FL-1

New Jersey Family Leave Benefits Application

myLeaveBenefits.nj.gov

Division of Temporary Disability & Family Leave Insurance
P.O. Box 387, Trenton, NJ 08625-0387
Fax: 609-984-4138

FLFLFL

PART A *YOUR INFORMATION*

Internal Code

Social Security Number ☐☐☐ ☐☐ ☐☐☐☐

Profile Information

1 Last name First name Middle

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

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

4 Date of Birth ____|____|____ mm | dd | yy

5 Gender _____

6 County

7 Phone (____) _____

Questions 8 and 9 are for statistical purposes only and do not affect eligibility

8 With which racial/ethnic group(s) do you most identify?
☐ Caucasian ☐ African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native
Latino/Hispanic ☐ Yes ☐ No

9 Check the highest level of schooling you have completed.
☐ Have not graduated high school ☐ High School Graduate/GED ☐ Associates/Bachelor's Degree ☐ Graduate Degree

Leave Information

10 Date your Family Leave began ____|____|____

11 Date you returned/will return to work ____|____|____

12 Reason for family leave ☐ Bond with child → Complete **Parts A & B**

☐ Care of family member → Complete **Parts A, B, & C**

Bonding claims: *If you are the birth mother of the child, you may be eligible for Temporary Disability maternity benefits before collecting Family Leave bonding benefits. If you would like to apply for these benefits during your pregnancy and recovery, complete the Temporary Disability Benefits Application (form DS-1).*

13 Person you are caring for or bonding with

Last name _____ First _____ Relationship_____ Phone (____) _____

Date of Birth ____|____|____ Date of Adoption/Foster Placement *(if applicable)* ____|____|____

14 Are you taking all 42 days of Family Leave benefits in a row? ☐ Yes ☐ No

→ Complete **Part D** (Partial Leave Schedule) on Page 3

Additional Benefit Information

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

16 During the period of Family Leave covered by this claim, have you received or applied for:

a **Federal** Social Security Disability benefits? ☐ Yes ☐ No If Yes, enter start/application date ____|____|____

b Pension benefits from your current employer? ☐ Yes ☐ No

c Workers' Compensation benefits? ☐ Yes ☐ No If Yes, enter start date ____|____|____ Monthly amount $_____

d Unemployment Insurance benefits? ☐ Yes ☐ No

Certification and Signature

17 I certify I was unavailable to work during the period for which I am claiming benefits. 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 Number, and obtain any medical, employment and Social Security benefit information necessary to determine my eligibility for benefits.

Sign Here _____ Date ____|____|____

Note: The Division of Family Leave 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 family leave and the records may only be used in proceedings arising under the law.

Name _____

Address _____

Phone (___)_____

Social Security Number

☐☐☐ ☐☐ ☐☐☐☐

PART B *EMPLOYMENT INFORMATION*

Instructions: Starting with your last employer, provide information for all your employers in the 6 months before your leave began.
If you need to list more employers, make a copy of this page. Be sure to state the first and last day you physically reported to work. Do not write "present" or "current."

1 Name of your most recent employer

Company_____

Street_____City_____State_____

2 Federal Employer Identification Number (FEIN) *(see instructions)*

☐☐–☐☐☐☐☐☐☐

3 Date of hire ____|____|____ (mm | dd | yy) to Last *physical* day of work before your leave ____|____|____ (mm | dd | yy)

4 ☐ Full time ☐ Part time

5 Union ☐ Yes ☐ No

6 Occupation _____

7 Work Location City _____ State _____

8 Separation from this employer is ☐ Temporary ☐ Permanent

9 Which days do you normally work? ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat

10 Regular Weekly Earnings $_____

11 Supervisor's Name _____

12 Phone (___)_____

13 Have you provided this employer with at least 15 days' notice that you would be taking this leave? ☐ Yes ☐ No

14 Did you collect temporary disability benefits under this employer's approved private plan? ☐ Yes ☐ No

If yes, give dates ____|____|____ to ____|____|____ $_____ per week

15 Have you been paid for any days after your last day of work? ☐ Yes ☐ No

If yes, from ____|____|____ to ____|____|____

Total amount paid $_____

This pay represents:

☐ Paid time off (vacation, sick, personal, etc.)
☐ Difference between regular wages and disability benefits
☐ Other pay from your employer (explain) _____
☐ Severance pay ☐ With notice ☐ In lieu of notice
☐ Donated Leave

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1 Name of other employer *(if applicable)*

Company_____

Street_____City_____State_____

2 Federal Employer Identification Number (FEIN) *(see instructions)*

☐☐–☐☐☐☐☐☐☐

3 Date of hire ____|____|____ (mm | dd | yy) to Last *physical* day of work before your leave ____|____|____ (mm | dd | yy)

