SDI Online Tutorial Claimant Registration, Online Access, and Claim Filing



This tutorial will explain how to:

- 1. Create a Benefit Programs Online Account (Step 1)
- 2. Register as a Claimant in SDI Online (Step 2)
- 3. Access Your SDI Online Account
- 4. File a Disability Insurance Claim
- 5. File a Paid Family Leave Bonding Claim New Mother
- 6. File a Paid Family Leave Bonding Claim for New Mothers (without a prior pregnancy-related disability claim), New Fathers, or Foster Care or Adoptive Parents
- 7. Submit Paid Family Leave Bonding Claim Attachments
- 8. File a Paid Family Leave Care Claim
- 9. Submit Paid Family Leave Care Claim Attachments
- 10. File a Paid Family Leave Military Assist Claim
- 11. Submit Paid Family Leave Military Assist Claim Attachments
- 12. Update My Benefit Programs Online Profile Email, Password, Security Questions, or Personal Image and Caption
- 13. Complete Paper Claim Forms

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Create a Benefit Programs Online Account (Step 1)

First time access to Employment Development Department (EDD) benefits services requires a one-time registration for Benefit Programs Online.

Benefit Programs Online allows you to use a single login to access the following EDD services:

- Unemployment or Pandemic Unemployment Assistance
- Disability
- Paid Family Leave
- Benefit Overpayments

Watch EDD's <u>Benefit Programs Online: Overview and</u> <u>Registration for New Users</u> YouTube video for detailed instructions on how to register a new account.

If you have already completed the one-time registration in Benefit Programs Online, skip to <u>Register as a Claimant in SDI Online</u> (<u>Step2</u>).

Benefit Programs Online Registration:

- 1. Visit <u>Benefit Programs Online</u> (edd.ca.gov/BPO) to complete a one-time registration.
- From the Benefit Programs Online login screen, select Register now to create an account. To change the language of all screens to Spanish, select En español on the login screen.
- 3. Accept the **Terms and Conditions**. You must select **I Agree** in order to establish an online account.
- 4. Provide a personal email address that is current and is used only by you.
- 5. Set up a password that is between 8 and 20 characters. The password is case sensitive and must contain at least:
 - One uppercase letter
 - One lowercase letter
 - One number
 - One special character from this list: !@#\$%^&*()
- 6. Create the **Security Profile** with security questions and answers and a personal image and caption.
- 7. Once you submit your registration information, an email with a link will be sent to you. Select the unique link within 48 hours to complete your registration.
- After you have registered for and logged in to Benefit Programs Online, select SDI Online. You will directed to the SDI Online Registration Options (see <u>Register as a</u> <u>Claimant in SDI Online</u>). You will always use Benefit Programs Online to access SDI Online to file a Disability Insurance or Paid Family Leave claim.

1 2 3 4 5 6 7 8 9 10 11 12

Register as a Claimant in SDI Online (Step 2)



Once you have completed your Benefit Programs Online registration, return to **Benefit Programs Online** and log in to complete the SDI Online registration process.

Follow these directions to log in to Benefit Programs Online:

- 1. Enter the email address that you used to register.
- 2. Complete the security check.
- 3. Select Log In.

For Spanish, select the En español link.

State of California Employment Development Department	
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 Password To log in to Benefit Programs Online, you must verify your personal image and personal caption, and enter your password. * Use the latest version of Chrome or Firefox for the best experience. 4. Personal Image: Personal Caption: Cup 	
* Password: Forgot Password?	
6. Previous Log In	
Contact EDD Conditions of Use Privacy Policy Accessibility Copyright © 2019 State of California	

4. Verify your **Personal Image** and **Personal Caption** are correct.

If you do not recognize your personal image and caption, select **Previous** to review the email address entered on the login screen to ensure it is correct. If you are unable to verify your personal image, select <u>Contact EDD</u> (edd.ca.gov/about_edd/contact_edd.htm) for further assistance.

5. Enter the password you created during the Benefit Programs Online registration process.

6. Select Log In.

<u>CA</u>	State of California v Employment Develo	pment Department		Log Out	To log out of Benefit
My Profile My Profile Denefit Programs Online UI Online SM Select UI Online to file a claim for Unemployment Insurance (UI) benefits or to create or access your UI Online account.		Benef SDI Online Select SDI Online to file a claim for Disability Insurance (DI) or Paid Family Leave (PFL) benefits or to create or access your SDI Online account.	Programs Online, select the Log Out link in the top right hand corner of any screen.		
	To use UI Online Mobile, you must have already created a UI Online account. UI Online UI Online Mobile	SDI Online	Benefit Overpayments		
,	Note: You will be logged out after 30 minutes on an Conta	y page. ct EDD Conditions of Use Privacy Policy Acc Copyright © 2019 State of California	essibility		

From your Benefit Programs Online account, select the **SDI Online** link to begin your registration for SDI Online.

Note: If you already filed your Disability Insurance claim by paper, you will still be able to view and manager your claim through SDI Online. At this time, you can only file Paid Family Leave claims through SDI Online.

SDI Online Registration Select your account type. Claimant Select Register as a Claimant to:

- File a Disability Insurance (DI) or Paid Family Leave (PFL) claim.
- Access your claim information.

2

View your benefit payment history.

You will need:

- Social Security number
- California driver license (CDL) or identification (ID) card

Note: If you do not have a CDL or ID, you will need to file DI by mail or file PFL by mail.

Claimant registration is available from Monday to Saturday 6 a.m. to 6 p.m. and Sunday 6 a.m. to 5:30 p.m.

Register as a Claimant

Employer

Select Register as an Employer if you represent an employer.

You will need:

- Employer Account Number (EAN)
- Employer ZIP Code (as filed with the EDD Tax Branch)
- Total Subject Wages from the most recent DE 9C

Register as an Employer

Physician/Practitioner

Select Register as a Physician/Practitioner to certify Disability Insurance (DI) or Paid Family Leave (PFL) claims for your patients.

You will need:

- · Medical license information (as filed with the California Department of Consumer Affairs)
- California driver license (CDL) or identification (ID) card

Physician/practitioner registration is available from Monday to Saturday 4 a.m. to 12 midnight and Sunday 4 a.m. to 9 p.m.

Register as a Physician/Practitioner

You will be directed to the **SDI Online Registration** account type screen.

Select the **Register as a Claimant** link.

Claimant: Terms and Conditions
Terms and Conditions
Please read through the entire Terms and Conditions before proceeding. The information you provide may be used to verify your identity with federal and/or state agencies. If "I Do Not Agree" is selected, you will not be able to establish an online account.
These Terms and Conditions, which include the Conditions of Use and Privacy Statements, govern the use of and access to: (i) this website (www.edd.ca.gov/); and (ii) the information on or provided through this website.
If you establish an online account you are responsible for maintaining the confidentiality of your username and password, and you are responsible for all activities which you authorize under your username and password. You agree to: (i) immediately notify the Employment Development Department (EDD) of any unauthorized use of your username and password or any other breach of security; and (ii) log out from your account at the end of each session.
By registering for an online account, you agree to check your account regularly and frequently for messages from the EDD. Please note that e-mails will only be used to send notifications to log in to your account or when you request to reset your username or password. No confidential claim information will be sent via e-mail.
The information submitted by any party will be used by the Employment Development Department to carry out its responsibilities under the California Unemployment Insurance Code, which may include the sharing of the information with other entities as required by law.
These Terms and Conditions may change from time to time and it is your responsibility to check for updates. The last revision date for these Terms and Conditions is February 1, 2012.
I have read and understand all the above information and wish to continue with establishing an account in the State Disability Insurance (SDI) Online.
I Do Not Agree

Next, read the Terms and Conditions before proceeding. Select I Agree.

You must agree to these Terms and Condition in order to establish an online account.

1 2 3 4 5	6 / 8	B 9	10	11	12	13
Claimant Registration *Indicates Required Field						
Personal Information						
To register for a new SDI Online account, you must enter your full legal name and date of birth a	s it appears on your California driver license or identificatior	ı card.				
*First Name:		7				
Middle Name:	(If you have no middle name, leave blank.)					
*Last Name:]				
Suffix:	(If you have no suffix, leave blank.)]				
E-mail Address:	jdoe@gmail.com					
*Gender:	Select 🔻					
*Date of Birth:	(MMDDYYYY)					
*Social Security Number:	(Do not enter dashes)					
*Retype Social Security Number:						
*California Driver License or Identification Number:						
*Retype California Driver License or Identification Number:						
Cano	el	Next				

You **must** provide the following personal information. Required fields are marked with a red asterisk (*).

- Your full legal name as it appears on your California Driver License or Identification card.
- Gender.
- Date of birth as shown on your California Driver License or Identification card.
- Social Security number.
- California Driver License or Identification number.

Select Next.

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	*Indicates Required F	Field									
	Residence	Address									
				*Address Line 1:	US O International						
				Address Line 2:							
				*City:	STOCKTON						
				*State:	CA 🔻						
				*ZIP Code:	95201						
	Mailing Add	dress									
	All written correspond	dence from EDD regard	ing this account will be	e sent to this address.							
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	, c	neck nere to copy you	ur Residence Address (to your Mailing Address:							
					US O International						
				*Address Line 1:							
				Address Line 2:							
				*City:	folsom						
				*State:	CA 🔻						
				*ZIP Code:	95630]				

Complete and review your:

- residence address (can include a PO Box)
- mailing address

Required fields are marked with a red asterisk (*).

2 3	4 5 0		0 0	10		12
	Phone Numbers					
	Phone Numbers					
	Choose the phone number that you would like to select as	your primary phone number.			-	
		*Primary Phone Number:	Home Phone Number	Cell Phone Number		
		Home Phone Number:]	
			Check here if the phone m	umber is international	-	
		Cell Phone Number:	(No dashes or spaces)		1	
			Check here if the phone r	umber is international	1	
					_	
	Preferred Language					
		*Preferred Language:	English X			
		5.5	English			
		Other Language:				
	Communication Preferences					
	Indicate below how you prefer to be notified.					
	Note: It may be necessary to send some documents via US	S Postal Service. This includes Paid F	amily Leave (PFL) payments and	PFL claim-related forms. Upd	ates made to your	
	communication preference may take additional time to ta	ke effect.			2	
		*Preferred Communication:	I prefer to be notified by e	e-mail.		
			 I prefer to be notified by p 	paper mail		L
		Ca	ncel		Submit	

Next, provide your:

- Home and/or cell phone number
- Preferred language
- Communication preference

Required fields are marked with a red asterisk (*).

Select Submit.

Claimant: Personal Profile Information	
* Indicates Required Field	
Address Validation	
The address you have provided has been updated to meet USPS standards. Please verify the address is correct.	
Entered Address	
1123 Main Street Sacramento CA 95814	
Updated Address	
123 Main Street Sacramento CA 95814	
Would you like to proceed with the standardized address? Select 'Yes' to proceed or 'No' to return to correct the address.	
No Yes	

The SDI Online system may adjust your address information under the **Updated Address** field to follow USPS standards.

• Verify the address shown is correct by selecting **Yes**.

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• If the address information is incorrect, select **No** to re-enter the correct address.

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When the above message displays, you have successfully completed your SDI Online account registration.

Please keep and secure your assigned EDD Customer Account Number for future reference. You may be asked to provide this information when requesting assistance from a customer service representative.

You may now file your Disability Insurance or Paid Family Leave claim by:

- 1. Selecting the Benefit Programs Online link.
- 2. Logging in to Benefit Programs Online.
- 3. Selecting the SDI Online button.
- 4. Selecting New Claim from your SDI Online account main menu bar.

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Access Your SDI Online Account

State of California Employment Developmen	nt Department
Cog in to Benefit Programs Online En español Email: 1. 2. m not a robot reCATICHA Wirkey-Terms 3. Log In Don't have an account? Register now.	Benefit Programs Online gives you access to these EDD services: • Unemployment or Pandemic Unemployment Assistance • Disability • Paid Family Leave • Benefit overpayments

To access your SDI Online account, go directly to <u>Benefit Programs Online</u> (edd.ca.gov/BPO) to log in.

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Follow these directions to log in to Benefit Program Online:

- 1. Enter the email address that you used to register.
- 2. Complete the security check.
- 3. Select Log In.

For Spanish, select the En español link.

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D Pa	ssword
To lo	og in to Benefit Programs Online, you must verify your personal image and personal caption, and enter your password.
* Us	e the latest version of Chrome or Firefox for the best experience.
4.	Personal Image:
	Personal Caption: Cup
5.	* Password:
•	
6. –	Previous Log In
	Contact EDD Conditions of Use Privacy Policy Accessibility Copyright © 2019 State of California

4. Verify your Personal Image and Personal Caption are correct.

If you do not recognize your personal image and caption, select **Previous** to review the email address entered on the login screen to ensure it is correct. If you are unable to verify your personal image, select <u>Contact EDD</u> (edd.ca.gov/about_edd/contact_edd.htm) for further assistance.

