Family Leave Insurance Regulations

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Family Leave Insurance Regulations

CHAPTER 15
SCOPE

SUBCHAPTER 1. GENERAL PROVISIONS

12:15-1.1 Purpose and scope of rules and regulations

(a) Under the Unemployment Compensation Law and the Temporary Disability Benefits Law, benefits financed from tax or contributions are paid to eligible workers who become unemployed, disabled or who require leave from work to participate in the providing of care for a family member made necessary by a serious health condition of the family member or to bond with a newborn or newly adopted child.

(b) The unemployment benefits are paid from moneys contributed to a State Unemployment Compensation Fund, and both temporary disability benefits and family leave insurance benefits from moneys contributed to the State Disability Benefits Fund or from private plans approved by the Department of Labor and Workforce Development and established by employers for such purposes.

(c) The rules and regulations contained in this subchapter are agency statements of general applicability, and are intended to assist in the implementation of the basic provisions of the laws pertaining to unemployment compensation; temporary disability benefits and family leave insurance benefits.

12:15-1.1A Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Bond" or "bonding" with a newborn child or newly adopted child means to develop a psychological and emotional attachment between a child and his or her primary care giver(s). The development of this attachment or bond between child and care giver(s) requires being in one another's presence.

"Care" means, but is not limited to, physical care, emotional support, visitation, assistance in treatment, transportation, arranging for a change in care, assistance with essential daily living matters and personal attendant services.

"Child" means a biological, adopted, or foster child, stepchild or legal ward of a covered individual, child of a domestic partner of the covered individual, or child of a civil union partner of the covered individual, who is less than 19 years of age or is 19 years of age or older but incapable of self-care because of mental or physical impairment.

As used in this definition, "incapable of self-care" means that the individual requires active assistance or supervision to provide daily self-care in three or more of the "activities of daily living" (ADLs) or "instrumental activities of daily living" (IADLs). Activities of daily living include adaptive activities, such as caring appropriately for one's grooming and hygiene, bathing, dressing and eating. Instrumental activities of daily living include cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, using a post office, etc.

As used in this definition, "mental or physical impairment" means: 1. any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitor-urinary, hemic and lymphatic, skin, and endocrine; or 2. any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"Civil union" means a civil union as defined in *N.J.S.A. 37:1-29*.

"Domestic partner" means a domestic partner as defined in *N.J.S.A. 26:8A-3*.

"Family leave" or "family temporary disability leave" means leave taken by a covered individual from work with an employer to participate in the providing of care for a family member of the individual made necessary by a serious health condition of the family member or to be with a child during the first 12 months after the child's birth, if the individual or the domestic partner or civil union partner of the individual, is a biological parent of the child, or the first 12 months after the placement of the child for adoption with the individual. "Family leave" does not include any period of time during which a covered individual is paid temporary disability benefits pursuant to *N.J.S.A. 43:21-25* et seq. (the New Jersey Temporary Benefits Law), because the individual is unable to perform the duties of the individual's employment due to the individual's own disability.

"**Family member"** means a child, spouse, domestic partner, civil union partner or parent of a covered individual.

"Family temporary disability benefits" or "family leave insurance benefits" means the benefits payable to a covered individual under P.L. 2008, c. 17 in order to compensate for wage loss suffered because of the need of the covered

individual to participate in providing care for a family member or to bond with a newborn or newly adopted child.

"Parent of a covered individual" means a biological parent, foster parent, adoptive parent, or stepparent of the covered individual or a person who was a legal guardian of the covered individual when the covered individual was a child.

"Serious health condition" means an illness, injury, impairment, or physical or mental condition, which requires:

1. Inpatient care in a hospital, hospice, or residential medical care facility; or

2. Continuing medical treatment or continuing supervision by a health care provider.

As used in this definition, "continuing medical treatment or continuing supervision by a health care provider" means:

1. A period of incapacity (that is, inability to work, attend school or perform regular daily activities due to a serious health condition, treatment therefore and recovery therefrom) of more than three consecutive days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:

i. Treatment two or more times by a health care provider; or

ii. Treatment by a health care provider on one occasion, which results in a regimen of continuing treatment under the supervision of a health care provider;

2. Any period of incapacity due to pregnancy, or for prenatal care;

3. Any period of incapacity or treatment for such incapacity due to a chronic serious health condition;

4. A period of incapacity, which is permanent or long-term, due to a condition for which treatment may not be effective (such as Alzheimer's disease, a severe stroke or the terminal stages of a disease) where the individual is under continuing supervision of, but need not be receiving active treatment by a health care provider; or

5. Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity or more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer

(chemotherapy, radiation, etc.), severe arthritis (physical therapy) or kidney disease (dialysis).

"Stepparent of the covered individual" means the person to whom the covered individual's biological parent is either currently married or with whom the covered individual's biological parent is currently sharing a civil union.

"Twelve-month period" means, with respect to an individual who establishes a valid first claim for family leave insurance benefits, the 365 consecutive days that begin with the first day that the individual establishes the claim.

"Week" means a period of seven consecutive days.

12:15-1.2 Maximum weekly benefit rates

(a) In accordance with the provisions of the Unemployment Compensation Law, N.J.S.A. 43:21-1 et seq., the maximum weekly benefit rate under the Unemployment Compensation Law is hereby promulgated as being $584.00 per week.

(b) The maximum weekly benefit rate for State Plan temporary disability and family leave insurance benefits under the Temporary Disability Benefits Law is hereby promulgated as being $ 546.00 per week.

(c) These maximum benefits shall be effective for the calendar year 2009 on unemployment compensation benefit years and periods of disability and family leave commencing on or after January 1, 2009.

12:15-1.6 Alternative earnings test

In accordance with the provisions of *N.J.S.A. 43:21-4(e)(4)(B)* and *43:21-41(d)(2)*, in those instances in which the individual has not established 20 base weeks, the alternative earnings amount for establishing eligibility is hereby promulgated as being $ 7,200 for unemployment compensation benefit years and periods of disability and family leave commencing on or after January 1, 2007.

SUBCHAPTER 2. DISCLOSURE OF INFORMATION

12:15-2.3 Benefit appeal related information

Any request for the release of information connected with the proper presentation of an unemployment, [or] temporary disability benefits or family leave insurance benefits claim before the Appeal Tribunal or the Board of Review shall be considered in accordance with *N.J.A.C. 1:12-10.1*.

SUBCHAPTER 22. CLAIMS FOR FAMILY LEAVE INSURANCE BENEFITS DURING UNEMPLOYMENT

12:17-22.1 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Bond" or "bonding" with a newborn child or newly adopted child means to develop a psychological and emotional attachment between a child and his or her primary care giver(s). The development of this attachment or bond between child and care giver(s) requires being in one another's presence.

"Care" means, but is not limited to, physical care, emotional support, visitation, assistance in treatment, transportation, arranging for a change in care, assistance with essential daily living matters and personal attendant services.

"Care giver" means the family member who is providing the required care. This term is used interchangeably with "claimant."

"Care recipient" means the family member who is receiving care for a serious health condition or the newborn child or newly adopted child with whom the "care giver" is bonding.

"Child" means a biological, adopted, or foster child, stepchild or legal ward of a covered individual, child of a domestic partner of the covered individual, or child of a civil union partner of the covered individual, who is less than 19 years of age or is 19 years of age or older but incapable of self-care because of mental or physical impairment.

As used in this definition, "incapable of self-care" means that the individual requires active assistance or supervision to provide daily self-care in three or more of the "activities of daily living" (ADLs) or "instrumental activities of daily living" (IADLs). Activities of daily living include adaptive activities such as caring appropriately for one's grooming and hygiene, bathing, dressing and eating. Instrumental activities of daily living include cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, using a post office, etc.

As used in this definition, "mental or physical impairment" means: 1. any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitor-urinary, hemic and lymphatic, skin, and endocrine; or 2. any mental or psychological disorder, such as mental

retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"Civil union" means a civil union as defined in *N.J.S.A. 37:1-29*.

"Covered individual" or "employee" means any individual who is in employment, as the term "employment" is defined at *N.J.S.A. 43:21-19(i)(1)* or any individual who has been out of such employment for less than two weeks.

"Director" means the Director of the Division of Temporary Disability Insurance in the Department of Labor and Work-force Development.

"Division" means the Division of Temporary Disability Insurance in the Department of Labor and Workforce Development.

"Domestic partner" means a domestic partner as defined in *N.J.S.A. 26:8A-3*.

"Family leave" or "family temporary disability leave" means leave taken by a covered individual from work with an employer to participate in the providing of care for a family member of the individual made necessary by a serious health condition of the family member or to be with a child during the first 12 months after the child's birth, if the individual or the domestic partner or civil union partner of the individual, is a biological parent of the child, or the first 12 months after the placement of the child for adoption with the individual. "Family leave" does not include any period of time during which a covered individual is paid temporary disability benefits pursuant to *N.J.S.A. 43:21-25* et seq. (the New Jersey Temporary Benefits Law), because the individual is unable to perform the duties of the individual's employment due to the individual's own disability.

"Family member" means a child, spouse, domestic partner, civil union partner or parent of a covered individual.

"Family temporary disability benefits" or "family leave insurance benefits" means the benefits payable to a covered individual under P.L. 2008, c. 17 in order to compensate for wage loss suffered because of the need of the covered individual to participate in providing care for a family member or to bond with a newborn or newly adopted child.

"Family Temporary Disability Leave Account" means a separate account within the State Disability Benefits Fund into which is deposited all worker contributions collected under *N.J.S.A. 43:21-7(d)(1)(G)(ii)*.

"Health care provider" means any person licensed under Federal, state, or local law, or the laws of a foreign nation, to provide health care services; or any other person who has been authorized to provide health care by a licensed health care provider.

"Licensed medical practitioner" means a licensed physician, dentist, optometrist, podiatrist, practicing psychologist, advanced practice nurse or chiropractor.

"Parent of a covered individual" means a biological parent, foster parent, adoptive parent, or stepparent of the covered individual or a person who was a legal guardian of the covered individual when the covered individual was a child.

"Private plan" means a private plan approved by the Division of Temporary Disability Insurance as defined in *N.J.S.A. 43:21-32*.

"Serious health condition" means an illness, injury, impairment, or physical or mental condition, which requires:

1. Inpatient care in a hospital, hospice, or residential medical care facility; or

2. Continuing medical treatment or continuing supervision by a health care provider.

As used in this definition, "continuing medical treatment or continuing supervision by a health care provider" means:

1. A period of incapacity (that is, inability to work, attend school or perform regular daily activities due to a serious health condition, treatment therefore and recovery therefrom) of more than three consecutive days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:

i. Treatment two or more times by a health care provider; or

ii. Treatment by a health care provider on one occasion, which results in a regimen of continuing treatment under the supervision of a health care provider;

2. Any period of incapacity due to pregnancy, or for prenatal care;

3. Any period of incapacity or treatment for such incapacity due to a chronic serious health condition;

4. A period of incapacity, which is permanent or long-term, due to a condition for which treatment may not be effective (such as Alzheimer's disease, a severe stroke or the terminal stages of a disease) where the individual is under continuing supervision of, but need not be receiving active treatment by a health care provider; or

5. Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity or more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy) or kidney disease (dialysis).

