

DIVISION OF TEMPORARY DISABILITY INSURANCE
APPLICATION FOR FAMILY LEAVE INSURANCE BENEFITS (FL-1)

DETACH THIS PAGE AND KEEP FOR YOUR RECORDS

RULES FOR FILING A CLAIM AND APPEAL RIGHTS

1. It is **your** responsibility to file this claim form promptly **after** you stop working and begin your family leave. Filing your claim before your last day of work will delay its processing. The law requires that claims must be filed within 30 days after the beginning of the family leave. **Benefits may be denied or reduced if the claim is filed late**. If your claim is filed beyond the thirty day period, please use the space provided on the reverse side of Part A to give your reasons for the late filing.
2. Your signature certifies that you understand any misrepresentation of fact or failure to disclose a material fact may be punishable under the law. This includes any changes to the care recipient's Medical Certificate or the Employer's Statement made by you without authorization by the care recipient's physician or your employer.
3. You must inform us of any other payments you are receiving such as paid time off, a pension from your most recent employer, workers' compensation benefits, Social Security Disability benefits, disability benefits from your employer or union or Unemployment Insurance benefits.
4. If you receive a Family Leave Insurance Continued Claim Certification (Form FL3), it must be completed before further benefits can be authorized. Follow the instructions provided on the form and return it promptly.
5. If you return to work during the period for which you claimed Family Leave Insurance benefits, you must report this date immediately to the Division of Temporary Disability Insurance, at the telephone number listed below.
6. Family Leave Insurance benefits are subject to federal income tax and to federal rules that apply to the reporting of income and payment of taxes. However, these benefits are not subject to New Jersey state income tax. When you file your application for benefits, you can voluntarily have 10% of your benefits withheld for federal income tax. Following the end of each calendar year, you will be mailed a statement (Form 1099-G) of the total amount of benefits you received during the year. This information will also be given to the Internal Revenue Service (IRS).
7. If your home and/or mailing address changes, you must notify the Division of Temporary Disability Insurance, PO Box 387, Trenton, NJ 08625-0387 in writing. Notification must include your Social Security Number and signature. Family Leave Insurance checks cannot be forwarded by the postal service.
8. If you disagree with a determination on your claim you may appeal. Instructions for filing an appeal will appear on your Notice of Determination.

CLAIM ASSISTANCE:

If you require any assistance with your claim, call:

Customer Service Section (609) 292-7060.

Hearing Impaired Individuals May Contact Our Office By:

Telecommunication Device for the Deaf (TDD) (609) 292-8319

New Jersey Relay Service: TT user 1-800-852-7899

Voice User: 1-800-852-7897

Important: Please allow fourteen (14) days processing time before inquiring about your claim.

Division of Temporary Disability Insurance FAX number: (609) 984-4138

For additional information about the Family Leave Insurance Program, visit our website at:

www.nj.gov/labor

READ THE FOLLOWING INSTRUCTIONS BEFORE COMPLETING THE ATTACHED APPLICATION FOR FAMILY LEAVE INSURANCE BENEFITS

A Family Leave Insurance claim can be filed when you:

Care for a seriously ill family member as supported by a certification provided by a health care provider. Family member means child (biological, adopted, foster, stepchild, legal ward or child of a civil union or domestic partner) less than 19 years of age, child over 19 and incapable of self care, spouse, domestic partner, civil union partner or parent of a covered individual. Claims may be filed for six consecutive weeks, for intermittent weeks or for 42 intermittent days during the 12 month period beginning with the first date of the claim.

or

Bond with a new born or newly adopted child during the first 12 months after the child's birth or adoption. Bonding leave must be for a single continuous period of time unless the employer permits the leave to be taken in non-consecutive periods. In this case, each leave period must be at least seven days.

Requirements for taking Intermittent Leave

If your claim is for intermittent leave, you **must complete** Part E of this form, Intermittent Family Leave Schedule. The schedule must include the dates that you have been or will be absent from work to care for a family member or bond with a newborn or newly adopted child. Be sure to include your name and social security number on the schedule.

