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 30-day period, please use the space provided on the reverse side of Part A to give your reasons for the late filing. **If you are receiving temporary disability benefits from the State Plan for a pregnancy related disability, you will receive instructions for claiming Family Leave benefits for bonding with your newborn child.**

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

FL-1

STATE OF NEW JERSEY – DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF TEMPORARY DISABILITY INSURANCE

APPLICATION FOR FAMILY LEAVE INSURANCE BENEFITS

PART A | **TO BE COMPLETED BY THE CARE OR BONDING PROVIDER - Print or Type** FL-1(R-6-10)

1. **Name**: Last First Middle | 2. **Birth Date** | 3. **Social Security Number**

4. **Home Address – required** (Street, Apt #, City, State, Zip Code) | 5. County

6. **Mailing Address – if different** (Street, Apt #, City State, Zip Code) | 7. Male ☐ Female ☐ | 8. Occupation

9. Are you a citizen of the United States? Yes ☐ No ☐
If no, answer #10 & 11 and give country of origin: _____ | 10. Alien Reg. No. | 11. Work Authorization From _____ To _____

12. What was the last day that you worked? _____ (Month Day Year)

13. Date you want your Family Leave Insurance claim to begin:
(Include Saturday, Sunday, or Holiday.) **If this date is in the future or if this date is left blank, this application will be returned to you.** _____ (Month Day Year)

14. Reason for family leave: ☐ Care of Family Member ☐ Bond With Child

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: ☐ Male ☐ Female

18. The Care Recipient is your: ☐ Child ☐ Spouse/ Civil Union Partner/ Domestic Partner ☐Parent ☐ Other: _____

Employment Information – Beginning with your last employer, list all employment (both full and part-time) in the past 18 months. If needed, space to list additional employers can be found on the reverse side of Part E.

19a. Name and address of your most recent employer:
_____
_____
(Street) (City) (State) (Zip)

Period of employment: From _____ (month/day/year) To _____ (month/day/year)

Telephone: _____ Work Location _____ City State

Occupation: _____ Full time ☐ Part time ☐ Union _____ Division _____

Check the days of the week you normally work. SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐

19b. Name and address of additional employer:
_____
_____
(Street) (City) (State) (Zip)

Period of employment: From _____ (month/day/year) To _____ (month/day/year)

Telephone: _____ Work Location _____ City State

Occupation: _____ Full time ☐ Part time ☐ Union _____ Division _____

Check the days of the week you normally work. SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐

19c. Name and address of additional employer:
_____
_____
(Street) (City) (State) (Zip)

Period of employment: From _____ (month/day/year) To _____ (month/day/year)

Telephone: _____ Work Location _____ City State

Occupation: _____ Full time ☐ Part time ☐ Union _____ Division _____

Check the days of the week you normally work. SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐

FL-1(R-6-10)

Claimant's Name: _____

Claimant's Address: _____

Claimant's Telephone No:(_____) _____

Social Security Number

| | |

BONDING CERTIFICATION

Part B

To be completed by the person claiming Family Leave Insurance benefits to bond with a newborn or newly adopted child. NOTE: Benefits are not payable for bonding with a foster child.

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.

DO NOT use this claim form if you are filing for Family Leave Insurance benefits to bond with your newborn child immediately after your claim for State Plan Temporary Disability or Disability During Unemployment ends. Instructions for filing a transitional bonding claim will be sent to you by the Division of Temporary Disability Insurance.

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
- ☐ Domestic or Civil Union Partner's newborn or newly adopted child

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. The document that you submit must show your name and your child's name. **(Do not send original document, it will not be returned.)**

- ☐ Child's Birth Certificate
- ☐ Birth Mother May Submit Child's Hospital Discharge Record
- ☐ Declaration of Paternity
- ☐ Certificate of Placement for Adoption
- ☐ Independent Adoption Placement Agreement
- ☐ Other_____

8. Have you provided your employer with at least 30 days notice that you would be taking this leave? ☐ Yes ☐ No

9. **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 _____

1. Claimant's Name: _____ Clt's Tele #(___)_____ Clt's Address: _____	SOCIAL SECURITY NUMBER | |

PART D **EMPLOYER'S STATEMENT - SECTION 1**
TO BE COMPLETED BY YOUR EMPLOYER OR COMPANY REPRESENTATIVE

 FL-1(R-6-10)

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. PRIVATE PLAN TEMPORARY DISABILITY BENEFITS
a. Do you have an approved private plan for temporary disability benefits? ☐ Yes ☐ No If yes, please provide the following:
1. Did the claimant collect benefits from your approved private plan immediately prior to the family leave? ☐ Yes ☐ No
2. If the claimant collected temporary disability benefits, did they return to work prior to the family leave? ☐ Yes ☐ No
3. If known, provide the dates and Weekly Benefits Rate that your private plan paid temporary disability benefits:

From ___|___|___ (Month Day Year) through ___|___|___ (Month Day Year) Weekly Benefit Rate $_____

5. 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)

6. ENTITLEMENT REDUCTION OPTION (do not enter dates prior to family leave)
a. Do you want to reduce the employee's maximum entitlement up to two (2) weeks if the employee is required to use paid time off (vacation, sick, personal, etc)? ☐Yes ☐ No

b. If yes, provide the dates and the number of full days the employee is required to use.

From ___|___|___ (Month Day Year) To ___|___|___ (Month Day Year) Number of Days _____

7. OTHER PAID TIME OFF
a. Is the employee receiving or will he/she receive any paid time off not included in (6b.) above. ☐ Yes ☐No If yes, please provide the following.

Dates Paid : From ___|___|___ (Month Day Year) To ___|___|___ (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. **Note:** Items 3 and 4 will not affect the benefits.
☐ 1. Paid Time Off (Vacation, Sick, Personal, etc)
☐ 2. Pension
☐ 3. Supplemental benefits or gratuities
☐ 4. Difference between regular weekly wage and Family Leave Insurance benefits to be received or full salary advanced to effect the difference.

8. 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

9. 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

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

PLEASE BE SURE TO COMPLETE AND SIGN SECTION 2 ON THE REVERSE SIDE OF THIS PAGE

Claimant's Name: ______________________________ **Clt's Tele #(____)** ______________

Clt's Address: ____

SOCIAL SECURITY NUMBER

| | |

PART E

INTERMITTENT FAMILY LEAVE CLAIM

FL-1(R-6-10)

Instructions: This form must be completed if you are filing a claim for intermittent Family Leave Insurance. Family Leave Insurance may only be claimed for whole days of leave. Benefits will not be paid for partial days of leave. Additionally, in order to prevent overpayment, no benefits will be authorized beyond the date of your employer's signature.

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 absent from work to care for a family member or bond with a newborn or newly adopted child. Claims for bonding must be in increments of at least seven consecutive days.
3. An authorized employer representative must sign below confirming the dates you have entered.

Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
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Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐	Week Beginning Date ______________ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐

Firm Name: ____ Telephone No: ______________

Employer's Representative: ________________________________ Date: ____________________
(print or type name)

Signature of Employer's Representative: ____