"Stepparent of the covered individual" means the person to whom the covered individual's biological parent is either currently married or with whom the covered individual's biological parent is currently sharing a civil union.

"Twelve-month period" means, with respect to an individual who establishes a valid first claim for family leave insurance benefits, the 365 consecutive days that begin with the first day that the individual establishes the claim.

"Week" means a period of seven consecutive days.

12:17-22.2 Notice and proof of family leave

(a) A written notice of family leave on which a claim for family leave insurance benefits during unemployment is based shall, within 30 days after the commencement of the period of family leave for which benefits are claimed, be furnished to the Division of Temporary Disability Insurance within the Department of Labor and Workforce Development by the claimant or an authorized representative. The notice shall state the claimant's full name, address and Social Security Number, as well as the date on which the claimant was unable to work due to the need to participate in the providing of care for a family member of the claimant made necessary by a serious health condition of the family member or to be with a child during the first 12 months after the child's birth, if the claimant or the domestic partner or civil union partner of the claimant, is a biological parent of the child, or the first 12 months after the placement of the child for adoption with the individual. The filing of Form FL-1 (Proof and claim for family leave insurance benefits) shall constitute notice of family leave.

(b) Proof of family leave on which a claim for benefits under the family leave insurance benefits during unemployment program is based shall be furnished by any claimant who expects to be unable to work due to the need to participate in the providing of care for a family member of the claimant made necessary by a serious health condition of the family member or to be with a child during the first 12 months after the child's birth, if the claimant or the domestic partner or civil union partner of the claimant, is a biological parent of the child, or the first 12 months after the placement of the child for adoption with the individual. Such proof may also be furnished by the claimant's authorized representative. When requested by the Division, additional certification from a health care provider or

licensed medical practitioner shall be filed as proof of continued need to participate in the providing of care for a family member of the claimant made necessary by a serious health condition of the family member.

(c) The failure to furnish written notice of or proof of family leave within the 30-day time period required by (a) above shall not invalidate or reduce any claim, if the Division determines that there was good cause for late filing. If a notice or proof is furnished after 30 days and the claimant does not have good cause for failing to submit the notice of proof in a timely manner, the claim shall be reduced and limited to the period commencing 30 days prior to the receipt or postmark of the notice of proof of family leave, subject to the waiting period requirement. For purposes of this subsection, "good cause" means any situation over which the claimant did not have control and which was so compelling as to pre-vent the claimant from filing his or her claim within the prescribed period.

12:17-22.3 Procedures for filing of claims for benefits

(a) All claims and other required documents relating to a claim for family leave insurance benefits during unemployment may be filed by mail, except in those cases where the claimant is notified by the Division of Temporary Disability Insurance that a personal appearance or examination will be required. Filing by mail shall be deemed complete as of the postmarked date unless the claimant can provide evidence of an earlier date of mailing.

(b) Family leave insurance benefits shall be payable to a claimant residing in another state or in Canada, provided he or she complies with the requirements of the Unemployment Compensation Law and this subchapter.

(c) If an independent medical examination of a care recipient is required, the Division shall authorize such examination to be made by a licensed medical practitioner. The payment of examination fees shall be consistent with those fees established in *N.J.A.C. 12:21-3.1(g)* concerning family leave insurance benefits examination fees.

(d) If a care recipient refuses to submit to an independent medical examination by a licensed medical practitioner designated by the Division of Temporary Disability Insurance, the claimant shall be disqualified from receiving all benefits for the period of family leave in question, except for benefits already paid.

12:17-22.4 Waiver of registration and reporting requirements

The giving of notice of family leave and the filing of proof of a claim for family leave insurance benefits during unemployment shall dispense with the requirements of N.J.A.C. 12:7-4 concerning registering for work and reporting to the Division of Temporary Disability Insurance for the period covered by the claim.

12:17-22.5 Payment of family leave insurance benefits during unemployment for individuals working for exempt employers

(a) This section provides that weeks and wages earned by an individual employed by an out-of-State employer or by the Federal government, shall be excluded from benefit calculations under the Family Leave Insurance Benefits During Unemployment Program.

(b) Where a claimant's most recent employing unit was not a covered employer, family leave insurance benefits during unemployment shall be paid to the individual under *N.J.S.A. 43:21-4(f)(2)*, provided the claimant has sufficient weeks and wages as a covered individual during the base year to establish a valid claim and is otherwise eligible.

(c) A claim for family leave insurance benefits during unemployment, which was previously established as a valid unemployment claim based wholly or in part on wages from employment that is not with a covered employer shall be redetermined. Eligibility for family leave insurance benefits during unemployment shall be based solely on wages earned as a covered individual during the base year to establish a valid claim for benefits.

12:17-22.6 Simultaneous unemployment and family leave insurance benefit periods

(a) No period of less than seven days shall be payable on a claim filed for family leave insurance benefits during unemployment under *N.J.S.A. 43:21-4(f)(2)*.

(b) Where, during a week of unemployment, an individual would be eligible for unemployment benefits except for his or her inability to work due to the need to participate in the providing of care for a family member of the claimant made necessary by a serious health condition of the family member or to be with a child during the first 12 months after the child's birth, if the claimant or the domestic partner or civil union partner of the claimant, is a biological parent of the child, or the first 12 months after the placement of the child for adoption with the individual, during a portion of such week, a claim for family leave insurance benefits during unemployment may be filed and benefits paid to such an individual, provided that he or she is otherwise eligible and any of the following conditions apply:

1. If the simultaneous benefit period occurs immediately prior to the family leave, the claimant must file a claim for family leave insurance benefits in accordance with N.J.A.C. 12:17-22.2; or

2. If the simultaneous benefit period occurs at the end of the family leave, the claimant must assert his or her ability to work by reporting to the Division during

the calendar week that the family leave ends or in the calendar week immediately following.

12:17-22.7 Benefit determination

A claimant shall be given written notice of any determination on his or her claim and of the reason for any denial of his or her claim. A copy of the determination and the probable duration for which benefits will be paid, shall be mailed to the claimant. The claimant's appeal rights shall also be clearly stated on the determination.

12:17-22.8 Payment of family leave insurance benefits during unemployment

For each claimant who establishes entitlement to family leave insurance benefits during unemployment under *N.J.S.A. 43:21-4(f)(2)*, his or her claim shall be paid from the Family Temporary Disability Leave Account.

12:17-22.9 Reduction of benefits

An employee's maximum family leave insurance benefits entitlement under *N.J.S.A. 43:21-3* and 4 as an unemployed claimant for a given 12-month period shall be reduced by the number of days of family leave insurance benefits that have been paid to the employee during that 12-month period under the State plan or a private plan.

CHAPTER 21
FAMILY LEAVE INSURANCE BENEFITS

SUBCHAPTER 1. GENERAL PROVISIONS

12:21-1.1 Purpose and scope

(a) The purpose of this chapter is to implement P.L. 2008, c. 17, which amends *N.J.S.A. 43:21-25* et seq., the Temporary Disability Benefits Law.

(b) P.L. 2008, c. 17 extends the temporary disability benefits program, so as to provide to covered individuals family leave insurance benefits, a monetary benefit (not a leave entitlement), which protects the covered individual against wage loss suffered because of the need of the covered individual to participate in providing care for a family member who has a serious health condition or to bond with a newborn or newly adopted child.

(c) Neither P.L. 2008, c. 17, nor this chapter, establishes the right of a covered individual to take leave from work to participate in providing care for a family member who has a serious health condition or to bond with a newborn or newly

adopted child; that is, neither P.L. 2008, c. 17, nor this chapter, establishes the right of a covered individual to be restored to employment following a period of leave from work to participate in providing care for a family member who has a serious health condition or to bond with a newborn or newly adopted child.

(d) Any reference within P.L. 2008, c. 17, or within this chapter, to "family leave" or "family temporary disability leave" does not create a new type of leave, but rather, pertains solely to the manner, pursuant to P.L. 2008, c. 17, in which an otherwise established type of leave must be taken by an individual in order for the individual to avoid consequences under P.L. 2008, c. 17, which may include ineligibility for or a reduction of the individual's family leave insurance benefits.

(e) Any reference within P.L. 2008, c. 17, or within this chapter, to pre-conditions related to leave (for example, the requirement under P.L. 2008, c. 17, §12, with regard to family leave to bond with a newborn or newly adopted child that a covered individual must provide the employer with prior notice of the leave not less than 30 days before the leave commences) are solely referring to pre-conditions to the payment of full family leave insurance benefits (a monetary benefit). The potential consequence to a covered individual for failure to satisfy these pre-conditions related to leave would be limited solely to those sanctions that are expressly set forth within P.L. 2008, c. 17 and this chapter, which sanctions affect entitlement to family leave insurance benefits. Those sanctions should in no way affect entitlement to leave under the New Jersey Family Leave Act, *N.J.S.A. 34:11B-1* et seq., the Federal Family and Medical Leave Act, *29 U.S.C. §§2601* et seq., any other statutory leave program, a collective bargaining agreement or an individual employer policy.

12:21-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Act" means the Temporary Disability Benefits Law, *N.J.S.A. 43:21-25* et seq., as amended by P.L. 2008, c. 17, which extends the temporary disability benefits program, so as to provide to covered individuals family leave benefits, a monetary benefit (not a leave entitlement), which protects the covered individual against wage loss suffered because of the need of the covered individual to participate in providing care for a family member who has a serious health condition or to be with a newborn or adopted child.

"Base year" with respect to a period of family leave means the 52-consecutive-calendar weeks immediately preceding the calendar week in which the period of family leave commenced, except that with respect to a period of family leave for an individual who has a period of family leave immediately after the individual has a period of disability for the individual's own disability, the period of family leave is deemed, for the purpose of specifying the time of the 52-week period in

which base weeks or earnings are required to be established for family leave benefit eligibility to have commenced at the beginning of the period of disability for the individual's own disability, not the period of family leave. "Disability" for the purpose of determining the base year with respect to a period of family leave for an individual who has a period of family leave immediately after the individual has a period of disability for the individual's own disability, means where an individual suffers any accident or sickness resulting in the individual's total inability to perform the duties of employment. For the purpose of defining the term "base year," the date on which a period of family leave commences is synonymous with the first day on which the individual establishes a claim for family leave insurance benefits.

"Benefits" or "family temporary disability benefits" or "family leave insurance benefits" means the benefits payable to a covered individual under P.L. 2008, c. 17 in order to compensate for wage loss suffered because of the need of the covered individual to participate in providing care for a family member who has a serious health condition or to bond with a newborn or newly adopted child.

