Important information about Family Leave Insurance

READ before completing the application for benefits

Family Leave Insurance benefits helps people who need to

• care for a seriously ill family member or • bond with a newborn or recently adopted child.

If you need to care for a family member, a health care provider must certify that your family member needs your help. (If *you* are the person with a temporary disability, use form **DS-1**.)

Family member means:

- child under 19 years old (biological, adopted, foster, stepchild, legal ward, or child of a civil union or domestic partner)
- child over 19 and incapable of self care
- spouse, domestic partner, or civil union partner
- parent

Family leave allows up to 42 days (6 weeks) of paid benefits during the 12 months immediately following your first day of leave. When caring for an ill family member, you may take all 42 days at once, or take days or weeks intermittently.

You may use family leave to bond with a newborn or 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 allows you to take leave in non-consecutive periods (intermittent leave). In this case, each leave period must be at least 7 days.

Taking Intermittent Leave

- ▷ If your claim is for intermittent leave, you must complete Part E: Intermittent Family Leave Schedule.
- ▷ The schedule must show the dates that you were absent from work to care for a family member or bond with a newborn or newly adopted child.
- ▷ Include your name and Social Security number on the schedule.
- ▷ No benefits can be authorized beyond the date of your employer's signature.
- ▷ Family Leave benefits may be claimed only for whole days of leave. Benefits will not be paid for partial days of leave.

Your Rights and Responsibilities as a Claimant

To file a claim for family leave benefits

It is your responsibility to file this claim promptly *after* you stop working and begin your family leave. We cannot process claims submitted for a period of leave in the future. Claims for future leave periods are discarded.

By law, you must file a claim within 30 days after starting your family leave. If you file later, benefits may be denied or reduced. If you file more than 30 days after your family leave started, give the reason why on the bottom of part A1.

If you are receiving New Jersey temporary disability benefits for a pregnancy-related disability, 35 days after your baby is born (you must tell us the delivery date) we will mail you instructions (form FL-2) for claiming family leave benefits while bonding with your newborn child. **Do not** complete this form if you intend to bond with your baby immediately after you stop collecting temporary disability benefits. Wait for the FL-2 instructions.

Other income

You must tell us about any other income you are receiving. This includes paid time off, pension, workers compensation or unemployment benefits, Social Security Disability benefits, or disability benefits from your employer or union.

Continued claim certification

If you are eligible for FLI benefits but do not initially claim the full 42 days, we will send you a request for continued claim certification (form FL-3). Use this form if you need to claim benefits for additional periods of leave. Complete and return the form promptly to ensure uninterrupted benefits.

Return to work

If you return to work during the period for which you claimed family leave benefits, report this date immediately to the Division of Temporary Disability Insurance to avoid overpayment.

Income tax withholding

Family leave benefits are subject to federal income tax. When you file for benefits you may choose to have 10% of your benefits withheld to avoid having to pay later.

Online information

about temporary disability benefits: *nj.gov/labor*

Help with your claim

Customer Service 609-292-7060

How to complete the Claim for Family Leave Benefits *(form FL-1)*

- ▷ You (the claimant) must complete the first 2 pages of the application (parts A1, A2 & A3).
- ▷ Complete part B *only* if you will be bonding with a newborn or adopted child.
- ▷ Part C should be completed by the care recipient (or authorized representative) and their doctor *only* if you will be caring for an ill family member. *Do not* complete part C if you are bonding with a child.
- ▷ ***You*** are responsible for having the care recipient's doctor complete the medical certificate, and for having your employer complete parts D & E.
- ▷ If you worked for more than one employer during the past year, you may copy part D for your other employer(s) to complete. This will help us process your claim more quickly.
- ▷ If the doctor and your employer(s) submit their parts separately, please complete and return relevant parts A–C as soon as possible. If you cannot send all parts together, we can process your claim quicker if we receive parts A–C first.
- ▷ Misrepresenting facts or failing to disclose material facts — including making unauthorized changes to a care recipient's medical certificate or an employer's statement — may be punishable by law.

