

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

PART D	EMPLOYER'S STATEMENT - SECTION 2		FL-1(R-6-10)
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11. EDUCATIONAL INSTITUTIONS (complete this section)

a. Is your facility classified as an "educational institution" which is approved to operate as a school by the State Department of Education? Yes No

b. Does any part of the period claimed occur during a school wide recess, vacation period or between academic terms? Yes No

If yes, list the dates: Beginning Date _____ Date School Resumes _____

12. BASE WEEKS AND BASE YEAR GROSS WAGES A BASE WEEK is a calendar week in which the claimant had New Jersey earnings of \$145 or more during the Base Year. The BASE YEAR is the 52 calendar weeks preceding the week in which the family leave began. If the claimant collected temporary disability benefits from either the State Plan or a Private Plan immediately prior to the family leave, the base year is the 52 weeks prior to the beginning of the temporary disability claim.

a. Total Number of **Base Weeks** _____

b. Total **Gross Wages in Base Year** _____

Include all wages earned by the claimant

13. REGULAR WEEKLY WAGE \$ _____

14. Weekly wages
 Indicate below: dates and claimant's GROSS earnings in N.J. employment during the listed calendar weeks. If the claimant collected temporary disability benefits from either the State Plan or a Private Plan immediately prior to the family leave, list the weekly wages prior to the beginning of the temporary disability claim.

Description of Calendar Week	Calendar Week Ending Date	Gross Wages	Description of Calendar Week	Calendar Week Ending Date	Gross Wages
Week Family Leave Began		\$	6 th Week Before Family Leave		\$
Week Before Family Leave		\$	7 th Week Before Family Leave		\$
2 nd Week Before Family Leave		\$	8 th Week Before Family Leave		\$
3 rd Week Before Family Leave		\$	9 th Week Before Family Leave		\$
4 th Week Before Family Leave		\$	10 th Week Before Family Leave		\$
5 th Week Before Family Leave		\$	Total Gross Wages for these Weeks		\$

I CERTIFY THE INFORMATION GIVEN ABOVE IS CORRECT

Firm Name _____

Address _____

City, State, Zip _____ Print or Type Name _____

Signature _____ Date _____

Mailing Address, if different _____ Official Title _____

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

Care Provider's Name: _____

Care Provider's Address: _____

Care Provider's Telephone No: (____) _____

Care Provider's
Social Security Number

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PART C

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CARE RECIPIENT'S RELEASE OF MEDICAL INFORMATION

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

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.

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's Signature _____ Date _____ Phone 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? _____

1a. What type of care can be provided to your patient by the family member submitting this claim?

(Example: ADL's, emotional support, transportation, visitation, etc)

1b. Check here if the family member is unable to provide any type of care for this patient

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 No. () _____

Claimant's Name: _____

Claimant's Address: _____

Claimant's Telephone No: (____) _____

Social Security Number

| |

PART A

Continued

MUST BE COMPLETED AND SIGNED BY THE CARE/BONDING PROVIDER

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.

Signature of Claimant _____ 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.

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 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. In order to prevent overpayment, no benefits can be authorized beyond the date of your employer's signature. Family Leave Insurance may only be claimed for whole days of leave. Benefits will not be paid for partial days of leave.

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.
3. 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

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