- 5. Enter the password you created during the Benefit Programs Online registration process.
- 6. Select Log In.

<i>Cl</i> .co	State of California V Employment Devel	opment Department		To log out of Benefit
	My Profile Benefit Programs Online UI Online SM Select UI Online to file a claim for Unemploymen Insurance (UI) benefits or to create or access yo Online account. To use UI Online Mobile, you must have already created a UI Online account. UI Online UI Online Note: You will be logged out after 30 minutes on	Bene SDI Online Select SDI Online to file a claim for Disability Insurance (DI) or Paid Family Leave (PFL) benefits or to create or access your SDI Online account. SDI Online any page.	fit Programs Online Benefit Overpayments Select Benefit Overpayments to view your benefit overpayment balance, make a payment, and set up ar installment agreement. Benefit Overpayments	Programs Online, select the Log Out link in the top right hand corner of any screen.
	Co	tact EDD Conditions of Use Privacy Policy Ac Copyright © 2019 State of California	cessibility	

From your Benefit Programs Online account, select the **SDI Online** link to access your SDI Online account **Home** screen.

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E-mail Address: Jdoe@gmail.com urrent Disability Insurance Claim(s) o Results Found ending Disability Insurance Claim Application(s) to Results Found to Results Found ubmitted Paid Family Leave Claim Forms ty forms you submitted online are listed below. To submit an electronic document for a previously submitted care or bonding claim, select New Claim. The status of your Paid Family to Results Found to Results Found to Result Found	Residence Address:	123 Main St Sacramento, CA 95814	Cell Phone Num	ber: 916-555-12	13				
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	No Results Found					^			

Use your SDI Online account Home screen to:

- File a new claim.
- Update profile information.
- Continue a saved draft.
- View claim history.
- View inbox messages and take required actions.
- View a current Disability Insurance claim summary, payment history, form history, and send claim requests.
- View a pending Disability Insurance claim.
- View your submitted Paid Family Leave claim information.

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File a Disability Insurance Claim

Employment SDI Home Inbox New Claim Profile History Follow these instructions to begin	1	2	3	4	5	6	7	8	9	10	11	12	13
		Employmen Developmen State of Californi	4 4 9	SDI Home	Inbox	New Claim	Draft	Profile H	fistory	Fol ins	low thes tructions	se s to begi	n

Phone Number:

Cell Phone Number:

916-555-1212

916-555-1213

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🖾 Message Center

Check the message center Inbox below to review messages and take required actions as needed.

Inbox [New: 0, Total: 0]

Personal Information

John Doe Full Name: EDD Customer Account Number: 123456789 Mailing Address: 123 Main St Sacramento, CA 95814 **Residence Address:** 123 Main St Sacramento, CA 95814

Jdoe@gmail.com E-mail Address:

Current Disability Insurance Claim(s)

No Results Found

Pending Disability Insurance Claim Application(s)

No Results Found

Submitted Paid Family Leave Claim Forms

Only forms you submitted online are listed below. To submit an electronic document for a previously submitted care or bonding claim, select New Claim. The status of your Paid Family Leave claim is currently not available online. For assistance with a Paid Family Leave claim, call 1-877-238-4373.

No Results Found

ning a Disability Insurance claim: 1. Access your SDI Online account by

logging in to **Benefit Programs** Online.

2. Select the **SDI** Online button to be directed to your SDI Online Home screen.

3. Select New Claim from the main menu bar on your SDI Online Home screen.

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

Note: It may be necessary to send some documents via US Postal Service.

Apply for Disability Insurance Benefits

Disability Insurance

Apply for Paid Family Leave Benefits

Paid Family Leave Bonding Submit Electronic Paid Family Leave Bonding Attachment Paid Family Leave Care Submit Electronic Paid Family Leave Care Attachment Paid Family Leave Military Assist Submit Electronic Paid Family Leave Military Assist Attachment

Saved Drafts

To open and complete a form that you saved, select the Form Name. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the Delete button.

Select the **Disability Insurance** link located under the **Apply for Disability Insurance Benefits** header to apply for Disability Insurance benefits.

Submit your claim no earlier than the first day your disability begins, but no later than 49 days after your disability begins, or you may lose benefits.

If you have already submitted a claim, do not submit a duplicate claim. It may take up to 14 days for your claim to be reviewed and processed.

Disability Insurance Claim Filing	Instructions		
Before You Start and After You File			
 Please have the following information available while completing this form: Most current employer(s) business name, telephone number, and mailin Last date you worked your regular or customary duties and hours. Date you began working at less than full duty or modified duty. Wages you received or expect to receive from your employer: sick leaves Workers' Compensation claim information, if applicable. The name, address, and telephone number, if any, of the Alcoholic Record You are responsible for obtaining a Physician/Practitioner Certification 30 days. Please note that your employer will be notified that you have signalized. 	ng address as stated on your W2 fo , paid time off (PTO), vacation pay overy Home or Drug-Free Facility w for your disability. Your claim will ubmitted a DI claim. However, you	orm and/or paycheck stub. v, annual leave, and wages earned after you stop vhere you are currently receiving in-patient trea be returned if the Physician/Practitioner Certific ur detailed claim information is confidential and	oped working. Itment. cation is not received within d will not be shared with your
	Cancel		Next

The **Disability Insurance Claim Filing Instructions** screen provides important information you will need to have readily available to file a Disability Insurance claim.

Read this screen and select **Next** to proceed.

Note: Selecting **Cancel** at any time during this process will cancel the claim and return you to your SDI Online Home screen.

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Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History	
Personal Information	on						
1 Personal Information	Initial Questions	3 Employ Inform	yment ation	4 Additional Inform	nation 5	Certification	
You are currently on Step 1 Personal Inform	ation						
Section 1 - Personal Inf	ormation						
Social Security Number:	XXX-XX-XXXX		EDD Customer	Account Number:	1234567890		
Legal Name:	John Doe		California Driver Lice	nse or ID Number:	X1234567		
Date of Birth:	01-01-XXXX			Gender:	Male		
Preferred Language:	English				400 M-I- 0		
Mailing Address:	123 Main St Sacramento, CA 95814		R	esidence Address:	123 Main St Sacramento, CA	95814	
Home Phone Number:			Ce	ell Phone Number:	555-123-4567		
Section 2 - Other Names	and Social Sec	curity Nur	nbers Used				
Please enter any other names or other Social S section blank.	ecurity Numbers under which	h you have worked	d. If you have never worked	l under another name	or Social Security N	lumber please leave this	
First Name:				Middle Initial:			
Last Name:				Suffix:			
Social Security Number:							
First Name:				Middle Initial:			
Last Name:				Suffix:			
Control Constitution Management							
social security number:				_	_		
Previous		Cancel	Save as Draft			Next	

The SDI Online system will automatically populate certain portions of the application.

Verify the information in **Section 1** and complete any open fields in **Section 2**, as appropriate.

If your personal information has changed, select **Save as Draft** and update your SDI Online account profile.

Select **Next** to proceed to the next step.

Note:

- Select Save as Draft at any point in the process to complete the form at a later time.
- Select **Previous** to return to the previous screen.

1	2	3	4	5	6	7	8	9	10	11	12	13

Next

Exployment Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History
Section 3 - Employme	ent Information					
	*Are	you self employed?	🔿 Yes 🔵 No			
	*Are you a State Gove	ernment employee?	🔿 Yes 🔵 No			
	If "Yes," indicate Barga	ining Unit Number:				
*At any time during your disabil authorities because yo	ity, were you in the custody ou were convicted of violatin	of law enforcement g law or ordinance?	🔿 Yes 🔵 No			
*Before your disal	bility began, what was the la	st day you worked?	(MMDDYYYY)			
	*When did yo	our disability begin?	(MMDDYYYY)			
Date you want your Disability Insurar	nce claim to begin if different	t than the date your disability began:	(MMDDYYYY)			
*Since your disability began, have y	ou worked or are you workir	ng any full or partial days?	🔾 Yes 🔵 No			
	*H	ave you recovered?	🔿 Yes 🔵 No			
	1	f "Yes," enter date:	(MMDDYYYY)			
	*Have you	u returned to work?	🔿 Yes 🔵 No			
	1	f "Yes," enter date:	(MMDDYYYY)			
	*What is your regular or cust	omary occupation?				
	*Why did	l you stop working?	Select	×		
*How would you describe or classify you Mostly sitting; occasionally standing ar Walking/standing most of the time; occ Constantly lift, carry, push, pull or othe Constantly lift, carry, push, pull or othe Constantly lift, carry, push, pull or othe	rr job? nd walking; occasionally lift, ca casionally lift, carry, push, pull rwise move objects that weig! rwise move objects that weig! erwise move objects that weig!	arry, push, pull or other or otherwise move obj h up to 10 lbs.; frequen h up to 20 lbs.; frequen h up to 20 lbs.; frequen	wise move objects that we lects that weigh up to 20 lb tly up to 20 lbs.; occasional tly up to 50 lbs.; occasional tly over 50 lbs.; occasional	igh 10 lbs. or less s. ly up to 50 lbs. ly up to 100 lbs. y over 100 lbs.		
*Has or will your employer co	ontinue to pay you during you	ur disability leave?	🔿 Yes 🔵 No			
	lf "Yes," indic	ate type(s) of pay:	Sick Vacation Paid Time Off Annual Leave Other Type of Pay			

Other Type of Pay:

Cancel

*Was this disability caused by your job?

○ Yes ○ No

○ Yes ○ No

🔿 Yes 🔵 No

🔿 Yes 🔵 No

Save as Draft

*May we disclose benefit payment information to your employer(s)?

*Are you a resident of an alcohol recovery home or drug-free facility?

*Have you filed or do you intend to file for Workers' Compensation benefits?

Previous

Complete Section 3 - Employment Information.

Required fields are marked with a red asterisk (*).

Please confirm all dates and information you enter are correct before proceeding to avoid a possible delay or loss in benefits.

Select Next.

Employment Su	mmary			
Personal Information	Initial Questions	3 Employment Information	4 Additional Information	5 Certification
You are currently on Step 3 Employm	ent Information			
Section 4A - List of E	mployers			
Please click the "Add" button to add inf	formation about your last or current of	employer. You must add at least o	one employer.	
No Results Found				
Previous	Cancel	Add	Save as Draft	Next

Click the Add button to begin entering information about your most current employer.

You must add at least one employer.

1 2 3	4	5	6 /	8	9	10	11	12
Employer Search								
Personal Information	Initial Questions	3 Employ Informa	rment ation	4 Additional Information	5 Certif	ication		
You are currently on Step 3 Employment Info	rmation							
* Indicates Required Field								
Section 4B - Search Crite	ria							
Please search for your current or most recent er	nployer. After clicking the	"Search" button, if yo	ur employer is not found,	click the "Not Found" butto	n to enter your empl	oyer information.		
* Employer Name:	Begins With	\checkmark	B Dalton					
		Reset	Search					

To search your employer, select a search option from the drop down menu. Search options include "Begins With," "Exact," and "Sounds Like."

Enter your employer's name as stated on your W-2 or paystub.

Select Search to proceed.

1 2 3	4	5 6		8 9	10	11	12
Section 4B - Search Crite	eria						
Please search for your current or most recent e	mployer. After clickin	g the "Search" button, if	f your employer is not found, o	click the "Not Found"	' button to enter your e	mployer information.	
* Employer Name:	Begins With	\checkmark	B Dalton				
		Reset	Search				
Search Results							
Employer Name				Action			
B Dalton Bookseller	-			Select			
				1			
Previous		Cancel	Not Found				

If your employer's name populates in the **Search Results** table, click **Select** under the **Action** column.

If your employer is not listed under Search Results, select Not Found and skip to slide 32.

1	2	3	4	5	6	1	Õ	9	10	
Section 4C - I	Employer	Contact Inf	formation							
F				and (an anyoli a shaha d	6 Ctata					
Caltrans). If you are self-e	mployed, enter "	Self."	n as found on your w2	and/or paycheck stub.	r you are a State governm	ent employee, enter the	agency name (for example,			
		Last or	Current Employer Na	ame: B Dalton Book	seller					
				🖲 US 🔵 I	nternational					
			Address Li	ne 1:						
			Address Li	ne 2:						
				City:						
			S	tate: CA 💙						
			ZIP C	ode:						
		I	Employer Phone Num	ber: (No dashes	or spaces)	Ext:				
				Check here	if the phone number is ir	iternational				
Employment	Informa	tion								
* Before your disabil	ity began, what	was the last day you	worked for this em	ployer? (MMDDY	YY)					
* Do you cu	rrently have an	other employer that	you have not yet rep	oorted? OYes	◯ No					
Previous			Cancel	Save a	s Draft		Next			

If you selected your employer from the search results in Section 4B, you will be asked to complete the **Employer Contact Information** and **Employment Information** sections (if you selected **Not Found** in Section 4B, please skip to the next slide).