Instructions

Complete both sides of the claimant's portion of this form (Part A) making sure to:

- ❖ Include your full name and complete address.
 - ❖ Print or type all information clearly. Illegible information will cause a delay in processing.
 - ❖ List exact dates.
 - ❖ Be sure that your social security number appears on all attachments.
 - ❖ Sign your application.
1. If you are claiming benefits because you are bonding with a child, you must complete Part B and have Part D completed by your employer. Do not complete Part C.
 2. If you are claiming benefits because you are caring for a seriously ill family member, you are responsible for having Part C completed by the care recipient and the care recipient's health care provider and Part D completed by your employer. Do not complete Part B.

If you have worked for more than one employer during the past year, you may copy Part D for completion by the other employer(s) to avoid processing delays. **Any missing or incorrect entries on this form will delay processing of your claim.** If you cannot have the entire application completed timely, complete Part A and submit the application as soon as possible.
 4. Read all questions carefully! Print or write clearly since this information is used to determine your right to benefits. If you need any assistance in completing this form, please call the Customer Service Section in Trenton at (609) 292-7060 and hold for an agent.
 5. **BE SURE TO WRITE YOUR SOCIAL SECURITY NUMBER, NAME, ADDRESS AND TELEPHONE NUMBER ON EACH PORTION OF YOUR CLAIM.**

Important: We suggest that you keep a copy of the completed claim form for your records.



SENDING IN SEPARATE PARTS OF THE APPLICATION WILL DELAY YOUR CLAIM. NOTE: IF YOU CHOOSE TO FAX THIS FORM TO OUR OFFICE, BE SURE TO FAX BOTH SIDES OF EACH PAGE.

MAIL OR FAX PARTS A, B, C, D and E TOGETHER TO:

Division of Temporary Disability Insurance
PO Box 387
Trenton, NJ 08625-0387
FAX No: (609) 984-4138

FL-1(R-7-09)

FL-1**APPLICATION FOR FAMILY LEAVE INSURANCE BENEFITS****PART A****TO BE COMPLETED BY THE CARE OR BONDING PROVIDER - Print or Type**

FL-1(R-7-09)

1. Name: Last _____	First _____	Middle _____	2. Birth Date _____	3. Social Security Number _____
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4. Home Address - required (Street, Apt #, City, State, Zip Code) _____	5. County _____
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6. Mailing Address - if different (Street, Apt #, City State, Zip Code) _____	7. Male <input type="checkbox"/> Female <input type="checkbox"/>	8. Occupation _____
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9. Are you a citizen of the United States? Yes <input type="checkbox"/> No <input type="checkbox"/> If NO , answer #10 & 11 and give country of origin: _____	10. Alien Reg. No. _____	11. Work Authorization From _____ To _____
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12. What was the last day that you worked? _____ (Month Day Year)
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13. Date you want your Family Leave Insurance claim to begin: (Include Saturday, Sunday, or Holiday) _____ (Month Day Year)

14. Reason for family leave: <input type="checkbox"/> Care of Family Member <input type="checkbox"/> Bond With Child
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15. Will your family leave be taken on an intermittent basis? Yes No. **NOTE:** To claim benefits for intermittent family leave you must complete the Intermittent Family Leave Schedule, Part E, of this form (see instruction page for required information). If the intermittent leave is to bond with a newborn or newly adopted child, your employer must approve the schedule and the leave must be taken in non-consecutive periods of seven days or more.

16. Date you returned to work or will return to work: _____ (Month Day Year)

17. Person For Whom You Are Caring/Bonding: Last _____ First _____ Middle _____ Street _____ City _____ State _____ Zip _____ Telephone No: _____ Date of Birth _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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18. The Care Recipient is your: <input type="checkbox"/> Child <input type="checkbox"/> Spouse/ Civil Union Partner/ Domestic Partner <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____

Employment Information - Beginning with your last employer, list all employment (both full and part-time) in the past 18 months. If additional space is needed attach list.

