

ORIGINAL  
TO BE SUBMITTED TO THE  
DIVISION OF  
TEMPORARY DISABILITY INSURANCE  
PO BOX 957  
TRENTON, NEW JERSEY 08625-0957

FDP-1 (R-09-08)  
STATE OF NEW JERSEY  
DEPARTMENT OF LABOR  
AND WORKFORCE DEVELOPMENT  
DIVISION OF TEMPORARY DISABILITY INSURANCE  
APPLICATION FOR APPROVAL OR MODIFICATION OF  
INSURED PRIVATE PLAN FOR  
**FAMILY LEAVE INSURANCE**

\_\_\_\_\_  
New Jersey Employer  
Identification No.

\_\_\_\_\_  
F.L.I. Private Plan No.

1.  Approval is requested for an insured Private Plan  
**CHECK ONE {**  Modification is requested for the insured Private Plan indicated above **}** to provide New Jersey Family Leave Insurance Benefits

effective \_\_\_\_\_, as described below and in accordance with the details attached for the employees of:

\_\_\_\_\_  
(Name of Employer, exactly as registered with the Department of Labor and Workforce)

\_\_\_\_\_  
(Telephone Number)

\_\_\_\_\_  
(Address)

2. The policyholder, if other than employer named in Item 1 above, will be:

\_\_\_\_\_  
(Policy Holder Name)

\_\_\_\_\_  
(Address)

3. Any and all notices, order, or communications **to the employer** may be served by mail, addressed to the following designated person as the duly authorized representative of the above-named employer:

\_\_\_\_\_  
(Employer Representative)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Telephone No.)

\_\_\_\_\_  
(Representative's Address)

4. The Family Leave Private Plan will cover:

- (a)  All covered employees of the employer. Number of New Jersey employees: \_\_\_\_\_  
(b)  Other (describe classes covered) \_\_\_\_\_

If more space is required, attach sheet.

**Form FDP-1A must be attached for excluded classes.**

5. The contributions required of employees covered by the Family Leave Private Plan will be:

- CHECK ONE {** (a)  0.12 % of taxable wages, (statutory taxable wage base) (.09% for calendar year 2009)  
(b)  Other \_\_\_\_\_% of statutory taxable wage base (must be less than 0.12 %)(.09% in 2009)  
(c)  None. Employees were informed on \_\_\_\_\_ that no deductions would be taken for New Jersey Family Leave Insurance Benefits.

Method used: 1.  Written Notice 2.  Verbal Notice 3.  Bulletin Board Notice  
4.  Other \_\_\_\_\_

6. Employees' election: Employees' agreement to establishment or modification of the Plan (**Required** if employees contribute to the cost of the Plan, unless, in the case of a modification, such modification does not include either a reduction in the amount or duration of benefits or an increase in the rate of employee contributions.)

- (a) Date election was held: \_\_\_\_\_  
(b) Total number of employees required to contribute to the Family Leave Plan: \_\_\_\_\_  
(c) Number of employees in Line (b) agreeing to the Family Leave Plan: \_\_\_\_\_

**The original records of the election are submitted with this application.**

(After being recorded by the Division of Temporary Disability Insurance, they will be returned to the employer, who shall retain them during the existence of the Family Leave Private Plan and make them available for inspection by any authorized representative of the Division.)

7. The benefits provided by the Family Leave Private Plan, payable in accordance with the details attached, will be as follows: (If more space is required, attach sheet.)

- | (a) <u>Weekly Rate</u>                      | (b) <u>Limitations</u>   | (c) <u>Eligibility Requirement</u>                          |
|---|--|---|
| <input type="checkbox"/> Statutory          | <input type="checkbox"/> All provided by NJSA 43:21-39 of the NJ Temporary Disability Benefits Law | 20 Base weeks or 1000 times the State minimum wage invoked. |
| <input type="checkbox"/> Other (list) _____ | <input type="checkbox"/> Other   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |

(d) Duration of Family Leave Insurance Benefits. The maximum duration of benefits for any individual will be:

(1)  The lesser of 6 times the weekly benefits amount or 42 days or 1/3 total wages in base year in a 12 month period.

CHECK ONE {

(2)  6 weeks (42 days) of family leave in a 12 month period.

(3)  Other (describe) \_\_\_\_\_

(e) When Benefits commence. Benefits for each period of family leave will commence:

(1)  Statutory

CHECK ONE {

(3)  Other (describe) \_\_\_\_\_

(f) **Guaranteed Minimum Benefits.** Anything in this Family Leave Private Plan to the contrary notwithstanding, the benefits payable to any employee for any period of family leave commencing while insured hereunder, shall not be less than the employee would have been entitled to receive for such period under Article III of the NJ Temporary Disability Benefits Law, but for the employee's coverage under this Family Leave Private Plan.

8. The undersigned employer agrees to the establishment of the above Family Leave Private Plan in accordance with the New Jersey Temporary Disability Benefits Law.

(Note: Pursuant to the NJAC 12:18-2.9(b), if an employer provides family leave benefits through a multi-benefit plan that does not comply with the New Jersey Temporary Disability Benefits Law, the employer shall establish a separate plan, maintained solely for the purpose of complying with the provisions of the Law.)

**Employer's Signature:** \_\_\_\_\_ Signature: \_\_\_\_\_  
 Date: \_\_\_\_\_ Title: \_\_\_\_\_  
**Must be:** (Owner, Partner, or Corporate Officer; Pres., V.P., Secy., Treas.)  
 Printed Name: \_\_\_\_\_

**FOR INSURANCE COMPANY USE**

9. Insurer's Agreement:

The undersigned insurer **agrees**, upon approval by the Division of Temporary Disability Insurance of the New Jersey Department of Labor and Workforce Development, to insure the Family Leave Private Plan described in this application and accompanying details, to pay the benefits referred to in Item 7 of this application, to furnish any required documentation to the Division, and to furnish a policy of insurance consistent with the provisions of the approved Family Leave Private Plan. A copy of the completed policy will be submitted to the Division of Temporary Disability Insurance within **forty-five (45)** days of the date of approval of this application.

Any and all notices, orders, or communications to the insurer should be mailed to:

\_\_\_\_\_, \_\_\_\_\_  
 (Name) (Title)  
 \_\_\_\_\_  
 (Address)  
 \_\_\_\_\_  
 (Name of Insurer)  
 Date Signed: \_\_\_\_\_ Signature: \_\_\_\_\_  
 (Insurer's Authorized Representative)  
 Title: \_\_\_\_\_