Add your most current employer's business name, phone number, and mailing address as stated on your W-2 or paystub.

If you have more than one employer, enter additional employers by selecting **Yes** to "Do you currently have another employer that you have not yet reported?"

Select Next.

1	2	3	4	5	6		7		8	9	10	11	12	13
Employ	yment De	tails (Add Ei	mployer)											
* Indicates Requ	uired Field													
Section	4D - Employ	ver Contact Info	ormation											
Enter your most each additional	t recent employer first. employer. If you are a S	If your employer has a PO Bo State government employee	ox, please use that as the e, enter the agency name	ir mailing address. I (for example Caltra	If you have more than no in the self e	an one emplo mployed, ent	oyer, you must pr er "Self."	rovide the infor	nation for					
		* Last or C	Current Employer Name	Bob Jones										
Please provide y	your most current empl	loyer's mailing address as fo	ound on your W2 form and	d/or paycheck stubs	s. If your employer h	nas a PO Box j	please use that a	as their mailing	address.					
				🖲 US 🔵 I	nternational									
			* Address Line 1	800 Capitol M	Mall									
			Address Line 2	:										
			* City	Sacramento										
			* State	CA 🔽										
			* ZIP Code	95814										
		E	mployer Phone Number:	9161234567		Ext:	123							
				Check here	if the phone numbe	r is internatio	nal							
Employ	/ment Inforn	nation												
* Before yo	our disability began, w	what was the last day you we	orked for this employer?	07312018										
· ·	Do you currently have	e another employer that you	u have not yet reported?	🖲 Yes 🔿 N	lo									
Previo	ous		Cancel	Save as Dra	aft			Nex	t					

If you selected **Not Found** in Section 4B, you will add your most current employer's business name, phone number, and mailing address as stated on your W-2 or paystub under **Section 4D – Employer Contact Information**.

Required fields are marked with a red asterisk (*).

To enter additional employers, select **Yes** to "Do you currently have another employer that you have not yet reported?"

Select Next.

Employment Details (Add Employer)												
* Indicates Required Field												
Address Validation												
The address you have provided has been updated to meet USPS standards. Please verify the address is correct.												
Entered Address												
800 Captiol Mall Sacramento CA 95814												
Updated Address												
800 Capitol Mall												
Sacramento CA 95814 - 4807												
Would you like to proceed with the standardized address? Select 'Yes' to proceed or 'No' to return to correct the address.												
No Yes												

The SDI Online system may adjust the employer address information to follow USPS standards.

• Confirm the **Updated Address** section is correct by selecting **Yes**.

Δ

• Select **No** to go back to the previous screen and re-enter the address.

	4 5	0		0	9		0		12
Declaration									
Personal Information	Initial Questions	Employ Informa	ment tion	Ad	lditional Inforn	nation	5	Certification	
You are currently on Step 5 Certification									
*Indicates Required Field									
Section 9 - Payment C	hoice								
If you are eligible to receive benefits, you h the Employment Development Departmen	ave two options to receive your b it (EDD). You do not have to accep	enefit payments: b t the EDD Debit Ca	y the EDD Debit Caro rd. Select your prefe	d sM , through rred paymer	Bank of Ameri It method belo	ca, or by ch w.	ieck, whic	h is mailed to	you from
	*Preferred Pa	/ment Method:	 EDD Debit Card Check 	b					
	Disclosu	es Agreement:	EDD Debit Card Fe	e Disclosure	s, DE 5617PD (I	PDF)			
* Incknowledge that I have reviewed the	e EDD Debit Card Fee Disclosures.								

In **Section 9 – Declaration**, you have the option to select your preferred payment method. You may select to receive benefit payments by EDD Debit Card or by check. You do not have to accept the EDD Debit Card.

If your preferred payment method is the EDD Debit Card, select the *EDD Debit Card Fee Declaration* (DE 5617PD) (PDF) link to view the disclosure agreement.

Select the check box below to acknowledge you have reviewed the disclosures.

•		0	0		J	6			 1 =	10
Section 10 - Declaratic " By my signature on this claim statement fals: statement or concealing a mater but. I declare under penalty of perjuin complete. By my signature on this claim Insurance all facts concerning my disa and use of information as stated in the this authorization shall be as valid as my signature of the effective date of t	ON ent, I claim benefits and cer rial fact in order to obtain p ny that the foregoing stater im statement, I authorize t ability, wages or earnings, a einformation Collection a the original, and I understa the claim, whichever is late	tify that for the period cov bayment of benefits is a vic nent, including any accom he California Department and benefit payments that und Access" section of the nd that authorizations con r.	vered by this claim I wa alation of California lav panying statements, is of Industrial Relations are within their knowl Important Disability In ntained in this claim st	as unemployed and dis v and that such violatic s to the best of my kno and my employer to fu ledge. By my signature isurance Program Infor atement are granted fr	sabled. I understan on is punishable by wledge and belief urnish and disclose e on this claim state rmation page. I agr or a period of fiftee	Ind that willfully may y imprisonment of true, correct, and to State Disabilit ement, I authorize ree that photocop en years from the	laking a or fine or d ty e release of date of			
Health Insurance Portability and Accour	ntability Act (HIPAA)									
I au horize the below named Physicial reh bilitation, and biling records con Development Department (EDD): Disa information in order to process my cla the information released to EDD may California Unemployment Insurance C by sending written notification stoppi is received. I understand that the cons revoked by me in writing, this authori revoke this authorization to avoid pro and that payment or eligibility for my incomplete claim form that cannot be	an/Practitioner to furnish an accerning my disability for w ability Insurance Branch ex- aim and/or determine eligi no longer be protected by Code. I agree that photocop- ing this authorization to th sequences for my revoking ization is valid for fifteen ye bescution or to prevent EDI benefits will be affected if e processes for payment of Authorized Physicia	nd disclose all my health in hich this claim is filed that aminers, their direct super bility for State Disability In federal privacy regulations oies of this authorization s e EDD, DI Branch MIC 29, P this authorization may re- ars form the date received b's recovery of monies to w d do not sign this authoriza State Disability Insurance	are within their knowl visors/managers and a surance benefits. I und s. (45 CFR Section 164.) hall be as valid as the O Box 826880, Sacram sult in denial of further I by EDD or the effectiv /hich it is legally entitle tion. The consequenc benefits. I understand	w inspection of and pri- ledge to the following any other EDD employ derstand that EDD is no 508(c)(2)(iii)). EDD may original. I understand I ento, CA 94280. The at 'S state Disability Insura re date of the claim, wh ed. I understand that I es for my refusal to sig I have the right to reco	ovide copies of any employees of the Q ee who may have a ot a health plan or y disclose informat have the right to re- thorization will str ance benefits. I und nichever is later. I u am signing this aut n this authorizatio eive a copy of this a	y medical, vocatio California Employ in need to access th health care provision as authorized evoke this author op on the date my derstand that, unt understand that, unt thorization volumi n may result in an authorization.	onal rment his der, so I by the rization y request less may not tarily n			
To print or view your application in a new	window, select <u>Claim for D</u>	isability Insurance (DI) Ber	nefits (DE 2501). To sav	e and file your claim, s	elect Submit.					
View Claim: Claim for Disability Insurance	(DI) Benefits (DE 2501)							4		
Previous		Cancel	Save as Draft			Su	ubmit			

In **Section 10 – Declaration**, select both check boxes to authorize an electronic signature and release of information, and enter the name of your physician/practitioner in the open field. Both boxes must be selected to complete your claim.

Select the View Claim: Claim for Disability Insurance (DI) Benefits (DE 2501) link to view, save, or print your application for your records.

Select Submit to send your claim to the EDD.

Note: Your claim is NOT complete. Your physician/practitioner must submit the "Physician/Practitioner's Certification" section of the *Claim for Disability Insurance (DI) Benefits* (DE 2501).

	-
Confirmation	
Confirmation	
You are responsible for providing your claim receipt number to your physician/practitioner so they may complete and submit a medical certification for your claim. Your claim form is not complete without the Physician/Practitioner's Certificate. For faster processing, your physician/practitioner may complete and submit this form online at www.edd.ca.gov.	
Alternatively, your physician/practitioner may submit the Physician/Practitioner's Certificate using the paper "Claim for Disability Insurance (DI) Benefits", DE 2501 form and mailing it to the EDD. Have your physician/practitioner complete and sign "Part B - PHYSICIAN/PRACTITIONER'S CERTIFICATE." Certification may be made by a licensed physician or practitioner authorized to certify to a patient's disability or serious health condition pursuant to California Unemployment Insurance Code, Section 2708. If you are under the care of an accredited religious practitioner, obtain a "Claim for Disability Insurance Benefits - Religious Practitioner's Certificate," DE 2502, by calling 1-800-480-3287 and ask your religious practitioner to complete and sign it. Rubber stamp signatures are not accepted.	
Your completed claim form must be received no earlier than 9 days, but no later than 49 days, after the first day you became disabled. If your completed claim form is late, you may lose benefits. Most claims are processed within 14 days of receipt of a properly completed claim form, which includes your portion of the DE 2501 and the Physician/Practitioner's Certificate.	
If you are receiving temporary workers' compensation benefits and are filing for reduced Disability Insurance benefits for the same days, "PART B - PHYSICIAN/PRACTITIONER'S CERTIFICATE" of this form is not required, however after filing, contact SDI by calline 1-800-480-3287.	
Customer Satisfaction Survey	
Your opinion is important to us. Select the link below to complete a survey about your online experience.	
Link to Survey	

On the Confirmation screen, you will be assigned a Form Receipt Number.

Save this number and provide it to your physician/practitioner so they can submit the medical certification.

Your physician/practitioner can complete the medical certificate through SDI Online or by completing Part B of the paper claim form, *Claim for Disability Insurance (DI) Benefits* (DE 2501).

Selecting the **Form Receipt Number** link will open a PDF printer-friendly view of the information that you submitted. ³⁶
1	2	3	4	5	6	7	8	9	10	11	12	13
---	---	---	---	---	---	---	---	---	----	----	----	----

File a Paid Family Leave Bonding Claim – New Mother

New mothers transitioning from a pregnancy-related Disability Insurance claim to a Paid Family Leave Bonding claim will:

5

- Receive a Claim for Paid Family Leave (PFL) Benefits New Mother (DE 2501FP) automatically by mail in a separate envelope at the time your final Disability Insurance payment is issued.
- Or, if you have an SDI Online account, the link to the DE 2501FP will automatically be sent to your inbox at the time your final Disability Insurance payment is issued.

Note: If you are a new mother who did not have a pregnancy-related Disability Insurance claim, a new father, or a foster/adoptive parent, please refer to the <u>File a Paid Family Leave Bonding Claim for New Mothers</u> (without a prior pregnancy-related disability claim), New Fathers, or Foster <u>Care or Adoptive Parents</u> section of the tutorial.

1 2 3	4	5	6 /	8	9	10	11
Employment Development State of California	SDI Home	Inbox	New Claim	Draft	Profile	History	
Home			-				
Message Center							
Check the message center Inbox below to re Inbox [New: 0, Total: 0] Personal Information	view messages and take	required actions as	s needed.				
Full Name:	Jane Doe		EDD Customer	Account Number:	123456789		
Mailing Address:	123 Main St Sacramento, CA 9	5814		Phone Number:	916-555-1212		
Residence Address:	123 Main St Sacramento, CA 9	5814	Ce	ell Phone Number:	916-555-1213		
E-mail Address:	Jdoe@gmail.com						
Current Disability Insura	nce Claim(s)						

Follow these instructions to begin filing a Paid Family Leave - New Mother claim:

- 1. Access your SDI Online account by logging in to Benefit Programs Online.
- 2. Select the SDI Online button to be directed to your SDI Online Home screen (screen above).
- 3. Select Inbox from the SDI Online main menu bar or the Message Center.

12

1 2 3		0	0	10
Forms Available to a	Submit Online			
Claim Information				
Claimant Name:	Jane Doe	Clair	n ID: DI-1000-XXX-XXX	
Expected Return to Work Date:	03-05-2018	Claim Effective I	late: 02-15-2018	
Forms Available to Subr	nit			
Below is a list of forms available to submit elec be processed.	ctronically. If you have received a form in the mail,	return it by the due date listed on the	orm. Please allow 5-7 business days	s for your form to
If you have already submitted or mailed any of	f the forms listed below, do not submit a duplicate	form. Submitting duplicate forms may	delay the processing of your claim.	
Note: "The DE 2587 Notice-Automatic Paymen	nt" will only apply to your Disability Insurance clair	m and should not be used if you are cu	rently receiving Paid Family Leave b	enefits.
Note: It may be necessary to send some docun Paid Family Leave Bonding	nents via US Postal Service.			
Saved Drafts				
To open and complete a form that you saved, s draft immediately, select the checkbox and the	select the Form Name. Saved drafts are stored for en select the Delete button.	a limited number of days and will be a	tomatically deleted on the date ind	icated. To delete a
Form Name		Saved Date	Drafts will be saved until	Select
2500A Cert for Continued Benefits		06-29-2018	07-29-2018	
				Doloto
				Delete

Select the Paid Family Leave Bonding link under the Forms Available to Submit header.