For quicker processing

- ▷ It is very important that you provide information that is accurate and true. Missing, incorrect, or illegible information will delay payment of your benefits. Print clearly. Sign and date your application.
- ▷ Write your name and Social Security number on each part of your claim and on all attachments.
- ▷ Give exact dates when dates are requested.
- ▷ If you need help completing the form, call 609-292-7060. You may need to hold to speak to an agent.

Submitting your application

1. Whenever possible, send all parts of your claim together. Sending separate pages will delay your claim. **Sending duplicate copies will also delay your claim.** Send additional copies *ONLY* if information has changed.
2. If you fax your claim, be sure to fax all 5 pages — parts A, B, C, D & E *together* (but not these instructions).
3. Send all parts and any attachments to:

   mail: Division of Temporary Disability Insurance / P.O. Box 387 / Trenton, NJ 08625-0387

   fax: 609-984-4138

— KEEP THIS PAGE FOR YOUR RECORDS — DO NOT RETURN —

FL-1
PART A-1

New Jersey – Family Leave Insurance Application

TO BE COMPLETED BY THE PERSON PROVIDING CARE TO A SICK FAMILY MEMBER OR BONDING WITH A NEWBORN

Print clearly and answer ALL questions or your benefits may be delayed. FL-1 (2/17)

1 Name: Last First Middle **FLFLFL**

2 Date of Birth _____|_____|_____

Internal Code:

3 Social Security Number

4 ☐ Male ☐ Female

5 Home Address (Street, Apt #, City, State, ZIP Code)

6 County

7 Mailing Address – *if different from home address* (Street, Apt #, City, State, ZIP Code)

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 _____

	Month	Day	Year
12 What was the last day that you actually worked before your Family Leave began?			
13 Date you want your Family Leave to begin: *(If this date is blank or in the future, your claim can't be processed and will be shredded.)*			
14 Date you returned to work or will return to work: *(If you return to work before this date, immediately call: 609-292-7060)*			

15 Reason for family leave ☐ Care of family member ☐ Bond with child

16 Do you want 10% of your benefits withheld for federal income tax? ☐ Yes ☐ No

17 Other benefits - During the period of Family Leave covered by this claim, have you received or applied for:

a Sick or vacation pay from your employer? ☐ Yes ☐ No

b Federal Social Security Disability benefits? ☐ Yes ☐ No
If Yes, enter start/application date _____|_____|_____
If you received a Social Security award letter, attach a copy

c Pension benefits from your current employer? *If Yes, attach a copy of award letter* ☐ Yes ☐ No

d Disability benefits provided by your employer or union? ☐ Yes ☐ No
If Yes, date benefit began: _____|_____|_____ date benefit will end: _____|_____|_____

e Worker's compensation benefits? ☐ Yes ☐ No

f Unemployment insurance benefits? ☐ Yes ☐ No

18 Certification and Signature: I was unable to work during the period for which I am claiming benefits. I certify that I have read and understand my benefit rights and responsibilities. I am aware that if I provide any information in this application that I know to be false, or if 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 Social Security benefit information necessary to determine my eligibility for benefits.

Sign Here _____ **Date**_____|_____|_____

Witness signature if claimant writes an "X" _____

Phone ( ) _____ Alternate/ Phone ( )_____ E-Mail _____

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.

If you are submitting this claim more than 30 days after your first day of Family Leave, provide your reason:

_____

_____

WDS-1 (1/17)

Claimant's Name _____

Claimant's Address _____

Claimant's Phone ( ) _____

Social Security Number

__ __ __- __ __- __ __ __ __

PART A-2 Employment Information

Beginning with your last employer, list all employment (both full and part-time) in the past 12 months.

1a Name and address of your most recent employer:

MILLVILLE PUBLIC SCHOOLS

110 N. 3RD ST. MILLVILLE NJ 08332
Street City State ZIP

Period of employment: from ____|_____|_____ to____|_____|____
month day year month day year

Work Phone _____ Location _____
City State

Occupation _____ ☐ Full time ☐ Part time Union _____

Check the days of the week you normally work ☐ Sun ☑ Mon ☑ Tue ☑ Wed ☑ Thur ☑ Fri ☐ Sat

1b Name and address of additional employer:

_____

_____
Street City State ZIP

Period of employment: from ____|_____|_____ to____|_____|____
month day year month day year