"Bond" or "bonding" with a newborn child or newly adopted child means to develop a psychological and emotional attachment between a child and his or her primary care giver(s). The development of this attachment or bond between child and care giver(s) requires being in one another's presence.

"Care" means, but is not limited to, physical care, emotional support, visitation, assistance in treatment, transportation, arranging for a change in care, assistance with essential daily living matters and personal attendant services.

"Care giver" or "claimant" means the family member who is providing the required care.

"Care recipient" means the family member who is receiving care for a serious health condition or the newborn child or newly adopted child with whom the "care giver" is bonding.

"Child" means a biological, adopted, or foster child, stepchild or legal ward of a covered individual, child of a domestic partner of the covered individual, or child of a civil union partner of the covered individual, who is less than 19 years of age or is 19 years of age or older but incapable of self-care because of mental or physical impairment.

As used in this definition, "incapable of self-care" means that the individual requires active assistance or supervision to provide daily self-care in three or more of the "activities of daily living" (ADLs) or "instrumental activities of daily living" (IADLs). Activities of daily living include adaptive activities such as caring appropriately for one's grooming and hygiene, bathing, dressing and eating.

Instrumental activities of daily living include cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, using a post office, etc.

As used in this definition, "mental or physical impairment" means: 1. any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitor-urinary, hemic and lymphatic, skin, and endocrine; or 2. any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"Civil union" means a civil union as defined in *N.J.S.A. 37:1-29*.

"Claimant" means an individual who has filed a claim for family leave insurance benefits or who has notified the Division or the employer, nominee, designee, trustee, union, association of employees, insurer or organization paying bene-fits under a private plan that he or she expects to file such a claim.

"Commissioner" means the Commissioner of Labor and Workforce Development.

"Continued claim" means a claim for family leave insurance benefits filed subsequent to the first or reestablished claim, which claim is within the same 12-month period, for the same care recipient and during or following employment with the same employer. A continued claim shall include scheduled intermittent family leave and extensions of scheduled intermittent family leave.

"Covered individual" or "employee" means any individual who is in employment, as the term "employment" is defined at *N.J.S.A. 43:21-19(i)(1)* or any individual who has been out of such employment for less than two weeks.

"Director" means the Director of the Division of Temporary Disability Insurance in the Department of Labor and Work-force Development.

"Division" means the Division of Temporary Disability Insurance in the Department of Labor and Work-force Development.

"Domestic partner" means a domestic partner as defined in *N.J.S.A. 26:8A-3*.

"Employer" means any individual or type of organization, including any partnership, association, trust, estate, joint-stock company, insurance company or domestic or foreign corporation, or the receiver, trustee in bankruptcy, trustee or successor thereof, or the legal representative of a deceased person, who is an employer subject to the "Unemployment Compensation Law" (*N.J.S.A. 43:21-1* et

seq.), including any governmental entity or instrumentality, which is an employer under *N.J.S.A. 43:21-19(h)(5)*, notwithstanding that the governmental entity or instrumentality has not elected to be a covered employer pursuant to *N.J.S.A. 43:21-27(a)(2)*.

“Family leave" or "family temporary disability leave" means leave taken by a covered individual from work with an employer to participate in the providing of care for a family member of the individual made necessary by a serious health condition of the family member or to be with a child during the first 12 months after the child's birth, if the individual or the domestic partner or civil union partner of the individual, is a biological parent of the child, or the first 12 months after the placement of the child for adoption with the individual. "Family leave" does not include any period of time during which a covered individual is paid temporary disability benefits pursuant to *N.J.S.A. 43:21-25* et seq., the New Jersey Temporary Benefits Law, because the individual is unable to perform the duties of the individual's employment due to the individual's own disability.

"Family member" means a child, spouse, domestic partner, civil union partner or parent of a covered individual.

"Family Temporary Disability Leave Account" means a separate account within the State Disability Benefits Fund into which is deposited all worker contributions collected under *N.J.S.A. 43:21-7(d)(1)(G)(ii)*.

"First claim" means the claim for family leave insurance benefits initially filed on a form prescribed by the Division, the filing of which claim begins the running of the 12-month period during which a claimant is entitled to the maximum family leave insurance benefit prescribed at *N.J.S.A. 43:21-38*.

"Fund" means the State Disability Benefits Fund, as set forth in *N.J.S.A. 43:21-46*.

"Health care provider" means any person licensed under Federal, state, or local law, or the laws of a foreign nation, to provide health care services; or any other person who has been authorized to provide health care by a licensed health care provider.

"Insurer" means any insurance company duly authorized to do business in the State of New Jersey, employer acting as a self-insurer, nominee, designee, trustee, union, association of employees or organization, which has undertaken to pay benefits under a private plan.

"Intermittent family leave" means periods of non-consecutive leave taken within a 12-month period in intervals of not less than one day.

"Licensed medical practitioner" means a licensed physician, dentist, optometrist, podiatrist, practicing psychologist, advanced practice nurse or chiropractor.

"Parent of a covered individual" means a biological parent, foster parent, adoptive parent, or stepparent of the covered individual or a person who was a legal guardian of the covered individual when the covered individual was a child.

"Private plan" means a private plan approved by the Division as defined in *N.J.S.A. 43:21-32*.

"Reestablished claim" means a claim for family leave insurance benefits filed subsequent to a first claim within the same 12-month period, which claim is either a claim for a different care recipient or a claim during or following employment with a different employer.

"Serious health condition" means an illness, injury, impairment, or physical or mental condition which requires:

1. Inpatient care in a hospital, hospice, or residential medical care facility; or

2. Continuing medical treatment or continuing supervision by a health care provider.

As used in this definition, "continuing medical treatment or continuing supervision by a health care provider" means:

1. A period of incapacity (that is, inability to work, attend school or perform regular daily activities due to a serious health condition, treatment therefore and recovery therefrom) of more than three consecutive days, and any subsequent treatment or period of incapacity relating to the same condition that also involves:

i. Treatment two or more times by a health care provider; or

ii. Treatment by a health care provider on one occasion, which results in a regimen of continuing treatment under the supervision of a health care provider;

2. Any period of incapacity due to pregnancy, or for prenatal care;

3. Any period of incapacity or treatment for such incapacity due to a chronic serious health condition;

4. A period of incapacity, which is permanent or long-term, due to a condition for which treatment may not be effective (such as Alzheimer's disease, a severe stroke or the terminal stages of a disease) where the individual is under

continuing supervision of, but need not be receiving active treatment by a health care provider; or

5. Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity or more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy) or kidney disease (dialysis).

"Stepparent of the covered individual" means the person to whom the covered individual's biological parent is either currently married or with whom the covered individual's biological parent is currently sharing a civil union.

"Twelve-month period" means, with respect to an individual who establishes a valid first claim for family leave insurance benefits, the 365 consecutive days that begin with the first day that the individual establishes the claim.

"Waiting period" means the first seven consecutive days of a first claim or of a reestablished claim, during either of which no family leave insurance benefits shall be payable to any individual under the State plan, except that:

1. If benefits shall be payable for three consecutive weeks with respect to any period of family leave, then benefits shall also be payable with respect to the first seven days thereof;

2. In the case of intermittent family leave, in a single period of family leave taken to provide care for a family member of the individual with a serious health condition, family leave insurance benefits shall be payable with respect to the first day of leave taken after the first one-week period following the commencement of the period of family leave and each subsequent day of leave during that period of family leave; and if benefits become payable on any day after the first three weeks in which leave is taken, then benefits shall also be payable with respect to any leave taken during the first one-week period in which leave is taken; and

3. In the case of an individual taking family leave immediately after the individual has a period of disability for the individual's own disability, there shall be no waiting period between the period of the individual's own disability and the period of family leave.

"Week" means a period of seven consecutive days.

12:21-1.3 Service of papers

(a) Any and all written communications issued by the Division may be served personally or by registered or certified mail. A copy of the notice may be left at the principal office or place of business in New Jersey of the person required to be served.

(b) Such service shall constitute due notice.

(c) The verification by the individual who served the notice or the return post office receipt of the registered or certified mail shall be proof that notice was served.

12:21-1.4 Reimbursement of funds

If benefits have been paid in error to a claimant by one program (either the State plan, family leave insurance benefits during unemployment, or a private plan) for a period of family leave and the claimant is correctly entitled to benefits under another program (either the State plan, family leave insurance benefits during unemployment, or a private plan) for that same period of family leave, the Division may arrange for a reimbursement of funds between the two programs. If it is determined that the benefits were received as a result of the claimant's making a false statement knowing it to be false or knowingly failing to disclose a material fact, the individual shall be subject to a fine and re-payment of the overpaid amount under the provisions of *N.J.S.A. 43:21-55(a)*.

12:21-1.5 Completion of medical certifications by health care provider or licensed medical practitioner

No health care provider or licensed medical practitioner shall charge a claimant or care recipient a fee for services rendered in completing forms issued by the Division of Temporary Disability Insurance or by any insurer requesting medical information associated with the filing of any claim for payment of family leave insurance benefits.

12:21-1.6 Payment of benefits

(a) The Division (for State plan and family leave insurance benefits during unemployment) or the insurer (for private plan), shall make all family leave insurance benefit checks payable to the claimant, except under the following circum-stances:

1. As prescribed under *N.J.S.A. 43:21-42(b)*, relative to the payment of benefits due a deceased claimant; or

2. As prescribed under *N.J.S.A. 43:21-42(c)*, relative to the payment of benefits due a minor.

(b) The Division (for State plan and family leave insurance benefits during unemployment) or the insurer (for private plan), shall deliver all family leave insurance benefit checks directly to the claimant, except under the circumstances set forth in (c) below.

(c) The Division (for State plan and family leave insurance during unemployment) or the insurer (for private plan), may deliver family leave insurance benefit checks to the employer, which family leave insurance benefit checks shall have been made payable to the claimant pursuant to (a) above, only when all of the following conditions have been met:

1. The employer has advanced moneys to the claimant in an amount equal to or in excess of the family leave insurance benefits to which the claimant is entitled under the State or private plan; and

2. The claimant has knowingly and voluntarily signed a written agreement authorizing the delivery of his or her family leave insurance benefit check to the employer.

12:21-1.7 Plan jurisdiction

Whether the claimant for a particular claim is covered by the State plan or a private plan shall be determined based on the coverage (State plan or private plan) provided by the current employer at the time the first or reestablished claim is filed or, where the claimant has become unemployed within the 14 days immediately preceding the claim, his or her most recent previous employer at the time the first or reestablished claim is filed.

12:21-1.8 Notice to workers

(a) Each employer shall post in each of the employer's worksites, in a place or places accessible to all employees at the worksite, a printed notification of covered individuals' rights relative to the receipt of family leave insurance benefits under P.L. 2008, c. 17 and this chapter.