Submit your claim no earlier than the first day your family leave begins, but no later than 41 days after your family leave begins, or you may lose benefits.

If you have already submitted a claim, do not submit a duplicate claim. It may take up to 14 days for your claim to be reviewed and processed.

Prescreening Questions					
* Indicates Required Field					
Prescreening Questions					
* Are you a mother bonding with your newborn?	Yes	◯ No			
* Did you receive California State Disability Insurance benefits for your pregnancy with this newborn?	Yes	◯ No			
Са	ncel		[Next	

Answer the prescreening questions:

• New mothers applying for bonding benefits who are transitioning from a Disability Insurance pregnancy claim, will select **Yes** for both questions and select **Next**.

Note: Selecting **Cancel** at any time during this process will cancel the claim and return you to your SDI Online Home screen.

1 2 3	4 0 0	7 0	5 10	11 12 13
Initial Questions Initial Questions You are currently on Step 1 Initial Questions * Indicates Required Field	2 DI Claim Information	3 Claim Information	4 Declaration	Note: • Select Save as Draft at any point in the process to complete the form at a later time
Section 1 - Contact Info Claimant Name: Mailing Address:	Jane Doe 123 Main St Sacramento, CA 95814	EDD Customer Account Number: Phone Number:	123456789 916-555-1212	 Select Previous to return to the previous screen.
If your personal information has changed, sele Leave (PFL) Benefits – New Mother, DE2501FP, Is this address different from the addres * Have you stop Previous	ect Save as Draft. To update your personal inform is available Monday – Saturday, 6 a.m. to 6 p.m ss where you received your last payment for your Disability Insurance claim? opped claiming Disability Insurance benefits? Cancel	mation before completing this form, select Profil . and Sunday, 6 a.m. to 5:30 p.m. Yes No Yes No Save as Draft	e. Submission of the Claim for Paid Family	

The SDI Online system will automatically populate certain portions of the Paid Family Leave claim form.

Verify the information is correct. If your personal information has changed, select **Save as Draft** and update your SDI Online account profile.

Note: If you have not stopped claiming Disability Insurance benefits, you will not be able to complete this claim form. Please submit this form after the final Disability Insurance payment has been issued.

DI Claim Informatio	n		
Initial Questions	2 DI Claim Information	3 Claim Information	4 Declaration
You are currently on Step 2 DI Claim Informat	ion		
Section 2 - DI Claim Info	ormation		
Social Security Number:	XXX-XX-XXXX	* Disability Insurance Claim Effective Date:	(MMDDYYYY)
* Final Date of Disability Insurance Benefits:	(MMDDYYYY)		
Do not submit this form unless you have stoppe	d claiming Disability Insurance benefits and yo	ou are ready to claim PFL benefits to bond with	your baby/babies.
Previous	Cancel	Save as Draft	Next

As a reminder, do not file for Paid Family Leave Bonding benefits unless you have fully recovered and have been issued your final Disability Insurance payment.

If you have **not** stopped claiming Disability Insurance benefits, select **Save as Draft** and complete the form at a later date.

To continue, verify the populated information is correct. Next, enter the date your Disability Insurance claim started and ended to ensure your Paid Family Leave claim is processed correctly.

Select Next to proceed.

		5			
Paid Family Leave Claim Infor	mation				
Initial Questions	ation	3 Cla	im Information	4 Dec	laration
You are currently on Step 3 Claim Information "Indicates Required Field					
Section 3 - Baby Information					
If you had a multiple birth, provide information for only one baby.					
	Baby's First Name:				
8	aby's Middle Initial:				
	Baby's Last Name:				
	Baby's Suffix:				
	aby's Date of Birth:	(MMDDY)	nn)		
	Baby's Gender:	O Male	O Female		
Section 4 - Paid Family Leave Claim II	nformation				
Any overlapping period between Disability Insurance and Paid Family L	eave will result in a dis	qualification o	of benefits from o	one of the programs.	
	*Last Day Worked:	(MMDDY)	nn)		
*Do you want your Paid Family Leave claim to begin on the day aft disability	er you stop claiming insurance benefits?	() Yes	O No		
If "No," enter the date you want your Paid Family L	eave claim to begin:	(MMDDY)	()))		
*Do you want to claim the maximum amount of	benefit weeks now?	() Yes	O No		
If "No," enter the date you want	to be paid through:	(MMDDY)	MM)		
Section 5 - Employer Information					
*Will you work at any time durin	g your family leave?	O Yes) No		
If "Yes," enter the date yo	u returned to work:	(MMDDYY)	nn)		
*Will you continue to receive wages from your employer(s) durin claiming Paid Far	g the period you are nily Leave benefits?	O Yes) No		
If "Yes,"	indicate type of pay	Select		*	
Begin	ning Payment Date:	(MMDDYY	n)		
En	ding Payment Date:	(MMDDY)	n)		
*Do you have more	than one employer?	O Yes) No		
*Have you filed or do you intend to file for workers' com	pensation benefits?	O Yes) No		
Previous	Cancel	Save as	Draft		Next

You must complete the following sections:

- Section 3 Baby Information
- Section 4 Paid Family
 Leave Claim Information
- Section 5 Employer
 Information

Confirm you are entering the correct information and dates to avoid a possible delay or loss of benefits before proceeding.

Required fields are marked with a red asterisk (*).

Select Next to proceed.

						_
Declara	ition					
🖌 Initial Qu	uestions	DI Claim Information	Cla	aim Information	4 Declarat	tion
You are currently	y on Step 4 Declaratio	on				
* Indicates Requir	red Field					
Section 6 - Payment Choice						
If you are eligible the Employment	to receive benefits, yo Development Departn	ou have two options to receive your ben nent (EDD). You do not have to accept th	efit payments: by the EDD De he EDD Debit Card. Select yor	ebit Card SM , through Bank (ur preferred payment meth	of America, or by check, wh ood below.	ich is mailed to you from
		* Preferred Payn	nent Method: EDD De Check	ebit Card]	
		Disclosure	s Agreement: EDD Debit	Card Fee Disclosures, DE 5	617PD (PDF)	
* 🗌 I acknowled	ge that I have reviewe	d the EDD Debit Card Fee Disclosures.				

You have the option to select your preferred payment method. You may select to receive benefit payments by the **EDD Debit Card** or by **check**. You do not have to accept the EDD Debit Card.

If your preferred payment method is the EDD Debit Card, you may view the disclosure agreement by selecting the *EDD Debit Card Fee Disclosures* (DE 5617PD) (PDF) link.

Select the check box to acknowledge you have reviewed the disclosure agreement.

Section 7 - Declaration	
Read the information below and check the box if you agree. A check in the box indicates an electronic signature executed by you, and is a legally binding equiv- written signatures.	alent of traditional hand-
* If y my electronic signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was bonding recipient named above; (2) authorize EDD to release my personal information as shown on this claim to the bonding recipient; (3) authorize my electronic signature on that are within their knowledge; and (4) authorize release and use of information as stated in the Information Corescention of the Important Paid Family Leave Program Information page. I understand that willfully making a false statement or concealing a material fact in of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, inclustatements, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the ori that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my electronic signature or the effective date is later.	as bonding with the employer(s) to disclose to ollection and Access n order to obtain payment luding any accompanying iginal, and I understand e of the claim, whichever
Previous Cancel Save as Draft	Submit

5

Next, select the box to authorize an electronic signature and the release of your information.

Select Submit to send your Paid Family Leave – New Mother claim form to the EDD.

1	2	3	4	5	6	7	8	9	10	11	12	
Print Famil Most of	this page for your <i>y Leave (PFL) – N</i> claims are process	r records. If a pri <i>lew Mother</i> (DE 2 ssed and a decis	inter is unavailal 2501FP) applicat iion is made with	ole at this time, ion. You will not	record the Form to able to acces f the date the clai	Receipt Number s your confirmat im was submitted	below. The Form ion page and Forr d. If you have not	Receipt Number m Receipt Numbe received anythin	is required to ret er after this windo g from PFL within	rieve a copy of th ow is closed. n 10 days or if yo	ne <i>Claim for Paid</i> u have any	1
C	Onfirmat You requested to egin on this date your PFL claim after you sto	ion Infor Claimant Claimant have your PFL If this field is will begin on t op claiming Dis Insurance be	Mame: Jane [L claim blank, he day rability nefits:	Doe			Social	Security Numbe Receipt Numbe	er: XXX-XX-XX er: R1000000	xx 00035399		
Wa You w subm	ITTNING Vill receive a pape itted online.	r version of the	Claim for Paid Fa	amily Leave (PF.	L) – New Mother ((DE 2501FP) in th	e mail. Do NOT re	turn the paper fo	orm for the benef	it period you just	t successfully	

On the **Confirmation** screen, save and secure your **Receipt Number** for future reference. You may be asked for this number when requesting assistance from a customer service representative.

Most claims are processed and a decision is made within 14 days from the date the claim was submitted. Do not file a duplicate claim during this time, you may delay payment further.

If you need additional assistance, view your options to <u>Contact the EDD</u> (edd.ca.gov/about_edd/contact_edd.htm).

Information for Before You Start and After You File

Before you Start: Information you need to submit a *Claim for Paid Family Leave (PFL) Benefits – New Mother* (DE 2501FP)

When your pregnancy-relate After You Have Filed Your Application The last date you work WHEN YOUR CLAIM IS SUCCESSFULLY SUBMITTED Whether you returned Information concernin The PFL office will notify you of your weekly benefit amount and request any additional information needed to determine your eligibility. If you meet all requirements, a payment will be issued to you. The majority of claims are processed and payments issued within 14 days of receipt of a correctly completed claim. Information as to whet and a false statement of Note: It may be necessary to send some documents via US Postal Service. This includes Paid Family Leave (PFL) payments and PFL claim-related forms. · Whether you have claim YOUR RIGHTS Whether you were you The date you want you Information about your claim will be kept confidential, except for the purposes allowed by law. California Civil Code, section 1798.34, gives you the right to inspect any personal records maintained about you by EDD. Section 1798.35 permits you to request that the record be corrected if you believe it is not accurate, relevant, timely, or complete. Certain types of information that would generally be considered personal are exempt from disclosure to you: medical or psychological records where knowledge of the contents might be harmful to the subject (Civil FILING A DRAFT Code, section 1798.40); records of active criminal, civil or administrative investigations (Civil Code, section 1798.40). If you are denied access to records which you believe you have a right to inspect or if you request to amend your records is refused, you may file an appeal with the PFL office. You may Saves your entered informat request a copy of your file by calling the telephone number shown on your Notice of Computation (DE 429D). You also have the right to appeal any disqualification, overpayment, or penalty. Specific instructions on how to appeal will be provided on any appealable document you receive. To retrieve your saved draft(SPECIAL CIRCUMSTANCE RELATING TO YOUR PAID FAMILY LEAVE CLAIM All available information wil Child Support Obligations, Questions should be directed to the Department of Child Support Services at 1-866-249-0773. reduced, you will receive an Spousal or Parental Support Obligations. Questions should be directed to the District Attorney's office administering the court order. Death of Claimant. If a person receiving PFL benefits dies, an heir or legal representative should report the death to PFL. Benefits are payable through date of death, if otherwise eligible. Death of Care or Bonding Recipient. If the child with whom you are bonding dies, report the death to PFL. Benefits are payable through the date of death, if otherwise eligible. Job Benefits and Protection Programs. Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) offer job protected leave to "eligible" employees for certain family and medical reasons. Contact FMLA at 866-487-9243 or the Department of Labor Web site: https://www.dol.gov/whd/fmla or CFRA at 800-884-1684 or the Department of Fair Employment and Housing Web site: https://www.dfeh.ca.gov for additional information on these programs. Phone Number Link https://www.edd.ca.gov/Disability/Contact_SDI.htm#byphone Frequently Asked Questions Link https://www.edd.ca.gov/Disability/FAQs.htm#pfl Cancel Next

Read all information carefully. Select Next.

Applying for Claim for * Indicates Required Field	Paid Family Leave (PFL) Benefits -	New Mother
Applying for Claim for Paid Read the information below and check the box if you	Family Leave (PFL) Benefits - New Mother	s a legally binding equivalent of traditional hand-
written signatures.		5 5 6 1
★ ✓ I have read and understand the instructions about the period of	ove. I understand that failure to supply any or all information may cause delay in iss presentation or knowingly withhold of a material fact to obtain or increase any bene iate criminal prosecution against me.	suing benefit checks or may cause a denial lefit or payment, EDD will disqualify me from
Previous	Cancel	Next

Select the box to authorize an electronic signature.

