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. This leave must be for a continuous period greater than seven days unless the employer permits the leave to be taken in non-consecutive periods greater than 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
- P.O. Box 387
- Trenton, NJ 08625-0387
- FAX No: (609) 984-4138
APPLICATION FOR FAMILY LEAVE INSURANCE BENEFITS

PART A TO BE COMPLETED BY THE CARE OR BONDING PROVIDER - Print or Type

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

12. What was the last day that you worked?

13. Date you want your Family Leave Insurance claim to begin:

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:

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 ☐ Parent ☐ Domestic Partner ☐ Civil Union Partner ☐ 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 ☐ 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 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 ☐ 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 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 ☐ Part time ☐ Union Division___________________
Check the days of the week you normally work.   SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐
Part A

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 ☐

   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.
Part B

**BONDING CERTIFICATION**

**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  
   - [ ] 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. (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

   - [ ] Child’s Passport Showing Immigration and Naturalization Service Stamp I-551
   - [ ] 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 _____________

Page 3 of 6
**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

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? ____________________________________________

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: (       )_____________________

### PART D

**1. Claimant's Name:** ________________________________

**Clt's Address:** ____________________________________________________________________

**SOCIAL SECURITY NUMBER**

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

**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. CONTINUED PAY (do not enter wages earned prior to family leave)**

a. Have you paid or expect to pay the claimant for any period after the last day of work?  □ Yes  □ No

b. If “yes” give dates: FROM ______|_____|______ TO _____|_____|_____

(Month / Day / Year)           (Month / Day / Year)

c. Amount per week $___________, if amount varies attach list of dates and amounts.

d. Check the number that best describes the monies paid in item c.

□ 1. Paid Time Off (Vacation, Sick, Personal, etc)

□ 2. Pension

□ 3. Difference between regular weekly wage and Family Leave Insurance benefits to be received

□ 4. Full salary advanced to effect #3 above

□ 5. Supplemental benefits or gratuities

**Note:** No benefits will be paid for any period the employee receives paid time off. Pensions may affect benefit entitlement. Items 3,4,5 will not affect the benefits.

e. You may also request that the Division reduce the employee’s maximum entitlement (typically 6 weeks) if the employee was required to use paid time off. The reduction is limited to a maximum of 14 days. If you are making this request, check here □ and provide the number of days the employee was required to use. Number of Days ______

**6. 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

**7. 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

**8. 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

**9. REGULAR WEEKLY WAGE $_____**

**10. Weekly wages**

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

<table>
<thead>
<tr>
<th>Description of Calendar Week</th>
<th>Calendar Week Ending Date</th>
<th>Gross Wages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week Family Leave Began</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Week Before Family Leave</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>2nd Week Before Family Leave</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>3rd Week Before Family Leave</td>
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<td>4th Week Before Family Leave</td>
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<td>5th Week Before Family Leave</td>
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<td>6th Week Before Family Leave</td>
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<td>7th Week Before Family Leave</td>
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<td>8th Week Before Family Leave</td>
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<tr>
<td>9th Week Before Family Leave</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>10th Week Before Family Leave</td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL GROSS WAGES FOR ABOVE WEEKS $_____**

**11. Check the days of the week the employee normally works.**

SUN □ MON □ TUE □ WED □ THUR □ FRI □ SAT □

Firm Name __________________________________________

Address ____________________________________________

City, State, Zip ____________________________

Print or Type Name ____________________________

Mailing Address, If Different ____________________________________________________________________

official Title ____________________________________

FAX No. (      ) _______________________ Telephone (       ) _____________________

E-Mail Address ____________________________

I CERTIFY THE INFORMATION GIVEN ABOVE IS CORRECT

Signed ____________________________ Date ____________________________
PART E

INTERMITTENT FAMILY LEAVE SCHEDULE

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

1. Write the month and year in the space provided.
2. Place an “X” in each day 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.
3. An authorized employer representative must sign below confirming the dates you have entered.

<table>
<thead>
<tr>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
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<td>3</td>
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<tr>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

Employer Representative: __________________________ Date: __________________________