19a. Name and address of your most recent employer: _____ _____ (Street) (City) (State) (Zip)	Period of employment: From _____ To _____ month/day/year month/day/year Work Telephone: _____ Location _____ City State Occupation: _____ Full time <input type="checkbox"/> Part time <input type="checkbox"/> Union _____ Division _____
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Check the days of the week you normally work. SUN <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THUR <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/>

19b. Name and address of your most recent employer: _____ _____ (Street) (City) (State) (Zip)	Period of employment: From _____ To _____ month/day/year month/day/year Work Telephone: _____ Location _____ City State Occupation: _____ Full time <input type="checkbox"/> Part time <input type="checkbox"/> Union _____ Division _____
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Check the days of the week you normally work. SUN <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THUR <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/>

19c. Name and address of your most recent employer: _____ _____ (Street) (City) (State) (Zip)	Period of employment: From _____ To _____ month/day/year month/day/year Work Telephone: _____ Location _____ City State Occupation: _____ Full time <input type="checkbox"/> Part time <input type="checkbox"/> Union _____ Division _____
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Check the days of the week you normally work. SUN <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THUR <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/>

Claimant's Name: _____

Social Security Number

Claimant's Address: _____

| |

Claimant's Telephone No:(_____) _____

PART A

MUST BE COMPLETED AND SIGNED BY THE CARE/BONDING PROVIDER

Continued

20. Have you received Family Leave Insurance benefits in the last 18 months? Yes No

21. You Must Answer Each Question Listed Below For the Period of Family Leave Covered By This Claim:

- a. Did you or will you receive paid time off from your employer? Yes No
- b. Have you been involved in a labor dispute (strike, lockout, etc)? Yes No

22. Since your last day of work have you received or applied for any of the following? If yes, please list dates in the space provided.

- a. Federal Social Security Disability Benefits? Yes No
- b. Pension benefits from your most recent employer? Yes No
- c. Disability benefits provided by your employer or union? Yes No
- d. Unemployment Insurance Benefits? Yes No
- e. Worker's Compensation Benefits? Yes No

Date benefit began: _____ Date benefit will end: _____

23. Do you wish to have 10% of your benefits withheld for federal income tax? Yes No

USE THIS SPACE TO PROVIDE ANY ADDITIONAL INFORMATION FOR QUESTIONS ON PART A

If more space is needed, attach an additional sheet of paper. Be sure your Social Security Number appears on all pages.

Certification and Signature I claim Family Leave Insurance benefits and certify that throughout the period covered by this claim I was providing care for or bonding with the care recipient identified in Part A. I hereby certify that I have read and understand my benefit rights and responsibilities. I am aware that if any of the foregoing statements made by me are known to be false, or I knowingly fail to disclose a material fact, I may be subject to penalties, which may include criminal prosecution. You are hereby authorized to verify my Social Security Account Number, and obtain any medical, employment and other benefit entitlement information that is necessary to determine my eligibility for benefits.

Sign Here _____ **Date** _____

Witness signature if claimant writes an "X" _____

Phone No. (_____) _____ Cell Phone No (_____) _____

E-Mail Address _____

Note: The Division of Temporary Disability Insurance is not a "covered entity" under the Federal Health Information Portability & Accountability Act (HIPAA). All medical records of the Division, except to the extent necessary for the proper administration of the Temporary Disability Benefits Law are confidential & are not open to public inspection. The Division protects all records that may reveal the identity of the claimant, or the nature or cause of the disability/family leave and the records may only be used in proceedings arising under the Law.

Claimant's Name: _____

Claimant's Address: _____

Claimant's Telephone No: (_____) _____

Social Security Number

| |

BONDING CERTIFICATION

Part B

DO NOT complete this portion of the application if the reason for this Family Leave Insurance benefits claim is to care for a sick family member. Complete Part C on the reverse side if your claim is for care giving.

(To be completed by the person claiming Family Leave Insurance benefits to bond with a newborn or newly adopted child)

1. Legal Name of Child:

(Last)

(First)

(Middle)

2. Child's Soc. Sec No.
(If Available)

| |

3. Child named in item 1 above is my:

- Child
- Adopted Child
- Stepchild

4. Child's Date of Birth

_____|_____|_____
(Month) (Day) (Year)

5. Date of Adoption

_____|_____|_____
(Month) (Day) (Year)

6. Gender

- Male
- Female

7. As evidence of the relationship in Item 3, check one of the following and **attach a copy** of the document checked. **(Do not send original document, it will not be returned.)**

- Child's Birth Certificate
- Child's Hospital Discharge Record
- Declaration of Paternity
- Certificate of Placement
- Independent Adoption Placement Agreement
- Other _____

8. Declaration and Signature: I authorize the medical provider, adoption agency or adoption party to disclose to the New Jersey Division of Temporary Disability Insurance all facts concerning the birth or adoption of the above-named child. I am aware that if any of the foregoing statements made by me are known to be false, or I knowingly fail to disclose a material fact, I may be subject to penalties, which may include criminal prosecution.