Select Next.

Paid Family Leave (PFL) Survey Questions

5

* Indicates Required Field

Paid Family Leave (PFL) Survey

The EDD has received your portion of your claim for Paid Family Leave benefits. There is one more step to complete before you receive your claim receipt number. Please answer the questions below and then select the "Submit" button for your receipt number.

* Before you filed your Paid Family Leave (PFL) claim, how did you learn about the Paid Family Leave (PFL) benefit program? Please select the response that best applies:

- From a brochure I received by U.S. mail.
- O From a friend or family member.
- From an SDI Online Notification.
- From my employer.
- From a social worker or hospital employee.
- None of these.

Submit

Complete the survey and select Submit.

File a Paid Family Leave Bonding Claim for New Mothers (without a prior pregnancy-related disability claim), New Fathers, or Foster Care or Adoptive Parents

Employment Development Department State of California	SDI Home Inbox	New Claim Draft	Profile H	istory	Follow these instructions to begin filing a Paid Family Leave claim
Home					from Disability Insurance), new fathers, foster care, or adoptive
Check the message center Inbox below to re Inbox [New: 0 , Total: 0]	view messages and take required actions as neede	ed.			1. Access your SDI Online account by logging in to
Personal Information	John Doo		12245 (700		Benefit Programs Online.
Full Name:	John Doe	EDD Customer Account Number:	123456789		2 Select the SDI Online button
Mailing Address:	123 Main St Sacramento, CA 95814	Phone Number:	916-555-1212		to be directed to your SDI Online
Residence Address:	123 Main St Sacramento, CA 95814	Cell Phone Number:	916-555-1213		Home screen.
E-mail Address:	Jdoe@gmail.com				3. Select New Claim from the main menu bar on your SDI
Current Disability Insura	nce Claim(s)				Online Home screen.

Note: You will need to upload or mail a "Proof of Relationship" document after completing your online Paid Family Leave Bonding claim. To skip to the instructions on uploading your document(s) to your SDI Online account, please view the <u>Submit Additional Paid</u> <u>Family Leave Bonding Attachments</u> section of this tutorial.

Apply for Benefits or Continue a Draft Application Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a Claim for Disability Insurance (DE 2501) or a Claim for Paid Family Leave (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim. Note: It may be necessary to send some documents via US Postal Service. Apply for Disability Insurance Benefits **Disability Insurance** Apply for Paid Family Leave Benefits Paid Family Leave Bonding nectronic Paid Family Leave Bonding Attachment Paid Family Leave Care Submit Electronic Paid Family Leave Care Attachment Paid Family Leave Military Assist Submit Electronic Paid Family Leave Military Assist Attachment Saved Drafts To open and complete a form that you saved, select the Form Name. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the Delete button.

To apply for Paid Family Leave Bonding benefits, select the **Paid Family Leave Bonding** link located under the Apply for Paid Family Leave Benefits header.

- Submit your claim no earlier than the first day your family leave begins, but no later than 41 days after your family leave begins, or you may lose benefits.
- If you have already submitted a claim, do not submit a duplicate claim. It may take up to 14 days for your claim to be reviewed and processed.
- If you are unsure about the type of claim to file for, refer to the <u>Types of Claims</u> (edd.ca.gov/Disability/Types_of_Claims.htm) on the EDD website.

1 2 3 4 5 6	1 0	9		12
Prescreening Questions * Indicates Required Field				
Prescreening Questions				
* Are you a mother bonding with your newborn?	🔿 Yes 🔵 No			
* Did you receive California State Disability Insurance benefits for your pregnancy with this newborn?	🔿 Yes 🔵 No			
Cance	el		Next	

You must answer the prescreening questions:

- If you are a new mother applying for bonding benefits and DID NOT file a Disability Insurance pregnancy claim, select Yes for the first question and No for the second question.
- If you are a new father or an adoptive/foster parent applying for bonding benefits, select No for both questions.

Required fields are marked with a red asterisk (*).

Note: Selecting **Cancel** at any time during this process will cancel the claim and return you to your SDI Online Home screen.

Information for Before You Start and After You File

Before you Start: Information you need to apply for Paid Family Leave (PFL) Initial Claim Form for Bonding (DE 2501F)

6

PFL will use information provided in your EDD online profile, including:

- Your name (including other names under which you have worked), date of birth, gender, preferred language, and Social Security account number.
- · Your mailing address (including ZIP code) and telephone number (including area code).
- The last date you worked for any employer.
- Your occupation.
- The name, mailing address and telephone number of your last employer or employers. (Be specific about the spelling of the employer's name and make sure the mailing address is correct. An incorrect address may delay benefit payments.)
- · Any period you returned to work or will continue to work during your period of PFL.
- The reason why you have reduced work hours or stopped working.

PROOF OF RELATIONSHIP FOR BONDING

To be eligible for PFL benefits to bond with a new minor child you will also need to submit one of the documents listed below to provide proof of your relationship to the child. ONLY send copies of these documents:

· Child's Birth Certificate

BE

· Official letter from foster care agency

Child's Hospital Birth Certificate

Adoptive Placement Agreement, AD-907

After You Have Filed Your Application

WHEN YOUR CLAIM IS RECEIVED

When you have successfully transmitted an electronic bonding claim, the PFL office will notify you of your weekly benefit amount and request any additional information needed to determine your eligibility. If you meet all eligible requirements, a payment will be issued to you from a central payment center. The majority of claims are processed and payments issued within fourteen (14) days of receipt of a correctly completed claim.

SPECIAL CIRCUMSTANCES RELATING TO YOUR PAID FAMILY LEAVE CLAIM

Child Support Obligations: Questions should be directed to the Department of Child Support Services at 1-866-249-0773.

Spousal or Parental Support Obligations: Questions should be directed to the District Attorney's office administering the court order.

Death of Claimant: If a person receiving PFL benefits dies, an heir or legal representative should report the death to PFL. Benefits are payable through date of death, if otherwise eligible.

Death of Care or Bonding Recipient: If the child with whom you are bonding dies, report the death to PFL. Benefits are payable through the date of death, if otherwise eligible.

Job Benefits and Protection Programs: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) offer job protected leave to "eligible" employees for certain family and medical reasons. Contact FMLA at 1-866-487-9243 or the Department of Labor Web site:

https://www.dol.gov/whd/fmla or CFRA at 1-800-884-1684 or the Department of Fair Employment and Housing Web site:

https://www.dfeh.ca.gov for additional information on these programs.

Phone Number Link http://www/edd/ca/gov/Disability/Contact_SDI.htm#byphone

Frequently Asked Questions Link http://www.edd.ca.gov/Disability/FAQs.htm#pfl

Cancel

The Information for Before You Start and After You File screen provides important information you will need readily available to file a Paid Family Leave Bonding claim.

Review and gather the information before proceeding.

Select Next.

9

Next

Applying for Paid Family Leave (PFL) Initial Claim Form for Bonding
*Indicates Required Field
Applying for Paid Family Leave (PFL) Initial Claim Form for Bonding (DE 2501F)
Please read these instructions and information before completing the electronic Claim for Paid Family Leave (PFL) Benefits (DE 2501F). Do not complete this claim form if you are insured by a Voluntary Plan maintained by your employer. (Ask your employer for the proper forms.)
The Paid Family Leave (PFL) program provides affordable, worker-funded benefits to eligible workers suffering a full or partial loss of wages due to the need to care for a seriously ill family member, to bond with a new child or assist with matters related to a family member's military deployment to a foreign country.
Th (B) Call 1-877-238-4373 for required forms and instructions if: Pre 1. A disability prevents you from completing the claim form and you need to designate a representative to sign for you. 2. You are an authorized representative filing for benefits on behalf of a physically or mentally incapacitated care provider/care recipient or a deceased care provider/care recipient. If y
dia htt Do NOT submit an electronic PFL Claim for bonding if the purpose of your family leave is to care for a seriously ill family member. Follow these instructions to file for a Paid Family Leave Care application.
1. Select New Claim. If t 2. Choose Paid Family Leave Care.
 PF You may apply for benefits even if you are not sure you are eligible. If you are found to be ineligible for all or part of a period claimed, you will be notified of the ineligible period and the reason(s) why you were not eligible. Below are some reasons why you may not be eligible for benefits: If you are claiming or receiving Unemployment Insurance or Disability Insurance (DI) benefits. If you are receiving workers' compensation benefits at a weekly rate equal to or greater than the PFL rate. If you are in custody of law enforcement authorities because you were convicted of violating law or ordinance.
If you are eligible for further benefits, additional payments will either be sent automatically or in response to your submitted certification, whichever is appropriate to your claim. You will be paid 1/7 of your weekly benefit amount for each calendar day you are eligible unless benefits are reduced for some reason. (See Calculating Paid Family Leave Benefit Payment Amounts for more information.)
YOU TAXABILITY OF BENEFITS: Paid Family Leave benefits are subject to federal income taxes and will be reported to the Internal Revenue Service. Each person receiving PFL benefits will receive a 1099G form to include with his/her federal income tax return. PFL benefits are not subject to California income taxes. File OVERPAYMENT: An overpayment results when you receive PFL benefits you were not eligible to receive. Once PFL determines that you were overpaid, the PFL office will contact you to explain the reason for your overpayment. It is important that you complete and return all information requests, as there are some instances when an overpayment can be waived. If it is determined that you were overpaid and the overpayment cannot be waived, you must repay this money. Benefit payments issued after an overpayment is established may be reduced by 25 to 100 percent to collect your payment. You will receive a "Notice of Overpayment Offset" if a reduction is taken for a DI, PFL, or Unemployment Insurance (UI) overpayment.
DISQUALIFICATION: All available information will be considered before paying or disqualifying your claim. Benefits will be paid only for the days for which you are eligible. If payment of benefits is denied or reduced for any period, you will receive a written notice stating the reason for the disqualification or reduction.
If you deliberately report incorrect information, willfully omit or withhold information, a false statement disqualification of up to 92 days may be assessed. In addition, any resulting
I we read and understand the instructions above. I understand that failure to supply any or all information may cause delay in issuing benefit payments or may cause a denial of occurs. If I make any false statement or misrepresentation or knowingly withhold of a material fact to obtain or increase any benefit or payment, EDD will disqualify me from receiving benefits and/or services and may initiate criminal prosecution against me.
Previous Cancel Next

6

This screen provides additional information about filing a Paid Family Leave Bonding claim.

13

Review the information and select the check box to agree to the terms.

Select Next to proceed.

Note:

- Select Save as Draft at any point in the process to complete the form at a later time.
- Select **Previous** to return to the previous screen.

Personal Information								
1 Personal Information 2 Empl Inform	loyment 3 Additional Questions	4 Certification	5 Qualifying Events	6 Declaration				
You are currently on Step 1 Personal Information								
Verify Your Personal Inf	formation							
If your personal information has changed, se	elect Save as Draft, then select Profile	from the main menu to update your informati	ion before completing this	form.				
Social Security Number:	XXX-XX-XXXX	EDD Customer Account N	Number: 123456789					
Full Name:	John Doe	Other Names (if any, under wh have w	hich you vorked):					
Date of Birth:	XX-XX-XXXX		Gender: Male					
Mailing Address:	123 Main St Sacramento, CA 95814 United States	Phone N	Number: 916-555-121	13				
Preferred Language:	English							
Previous	Cancel	Save as Draft		Next				

The SDI Online system will automatically populate certain portions of the Paid Family Leave claim form.

Verify the information is correct. If your personal information has changed, select **Save as Draft** and update your SDI Online account profile.

Select Next to proceed.

1	2 3 4	5 6	7	8 9	10	11	12	,
	Epoperat							
	State of California SDI Home In	nbox New Claim Draft	Profile History					
	Employment Information							
	Personal 2 Employment 3 Additio	nal 4 Certification 5	Qualifying Events 6 Declaration					
	You are currently on Step 2 Employment Information "Indicates Required Field							
	Your Employment Details							
	*oc	cupation:						
	*Are you a state government e	mployee? O Yes O No						
	If "Yes," indicate bargaining uni	t number:						
	*May we disclose benefit payment information to your emp	ployer(s)? O Yes O No						
	*Do you have more than one e	employer? Yes No						
		O Other						
	Othe	er Reason:						
	Employer Information							
	Enter your current or most recent employer information.							
	Note: An incorrect employer name or address can delay benefit payments.							
	*Name of I	Employer:						
		US O International						
	*Addre	ess Line 1:						
	Addre	ess Line 2:						
		*City:						
		*State: CA 🗸						
	Employer Pho	9161234567 Ext						
		Check here if the phone number is inte	rnational					
	Previous	ancel Save as Draft	Next					
Waiting for edddiastr	rZext.network1.corp.edd.ca.gov							

Complete Section 2 - Employer Information. Required fields are marked with a red asterisk (*).

Add your most current employer's business name, phone number, and mailing address as stated on your W-2 or paystub.

