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

FDP-1 (R-1-12)
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.

_____
Family Leave Private Plan No.

1. ☐ **Approval** is requested for an insured Private Plan

CHECK ONE { **}** to provide New Jersey **Family Leave Insurance Benefits**

☐ **Modification** is requested for the insured Private Plan indicated above

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

_____, _____*(Telephone Number)*
(Name of Employer, exactly as registered with the Department of Labor and Workforce Development)

_____
(Address)

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

_____
(Policy Holder Name)

_____
(Address)

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3. Any and all notices, orders, 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:

_____, _____, _____ *(Telephone No.)*
(Employer Representative, Title)

_____
(Address)

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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.

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

(a) ☐ Statutory percentage of taxable wages, *(amount set annually by Law)*
CHECK ONE { (b) ☐ Other _____**%** of statutory taxable wage base *(must be less than statutory)*
(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 _____

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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) Weekly Rate	(b) Limitations	(c) Eligibility Requirement
☐ Statutory	☐ 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.
☐ Other (list) _____	☐ Other	☐ Yes ☐ No

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

CHECK ONE {
- (1) ☐ The lesser of 6 times the weekly benefit amount, or 42 days or 1/3 total wages in a base year in a 12 month period.
- (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:

CHECK ONE {
- (1) ☐ Statutory
- (2) ☐ Other (describe) _____

(f) Guaranteed Minimum Benefits. Anything in this Plan to the contrary not withstanding, 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 Plan.

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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 12:21-2.9(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:

Melanie Rees, **Manager, Group Operations**
(Name) (*Title)*

2 Court Street, Suite 102 Binghamton, NY 13901
(Address)

Company of America **Renaissance Life and Health Insurance**

(Name of Insurer)

Date Signed: _____ Signature: _____
(Insurer's Authorized Representative)

Title: _____