Signature of Claimant _____ Date _____

Care Provider's Name: _____

Care Provider's Address: _____

Care Provider's Telephone No: (_____) _____

Care Provider's
Social Security Number

| |

PART C

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CARE RECIPIENT'S RELEASE OF MEDICAL INFORMATION

DO NOT complete this portion of the application if the reason for this Family Leave Insurance benefits claim is to bond with a child. Complete Part B on the reverse side if your claim is for bonding.

(Must be signed by the care recipient or the care recipient's authorized representative)

1. Care Recipient's Name:

(Last) (First) (Middle)

2. Care Recipient's Social Security Number

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3. Care Recipient's Medical Disclosure Authorization and Confirmation

I authorize my physicians/health care providers to disclose my current personal health information to my care provider, identified above and to the New Jersey Division of Temporary Disability Insurance. I make this authorization to support my care provider's claim for Family Leave Insurance benefits. I understand that I may not revoke my authorization to avoid prosecution or to prevent the Division of Temporary Disability Insurance's recovery of money to which it is legally entitled. I further understand that copies of my signature below are as valid as the original.

Note: The Division of Temporary Disability Insurance is not a "covered entity" under the Federal Health Information Portability & Accountability Act (HIPAA). All of your medical records, except to the extent necessary for the proper administration of the Temporary Disability Benefits Law are confidential & are not open to public inspection. The Division also protects all records that may reveal your identity or the identity of your care provider.

Care Recipient's Signature _____ Date _____

Witness signature if care recipient writes an "X" _____

If unable to sign, Item 4 below must be completed.

4. Authorized representative signing on behalf of care recipient must complete the following:

I _____, represent the care recipient in this matter and I am authorized by
(print name)

parental right power of attorney (attach copy) court order (attach copy) to do so.

Representative Signature _____ Date _____ Telephone No _____

MEDICAL CERTIFICATE - To be completed by the care recipient's physician or health care provider

1. Does your patient require full time care? Yes No If no, how many days per week does your patient require care? _____

What type of care does patient require? _____

Can the care be provided by the care provider listed above? Yes No

2. Date patient's condition commenced:

_____|_____|_____
Month Day Year

3. First date care is needed:

_____|_____|_____
Month Day Year

4. Date you estimate patient will no longer require care by the care provider:

_____|_____|_____
Month Day Year

5. Date you expect patient to recover:

_____|_____|_____
Month Day Year

6. Diagnosis: (nature and cause of the condition which requires care from care provider) _____

ICD Code: _____

7. I certify that the above statements, in my opinion, truly describes the patient's condition and need for care and the estimated duration thereof:

(Print Name and Degree)

(Original Signature Required)

(Date Signed)

(Address)

(Certificate License No. and State)

(City)

(State)

(Zip Code)

(Specialty of Treating Physician)

If Resident, check Telephone Number: () _____ FAX Number: () _____

1. Claimant's Name: _____ Clt's Tele # (____) _____

SOCIAL SECURITY NUMBER

Clt's Address: _____

PART D

TO BE COMPLETED BY YOUR EMPLOYER OR COMPANY REPRESENTATIVE

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2. EMPLOYER STATUS

What is your Federal Employer Identification Number: _____
Payroll number (For N.J. State Employers) _____

3. PRIVATE PLAN COVERAGE (NJ approved plan/replaces State Plan coverage)

a. Do you have a N.J. approved Private Plan for family leave? Yes No
b. If "Yes", is claimant covered? Yes No

4. LAST ACTUAL DAY WORKED before the family leave

(do not use payroll week ending dates) _____
Month Day Year

a. Is the separation permanent? Yes No

Reason for separation: _____

b. Has claimant returned to work? Yes No

If "Yes", give date _____
Month Day Year

5. REQUIRED PAID TIME OFF (do not enter wages earned prior to family leave)

a. Have you paid or expect to pay the claimant during the period of family leave? Yes No
b. You may request that the employee's maximum entitlement be reduced by up to two (2) weeks if the employee is required to use paid time off (Vacation, Sick, Personal, etc). If you are making this request, check here and provide the dates and the number of full days the employee is required to use.