2 3	4 5	0 /	0		11 12
Employment Det	ails				
Personal Information	2 Employment Information	3 Additional Questions	4 Bonding Certification	5 Declaration	
You are currently on Step 2 Employme	nt Information				
*Indicates Required Field					
Address Validation	undated to meet LISDS standary	te Dlassa varify the address is correct			
The address you have provided has been	updated to meet USPS standard	is. Please verify the address is correct			
Entered Address					
414 k st sacramento CA 95834					
Updated Address					
414 K St					
Sacramento CA 95814 - 3335					
Would you like to proceed with the stand	lardized address? Select 'Yes' to J	proceed or 'No' to return to correct th	e address.		
		No Yes			

The SDI Online system may adjust the employer address information to follow USPS standards.

- Confirm the **Updated Address** section is correct by selecting **Yes**.
- Select **No** to go back to the previous screen and re-enter the address.

1	2	3	4	5 6	7	8	9	10	11	12	13
Addit	tional Que	stions									
✔ Per	rsonal Information	Employmen Information	t 3 Addit	onal Questions	Bonding Certification	5 Declaration					
You are curr *Indicates Re	rently on Step 3 Additio	nal Questions									
Sectio	n 7 - Additior	nal Questions	5								
			*Date you last worked:	(MMDDYYYY)							
The date you	u want your Paid Family	eave claim to begin sho	uld not be before the child's da	te of birth (or the Date of foste	r care or adoption placement).						
	*D	ate you want your Paid	Family Leave claim to begin:	(MMDDYYYY)							
	*Do you want to	claim the maximum ar	nount of benefit weeks now?	🔾 Yes 🔵 No							
		If "No," enter the date	you want to be paid through:	(MMDDYYYY)							
			Date you returned to work:	(MMDDYYYY)							
		Or dat	e you plan to return to work:	(MMDDYYYY)							
		Will you work at any ti	me during your family leave?	🔿 Yes 🔵 No							
If you v	vill receive any type of	oay from your employe	r(s) during your family leave,	Sick							
			multate type of pay.	 Employer Required Va Other Type of Pay 	cation						
		S	pecify if "Other type of pay":	Select							
enforceme	*At any time during you ent authorities because	ur Paid Family Leave, w you were convicted of	ere you in the custody of law violating a law or ordinance?	🔵 Yes 🔵 No							
*Have y	ou claimed or do you pl	an to claim Workers' Co portion of the p	ompensation Benefits for any period covered by this claim?	🔿 Yes 🔵 No							
Previ	ious		Cancel	Save as Draft		Next					

Complete Section 7 - Additional Questions and confirm the dates you entered are correct to avoid a possible delay or loss of benefits.

Required fields are marked with a red asterisk (*).

1 Z 3 4 3	
Bonding Certification	
 Personal Information Employment Information Addition 	onal Questions 4 Bonding Certification 5 Declaration
You are currently on Step 4 Bonding Certification	
* Indicates Required Field	
Section 3 - Personal Information	
* Child relationship:	Select •
If you select foster care, adoption or guardianship, please provide the date of placement:	(MMDDYYYY)
Section 4 - Child's Legal Name and Information	
Child's Social Security Number (if available):	(Do not enter dashes)
* Child's First Name:	
Middle Initial:	
* Last Name:	
Suffix:	
* Date of I	Birth: (MMDDYYYY)
* Child's Ge	nder: O Male O Female
* Is child's residence address different from your residence add	Iress? O Yes O No

In the **Section 3 - Personal Information**, select your relationship to the child you are bonding with from the drop-down menu. Complete **Section 4 - Child's Legal Name and Information** with the child's information.

Note: If the child's legal residence is different than yours, an additional screen will display to enter the child's legal address.

1	2	3	4	5	6	1	8	9	. 10		11	12		13
Sectio	on 5 - Proo	f of Relatio	onship		version "Dracef of Delation	shin" dogumant				Th Re	e accep	ied "Proo ip" docun	f of nent	
The "Proof	of Relationship" mu	ust be received by th	e Paid Family Leave (ou must submit an app Office no later than ten	(10) days from the date y	you submit your online	e bonding claim.			op •	tions are Child's	: Birth Ce	rtificate	е
Proof of Re Child Offici Child	<i>lationship documer</i> ''s Birth Certificate ial letter from foster ''s Hospital Birth Cer	rt includes: care agency rtificate								•	Officia foster	Letter fr	วm าcy	-
 Adop Decla Indep Appr 	tive Placement Agre aration of Paternity, pendent Adoption P oval of Family Caree	eement, AD-907 CS-909 Nacement Agreemen ziver Home, SOC-815	t, AD-924							•	Child's Certific	Hospital ate	Birth	
 Other * Please 	r evidence of relatio	onship of "Proof of Relativ	onship" you plan on	providing from the	Select		Ŧ			ŀ	Adopti Agree	ve Placer nent, AD	nent -907	
<i>Failure to s</i> on the con	ubmit the "Proof of firmation page.	Relationship" will re	esult in claim disqual	ification and no payme	ent will be issued. Furthe	r instructions for subn	itting "Proof of Rel	lationship" will be p	rovided	•	Declar CS-90	ation of F 9	'aternit	ty,
Pre	vious			Cancel	Save as Draft			Next	:	ŀ	Indepe Placer	ndent Ad nent Agre	option ement	t,

To be eligible for Paid Family Leave Bonding benefits, you must submit an approved "Proof of Relationship" document. Submit one of the accepted documents within 10 days from the date you submit your online bonding claim.

From the drop-down menu, select the "Proof of Relationship" document you will upload or mail after completing the online claim.

Further instructions to upload or mail your "Proof of Relationship" document(s) will be provided on the confirmation screen.

Select Next to proceed.

Approval of Family Caregiver Home, SOC-815

AD-924

 Other Evidence of relationship

Child's Residence Address		
Personal Information	al Questions 4 Bonding Certification 5	Declaration
You are currently on Step 4 Bonding Certification		
*Indicates Required Field		
Section 6 - Residence Address		
	● US O International	
*Address Line 1:		
Address Line 2:		
*City:		
*State:	CA V	
*ZIP Code:		
Previous Cancel	Save as Draft	Next

If you selected **Yes** to "Is the child's residence address different from your resident address?" in **Section 4 – Child's Legal Name and Information**, you must enter the child's residential address information here.

Required fields are marked with a red asterisk (*).

If you selected **No** to the above question, you will not see this screen. Please skip to the next slide.

	, v	• • • • • • • • • • • • • • • • • • •						
Declaration					٦			
Personal Information Personal Information	loyment addition	onal Questions 🖉 🖌 Bo	onding Certification	5 Declaration				
You are currently on Step 5 Declaration								
* Indicates Required Field								
Section 8 - Payment Choice								
f you are eligible to receive benefits, you have two opt the Employment Development Department (EDD). You	tions to receive your benefit payments:	by the EDD Debit Card™, through ard. Select your preferred paymer	Bank of America, or by cl	heck, which is mailed to you from	I			
	* Preferred Payment Method:	 EDD Debit Card Check 			I			
_	Disclosures Agreement:	EDD Debit Card Fee Disclosure	s, DE 5617PD (PDF)					
*								

You have the option to select your preferred payment method. You may select to receive benefit payments by the **EDD Debit Card** or by **check**. You do not have to accept the EDD Debit Card.

If your preferred payment method is the EDD Debit Card, you may view the disclosure agreement by selecting the *EDD Debit Card Fee Disclosures* (DE 5617PD) (PDF) link.

Select the check box below to acknowledge you have reviewed the disclosure agreement.

Section 9 - Declaration	
Read the information below and check the box if you agree. A check in the box indicates an electronic signature executed by you, and is a legally binding equiva written signatures.	lent of traditional hand-
* By my signature on this bonding certification, I authorize the medical provider, adoption agency, adoption party(ies), or foster care placement agency to d Enployment Development Department all facts concerning the birth, adoption, or foster care placement of the above-named child. I understand that will statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I perjury that the foregoing statement, including any accompanying statements or documents, is to the best of my knowledge and belief true, correct, and o photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a from the date of my signature or the effective date of the claim, whichever is later.	isclose to the ully making a false declare under penalty of omplete. I agree that period of fifteen years
* By my electronic signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was bonding recipient named above; (2) authorize EDD to release my personal information as shown on this claim to the bonding recipient; (3) authorize my er EDD all facts concerning my employment that are within their knowledge; and (4) authorize release and use of information as stated in the Information Co section of the Important Paid Family Leave Program Information page. I understand that willfully making a false statement or concealing a material fact in payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statem accompanying statements, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my electronic signature or the claim, whichever is later.	s bonding with the nployer(s) to disclose to lection and Access order to obtain nent, including any valid as the original, and effective date of the
Previous Cancel Save as Draft	Submit

Select both check boxes to authorize an electronic signature and the release of your information.

Required fields are marked with a red asterisk (*).

Select **Submit** to send your online claim to the EDD.

Paid Family Leave (PFL) Survey Questions	
*Indicates Required Field	
Survey Questions	
The EDD has received your portion of your claim for PFL benefits. There is one more step to complete before you receive your claim receipt number. Please answ then select the "Submit" button for your receipt number.	wer the question below and
*Before you filed your PFL claim, how did you learn about the PFL benefit program? Please select the response that best applies: From a brochure I received by U.S. mail. 	
○ From a friend or family member.	
O From an SDI Online Notification.	
○ From my employer.	
O From a social worker or hospital employee.	
🔿 None of these.	
	Submit

Complete the survey and select **Submit** to proceed to the next step.

Development Department S	DI Home Inbox	New Claim	Draft	Profile	History	
lost claims are processed and a decision is made wi uestions you may call 1-877-238-4373.	hin two weeks of the date the clair	m was submitted. If you have not	t received anything fron	n PFL within 10 days or i	f you have any	
Confirmation Information						
Claimant Name: Jo	in Doe	Social	l Security Number:	XXX-XX-XXXX		
Date you requested to have your Paid 07- Family Leave claim begin:	01-2018	[Receipt Number:	R10000000033001		
nstructions for Submitting	Proof of Relations	ship an approved "Proof of Relationsh	nip" document. The "Pr	oof of Relationship" mu:	st be received by the	
nstructions for Submitting o be eligible for Paid Family Leave benefits to bond ' aid Family Leave Office no later than ten (10) days fr ailure to submit the "Proof of Relationship" will resu Electronically	Proof of Relations with a new child you must submit a om the date you submit your onlin It in claim disqualification and no	ship an approved "Proof of Relationsh e bonding claim. payment will be issued.	nip" document. The "Pr	oof of Relationship" mu:	st be received by the	
nstructions for Submitting o be eligible for Paid Family Leave benefits to bond aid Family Leave Office no later than ten (10) days fr <i>ailure to submit the "Proof of Relationship" will resu</i> Electronically You may attach your electronic "Proc	Proof of Relations with a new child you must submit a om the date you submit your onlin It in claim disqualification and no f of Relationship" now:	an approved "Proof of Relationsh e bonding claim. payment will be issued. If you are mailing a mail originals. Or	nip" document. The "Pr Mi "Proof of Relationship" n each page include you	oof of Relationship" mu: ail ' document it must be a ır 9-digit Social Security	st be received by the photocopy. Do not Number, receipt	
nstructions for Submitting o be eligible for Paid Family Leave benefits to bond a aid Family Leave Office no later than ten (10) days fr ailure to submit the "Proof of Relationship" will resu Electronically You may attach your electronic "Proc Attach my Proof of Rela	Proof of Relations with a new child you must submit a om the date you submit your onlin It in claim disqualification and no f of Relationship" now: tionship	ship an approved "Proof of Relationsh e bonding claim. payment will be issued. If you are mailing a mail originals. Or number and date	nip" document. The "Pr M: "Proof of Relationship" each page include you you requested to have receipt number ca	oof of Relationship" mu: ail ' document it must be a ır 9-digit Social Security your Paid Family Leave n be found above.	st be received by the photocopy. Do not Number, receipt claim begin. The	
nstructions for Submitting o be eligible for Paid Family Leave benefits to bond i aid Family Leave Office no later than ten (10) days fr ailure to submit the "Proof of Relationship" will resu Electronically You may attach your electronic "Proof Attach my Proof of Rela You may also submit your electronic "Proof of Rela	Proof of Relations with a new child you must submit a om the date you submit your onlin It in claim disqualification and no f of Relationship" now: tionship cionship" at a later date by followin	ship an approved "Proof of Relationsh e bonding claim. payment will be issued. If you are mailing a mail originals. Or number and date	nip" document. The "Pr Mi "Proof of Relationship" n each page include you you requested to have receipt number ca	oof of Relationship" mu: ail ' document it must be a ır 9-digit Social Security your Paid Family Leave n be found above.	st be received by the photocopy. Do not Number, receipt claim begin. The	
nstructions for Submitting o be eligible for Paid Family Leave benefits to bond i aid Family Leave Office no later than ten (10) days fr ailure to submit the "Proof of Relationship" will resu Electronically You may attach your electronic "Proof Attach my Proof of Relations these navigation instructions: 1 Select New Claim on the Main Menu	Proof of Relations with a new child you must submit a om the date you submit your onlin It in claim disqualification and no f of Relationship" now: tionship tionship" at a later date by followin	ship an approved "Proof of Relationsh e bonding claim. payment will be issued. If you are mailing a mail originals. Or number and date	nip" document. The "Pr Mi "Proof of Relationship" each page include you you requested to have receipt number ca Mail your do	oof of Relationship" mu: ail ' document it must be a ır 9-digit Social Security your Paid Family Leave n be found above.	st be received by the photocopy. Do not Number, receipt claim begin. The	
nstructions for Submitting o be eligible for Paid Family Leave benefits to bond i aid Family Leave Office no later than ten (10) days fr ailure to submit the "Proof of Relationship" will resu Electronically You may attach your electronic "Proof Attach my Proof of Relations these navigation instructions: 1. Select New Claim on the Main Menu. 2. Choose Submit Electronic Paid Family Leave Bor	Proof of Relations with a new child you must submit a om the date you submit your onlin It in claim disqualification and no f of Relationship" now: tionship tionship" at a later date by followin ding Attachment.	ship an approved "Proof of Relationsh e bonding claim. payment will be issued. If you are mailing a mail originals. Or number and date	nip" document. The "Pr Mi "Proof of Relationship" each page include you you requested to have receipt number ca Mail your do EDD - Paid F PO BOX SACRAMENTO	oof of Relationship" mu: ail ' document it must be a rr 9-digit Social Security your Paid Family Leave n be found above. be found above. cocument to: 'amily Leave 997017 CA 95799-7017	st be received by the photocopy. Do not Number, receipt claim begin. The	

On the **Confirmation** screen, you will be assigned a **Receipt Number**.

