

**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](http://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. 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

FL-1(R-1-12)

**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-1-12)

1. Name: Last	First	Middle	2. Birth Date	3. Social Security Number
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4. Home Address – <b>required</b> (Street, Apt #, City, State, Zip Code)	5. County
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6. Mailing Address – <b>if different</b> (Street, Apt #, City State, Zip Code)	7. Male <input type="checkbox"/>	8. Occupation
	Female <input type="checkbox"/>	

9. Are you a citizen of the United States? Yes <input type="checkbox"/> No <input type="checkbox"/>	10. Alien Reg. No.	11. Work Authorization
If no, answer #10 & 11 and give country of origin:		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 increments of at least seven consecutive days.

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 _____ To _____ month/day/year month/day/year Work Location _____ Telephone: _____ City State
Occupation: _____ Full time <input type="checkbox"/> Part time <input type="checkbox"/> 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 _____ To _____ month/day/year month/day/year Work Location _____ Telephone: _____ City State
Occupation: _____ Full time <input type="checkbox"/> Part time <input type="checkbox"/> 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 _____ To _____ month/day/year month/day/year Work Location _____ Telephone: _____ City State
Occupation: _____ Full time <input type="checkbox"/> Part time <input type="checkbox"/> Union _____ Division _____	

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

Claimant's Name: \_\_\_\_\_  
 Claimant's Address: \_\_\_\_\_  
 Claimant's Telephone No: (\_\_\_\_) \_\_\_\_\_

**Social Security Number**

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**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**

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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.

Claimant's Name: \_\_\_\_\_  
 Claimant's Address: \_\_\_\_\_  
 Claimant's Telephone No: (\_\_\_\_) \_\_\_\_\_

Social Security Number

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### BONDING CERTIFICATION

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.**

#### Part B

**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)  
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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 \_\_\_\_\_

Care Provider's Name: \_\_\_\_\_  
 Care Provider's Address: \_\_\_\_\_  
 Care Provider's Telephone No: (\_\_\_\_) \_\_\_\_\_

Care Provider's  
 Social Security Number

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**CARE RECIPIENT'S RELEASE OF MEDICAL INFORMATION**

**PART C**

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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
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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)
If Resident, check <input type="checkbox"/> Telephone Number: ( ) _____		FAX No. ( ) _____

Claimant's Name: _____ Clt's Tele # (____) _____	<b>SOCIAL SECURITY NUMBER</b>                        
Clt's Address: _____	

<b>PART D</b>	<b>EMPLOYER'S STATEMENT - SECTION 1</b> <b>TO BE COMPLETED BY YOUR EMPLOYER OR COMPANY REPRESENTATIVE</b>	FL-1(R-1-12)
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**1. EMPLOYER STATUS**  
 What is your Federal Employer Identification Number: \_\_\_\_\_  
 Payroll number (For N.J. State Employers) \_\_\_\_\_

**2. 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

**3. 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 known, provide the dates and Weekly Benefits Rate that your private plan paid temporary disability benefits:  
 From \_\_\_\_\_ through \_\_\_\_\_ Weekly Benefit Rate \$ \_\_\_\_\_  
Month Day Year                    Month Day Year

**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. 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 \_\_\_\_\_ To \_\_\_\_\_ Number of Days \_\_\_\_\_  
Month Day Year                    Month Day Year

**6. OTHER PAID TIME OFF**  
 a. Is the employee receiving or will he/she receive any paid time off not included in (5b.) above.  Yes  No If yes, please provide the following.  
 Dates Paid : From \_\_\_\_\_ To \_\_\_\_\_  
Month Day Year                    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)                     3. Supplemental benefits or gratuities  
 2. Pension                     4. Difference between regular weekly wage and Family Leave Insurance benefits to be received or full salary advanced to effect the difference.

**7. 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

**8. OTHER BENEFITS**  
 Has the claimant filed for or received:  
 a. Workers' Compensation Benefits  Yes  No                    c. Unemployment Benefits  Yes  No  
 b. Sick Leave Injury (gov't workers only)  Yes  No

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

Claimant's Name: _____ Clt's Tele # (____) _____ Clt's Address: _____	<b>SOCIAL SECURITY NUMBER</b>                        
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<b>PART D</b> <small>Continued</small>	<b>EMPLOYER'S STATEMENT - SECTION 2</b> <small>Page 6 of 8</small>	<small>FL-1(R-1-12)</small>
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**10. 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 \_\_\_\_\_

**11. 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

**12. REGULAR WEEKLY WAGE \$** \_\_\_\_\_

**13. 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 <sup>th</sup> Week Before Family Leave		\$
Week Before Family Leave		\$	7 <sup>th</sup> Week Before Family Leave		\$
2 <sup>nd</sup> Week Before Family Leave		\$	8 <sup>th</sup> Week Before Family Leave		\$
3 <sup>rd</sup> Week Before Family Leave		\$	9 <sup>th</sup> Week Before Family Leave		\$
4 <sup>th</sup> Week Before Family Leave		\$	10 <sup>th</sup> Week Before Family Leave		\$
5 <sup>th</sup> Week Before Family Leave		\$	<b>Total Gross Wages for these Weeks</b>		\$

**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 \_\_\_\_\_



Claimant's Name: _____ Clt's Tele # (____) _____ Clt's Address: _____	<b>SOCIAL SECURITY NUMBER</b>                          
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<b>PART E</b>	<b>INTERMITTENT FAMILY LEAVE CLAIM</b>	FL-1(R-1-12)
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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 <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THUR <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/>	Week Beginning Date _____ SUN <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THUR <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/>
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Firm Name: \_\_\_\_\_ Telephone No: \_\_\_\_\_

Employer's Representative: \_\_\_\_\_ Date: \_\_\_\_\_  
(print or type name)

Signature of Employer's Representative: \_\_\_\_\_