From _____ To _____ Number of Days _____
Month Day Year Month Day Year

6. OTHER PAID TIME OFF

a. Is the employee receiving or will he/she receive any paid time off not included in (5b.) above. Yes No If yes, please provide the following.

Dates Paid : From _____ To _____
Month Day Year Month Day Year

Amount per week \$ _____, if amount or dates vary attach a list for each time period.

b. Check the number that best describes the monies paid in item a.

- 1. Paid Time Off (Vacation, Sick, Personal, etc)
- 2. Pension
- 3. Difference between regular weekly wage and Family Leave Insurance benefits to be received or full salary advanced to effect the difference.
- 4. Supplemental benefits or gratuities

Note: Items 3 and 4 will not affect the benefits.

7. LEAVE INFORMATION

a. Did your employee provide you with reasonable and practicable notice of this period of family leave? Yes No If no, attach explanation.

b. Is the employee taking this leave on an intermittent basis? Yes No

c. If yes, have you agreed to the intermittent schedule? Yes No

8. OTHER BENEFITS

Has the claimant filed for or received:

- a. Workers' Compensation Benefits Yes No
- b. Sick Leave Injury (gov't workers only) Yes No
- c. Unemployment Benefits Yes No

12. Check the days of the week the employee normally works. SUN MON TUE WED THUR FRI SAT

9. BASE WEEKS AND BASE YEAR GROSS WAGES

A BASE WEEK is a calendar week in which the claimant had New Jersey earnings of \$143 or more during the Base Year. The BASE YEAR is the 52 calendar weeks preceding the week in which the family leave began.

a. Total Number of Base Weeks _____

b. Total Gross Wages in Base Year _____
Include all wages earned by the claimant

10. REGULAR WEEKLY WAGE \$ _____

11. Weekly wages

Indicate below: dates and claimant's GROSS earnings in N.J. employment during the listed calendar weeks.

Description of Calendar Week	Calendar Week Ending Date	Gross Wages
Week Family Leave Began		\$
Week Before Family Leave		\$
2nd Week Before Family Leave		\$
3rd Week Before Family Leave		\$
4th Week Before Family Leave		\$
5th Week Before Family Leave		\$
6th Week Before Family Leave		\$
7th Week Before Family Leave		\$
8th Week Before Family Leave		\$
9th Week Before Family Leave		\$
10th Week Before Family Leave		\$
TOTAL GROSS WAGES FOR ABOVE WEEKS		\$

Firm Name _____ **I CERTIFY THE INFORMATION GIVEN ABOVE IS CORRECT**

Address _____ Signed _____ Date _____

City, State, Zip _____ Print or Type Name _____

Mailing Address, If Different _____ Official Title _____

FAX No. () _____ Telephone () _____ E-Mail Address _____

Claimant's Name: _____ Cl't's Tele # (____)_____	SOCIAL SECURITY NUMBER
Cl't's Address: _____	

PART E

INTERMITTENT FAMILY LEAVE SCHEDULE

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Instructions: This schedule must be completed if you are taking Intermittent Leave.

1. Indicate the start date of the week you are claiming intermittent leave beginning with Sunday. If more space is required, attach an additional list to the application. Be sure it includes your social security number
2. Check the day(s) that you have been or will be absent from work to care for a family member or bond with a newborn or newly adopted child. Bonding must be in increments of seven days or more.
3. An authorized employer representative must sign below confirming the dates you have entered.

Week Beginning Date _____ SUN <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THUR <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/>	Week Beginning Date _____ SUN <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THUR <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/>
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Employer Representative: _____ Date: _____

Employer Name: _____