Save the Receipt Number for future reference. You will need this number to upload your supporting documentation to the correct online claim.

The **Confirmation** screen will also provide instructions to upload the additional documentation for your Paid Family Leave Bonding claim.



To complete your Paid Family Leave Bonding claim, you will need to submit your "Proof of Relationship" either electronically or by mail.

- To submit electronically, select the Attach my Proof of Relationship link and follow the instructions. View the <u>Submit Paid Family Leave Bonding Claim Attachments</u> section of this tutorial for additional instructions.
- To submit by mail, send your proof of relationship to the address on the screen. Send photocopies of your documents, do not mail originals. On each page include your 9-digit Social Security number, **Receipt Number**, and your requested claim start date.

1	2	3	4	5	6	7	8	9	10	11	12	13
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Submit Paid Family Leave Bonding Claim Attachments

	2	5	4	J	0	, I	0	9	10	
State	Employment Development Department of California		SDI Home	I	nbox	New Claim	Draft	Profile	History	
Hc	ome									
	Message Center									
Che Inb	eck the message center	Inbox below to re	view messages a	nd take require	d actions as need	ded.				
Pe	ersonal Infor	mation								
		Full Name:	John Doe			EDD Custon	er Account Number:	123456789		
	м	ailing Address:	123 Main St Sacramento,	CA 95814			Phone Number:	916-555-1212		
	Resid	dence Address:	123 Main St Sacramento,	CA 95814			Cell Phone Number:	916-555-1213		
	E	-mail Address:	Jdoe@gmail.	com						
Cui	rre <mark>nt</mark> Disabil	ity Insura	ince Clai	m(s)						

To submit your "Proof of Relationship" document or if you need to submit more than one document (e.g. birth certificates for twins or to resubmit a previous document):

• Select **New Claim** from the main menu bar in your SDI Online account.

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

Note: It may be necessary to send some documents via US Postal Service.

Apply for Disability Insurance Benefits

Disability Insurance

Apply for Paid Family Leave Benefits

Paid Family Leave Bonding Submit Electronic Paid Family Leave Bonding Attachment Paid Family Leave Care Submit Electronic Paid Family Leave Care Attachment Paid Family Leave Military Assist Submit Electronic Paid Family Leave Military Assist Attachment

Saved Drafts

To open and complete a form that you saved, select the Form Name. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the Delete button.

Select the **Submit Electronic Paid Family Leave Bonding Attachment** link under the Apply for Paid Family Leave Benefits header.

Form Attachment

To attach a file to your successfully submitted Paid Family Leave claim form, choose the 'Select' link under the Action field. Most claims are processed and a decision is made within two weeks of the date the claim was submitted.

If you have not received anything from PFL within 10 days or if you have any questions you may call 1-877-238-4373.

Select Claim to Attach Document

Form Name	Submitted Date	Receipt Number	Action
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Bond with Child	06-27-2018	R1000000035357	Select
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Bond with Child	06-26-2018	R10000000035351	Select
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Bond with Child	06-26-2018	R10000000035352	Select
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Bond with Child	06-26-2018	R10000000035353	Select
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Bond with Child	06-26-2018	R1000000035356	Select
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Bond with Child	06-19-2018	R10000000035337	Select
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Bond with Child	06-08-2018	R10000000035335	Select
Cancel			

Verify the **Receipt Number** on the screen with the number you received when you filed the online claim.

If it matches your claim, choose the **Select** link from the **Action** column to attach a form to your claim.
1 2 3	4	5 6	1	Ō	9	10		12	
Attachment * Indicates Required Field]		
Identifying Informa Your Social Security Num Form Receipt Num	tion for Previous	ly Submitted Paid	Family Leave you requested to have you Family Leave claim	Initial Bon 17 Paid 05-06-203 begin:	ding Clai ®	m			
Previously Submittee	d Attachments fo	r Paid Family Leav	ve Initial Bonc	ling Claim					
Attachment To attach a document, select the Browse • File size: less than 5MB • File type: PDF,JPG, JPEG, TIF or TI	e button below. FF				_				
* Please click t Previous	he "Browse" button to browse * Do you want to attach	for the document: No file of Monormal Monormal Monormal Monormal Mono	chosen No	Brows	e	Submit			

To upload a document, select the **Browse** button.

To upload more than one document, select **Yes** and then select the **Browse** button. This will navigate you back to the **Attachment** screen to continue uploading documents.

When you are done uploading, select No and then select Submit.

Attachment Confirmation							
Identifying Information for Previously Submitted Paid Family Leave Initial Bonding Claim							
Your Social Security Number: XXX-XX-XXXX	Your Social Security Number: xxx-xx-xxxx Date you requested to have your Paid 02-02-2017 Family Leave claim begin:						
Form Receipt Number: R1000000035351							
Previously Submitted Attachments for Paid Family Leave Initial Bonding Claim							
File Name	Receipt Number						
Birth Certificate.jpg	R10000000035359						

This screen confirms that the attachment(s) were submitted to the EDD.

Save the **Receipt Number(s)** for future reference.

You have now completed your Paid Family Leave Bonding claim. Please allow up to 14 days for the EDD to process your claim.

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1	2	3	4	5	6	7	8	9	10	11	12	13
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File a Paid Family Leave Care Claim

1 2 3 4 5	6 7	8 9	10 11	12	13
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Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History
Home						
B Message Center						
Check the message center Inbox below to rev Inbox [New: 0 , Total: 0]	view messages and take requi	ired actions as needed	1.			
Personal Information						
Full Name:	John Doe		EDD Customer Ac	count Number:	123456789	
Mailing Address:	123 Main St Sacramento, CA 95	5814		Phone Number:	916-555-1212	
Residence Address:	123 Main St Sacramento, CA 95	5814	Cell I	Phone Number:	916-555-1213	
E-mail Address:	Jdoe@gmail.com					
Current Disability Insura	nce Claim(s)					
No Results Found						
Pending Disability Insura	ance Claim App	lication(s)				
No Results Found						
Submitted Paid Family L	eave Claim For.	ms				
Only forms you submitted online are listed belo Leave claim is currently not available online. Fo	ow. To submit an electronic d or assistance with a Paid Fami	ocument for a previou ily Leave claim, call 1-	isly submitted care or boi 877-238-4373.	nding claim, select	New Claim. The status of y	our Paid Family
No Results Found						

Follow these instructions to begin filing a Paid Family Leave Care claim:

- 1. Access your SDI Online account by logging in to Benefit Programs Online.
- 2. Select the **SDI Online** button to be directed to your SDI Online **Home** screen.
- 3. Select New Claim from the main menu bar on your SDI Online Home screen.



To apply for Paid Family Leave Care benefits, select the **Paid Family Leave Care** link located under the Apply for Paid Family Leave Benefits header.

- Submit your claim no earlier than the first day your family leave begins, but no later than 41 days after your family leave begins, or you may lose benefits.
- If you have already submitted a claim, do not submit a duplicate claim. It may take up to 14 days for your claim to be reviewed and processed.
- If you are unsure about the type of claim to file for, refer to the <u>Types of Claims</u> (edd.ca.gov/Disability/Types_of_Claims.htm) on the EDD website.

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This screen provides important information you will need readily available to file a Paid Family Leave Care claim.

- Review and gather the information on this screen.
- Select Next.

	Employment		
1 Personal Information 2	Information	3 Additional Questions 4 Care Certification	on 5 Declaration
You are currently on Step 1 Personal Informa	tion		
Section 1 - Personal Info	ormation		
Social Security Number:	XXX-XX-XXXX	EDD Customer Account Number:	123456789
Full Name:	John Doe	Other Names (if any, under which you have worked):	
Date of Birth:	XX-XX-XXXX	Gender:	Male
Mailing Address:	123 Main St Sacramento, CA 95814	Phone Number:	916-555-1212
Preferred Language:			
If your personal information has changed, selec	t Save as Draft. To update yo	ur personal information before completing this form, select Profi	ile.
Previous		Cancel Save as Draft	Next

The SDI Online system will automatically populate certain portions of the Paid Family Leave claim form.

- Verify the information is correct. If your personal information has changed, select Save as Draft and update your SDI Online account profile.
- Select **Next** to proceed.

Employment Details	
Personal Information 2 Employment Information 3 Add	itional Questions 4 Care Certification 5 Declaration
You are currently on Step 2 Employment Information * Indicates Required Field	
Section 2 - Employer Information	
Enter your current employer. If unemployed, enter your most recent employer. * Name of Your Employer:	
* Occupation:	
* Are you a state government employee? If "Yes", Indicate Bargaining Unit Number:	Ves No
* May we disclose benefit payment information to your employer(s)? * Do you have more than one employer?	 Yes ○ No Yes ○ No
* Reason for reducing work hours or stopping work	Care for Family Member Other
	● US 🔿 International
* Address Line 1: Address Line 2:	
* City:	
* State: * ZIP Code:	CA 💌
Employer Phone Number:	(No dashes or spaces) Ext:
Previous Cancel	Check here if the phone number is international Save as Draft Next

Complete Section 2 -Employer Information by entering your most current employer's business name, phone number, and mailing address as stated on your W-2 or paystub.

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Required fields are marked with a red asterisk (*).

Select **Next** to proceed.

1 2 3 4 5	6	7	8	9	10	11	12	13
Additional Questions								
Personal Information Personal Information Addition	nal Questions 4 Care Co	ertification	5 Declaration					
You are currently on Step 3 Additional Questions *Indicates Required Field								
Section 3 - Additional Questions								
*Date you last worked:	(MMDDYYYY)							
*Date you want your Paid Family Leave claim to begin:	(MMDDYYYY)							
*Do you want to claim the maximum amount of benefit weeks now?	🔿 Yes 🔵 No							
If "No," enter the date you want to be paid through:	(MMDDYYYY)							
Date you returned to work:	(MMDDYYYY)							
Or date you plan to return to work:	(MMDDYYYY)							
*Will you work at any time during your family leave?	🔾 Yes 🔵 No							
If you will receive any type of pay from your employer(s) during your family leave,	Sick							
indicate type of pay:	Employer Required Vacation Other Type of Pay							
Specify if "Other type of pay":	Select 💌							
*At any time during your Paid Family Leave, were you in the custody of law enforcement authorities because you were convicted of violating a law or ordinance?	🔿 Yes 🔵 No							
*Have you claimed or do you plan to claim Workers' Compensation Benefits for any portion of the period covered by this claim?	🔵 Yes 🔵 No							
Previous Cancel	Save as Draft		Next	t				

Complete Section 3 - Additional Questions and confirm all dates are correct to avoid a possible delay or loss of benefits.

Required fields are marked with a red asterisk (*).

Care Recipient's	Information			
Personal Information	Employment Information	Additional Questions	4 Care Certification	5 Declaration
You are currently on Step 4 Care Cert	ification			

8

* Indicates Required Field

Section 4 - Care Recipient's Information

You must submit a signed "Care Recipient Authorization of Disclosure of Personal Health Information" form and a signed "Statement of Care Recipient" form. Details on how to submit these forms will be provided on the confirmation page.