(b) Each employer shall provide each employee of the employer with a written copy of the notification referred to in (a) above under each of the following circumstances:

1. Not later than April 1, 2009;

2. At the time of the employee's hiring;

3. Whenever the employee provides notice to the employer under *N.J.A.C. 12:21-3.7* or under the analogous provision within a private plan;

4. At any time, upon the first request of the employee.

(c) The written notification under (b) above may be transmitted by the employer to the employee in electronic form.

(d) The notification poster referred to in (a) above and the written notification referred to in (b) above shall be made available by the Department to any employer upon request by the employer to the Department at the following address:

Department of Labor and Workforce Development
Office of Constituent Relations
P.O. Box 110
Trenton, New Jersey 08625-0110

SUBCHAPTER 2. PRIVATE PLANS

12:21-2.1 Extent of coverage

(a) All employees of the employer shall be covered by one or more private plans, without restrictions or exclusions, except that, subject to the approval of the Division, any private plan may exclude employees of a separate unit, craft, organization, plant, department or establishment, or other class or classes of employees. Application for such exclusion shall be submitted on a form and in a manner prescribed by the Director. The Division may not approve the exclusion of a class or classes of employees determined by the age, sex or race of the employees or by the wages paid such employees, if, in the opinion of the Division, such exclusion would result in a substantial selection of risk adverse to the State plan. For the purposes of this subsection, the employees of an employing unit (not a subject employer) performing ser-vices for an employer, as defined in *N.J.S.A. 43:21-19(g)* shall be considered a class of employees, which may be excluded.

(b) Employees excluded from a private plan shall be covered under the State plan and the employer shall be liable for the deduction and payment of workers' contributions, as required by *N.J.S.A. 43:21-7*.

(c) All proposed private plans shall be submitted for review and approval by the Division. An employer failing to secure the approval of a private plan shall be deemed to be covered under the State plan and the employer shall be liable for the deduction of workers' contributions and payments of workers' contributions to the Fund as required by *N.J.S.A. 43:21-7* until such date as a private plan is effective.

(d) An employee who ceases to be covered by a private plan, whether by termination of the plan, changing employers or for any other reason, shall, if otherwise eligible, become entitled to family leave insurance benefits from the Fund.

(e) The responsibility for coverage shall be established by the covered individual's last employer. The application for benefits shall be processed by the insurer, if the employer has an approved private plan and the individual is covered by that plan, or by the State plan if the employer has State plan coverage. However, claims coming within the purview of *N.J.A.C. 12:21-2.10* or *3.6* shall be governed thereby.

12:21-2.2 Benefits

(a) An employee shall not be entitled to any benefits from the Fund with respect to any period of family leave commencing while he or she is covered under a private plan.

(b) An employee shall not be paid any benefits for family leave insurance benefits during unemployment, *N.J.S.A. 43:21-3* and 4, for any period of family leave commencing while he or she is a "covered individual" as defined in *N.J.S.A. 43:21-27(b)(2)*.

(c) The benefits provided by a private plan shall be set forth in the plan both as to eligibility requirements and amounts payable.

(d) If application for benefits is made under the State plan or family leave insurance benefits during unemployment and it is determined that the claim should have been made under a private plan, an employee shall not be deprived of benefits under the private plan for failure to file a timely claim for benefits provided that:

1. The application to the State plan would have constituted a timely filed claim to the private plan if it had been then made; and

2. Proof of entitlement to family leave insurance benefits is furnished under such private plan within the period required therein or within 30 days after the employee has notice that the claim should have been made under the private plan.

(e) If an employee is overpaid benefits under a private plan, the amount of such overpayment shall not be deducted from the amount of benefits to which he or she may be entitled under the State plan or under *N.J.S.A. 43:21-3* and 4 as an unemployed claimant for a subsequent period of family leave. If an employee is overpaid benefits under the State plan, the amount of such overpayment shall

not be deducted from the amount of benefits to which he or she may be entitled under a private plan, or under *N.J.S.A. 43:21-3* and 4 as an unemployed claimant for a subsequent period of family leave.

(f) An employee's maximum family leave insurance benefit entitlement under a private plan for a given 12-month period shall be reduced by the number of days of family leave insurance benefits that have been paid to the employee during that 12-month period under the State plan or under *N.J.S.A. 43:21-3* and 4 as an unemployed claimant.

(g) If the benefits claimed by an employee under a private plan are denied, such denial shall be by a written notice to the employee, giving the reason therefor and stating the employee's appeal rights as provided under *N.J.A.C. 12:18-2.6* and 1:12A. Upon the issuance of such notice, the Division shall be immediately furnished with a copy of the claim and the notice of denial, or facsimiles thereof.

(h) The private plan shall provide for payment of benefits to employees weekly, biweekly, or at such intervals as the employee is customarily paid wages, unless otherwise approved by the Director.

(i) No reduction in the amount or duration of benefits or increase in the rate of employee contributions shall be made without prior approval of the Division. Approval shall be given if the Division finds that the plan, after such modification, continues to meet the requirements of the Act and this chapter and, if the employees are to contribute toward the cost of such modified plan, that a majority of the employees covered by the plan have agreed to the modification by written election (by ballot or otherwise) in accordance with this chapter.

1. The Division shall be given prompt notice of any change to a private plan, which change does not affect nor alter the provisions of the plan, and, therefore, does not require approval under this section.

12:21-2.3 Proof of coverage

Notice, in a form approved by the Director, of the benefits provided by the private plan shall be furnished to the covered employees either by individual certificates or other direct written notification at the time of coverage, or by conspicuous and continuing posting at the place of employment. This notice shall reflect current rates, eligibility requirements, benefit entitlements, and appeal rights to the Division as specified in *N.J.A.C. 12:21-2.6*. This notice shall be available for inspection at the work site. A copy of the notice shall be submitted annually to the Division.

12:21-2.4 Choice of health care provider

(a) A care recipient whose care giver is covered under a private plan shall have the right to choose his or her own health care provider. The care giver shall, if requested by the private plan insurer, have the care recipient submit to an examination by a licensed medical practitioner designated by the private plan insurer. The examinations shall not be more frequent than once a week, shall be made without cost to the care giver or care recipient and shall be held at a reason-able time and place. Refusal by the care recipient to submit to an examination shall disqualify the care giver from all benefits for the period of family leave in question, except from benefits already paid.

(b) Where a care recipient has utilized a health care provider, and that health care provider has examined the care recipient and has diagnosed him or her with a serious health condition, the insurer paying benefits may only deny benefits to the care giver during that period so certified where:

1. The insurer paying benefits has contacted the care recipient's health care provider and has reached a mutual agreement therewith as to a change in the period of either the care recipient's serious health condition or care required by the care giver;

2. A licensed medical practitioner designated by the insurer paying benefits has examined the care recipient and has determined that the care recipient either no longer has a serious health condition or requires care by the care giver. Where such a determination has been made, benefits shall not be paid beyond the date of the examination;

3. A care recipient refuses to submit to or fails to attend an examination conducted by a licensed medical practitioner designated by the insurer paying benefits, in which case the care giver shall be disqualified from receiving all benefits for the period of family leave in question, except as to benefits already paid; or

4. The insurer paying benefits has obtained credible factual evidence showing that the care recipient is performing activities that demonstrate a serious health condition does not exist. In such instances, benefits shall not be paid beyond the date that such factual evidence is obtained.

12:21-2.5 Nonprofit provision

No employer, union or association representing employees and no person acting in behalf of any of the foregoing shall so administer or apply the provisions of a private plan as to derive any profit therefrom.

12:21-2.6 Appeals

(a) The appeal procedures for private plan family leave insurance cases are found at *N.J.A.C. 1:12A* and at the *N.J.A.C. 12:18* Appendix.

(b) If a claimant covered under a private plan is denied benefits by the insurer for any period of family leave or he or she disagrees with a determination of benefits made by the insurer, he or she has the right to appeal the determination or denial.

(c) The appeal or complaint shall be filed with the Division within one year after the beginning of the period for which benefits are claimed. Such appeal or complaint shall be filed, either personally or by mail, by the claimant or his or her representative. A late appeal shall be considered on its merits if it is determined that the appeal was delayed for good cause. Good cause exists in circumstances where it is shown that:

1. The delay in filing the appeal was due to circumstances beyond the control of the appellant; or

2. The appellant delayed filing the appeal for circumstances that could not have been reasonably foreseen or prevented.

(d) Any appeal or complaint by a claimant claiming benefits under an approved private plan shall be filed on a form and in a manner prescribed by the Director. The claimant must include the reasons for the appeal or complaint and explain why he or she disagrees with the determination or denial of benefits on the form.

(e) Upon receipt of such appeal or complaint, the Division shall conduct an investigation and such informal conferences as it may deem necessary to determine the facts and settle the issues.

(f) Any appeal or complaint shall be deemed filed on the day it is delivered to the office of the Division of Temporary Disability Insurance, Labor and Workforce Development Building, PO Box 957, John Fitch Plaza, Trenton, New Jersey 08625-0957, or if mailed, the complaint shall be deemed filed on the postmarked date appearing on the envelope in which the complaint is mailed; provided, postage is prepaid and the envelope is properly addressed.

12:21-2.7 Review

(a) All approved private plans shall be reviewed by the Division during their continuance to insure compliance with the law and regulations thereunder.

(b) Where a decision to accept or deny a claim is not made within 45 days of filing of claim, the insurer shall notify the Division of such fact giving the reasons therefor.

12:21-2.8 Application for approval

(a) An employer desiring to establish a private plan for the payment of family leave insurance benefits to employees shall file an application on a form and in a manner prescribed by the Director. In requesting the form, the employer shall inform the Division whether the family leave insurance benefits will be provided by a contract of insurance, or by an agreement between the employer and a union or association representing the employees or by the employer as a self-insurer.

(b) If two or more employers desire to have their private plans insured by a single policy of insurance, either by mutual agreement or by agreement as set forth in (a) above, each shall file an application for approval on a form and in a manner prescribed by the Director, designating a nominee, designee, trustee or one of them as the duly authorized agent for the purposes of the Act.

(c) All documents required by the Division for the completion of the approval process shall be submitted within 90 days of the date the application is received. A new application shall be filed if all such documents are not received within 90 days unless the employer can demonstrate good cause for the delay. For the purposes of this section, "good cause" means any situation over which the employer did not have control and which was so compelling as to prevent the employer from submitting the documents as required by the Division.

(d) An application submitted for approval of a private plan shall bear the signature of an authorized representative of the insuring organization, if the private plan is to be insured by an admitted insurer or union welfare fund and:

1. A corporate officer if the employer is a corporation;

2. The owner if the employer is an individual; or

3. A partner if the employer is a partnership.

12:21-2.9 Minimum plan requirements

(a) Each private plan, in order to secure Division approval, shall provide to the employees covered thereby, rights equal at least to those set forth in *N.J.S.A. 43:21-37* to *43:21-42* inclusive, by assuring that:

1. The private plan shall cover all employees, except as provided elsewhere in this chapter, for benefits during any family leave commencing while the plan is in effect;

2. Eligibility requirements for family leave insurance benefits shall be no more restrictive than those requirements for benefits payable under the State plan; and

3. Except as provided for in *N.J.A.C. 12:21-2.10*, the family leave insurance benefits payable to each employee covered thereunder shall be at least equal, in both weekly amount and duration, to those which would be payable to the employee under the State plan, but for his or her inclusion in the private plan.