4 ☐ Full time ☐ Part time

5 Union ☐ Yes ☐ No

6 Occupation _____

7 Work Location City _____ State _____

8 Separation from this employer is ☐ Temporary ☐ Permanent

9 Which days do you normally work? ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat

10 Regular Weekly Earnings $_____

11 Supervisor's Name _____

12 Phone (___)_____

13 Have you provided this employer with at least 15 days' notice that you would be taking this leave? ☐ Yes ☐ No

14 Did you collect temporary disability benefits under this employer's approved private plan? ☐ Yes ☐ No

If yes, give dates ____|____|____ to ____|____|____ $_____ per week

15 Have you been paid for any days after your last day of work? ☐ Yes ☐ No

If yes, from ____|____|____ to ____|____|____

Total amount paid $_____

This pay represents:

☐ Paid time off (vacation, sick, personal, etc.)
☐ Difference between regular wages and disability benefits
☐ Other pay from your employer (explain) _____
☐ Severance pay ☐ With notice ☐ In lieu of notice
☐ Donated Leave

Name ______________________________

Address ______________________________

Phone (____)______________________________

Social Security Number

PART C *CAREGIVING CLAIMS*

SECTION 1 MEDICAL CERTIFICATE: To be completed by the care recipient's healthcare provider

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

2 What was the first day that your patient needed care? ____|____|____ mm | dd | yy

3 On what day do you estimate your patient will no longer require care ? ____|____|____ mm | dd | yy

4 Diagnosis (condition that requires care) ______________________________ # ICD Code __________

5 I certify the above statements describe the patient's condition, need for care, and the estimated length of disability:

Print Name ____________________ Signature ____________________ Date __________

Certificate License No. and State ______________________________ ☐ Check, if Resident

Street Address ______________________________

City ____________________ State __________ ZIP Code __________

Phone (____)____________________ Fax (____)____________________

SECTION 2 CARE RECIPIENT'S CERTIFICATION: To be completed by the care recipient

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 Family Leave 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 Family Leave 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 care recipient is unable to sign, Item 3 below must be completed.)
Note: The Division of Family Leave 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, ____________________ (print name), represent the care recipient in this matter and I am authorized by:

☐ Parental right ☐ Power of attorney *(attach copy)* ☐ Court order *(attach copy)*

Representative's Signature ____________________ Date __________ Phone (____) __________

PART D *PARTIAL LEAVE SCHEDULE*

If you are not claiming all 42 days in a row, mark your full days of absence on the schedule below. *Week Beginning Date* should be the Sunday of the week you are taking leave. No benefits will be approved beyond the date of your signature.

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

Claimant signature ______________________________ Date __________

FILE ONLINE FOR FASTER CLAIM PROCESSING AT myLeaveBenefits.nj.gov

How to Complete the Claim for Family Leave Benefits

- This application (form FL-1) is for family caregiving or bonding leave. If you wish to claim benefits for your own disability or for pregnancy and recovery, complete the application for Temporary Disability Benefits (form DS-1).
- You must complete the first 2 pages of the form (**Parts A and B**).
- You will need to provide your employer's Federal Employer Identification Number on **Part B**. You can get this number from either your last year's W-2 form or your Human Resources office. Your employer is not required to complete this form but you can ask them to help you with any questions on **Part B**.
- **Part C** must be completed by the care recipient and the doctor *only* if you are caring for an ill family member.
- **Part D** must be completed *only* if you are not claiming all 42 days in a row.
- If your reason for taking leave is related to a domestic violence or sexual violence case in which medical documentation is not applicable, attach documentation related to the case. For more information see myleavebenefits.nj.gov/keepingNJsafe.
- You have 30 days from the first day of your leave to file your claim. If your claim form is received more than 30 days from the first day of your leave, you must provide a reason why the claim was not filed on time. Benefits may be reduced or denied for late applications.

Remember

- You must complete every question accurately and write legibly.
- **Any missing information may cause your claim to be denied**.
- Demographic questions have no effect on the approval or denial of your claim.
- Write your name and Social Security number on each page of your claim and on all attachments.
- Exact dates must be given. Do not write "present" or "current."
- If you need to list more than 2 employers, make a copy of Part B to list additional employment.
- If you return to work while you are claiming Family Leave benefits, report this date immediately to the Division of Family Leave Insurance to avoid overpayment.

How to Send Us Your Claim Form

There are 2 options for you to submit this form. **Choose only one, as sending multiple copies will delay processing.** If you filed your claim online, do not also submit a paper application.

1. Fax this completed form to 609-984-4138
   – OR –
2. Mail this completed form to: Division of Temporary Disability Insurance / P.O. Box 387 / Trenton, NJ 08625-0387

After Submitting Your Claim

- If you are eligible for Family Leave Insurance 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.
- You can find more information and check your claim status at *myLeaveBenefits.nj.gov*
- For more help on your claim, call Customer Service: 609-292-7060