compensation claim.

K. I hereby agree to pay the Trustee of the S.U.B. Trust Fund the amount of any overpayment of supplemental benefits which may be made to me; and for that purpose I hereby authorize the Company to deduct and pay over to said Trustee, the amount of any such overpayment from any weekly benefits otherwise due me or from any monies hereafter becoming due to me from the Company.

I hereby certify that the foregoing information is true and complete and I understand that my credit units may be canceled if I willfully falsify or withhold a material fact to obtain benefits under the plan.

APPLICATION MUST BE SIGNED TO BE VALID.

Signature _____ Date _____

Mail this form with *Proof of Unemployment* or *Exhausted Benefits* or *Other Earnings* to your Work Location Payroll Department

CLIFFS NATURAL RESOURCES
 P.O. Box 2000
 ISHPEMING, MI 49849