(b) An employer may provide family leave insurance benefits through a plan established solely for the administration of benefits required pursuant to the Temporary Disability Benefits Law, *N.J.S.A. 43:21-25* et seq., or through a multi-benefit plan; provided, however, that, if the multi-benefit plan does not comply with all of the provisions of 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.

12:21-2.10 Concurrent coverage

(a) A private plan shall not preclude simultaneous or concurrent coverage by reason of an individual's employment with two or more employers. Such employee shall receive not less than the benefits payable under the State plan both as to benefit amount and duration.

(b) A covered individual is in "concurrent employment" if he or she is in employment with two or more employers during the last calendar day of employment immediately preceding the period of family leave. The term "concurrent employers" means the covered employers with whom an employee was employed on the last day of employment.

(c) If an employee is in concurrent employment and only one employer has a private plan, then the employee shall be entitled to receive benefits under that private plan, if otherwise eligible. Such benefits shall not be less than he or she would be eligible to receive under the State plan with respect to all employment, if he or she were covered under the State plan. No benefits shall be payable under the State plan for family leave commencing while he or she is covered under such private plan.

(d) If an employee is in concurrent employment with two or more employers and more than one employer has a private plan, the employee shall be entitled to receive benefits under each private plan, if otherwise eligible. Each private plan shall pay not less than the full amount the employee would be eligible to receive if covered under the State plan. When determining the amount to be paid, the

private plan may take into account coverage under other private plans and benefits may be apportioned among the plans in the same proportion that the employee earned wages with each employer in the last eight calendar weeks immediately preceding the period of family leave. In no event shall the employee receive less than the benefits to which he or she would be entitled under the most favorable plan, both as to weekly amount and duration.

12:21-2.11 Employee consent

If employees are required to contribute to the cost of a private plan, the employer shall submit, in writing, to the employees a brief summary of the provisions of the plan, including the weekly benefit rate, the maximum amount and du-ration of benefits and the contributions required from the employees with respect to the benefits to be provided thereby. A majority of the employees to be covered must agree by election (by written ballot or other manner prescribed by the Director) to the establishment of the plan, which shall include the worker's contribution required. Evidence of their consent shall be shown on the application for approval.

12:21-2.12 Evidence of consent

(a) There shall be submitted on the application for approval a statement showing the total number of eligible employees in employment by the employer and the number of employees who agreed to the plan, together with the individual bal-lots or documents verifying the employees' consent. The ballots or documents of consent, after review by the Division, shall be returned to the employer.

(b) The results of such election shall be posted promptly and the records pertaining thereto shall be maintained by the employer and be available for inspection by Division representatives during the existence of the private plan.

12:21-2.13 Certificate of approval; effective date

(a) The Division shall issue a "Certificate of Approval of Private Plan," which shall constitute evidence of approval of the plan by the Division.

(b) Each such private plan shall be submitted in detail to the Division and shall be approved by the Division to take effect as of the first day of the calendar quarter next following the submission date, or as of an earlier date if requested by the employer and approved by the Division. Grounds for approval of an earlier effective date include, but are not limited to, whether the plan:

1. Is the result of an agreement contained in a labor-management contract; or

2. Covers a newly formed subsidiary of an employer with an existing private plan; or

3. Is the result of a succession from an employer with an existing private plan. As provided in *N.J.S.A. 43:21-7(c)(7)(A)*, a successor in interest is an entity that acquires the organization, trade, or business, or substantially all the assets of an employer, whether by merger, consolidation, sale, transfer, descent, or otherwise.

(c) Approved contributory plans must remain in effect through at least December 31, 2009.

12:21-2.14 Withdrawal of certificate of approval

(a) A certificate of approval may be withdrawn or revoked upon notice and opportunity for hearing if the Division finds:

1. That there is danger that benefits accrued or to accrue will not be paid;

2. That the security for such payment is insufficient;

3. That there has been a failure to comply with the terms and conditions of the plan;

4. That there has been a failure to pay benefits to eligible claimants promptly;

5. That, in the case of an insured private plan, the insurance company has given notice of the cancellation of the policy of insurance thereunder;

6. That the employer, his or her duly authorized agent, the union or association representing the employees or any per-son acting in behalf of any of the foregoing are deriving a profit in instituting or administering the plan;

7. That the employer, or insurer or any other party responsible for the payment of benefits, as the case may be, has failed to comply with the Act and regulations; or

8. Other good cause.

(b) A certificate of approval may be withdrawn or revoked effective as of the date of the occurrence of the condition, violation, event or omission forming the basis for such withdrawal or revocation, or at any subsequent date which in the judgment of the Director or his or her authorized representative, shall be necessary for the protection of the benefit rights of the employees covered by the plan. The Division shall give the employer, the insurer or organization paying benefits, and all interested parties notice of revocation or withdrawal of the certificate of approval and an opportunity for a hearing.

12:21-2.15 Termination on petition by employees

Upon receipt by the Division of a petition to terminate a private plan, signed by not less than 10 percent of the employees covered by the private plan, the Division shall order an election, after 30 days' written notice to the employer. No such election shall be required more often than once in any 12 consecutive months. The Division shall, whenever it deems necessary, supervise such election.

12:21-2.16 Eligibility to petition

(a) An employee, to be eligible to sign any petition requesting an election to discontinue a private plan, shall be in the employ of the employer as of the date of the petition, and covered by the plan. The form of the petition requesting an election shall be prescribed by the Director.

(b) An employee, to be eligible to vote in any election to discontinue a private plan, shall be in the employ of the employer as of the date of the election and covered by the plan.

12:21-2.17 Requirements of election

(a) Any election to discontinue a private plan shall be in accordance with this subchapter. The election shall be by writ-ten ballot but the Director may order a secret ballot if the facts so warrant. The ballot shall be so worded as to give each employee voting an opportunity to vote for or against the discontinuance of the private plan. The time and place of the election shall be convenient to employees, and on not less than 30 days' written notice by the employer to the employees. The notice of the election and the results thereof shall be given to the employees affected by one of the following methods, by:

1. Posting on bulletin boards in the employer's establishment or place of business for a period of not less than 30 days;

2. Mail addressed to each employee; or

3. Personal service.

(b) A record of the method used shall be kept by the employer.

12:21-2.18 Retention of election records

The records pertaining to any election to discontinue a private plan shall be retained by the employer and shall be avail-able for inspection by the Division representatives for a one-year period from the date of termination.

12:21-2.19 Certification of election results

A statement shall be submitted forthwith by the employer to the Division showing the total number of employees eligible to vote, and the number of employees who voted for and against termination of the plan.

12:21-2.20 Discontinuance

(a) As provided in the Act, a private plan shall be discontinued when the Division withdraws its approval thereof upon being furnished satisfactory evidence that a majority of the covered employees have made election in writing to discontinue such plan.

(b) An employer may discontinue a private plan upon proper notice to the Division and to the covered employees.

12:21-2.21 Responsibility of employer on withdrawal of certificate of approval

(a) The employer shall be liable for the deduction of workers' contributions and payment of workers' contributions, as required by *N.J.S.A. 43:21-7*, with respect to wages paid for employment subsequent to the effective date of withdrawal or revocation of the certificate of approval, unless the Division has approved another private plan to become effective on the day immediately following.

(b) Form FDP-22, Notice of Withdrawal of Approval of Family Leave Insurance Benefits Private Plan, shall be conspicuously posted for a period of not less than 30 days at or in the employer's factory, establishment or other premises at which the workers, who were covered under the private plan, are employed, as evidence of the termination of that plan.

12:21-2.22 Insurer liability

(a) A policy of insurance providing for the payment of benefits under a private plan shall provide that the insurer shall remain liable for the payment of benefits to any employee covered by the policy and the private plan for any period of family leave commencing, during the continuance of the private plan, after the policy became effective and prior to the termination of the policy.

1. With respect to a period of family leave immediately after the individual has a period of disability during the individual's own disability, the period of disability is deemed, for the purposes of determining whether the period of disability commenced prior to the date of termination, to have commenced at the beginning of the period of disability during the individual's own disability, not the period of family leave.

(b) At least 60 days' notice shall be given to the Division by the insurer or the policyholder before termination of the policy becomes effective, except that, if the policy is being terminated by reason of a change of insurer, this requirement may be waived.

(c) If a policy is being terminated for nonpayment of premium, at least 15 days' written notice shall be given to the Di-vision before termination of the policy becomes effective.

12:21-2.23 Mandatory provision

Each contract of insurance providing for the payment of benefits under a private plan shall contain a clause or clauses guaranteeing that the benefits meet the requirements of *N.J.A.C. 12:21-2.9*, Minimum plan requirements.

12:21-2.24 Security required

(a) The security required by the Division from an employer whose private plan does not provide for the assumption of the liability to pay benefits by an insurer, duly authorized and admitted to do business in this State, shall be in the form of a cash deposit, a bond of an admitted surety insurer conditioned on the payment of obligations under the plan, or bearer bonds issued or guaranteed by the United States of America or issued by this State, the amount to be determined by the Division upon the basis of the size of the payroll, the class or classes of risks contemplated, the financial standing of the employer and any additional factors, which the Division may deem proper.

(b) The amount shall not be less than one-half of the contributions that would have been paid by the employees to be covered by the private plan during the previous year, or one-half of the estimated contributions of such employees for the ensuing year, whichever is greater.

12:21-2.25 Security exemption

(a) Exemption from the requirement of *N.J.A.C. 12:21-2.24*, Security required, shall be granted to any employer who:

1. Is exempt from insuring the employer's workers' compensation liability, as provided by law; or

2. Satisfies the Division as to the employer's financial responsibility to pay the benefits provided by the employer's plan by furnishing a complete, current financial statement and such other proof as may be acceptable to the Division. An annual review of the financial responsibility will be made.

12:21-2.26 Disposition of security upon termination

(a) The security provided for in this subchapter should be applied by the Division to the payment of any unpaid obligations under the private plan. Upon termination of a private plan, which does not provide for the assumption by an admitted insurer of the liability to pay benefits, or upon withdrawal of approval of such private plan, the Division shall retain the security deposited, for the purpose of securing the payment of the obligations of the private plan. Upon the expiration of all benefit claims outstanding after the lapse of five complete calendar quarters following the effective date of termination or withdrawal of approval, the Division shall make a final assessment of the charges against the employer as provided in the Act and this subchapter.

(b) The Division may make a partial return of the security at an earlier date if it finds that such security is in excess of that required.