Work Phone _____ Location _____
City State

Occupation _____ ☐ Full time ☐ Part time Union _____

Check the days of the week you normally work ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat

1c Name and address of additional employer:

_____

_____
Street City State ZIP

Period of employment: from ____|_____|_____ to____|_____|____
month day year month day year

Work Phone _____ Location _____

Occupation _____ ☐ Full time ☐ Part time Union _____

Check the days of the week you normally work ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat

PART A-3 Caring/Bonding Information

1 Have you received Family Leave Insurance benefits in the last 18 months? ☐ Yes ☐ No

2 If on maternity leave, have you filed for/received temporary disability benefits for this pregnancy? ☐ Yes ☐ No

3 Reason for Family Leave: ☐ Bond with child Or ☐ Care of family member

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

4 Are you taking all 6 weeks of your Family Leave benefits now? ☐ Yes ☐ No

NOTE: To claim benefits for individual periods of Family Leave, you must complete the Intermittent Family Leave Schedule, Part E, of this form. Your employer must approve the schedule and the leave must be taken in increments of at least 7 continuous days.

5 Person You are Caring for or Bonding with:

Last name _____ First _____ Social Security Number: __ __ __- __ __- __ __ __ __

Street _____ City_____ State _____ ZIP _____

Phone ( ) Date of Birth Gender ☐ Male ☐ Female

Claimant's Name _____ Phone **(____)**_____

Address _____

Social Security Number

__ __ __- __ __- __ __ __ __

PART B

BONDING CERTIFICATION

To be completed by the person claiming Family Leave Insurance benefits to bond with a newborn or newly adopted child. If your claim is for giving care to a sick family member, complete part C.

1 Legal Name of Child: Last_____ First_____

2 Child named in item 1 is my:
- ☐ Child
- ☐ Adopted Child
- ☐ Domestic or Civil Union Partner's newborn or newly adopted child

3 As evidence of the relationship in Item 2, check one of the following and **attach a copy** of the document checked.
The document that you submit must show your name, and Social Security number, and your child's name.
(Do not send original document. It will not be returned.)

- ☐ Child's hospital discharge record *(only **birth mother** may submit this)*
- ☐ Child's birth certificate *(father or mother may provide this)*
- ☐ Proof of **legally** established paternity
- ☐ Independent adoption placement agreement
- ☐ Certificate of placement for adoption
- ☐ Other _____

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

PART C

CARE RECIPIENT'S RELEASE OF MEDICAL INFORMATION

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

1 Care Recipient's Name: Last _____First _____

2 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 from recovering money to which it is legally entitled. I further understand that copies of my signature below are as valid as the original.

Care Recipient's Signature _____ **Date**_____

Witness signature if care recipient writes an "X"_____

If unable to sign, Item 3 below must be completed.

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 and are not open to public inspection. The Division also protects all records that may reveal your identity or the identity of your care provider.

3 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 ( ) _____

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: emotional support, transportation, etc)

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

2 Date patient's condition commenced	**3** First date care is needed	**4** Date you estimate patient will no longer require care by the care provider	**5** Date you expect patient to recover
_____|_____|_____ Month Day Year	_____|_____|_____ Month Day Year	_____|_____|_____ Month Day Year	_____|_____|_____ Month Day Year

6 Diagnosis:(condition which requires care)_____**ICD Code**: _____

7 I certify that the above statements truly describe the patient's condition, need for care, and the estimated extent of disability:

_____ Print Name and Degree

_____ Original Signature Required

_____ Date signed-must be on or after Item 3

_____ Address

_____ Certificate License No. and State

_____ City State ZIP Code

_____ Specialty of Treating Physician

Phone ( ) FAX ( ) ☐ Check, if Resident

Claimant's Name _____ Phone (____)_____

Address _____

Social Security Number

__ __ __- __ __- __ __ __ __

PART D

HAVE YOUR EMPLOYER OR COMPANY REPRESENTATIVE COMPLETE PART D.

