

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

DP-1 (R-01-12)  
STATE OF NEW JERSEY  
DEPARTMENT OF LABOR  
AND WORKFORCE DEVELOPMENT  
DIVISION OF TEMPORARY DISABILITY INSURANCE  
**APPLICATION FOR  
APPROVAL OR MODIFICATION OF INSURED PRIVATE  
PLAN**

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

\_\_\_\_\_  
Private Plan No.

1.  **Approval** is requested for an insured Private Plan  
CHECK ONE { } to provide New Jersey Temporary  
Disability Benefits

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

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

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

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

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

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

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

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

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

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ (Telephone No.)  
(Employer Representative, Title)

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

4. The Plan will cover:

(a)  All covered employees of the employer. Number of New Jersey employees: \_\_\_\_\_

(b)  Other (describe classes covered) \_\_\_\_\_

If more space is required, attach sheet.

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

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

**CHECK ONE** (a)  Statutory percentage of taxable wages, (amount set annually by Law)  
(b)  Other \_\_\_\_\_% of statutory taxable wage base (must be less than statutory)  
(c)  None. Employees were informed on \_\_\_\_\_ that no deductions would be taken for New Jersey Temporary Disability Benefits.

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

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

(a) Date election was held: \_\_\_\_\_

(b) Total number of employees required to contribute to the Private Plan: \_\_\_\_\_

(c) Number of employees in Line (b) agreeing to the Private Plan: \_\_\_\_\_

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

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

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

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

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

(1)  The lesser of 26 times the weekly benefit amount or 1/3 total wages in base year.

**CHECK ONE** { (2)  26 weeks for each period of disability.

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

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

(1)  On the eighth day with respect to either accident or sickness. (**Note:** If benefits are payable for three or more consecutive weeks then the first seven days become payable.)

**CHECK ONE** { (2)  On the first day with respect to any period of disability.

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

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

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

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

**Employer's Signature:** \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Title: \_\_\_\_\_

**Must be:** (Owner, Partner, or Corporate Officer; Pres., V.P., Secy., Treas.)

Printed Name: \_\_\_\_\_

### FOR INSURANCE COMPANY USE

9. Insurer's Agreement:

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

should

Notice of assessments made against the employer \_\_\_\_\_ be mailed to the insurer

should not

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

\_\_\_\_\_, \_\_\_\_\_  
(Name)

(Title)

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

\_\_\_\_\_  
(Name of Insurer)

Date Signed: \_\_\_\_\_

Signature: \_\_\_\_\_  
(Insurer's Authorized Representative)

Title: \_\_\_\_\_