12:21-2.27 Exchange of information

(a) If an employee's weekly benefit amount, determined under the benefit provisions of an employer's private plan, with respect to any period of family leave, is less than the maximum weekly benefit amount payable under the State plan, and such weekly benefit amount has been computed on a basis different from that provided for covered individuals under the State plan, the weekly benefit amount shall be recomputed in accordance with the provisions of the New Jersey Temporary Disability Benefit Law, *N.J.S.A. 43:21-40*, as amended.

(b) If such recomputed weekly benefit amount is less than the maximum weekly benefit amount payable under the State plan and the computation of the "average weekly wage" for such recomputation yields a result, which is less than the individual's average weekly earnings in employment with all covered employers during the base weeks in such eight calendar weeks, then the insurer, which has undertaken to pay the benefits provided by the plan shall request the Division to provide such payer with a statement of the weekly wages of the employee earned from all covered employers during the eight base weeks immediately preceding the calendar week in which the employee's family leave commenced.

(c) When requesting such information, such payer shall furnish the Division with the following information:

1. The name, address and Social Security Number of the employee;

2. The date on which the family leave commenced;

3. The names and addresses of such other employers, from whom the employee alleges to have earned wages immediately preceding his or her family leave, as

may be necessary to determine all wages earned in the required eight base weeks; and

4. The weekly earnings of the employee from the employer during each of the calendar weeks in the 52 calendar weeks immediately preceding the family leave, if any.

(d) If the private plan of an employer provides, as a condition of eligibility for benefits with respect to a period of family leave, that an otherwise eligible employee shall have established at least 20 or a lesser number of base weeks within the 52 calendar weeks preceding the week in which his or her period of family leave commenced and the employee has not established such base weeks from his or her employment with the employer, then the insurer, which has undertaken to pay the benefits provided by the plan shall request the Division to provide such payer with a statement of the number of base weeks in the employee's base year. When requesting such information, such payer shall furnish the Division with the following information:

1. The name, address and Social Security Number of the employee;

2. The date on which the family leave commenced;

3. The names and addresses of such other employers, from whom the employee alleges to have earned wages in the 52 calendar weeks immediately preceding his or her family leave, as may be necessary to determine the required number of base weeks; and

4. The number of calendar weeks in the 52 calendar weeks immediately preceding the calendar week in which the period of family leave commenced, during which the employee earned not less than the minimum base week requirement as defined in *N.J.S.A. 43:21-27(i)(4)* from the employer.

(e) If the private plan of an employer provides, with respect to periods of family leave commencing on or after July 1, 2009, that the maximum total benefits payable to any eligible employee may be computed as an amount equal to six times the weekly benefit rate or 1/3 of his or her total wages in his or her base year, whichever is lesser, where it appears that such provision will be applicable with respect to any period of family leave and where the insurer does not have sufficient information regarding wages earned with prior employers in the base year, then the insurer shall request the Division to provide a statement of the total wages in the employee's base year. When requesting such information, such insurer shall furnish the Division with the following information:

1. The name, address and Social Security Number of the employee;

2. The date on which the family leave commenced;

3. Names and addresses of other employers in the 52 weeks prior to the week in which the family leave occurred;

4. Total amount of wages earned by claimant with the most recent employer.

12:21-2.28 Notice from employers

Within 10 days after the mailing of a request for information with respect to a period of family leave, each employer having a private plan shall furnish the Division with any information requested or known to the employer, which may bear upon the eligibility of the claimant.

12:21-2.29 Reports by self-insurers

(a) For the one-year period ending December 31 of each calendar year during which a self-insured private plan is in effect, each employer shall, on a form prescribed by the Division, file a statement, on or before the 30th day following the end of the one-year period, showing the following information with regard to each of the following types of claims: care of sick child, care of sick spouse, care of sick domestic partner, care of sick civil union partner, care of sick parent, bonding by biological parent with a newborn child, bonding by domestic partner or civil union partner of biological parent with a newborn child, bonding by individual with newly adopted child:

1. The number of claims for family leave insurance benefits received during the one-year period;

2. The number of claims for family leave insurance benefits accepted during the one-year period;

3. The number of workers who received family leave insurance benefits during the one-year period;

4. The amount of family leave insurance benefits paid during the one-year period;

5. The average weekly family leave insurance benefit during the one-year period;

6. The amount of sick leave, vacation leave or other fully paid time, which resulted in reduced benefit duration during the one-year period;

7. With regard solely to family leave insurance benefit claims to care for sick family members, the amount of intermit-tent family leave insurance benefits paid during the one-year period

8. The average duration of family leave insurance benefits, in days, during the one-year period.

(b) The information reported under (a) above shall be broken down by sex and by age group, beginning at 25 years and under and increasing in increments of 10.

(c) On or before the 30th day following the close of each calendar year during which a self-insured private plan is in effect, the employer shall, on a form prescribed by the Division, file a report showing:

1. The amount of funds available at the beginning of that year for payment of family leave insurance benefits;

2. The amount contributed by workers during that year;

3. The direct cost of administration of the plan during that year;

4. The number of employees covered by the plan as of December 31; and

5. Such other information as the Division may require with respect to the financial ability of the self-insurer to meet the self-insured's obligations under the plan.

12:21-2.30 Reports by unions and other benefit payers

(a) For the one-year period ending December 31 of each calendar year, each union, association of employees, nominee, trustee or organization, which has assumed the liability to pay the family leave insurance benefits required under one or more private plans (which benefits are not guaranteed by a contract of insurance of an insurer duly authorized and admitted to do business in this State) shall, on a form prescribed by the Division, file a statement, on or before the 30th day following the end of the one-year period showing the following information with regard to each of the following types of claims: care of sick child, care of sick spouse, care of sick domestic partner, care of sick civil union partner, care of sick parent, bonding by biological parent with a newborn child, bonding by domestic partner or civil union partner of biological parent with a newborn child, bonding by individual with newly adopted child:

1. The number of claims for family leave insurance benefits received during the one-year period;

2. The number of claims for family leave insurance benefits accepted during the one-year period;

3. The number of workers who received family leave insurance benefits during the one-year period;

4. The amount of family leave insurance benefits paid during the one-year period;

5. The average weekly family leave insurance benefit during the one-year period;

6. The amount of sick leave, vacation leave or other fully paid time, which resulted in reduced benefit duration during the one-year period;

7. With regard solely to family leave insurance benefit claims to care for sick family members, the amount of intermit-tent family leave benefits paid during the one-year period

8. The average duration of family leave insurance benefits, in days, during the one-year period.

(b) The information reported under (a) above shall be broken down by sex and by age group, beginning at 25 years and under and increasing in increments of 10.

(c) On or before the 30th day following the close of each calendar year each union, association of employees, nominee, trustee or organization, which has assumed the liability to pay the family leave insurance benefits required under one or more private plans (which benefits are not guaranteed by a contract of insurance of an insurer duly authorized and admitted to do business in this State) shall, on a form prescribed by the Division, file a report showing:

1. The amount of funds available at the beginning of that year for payment of family leave insurance benefits;

2. The amount contributed by workers during that year;

3. The direct cost of administration of the plan during that year;

4. The number of employees covered by the plan as of December 31; and

5. Such other information as the Division may require with respect to the financial ability of the self-insurer to meet the self-insured's obligations under the plan.

12:21-2.31 Reports by insurance companies

(a) For the one-year period ending December 31 of each calendar year, each insurance company, which has assumed the liability to pay the family leave insurance benefits required under one or more private plans shall, on a form prescribed by the Division, file a statement, on or before the 30th day following the end of the one-year period showing the following information with regard to each of the following types of claims: care of sick child, care of sick spouse, care of sick domestic partner, care of sick civil union partner, care of sick parent, bonding by biological parent with a newborn child, bonding by domestic partner

or civil union partner of biological parent with a newborn child, bonding by individual with newly adopted child:

1. The number of claims for family leave insurance benefits received during the one-year period;

2. The number of claims for family leave insurance benefits accepted during the one-year period;

3. The number of workers who received family leave insurance benefits during the one-year period;

4. The amount of family leave insurance benefits paid during the one-year period;

5. The average weekly family leave insurance benefit during the one-year period;

6. The amount of sick leave, vacation leave or other fully paid time**,** which resulted in reduced benefit duration during the one-year period;

7. With regard solely to family leave insurance benefit claims to care for sick family members, the amount of intermit-tent family leave benefits paid during the one-year period

8. The average duration of family leave insurance benefits, in days, during the one-year period.

(b) The information reported under (a) above shall be broken down by sex and by age group, beginning at 25 years and under and increasing in increments of 10.

(c) On or before the 30th day following the close of each calendar year each insurance company, which has assumed the liability to pay the family leave insurance benefits required under one or more private plans shall, on a form prescribed by the Division, file a report showing:

1. The amount of funds available at the beginning of that year for payment of family leave insurance benefits;

2. The amount contributed by workers during that year;

3. The direct cost of administration of the plan during that year;

4. The number of employees covered by the plan as of December 31; and

5. Such other information as the Division may require with respect to the financial ability of the self-insurer to meet the self-insured's obligations under the plan.

12:21-2.32 Reports by employers having two or more plans

On or before the 30th day following the close of each calendar year, each employer having two or more approved private plans in effect during such calendar year or any portion thereof shall, on a form prescribed by the Division, file a report showing the amount of taxable wages paid during such calendar year to employees while covered under each such private plan.

12:21-2.33 Continuation of plan on successor employer

(a) If there is a change in the employer and the successor employer assumes the obligations and liability of the predecessor under the plan, the plan shall be transferred to the successor, if:

1. The workers to be covered by the plan immediately after the succession are not required to contribute to the cost of the plan;

2. The class or classes of workers covered by the plan immediately prior to the succession constitute a majority of the workers in the same class or classes employed by the successor immediately after the succession;

3. A majority of the workers in the class or classes covered by the plan in the employ of the successor immediately after the succession give their written consent to the plan; or

4. The plan is limited to the separate unit, plant, department or establishment operated by the predecessor and the provisions of (a)1, 2 or 3 above, are met with respect to such separate unit, plant, department or establishment.

12:21-2.34 Employee contributions to private plans

(a) Employee contributions to a private plan shall be deposited in a trust fund account and shall not be part of an employer's assets.

(b) Trust fund assets deposited by an employer as required under (a) above shall be used only for the administration and payment of family leave insurance benefits.

(c) Employers shall make trust fund accounts available for periodic inspection and audit by the Division at the discretion of the Director.

(d) Upon termination of a contributory private plan for family leave insurance benefits, excess contributions remaining in the trust account shall, after five completed calendar quarters, be remitted to the Division for deposit in the Fund.

SUBCHAPTER 3. STATE PLAN

12:21-3.1 Extent of coverage

(a) A claimant shall not be entitled to any benefits from the Fund with respect to any period of family leave commencing while he or she is covered under a private plan.