1 EMPLOYER STATUS

Federal Employer Identification Number (FEIN) 21-6000248

Payroll number (For NJ state employers) _____

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

a Do you have a NJ approved Private Plan for temporary disability? ☐ Yes ☑ No

b Did the claimant collect benefits under this approved Private Plan? ☐ Yes ☑ No

Give dates: _____|_____|_____ to _____|_____|_____ $ _____/week

3 Check the days of the week that the employee normally works.

Sun ☐ Mon ☑ Tues ☑ Wed ☑ Thurs ☑ Fri ☑ Sat ☐ Varies ☐

4 LAST ACTUAL DAY WORKED before this family leave

(Do not use a payroll week ending date) _____|_____|_____ (Month Day Year)

a Reason for separation from work _____

b Is separation ☐ Temporary? ☐ Permanent?

c Did they return to work? ☐ Yes ☐ No If Yes, give date _____|_____|_____ (Month Day Year)

5 ENTITLEMENT REDUCTION OPTION

a Do you want to reduce employee's maximum entitlement up to 2 weeks if employee is required to use paid time off (vacation, sick, etc.)? ☐ Yes ☑ No

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

from _____|_____|_____ (Month Day Year) to _____|_____|_____ (Month Day Year) Number of Days _____

6 OTHER PAID TIME OFF

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

b If Yes, give dates from _____|_____|_____ (Month Day Year) to _____|_____|_____ (Month Day Year)

c Amount per week $_____ (if amount varies please attach a list of dates/amounts)

d Total amount paid for entire given period $_____

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

☐ 1. Paid time off-vacation, sick, personal etc.

☐ 2. Pension (attach pension approval letter)

☐ 3. Supplemental benefits (unallocated payout will have no impact)

☐ 4. Difference between regular weekly wages and benefits to be received

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

7 LEAVE INFORMATION

a Did your employee provide you with 30 days' notice (bonding) or appropriate notice (care) of their request for 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 on 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

9 EDUCATIONAL INSTITUTIONS

Does any part of the period claimed occur during a school-wide recess, or vacation period, or between academic terms? ☐ Yes ☐ No If Yes, give dates:

_____|_____|_____ **to** _____|_____|_____

10 BASE WEEKS/BASE YEAR WAGES

A BASE WEEK is a calendar week in which the claimant had New Jersey gross earnings of **$168** or more.

a Total number of **Base Weeks** _____

b Total **Gross Wages** in Base Year $ _____ (52 weeks prior to first day of disability)

11 Weekly Wage (base hrs x rate) **$**_____

Hourly Rate **$**_____**/hr**

10 Weekly wages Enter dates and claimant's GROSS earnings in NJ employment.

Note: If the following weeks include overtime, bonuses, etc. Attach an explanation and separate the regular wages earned. SEE ATTACHED

Calendar Week	Week Ending	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	/ /	$
9th Week Before Family Leave	/ /	$
10th Week Before Family Leave	/ /	$
TOTAL GROSS WAGES		$

I CERTIFY THE INFORMATION GIVEN ABOVE IS CORRECT

Firm Name MILLVILLE PUBLIC SCHOOLS Phone (856) 327-7590

Title KAREN MCCAFFERTY - EX. ASST-HR Fax (856) 825-1545

Address PO BOX 5010 110 NORTH THIRD ST. MILLVILLE, NJ 08332

Signature_____

Do not sign/date before the last day worked

Date (required)_____

Claimant's Name ______________________ Phone (____)______________ Address ____	Social Security Number __ __ __- __ __- __ __ __ __

PART E	COMPLETE PART E AND HAVE YOUR EMPLOYER VERIFY, SIGN, AND DATE

Instructions: This form must be completed if you are filing a claim for intermittent Family Leave Insurance. Family Leave Insurance may be claimed only for whole days of leave. Benefits are not paid for partial days of leave. Also, 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 7 consecutive days.
3. An authorized employer representative must sign below confirming the dates you have entered.

Check the days of the week that the employee normally works.

Sun ☐ Mon ☑ Tues ☑ Wed ☑ Thurs ☑ Fri ☑ Sat ☐ Varies ☐

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

Firm Name MILLVILLE PUBLIC SCHOOLS Phone (856) 327-7590

Employer's Representative KAREN MCCAFFERTY Title EXECUTIVE ASST. - HR

Signature of Employer's Representative ______________________________ Date__________