(b) A claimant shall not be paid any benefits under *N.J.S.A. 43:21-3* and 4 for any period of family leave commencing while he or she is a "covered individual" as defined in *N.J.S.A. 43:21-27(b)(2)*.

(c) An individual who is covered by a private plan or is separated from his or her employment for a period of two weeks or more immediately prior to the family leave shall not be entitled to any benefits under the State plan.

(d) If application for benefits is made under a private plan or for family leave insurance benefits during unemployment, *N.J.S.A. 43:21-4*, and it is determined that the claim should have been made under the State plan, a claimant shall not be deprived of benefits under the State plan for failure to give timely notice provided that:

1. The application to the private plan or for family leave insurance benefits during unemployment, *N.J.S.A. 43:21-4*, would have been timely noticed to the State plan if it had been then made; and

2. Proof of family leave is made under the State plan not later than the time prescribed by the Act.

(e) If an employee is overpaid benefits under the State plan, the amount of such overpayment shall not be deducted from the amount of benefits to which he or she may be entitled under a private plan or under *N.J.S.A. 43:21-3* and 4 as an unemployed claimant for a subsequent period of family leave. If an employee is overpaid benefits under a private plan, the amount of such overpayment shall not be deducted from the amount of benefits to which he or she may be entitled under the State plan, or under *N.J.S.A. 43:21-3* and 4 as an unemployed claimant for a subsequent period of family leave.

(f) Where a care recipient has utilized a health care provider, and that health care provider has examined the care recipient and has diagnosed him or her with a serious health condition, the claimant may only be denied benefits during that period so certified where:

1. The Division has contacted the care recipient's personal health care provider and has reached a mutual agreement therewith as to a change in the period of the care recipient's serious health condition or care required by the care giver;

2. A licensed medical practitioner designated by the Commissioner of Labor and Workforce Development or his or her designee has examined the care recipient and has determined that the care recipient no longer has a serious health condition or requires care by the care giver. Where such a determination has been made, benefits shall not be paid beyond the date of examination;

3. A care recipient refuses to submit to or fails to attend an examination conducted by a licensed medical practitioner designated by the Commissioner of Labor and Workforce Development or his or her designee, in which case the claim-ant shall be disqualified from receiving all benefits for the period of family leave in question, except as to benefits already paid; or

4. The Division has obtained credible factual evidence showing that the care recipient is performing activities that demonstrate a serious health condition does not exist. In such instances, benefits shall not be paid beyond the date that such factual evidence is obtained.

(g) If a physical examination of a care recipient is required, the Commissioner of Labor and Workforce Development or his or her designee shall authorize such examination to be made by a licensed medical practitioner. Upon submission of a written report of the examination to the Department of Labor and Workforce Development, a fee customarily charged by a physician in a given specialty for each such examination, shall be paid to the examining medical practitioner, which fee shall be charged to the Family Temporary Disability Leave Account as a cost for the administration of family leave insurance benefits payments. Upon recommendation of the Director and upon a finding that an increase or decrease in the customary or "fair market" fee is necessary or appropriate to be cost effective and supply a sufficient pool of examiners, the Commissioner may increase or decrease the customary fee pursuant to a schedule issued by the Commissioner on a Statewide or county basis for one or more of these groups of examiners. In cases requiring the services of a specialist, or in cases requiring clinical tests supporting the diagnosis, the Commissioner or his or her designee shall, in his or her discretion, authorize such services or tests, the fees to be fixed in advance by the Commissioner.

(h) The responsibility for coverage shall be established by the covered individual's last employer. The application for benefits shall be processed by the insurer, if the employer has an approved private plan and the individual is covered by that plan, or by the State plan if the employer has State plan coverage. However, claims coming within the purview of *N.J.A.C. 12:21-2.10* or *3.6* shall be governed thereby.

12:21-3.2 Notice and proof of family leave

(a) Within 30 days after the commencement of a period of family leave, a written notice of family leave, on which a claim for State plan benefits is based, shall be furnished to the Division by the claimant. The notice need not be on any prescribed form but shall state the claimant's full name, address and valid Social Security Number, as well as the date on which claimant begins the period of family leave. The filing of Form FL-1 (Proof and claim for family leave insurance benefits) or Form FL-2 (Proof and claim for family leave insurance benefits for bonding immediately following a State plan claim for pregnancy disability) shall constitute notice of family leave.

(b) Proof of the care recipient's serious health condition or of the birth of a child or of the placement for adoption of a child on which a claim for family leave insurance benefits under the State plan is based shall be furnished by the claimant. The proof and claim accompanied, for claims relating to care of a family member (as opposed to bonding claims), by a certification of the health care provider, shall be furnished to the Division, on Form FL-1 (Proof and claim for family leave insurance benefits) not later than 30 days after the commencement of the period of family leave for which family leave benefits are claimed.

(c) The health care provider certification contained within Form FL-1 shall state the following:

1. The date, if known, on which the serious health condition of the family member commenced;

2. The probable duration of the serious health condition of the family member;

3. The medical facts regarding the serious health condition of the family member, of which the health care provider has personal knowledge;

4. A statement that the serious health condition of the family member requires the participation of the covered individual in providing care to the family member;

5. An estimate of the amount of time, total time and frequency, that the services of the covered individual are required in order to participate in providing care to the family member;

6. The dates of treatment of the family member if the family leave is for planned medical treatment; and

7. Such other information as the Division may require.

(d) A continued claim form on which the claimant must provide additional medical information in order to continue receiving family leave insurance benefits shall be filed as proof of continued family leave when requested by the Division.

(e) The failure to furnish a written notice or proof of family leave within the time or manner required by the Act and this subchapter shall not invalidate or reduce any claim, if it shall be shown to the satisfaction of the Division not to have been reasonably possible to furnish notice or proof and that such notice or proof was furnished as soon as reasonably possible. If such notice or proof is not furnished, the claim shall be reduced and limited to the period commencing 30 days prior to the receipt of the notice or proof of family leave.

(f) The Division shall require each claimant to have a valid Social Security Number when filing a claim for benefits. The claimant, upon request of the Division, shall provide proper identification, including proof of a valid Social Security Number, verification of the Social Security Number if there is a discrepancy, and documentation showing his or her legal name and address.

1. If unable to present proof of a valid Social Security Number, proper verification, or other appropriate documentation, the individual shall be determined ineligible for benefits until such time that he or she is able to present the required identification.

2. Any person who refuses or fails to cooperate with the Division in any effort to verify the validity of a Social Security Number, may be held ineligible for benefits from the date of claim and liable to refund any benefits previously paid.

3. Upon a showing of good cause by the claimant, the Division may, on a claimant-by-claimant basis, waive the requirement that the claimant have a valid Social Security Number when filing a claim for benefits.

12:21-3.3 Filing of claims for benefits

(a) All claims and other required documents relating thereto may be filed by mail or by such other means as prescribed by the Division (including by electronic means), except in those cases where the claimant is notified by the Division that a personal appearance will be required. Filing by mail or by such other means as prescribed by the Division (including by electronic means) shall be deemed complete based on the postmark date, or in its absence, the date received by the Division.

(b) Family leave insurance benefits shall be payable to any claimant while outside of this State, provided he or she complies with the Act and this subchapter.

12:21-3.4 Reestablished claims

(a) For a reestablished claim either where the care recipient is not the same as for the most recent previous claim or where the reestablished claim is filed during or following employment with a different employer than for the most re-cent previous claim, the claimant shall be required to serve a waiting period.

(b) For the claimant who satisfies the requirements of (a) above, the weekly benefit rate for the reestablished claim shall be recalculated pursuant to *N.J.S.A. 43:21-40*.

(c) For the claimant who satisfies the requirements of (a) above, the maximum total family leave insurance benefits payable in days for the existing 12-month period under *N.J.S.A. 43:21-38*, shall be reduced by the number of days in family leave insurance benefits, which have been paid to the claimant during that 12-month period.

(d) For a reestablished claim where both the care recipient is not the same as for the most recent previous claim and the reestablished claim is filed during or following employment with a different employer than for the most recent previous claim, the claimant shall be required to serve a waiting period.

(e) For the claimant who satisfies the requirements of (d) above, the weekly benefit rate for the reestablished claim shall be re-calculated pursuant to *N.J.S.A. 43:21-40*.

(f) For the claimant who satisfies the requirements of (d) above, the maximum total family leave insurance benefits pay-able in days for the existing 12-month period under *N.J.S.A. 43:21-38*, shall be reduced by the number of days in family leave insurance benefits which have been paid to the claimant during that 12-month period.

12:21-3.5 Reduction of benefits

(a) The amount of benefits otherwise payable to a claimant under the State plan for any week of family leave, or part thereof, shall be reduced by the amount paid concurrently under any governmental or private retirement, pension or permanent disability benefit or allowance program to which his or her most recent employing unit contributed on his or her behalf. If such latter benefits are being paid on a monthly basis, the amount thereof to be deducted for each day of family leave shall be determined as 1/30 of such monthly amount, multiplied by seven, and the amount (disregarding any fractional part of a dollar) shall be

subtracted from the weekly benefit rate. If such latter benefits are being paid on a weekly basis, the amount thereof to be deducted for each day of family leave shall be determined as 1/7 of the weekly amount multiplied by the number of days of family leave during that week and that amount (disregarding any fractional part of a dollar) shall be subtracted from the weekly benefit rate.

(b) The amount of benefits payable to a claimant under the State plan for any week of family leave, or part thereof, shall not be reduced by the amount of benefits payable under any program as mentioned above, unless one or more payments thereunder have been received by the claimant prior to the date on which the check in payment of benefits under the State plan is issued.

(c) The employer of a claimant may require the claimant, during a period of family leave, to use up to two weeks of paid sick leave, paid vacation time or other leave at full pay.

(d) The employer of a claimant may permit the claimant, during a period of family leave, to use in excess of two weeks of paid sick leave, paid vacation time or other leave at full pay.

(e) When the employer requires the claimant to use paid sick leave, paid vacation time or other leave at full pay under (c) above, the employer may within a reasonable and practicable time request of the State plan or the private plan, as the case may be, that the claimant's maximum family leave insurance benefits entitlement during the 12-month period be reduced by the number of days of leave at full pay required by the employer to be used by the claimant under (c) above and which has been paid by the employer to the claimant during the period of family leave.

(f) Where the employer requests a reduction of maximum family leave insurance benefits entitlement under (e) above, the State plan or private plan, as the case may be, shall reduce the claimant's maximum family leave insurance benefits entitlement during the 12-month period by the number of days of leave at full pay paid by the employer to the claimant during the period of family leave. This reduction in the maximum family leave insurance benefits entitlement during the 12-month period in number of days will result in a corresponding reduction, relative to the instant claim and any subsequent claims filed during the 12-month period, in the monetary amount of family leave insurance benefits, which reduction will be directly attributable to the above-mentioned reduction in the maximum family leave insurance benefit entitlement.

(g) Where the employer does not request a reduction of maximum family leave insurance benefits entitlement under (e) above, the State plan or private plan, as the case may be, shall not reduce the claimant's maximum family leave insurance benefits entitlement during the 12-month period by the number of days

of leave at full pay paid by the employer to the claimant during the period of family leave.

(h) When the employer permits the claimant to use paid sick leave, paid vacation time or other leave at full pay under (d) above, the claimant's maximum family leave insurance benefits entitlement during the 12-month period shall not be reduced by the number of days of leave at full pay permitted by the employer to be used by the claimant under (d) above and which has been paid by the employer to the claimant during the period of family leave.

(i) When the employer permits the claimant to use paid sick leave, paid vacation time or other leave at full pay under (d) above, no family leave insurance benefits shall be payable during the period that the claimant is absent from work using paid sick leave, paid vacation time or other leave at full pay.

(j) An employee's maximum family leave insurance benefit entitlement under the State plan for a given 12-month period shall be reduced by the number of days of family leave insurance benefits that have been paid to the employee during that 12-month period under a private plan or under *N.J.S.A. 43:21-3* and 4 as an unemployed claimant.

12:21-3.6 Concurrent coverage and multiple employers

(a) A covered individual is in "concurrent employment" if he or she is in employment with two or more employers during the last calendar day of employment immediately preceding the period of family leave. The term "concurrent employers" means the covered employers with whom an employee was employed on the last day of employment.

(b) If an employee is in concurrent employment and only one employer has a private plan, then the employee shall be entitled to receive benefits under that private plan, if otherwise eligible. Such benefits shall not be less than he or she would be eligible to receive under the State plan with respect to all employment, if he or she were covered under the State plan. No benefits shall be payable under the State plan for family leave commencing while he or she is covered under such private plan.

(c) If an employee is in concurrent employment and all employers are covered under the State plan, an individual shall have his or her weekly benefit amount under the State plan computed on the basis of his or her total wages with all such employers during the base weeks in the eight calendar weeks immediately preceding the calendar week in which the family leave commenced.

12:21-3.7 Notice from claimant to the employer

(a) With regard to a claim for family leave insurance benefits to bond with a newborn or newly adopted child, the covered individual shall provide the employer with notice of the period of family leave upon which the covered individual's claim for family leave benefits is based not less than 30 days prior to commencement of the family leave, unless the family leave commences while the individual is receiving unemployment benefits, in which case the covered individual shall notify the Division.

(b) Failure by the claimant to provide the employer with the 30 days notice set forth in (a) above, shall result in a reduction in the claimant's maximum family leave insurance benefits entitlement for the 12-month period by an amount of benefits attributable to two weeks of family leave, unless the time of the leave is unforeseeable or the time of the leave changes for unforeseeable reasons.

(c) With regard to a claim for family leave insurance benefits to care for a family member with a serious health condition, which family leave insurance benefits are taken on a continuous, non-intermittent basis, the claimant shall provide the employer with prior notice of the family leave in a reasonable and practicable manner, unless an emergency or other unforeseen circumstance precludes prior notice.

(d) Failure by the claimant to provide the employer with the notice set forth in (c) above, shall not result in a reduction in the claimant's maximum family leave insurance benefits entitlement, nor shall it result in the denial of a claim for family leave insurance benefits.

(e) With regard to a claim for family leave insurance benefits to care for a family member who has a serious health condition, which family leave insurance benefits are taken on an intermittent basis, the claimant shall provide the employer with prior notice of the family leave not less than 15 days prior to the first day on which family leave insurance benefits are paid for the intermittent leave, unless an emergency or other unforeseen circumstance precludes prior notice.

(f) Failure by the claimant to provide the employer with the notice set forth in (e) above, shall not result in a reduction in the claimant's maximum family leave insurance benefits entitlement, nor shall it result in the denial of a claim for family leave insurance benefits.

12:21-3.8 Notice from the Division to the claimant and employer

(a) A claimant shall be given written notice of any decision on his or her claim and of the reason for any denial of his or her claim.

(b) If the "Employer's Statement" on the application for benefits has not been completed by an employer or his or her representative, a request for information shall be mailed or delivered to the employer or employers by whom the claim-ant was employed at the commencement of the family leave or by whom he or she was last employed if out of employment less than two weeks.

(c) A copy of the decision of eligibility of the claimant stating his or her weekly benefit rate and the probable duration for which benefits will be paid, shall be mailed or delivered to the employer or employers by whom such claimant was employed at the commencement of the family leave or by whom he or she was last employed if out of employment less than two weeks.

12:21-3.9 Notice required from employers

(a) Within 10 days after the mailing of a request for information with respect to a period of family leave, an employer shall furnish the Division with any information requested or known to him or her, which may bear upon the eligibility of the claimant.

(b) If any employer or employing unit fails to respond to the request for information within 10 days after the mailing of such request, the Division shall rely entirely on information from other sources, including an affidavit completed by the claimant to the best of his or her knowledge and belief with respect to his or her wages and time worked. If it is deter-mined that any information in such affidavit is erroneous, no penalty shall be imposed on the claimant except in the event of fraud.

(c) Any employer failing to respond to a request for information within the prescribed time period shall be subject to the penalties provided under *N.J.S.A. 43:21-55(b)*.

(d) The employer, within two working days after receipt of the decision of eligibility, shall furnish the Division with any information known to him or her bearing upon the eligibility of the claimant or duration of payments to be made.

(e) If after receipt of a decision of eligibility an employer acquires information, which may render the claimant ineligible for benefits or reduce the rate or amount of benefits, such employer shall immediately forward the information to the Division.

12:21-3.10 Intermittent leave

(a) A covered individual shall not be eligible for family leave insurance benefits where the covered individual seeks to take intermittent family leave for the purpose of bonding with a newborn or newly adopted child, except that where both the covered individual and the employer agree that the covered individual

will be permitted to take family leave for the purpose of bonding with a newborn or newly adopted child in non-consecutive periods of seven days or more, family leave insurance benefits shall be payable for those periods of family leave.

(b) A covered individual shall be eligible for family leave insurance benefits where the covered individual seeks to take intermittent family leave for the purpose of providing care for a family member who has a serious health condition, so long as the following conditions are met:

1. The covered individual can establish that it is medically necessary to take the family leave intermittently;

2. The total period within which the intermittent family leave is to be taken does not exceed 12 months;

3. The covered individual makes a reasonable effort to schedule the leave, so as not to unduly disrupt the operations of the employer; and

4. Where possible, prior to the commencement of the intermittent family leave, the covered individual provides the employer with a regular schedule of the day or days of the week on which the intermittent family leave will be taken.

(c) In order to establish eligibility for family leave insurance benefits for a period of intermittent family leave to care for a family member with a serious health condition, a covered individual shall be required to support the claim for family leave benefits with a certification from a health care provider, which states the following:

1. The date, if known, on which the serious health condition of the family member commenced;

2. The probable duration of the serious health condition of the family member;

3. The medical facts regarding the serious health condition of the family member, of which the health care provider has personal knowledge;

4. A statement that the serious health condition of the family member requires the participation of the covered individual in providing care to the family member;

5. An estimate of the amount of time, total time and frequency (for example, for a total of three months, two days per week) that the services of the covered individual are required in order to participate in providing care to the family member;

6. A statement as to the medical necessity for the intermittent leave and the expected duration of the intermittent leave; and

7. The dates of treatment of the family member if the family leave is for planned medical treatment.

12:21-3.11 School employees

(a) Between academic years or terms or during a school-wide recess, for an individual who is an employee of an educational institution and who has a reasonable assurance of returning to work in the same or similar capacity during the succeeding academic year or term or following a period of school-wide recess, such individual shall be considered a covered individual and in-employment between academic years or terms or during a school-wide recess.

(b) Under the circumstances set forth in (a) above, the individual who does not work for the educational institution between academic years or terms or during a school-wide recess shall not be eligible for family leave insurance benefits between academic years or terms or during a school-wide recess.

(c) Under the circumstances set forth in (a) above, where the individual who is an employee of an educational institution has sufficient base year wages in other covered employment and where these wages are sufficient to establish a valid claim, family leave insurance benefits shall be paid based only upon the wages from such other covered employment for the period of time between the academic years or terms or during the school-wide recess.

(d) When an employee files a claim for family leave insurance benefits immediately following a period between academic years or terms or immediately following a school-wide recess covered under (a) above, because the employee is considered a covered individual and in employment during the period between academic years or terms or the school-wide recess immediately preceding the claim for family leave benefits, the claimant's lack of remuneration during the 14 days preceding the filing of the family leave insurance benefits claim shall not preclude coverage of the employee's claim for family leave insurance benefits under the State plan or a private plan.

(e) Under the circumstances set forth in (c) and (d) above, as in all circumstances, the "average weekly wage," which is a key component of the family leave insurance benefits calculation, shall be determined in accordance with *N.J.S.A. 43:21-27(j)*.

12:21-3.12 Leaves of absence and continuity of employment

(a) An employee who is on a voluntary and mutually agreed upon leave of absence, whether that leave of absence is paid or unpaid, including a leave of absence covered under the Federal Medical and Family Leave Act or the New Jersey Family Leave Act, shall be considered a covered individual and in-employment during such a leave of absence.

(b) When an employee files a claim for family leave insurance benefits immediately following a period of voluntary and mutually agreed upon leave of absence covered under (a) above, because the employee is considered a covered individual and in employment during the period of voluntary and mutually agreed upon leave of absence immediately preceding the claim for family leave benefits, the claimant's lack of remuneration during the 14 days preceding the filing of the family leave insurance benefits claim shall not preclude coverage of the employee's claim for family leave insurance benefits under the State plan or a private plan.

(c) Under the circumstances set forth in (b) above, as in all circumstances, the "average weekly wage," which is a key component of the family leave insurance benefits calculation, shall be determined in accordance with *N.J.S.A. 43:21-27(j)*.

12:21-3.13 Filing of appeals

Unless the claimant or the employer, within seven calendar days after the delivery of a determination or notification thereof, or within 10 calendar days after such notification was mailed to his or her last-known address, files an appeal from such determination, it shall be final and benefits shall be paid or denied in accordance therewith.

12:21-3.14 Rules on appeal

The rules of the Board of Review shall govern appeals in family leave insurance benefit cases under the State plan. See the appeal rules at *N.J.A.C. 12:20*.

12:21-3.15 Family leave insurance benefit calculation during period from July 1, 2009 through December 31, 2009

For the purpose of calculating the amount of family leave insurance benefits to which a covered individual is entitled with regard to a claim filed between July 1, 2009 and December 31, 2009, all wages earned during the 52 weeks immediately preceding the filing of the claim shall be used, including wages earned between July 1, 2008 and December 31, 2008, notwithstanding that no employee contributions to the Fund were collected under P.L. 2008, c. 17, prior to January 1, 2009.