These documents must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online care claim.

* First Name:	
Middle Initial:	
* Last Name:	
Suffix:	
* Gender:	O Male O Female
* Date of Birth:	(MMDDYYYY)
Is any other family member ready, willing, and able and available to provide care for the same period you are claiming Paid Family Leave benefits?	◯ Yes ◯ No
* Person you are caring for is your:	Select
Other Relationship:	
* Address Line 1:	US OInternational
Address Line 2:	
• City:	
* State:	CA V
* ZIP Code:	
Phone Number:	(No dashes or spaces) Ext:
	Check here if the phone number is international
	Check here if the phone number is international

Complete Section 4 - Care Recipient's Information and Residence Address with information about the person you are caring for.

Details on how to submit a signed "Statement of Care Recipient" form will be provided on the confirmation screen.

Required fields are marked with a red asterisk (*).

1 2 3 4	5 0		0		9	10		12	I.
Declaration									
Personal Information	mployment	Addition	nal Questions		Care Certifica	tion	5 Dec	aration	
You are currently on Step 5 Declaration									
* Indicates Required Field									
Section 5 - Payment Choic	e								
If you are eligible to receive benefits, you have two the Employment Development Department (EDD).	options to receive your benef You do not have to accept the	fit payments: b e EDD Debit Ca	y the EDD Debit Car d. Select your prefe	rd™, throug erred payme	h Bank of Am ent method b	nerica, or by o pelow.	check, which is i	mailed to you f	from
	* Preferred Payme	ent Method:	 EDD Debit Car Check 	ď					
	Disclosures	Agreement:	EDD Debit Card Fe	ee Disclosur	res, DE 5617P	D (PDF)			
* 🗌 I acknowledge that I have reviewed the EDD D	ebit Card Fee Disclosures.								

You have the option to select your preferred payment method. You may select to receive benefit payments by the EDD Debit Card or by check. You do not have to accept the EDD Debit Card.

If your preferred payment method is the EDD Debit Card, you may view the disclosure agreement by selecting the *EDD Debit Card Fee Disclosures* (DE 5617PD) (PDF) link. You do not have to accept the EDD Debit Card.

Select the check box below to acknowledge you have reviewed the disclosure agreement.

Section 6 - Declaration	
Read the information below and check each box if you agree. A check in the box indicates an electronic signature executed by you, and is a legally binding equiv written signatures.	valent of traditional hand-
* By ny electronic signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was care recipient named above; (2) authorize EDD to release my personal information as shown on this claim to the care recipient and to the care recipient's tr physician/practitioner as they are listed on this claim; (3) authorize my employer(s) to disclose to EDD all facts concerning my employment that are within the authorize release and use of information as stated in the EDD "Information Collection and Access" section of the Important Paid Family Leave Program Info understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punish or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to the best of my knowledge an and complete. I agree that photocopies of this authorization shall be valid as the original, and I understand that authorizations contained in this claim state period of fifteen years from the date of my electronic signature or the effective date of the claim, whichever is later.	s providing care for the reating their knowledge; and (4) ormation page. I shable by imprisonment nd belief true, correct, tement are granted for a
Previous Cancel Save as Draft	Submit

On **Section 6 – Declaration**, select the check box to authorize an electronic signature. You must select this box to complete your claim.

Select Submit to send the online portion of your claim to the EDD.

Note: Your claim is NOT complete. You must submit the "Statement of Care Recipient" and the "Physician's/Practitioner's Certification" sections of the *Claim for Paid Family Leave (PFL) Care Benefits* (DE 2501FC).

The **Confirmation** screen will provide instructions to complete and upload or mail the additional documentation for your Paid Family Leave Care claim.

Paid Family Leave (PFL) Survey Questions	
* Indicates Required Field	
Paid Family Leave (PFL) Survey	
The EDD has received your portion of your claim for Paid Family Leave benefits. There is one more step to complete before you receive your claim receipt number questions below and then select the "Submit" button for your receipt number.	r. Please answer the
* Before you filed your Paid Family Leave (PFL) claim, how did you learn about the Paid Family Leave (PFL) benefit program? Please select the response	that best applies:
O From a brochure I received by U.S. mail.	
○ From a friend or family member.	
○ From an SDI Online Notification.	
○ From my employer.	
○ From a social worker or hospital employee.	
○ None of these.	
	Submit

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Complete the survey and select Submit.

2

Confirmation

Print this page for your records. If a printer is unavailable at this time, record the Form Receipt Number below. The Form Receipt Number is required to retrieve a copy of the *Paid Family Leave Claim Care* (DE 2501F) application. You will not be able to access your confirmation page and Form Receipt Number after this window is closed.

Most claims are processed and a decision is made within two weeks of the date the claim was submitted. If you have not received anything from PFL within 10 days or if you have any questions you may call 1-877-238-4373.

Confirmation Informati	on	XXX-XX-XXX	x
Claimant Name:	Jane Doe	Social Security Number:	XXX-XX-1014
Date you requested to have your Paid Family Leave claim begin:	08-01-2018	Receipt Number:	R10000000033448

Instructions for Submitting Physician/Practitioner's Certification for Care Recipient

To be eligible for Paid Family Leave benefits to care for a family member, you must submit a "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information". These documents must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online care claim.

Failure to submit the "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information" will result in claim disqualification and no payment will be issued.

A paper "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information" is available to print from http://www.edd.ca.gov/pdf_pub_ctr/de2501fc.pdf. Follow the instructions below to submit the completed form electronically or through the mail.

Electronically

You may attach your electronic Physician/Practitioner's Certification for Care Recipient and Care Recipient Authorization for Disclosure of Personal Health Information

http://www.edd.ca.gov/pdf_pub_ctr/de2501fc.pdf

You may also submit it at a later time by following these navigation instructions: 1. Select New Claim 2. Choose Submit Electronic Paid Family Leave Care Attachment. Mail

8

You may mail your "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information".

> Mail your document to: EDD - Paid Family Leave PO BOX 997017 SACRAMENTO CA 95799-7017

On the **Confirmation** screen, you will be assigned a **Receipt Number**.

Save the **Receipt Number** for future reference. You will need this number to complete the additional documentation and to upload to the correct online claim.

The **Confirmation** screen also provides instructions to complete the additional documentation for your Paid Family Leave Care claim.



On the **Confirmation** screen, select the link to print a PDF copy of the *Claim for Paid Family Leave (PFL) Care Benefits* (DE 2501FC) form. It is your responsibility to ensure all forms are completed and signed by all parties and submitted to the EDD within 10 days.

- Once the DE 2501FC is completed and signed, upload and save it (as a PDF, JPG, JPEG, TIF, or TIFF file) to your computer to submit electronically.
- You may also mail the completed form to the address on this screen if you do not submit it electronically.

Note: You can also print the DE 2501FC in English and Spanish from <u>Paid Family Leave Forms</u> and <u>Publications</u> (edd.ca.gov/pfl_forms_and_publications.htm).



Claim for Paid Family Leave (PFL) Care Benefits

Enter your receipt number here.

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PART C – INSTRUCTIONS FOR PFL CARE CLAIMS

The care recipient (the person for whom you are providing care) must do the following: Complete and sign "Part C – Statement of Care Recipient." If the care recipient is physically or mentally unable to sign, call PFL at 1-877-238-4373 for instructions.

The care recipient's physician/practitioner must complete "Part D – Physician/ Practitioner's Certification" either electronically in SDI Online, or by completing and signing page 3 of *Claim for Paid Family Leave (PFL) Care Benefits* (DE 2501FC). If the care recipient is under the care of an accredited religious practitioner, call PFL at 1-877-238-4373 for the proper form *Practitioner's Certification for Paid Family Leave Benefits* (DE 2502F).

The easiest way to have your claim processed is to submit the completed forms electronically in SDI Online as an attachment. If submitting by mail, send to the following address: Paid Family Leave, PO Box 997017, Sacramento, CA 95899-7017. If submitting electronically, return to the Homepage of your SDI Online account. Select New Claim from the Menu, and select Submit Electronic Paid Family Leave Care Attachment.

PART C – STATEMENT OF CARE RECIPIENT	(MAY BE COMPLETED BY CLAIMANT II MUST BE SIGNED BY CARE RECIPIENT	F CARE RECIPIENT IS MENTALLY OR PHYSIC/ OR CARE RECIPIENT'S AUTHORIZED REPRES	ALLY UNABLE TO DO SO. SENTATIVE.)	
C1. CARE PROVIDER SSN	C2. RECIPIENT'S DATE OF BIRTH	C1. RECIPIENT'S PHONE NUMBER	C1. RECIPIENT'S GENDER	
C5. LEGAL NAME OF CARE RECIPIENT	(FIRST, MIDDLE INITIAL, LAST)			2
C6. CARE RECIPIENT'S RESIDENCE AD	DRESS			Z
C7. CONFIRMATION OF to disclose my curren Development Departr original. Care Redplett's Signature (DO NOT P Cal. Authorized Representative signing etis maner as authorized typ par	MEDICAL DISCLOSURE AL t personal-health information ment (EDD). I further understa RENT) on behalf of care recipient must complete the ental fight power of automoty (asach copy) (DO NOT PENT)	THORIZATION. I authorize n to my care provider and to the and that copies of my signature following: L cours order (aeach copy) (For spouse or do	ny physician/practitioner e California Employment e below are as valid as the Date Signed	
	·····		Date Signed	3
DE 2501FC Rev. 5 (12-20)	Pag	je1 of4	cu	

Claim for Paid Family Leave (PFL) Care Benefits (DE 2501FC)

Page 1 is the Statement of Care Recipient, Part C.

To avoid delays in claim processing:

- 1. Enter the **Receipt Number** you were given when you completed the online portion of your Paid Family Leave Care claim in the top right corner.
- 2. Make sure all applicable information is completed in the appropriate section.
- 3. The care recipient or his/her authorized representative must sign and date the bottom of this page.

Note: Page 2 is left blank intentionally and not shown in this tutorial.

Medical certifications must be completed to a patient's disability/serious health cond Section 2708.	by a licensed physician or practitioner authorizs Bition pursuant to California Unemployment Ins	id to certify arance Code Enter y R1	your receipt number here.	1
PART D - PHYSICIAN/PRACTITIO	NER'S CERTIFICATION			
D1. PFL CLAIMANT'S (CARE PROVIDER'S) SOCIAL SECURITY NUMBER	D2. PFL CLAIMANT'S NAME (FIRST, MEDDLE	INITIAL, LAST)		
D3. PATIENT'S DATE OF BIRTH	D4. DOES YOUR PATIENT REQUIRE CARE I	BY THE CARE PROVIDER?		
D5. PATIENT'S NAME (FIRST, MIDDLE I				-2
D6. DIAGNOSIS OR, IF NOT YET DET	FERMINED, A DETAILED STATEMENT OF SYMP	TOMS		
D7. PRIMARY ICD CODE	D8. SECONDARY ICD CODES		D9. DATE PATIENT'S CONDITION COMME	NCED
D10. FIRST DATE CARE NEEDED	D11. DATE YOU ESTIMATE PATIENT WILL N THE CARE PROVIDER	O LONGER REQUIRE CARE BY	D12. DATE YOU EXPECT RECOVERY	EVER
D13. APPROXIMATELY HOW MANY TO HOURS COMMENTS	DTAL HOURS PER DAY WILL PATIENT REQUIR	E CARE BY A CARE PROVIDER!	<u> </u>	
D14. WOULD DISCLOSURE OF THE M CERTIFICATE BE MEDICALLY OR YOUR PATIENT?	IEDICAL INFORMATION ON THIS PSYCHOLOGICALLY DETRIMENTAL TO	D15. PHYSICIAN/ PRACTITIONER'S LICENSE NUMBER	D16. STATE OR COUNTRY OF NOT U.S.A.) IN V PHYSICIAN/PRACTITIONER IS LICENS PRACTICE	WHICH ED TO
D17. PHYSICIAN/PRACTITIONER'S N/ D18. PHYSICIAN/PRACTITIONER'S AC	WHE (FIRST, MIDDLE INITIAL, LAST)	THE SOLE ADDRESS)		
מזץ	STATE/PROV ZIP OR POSTAL CO	ODE COU	UNTRY (IF NOT U.S.A.)	
D19. TYPE OF PHYSICIAN/PRACTITIO	NER	D20. SPECIALTY (IF ANY)		
D21. Physician/Peoclitioner's Certifical I certify under penalty of pedjury the patient. I am authorized to co Original Signature of physician/pr RUBRER STAMP IS NOT ACCEPTRALE PHYSICIAN/PRACTITIONER'S PH	ion: that this pattent has a serious health condition a thy a patient disability or serious health condit actitioner – HONE NUMBER	and requires a care provider. I ha lion pursuant to California Unen	we performed a physical examination and/or in sployment insurance Code section 2700.	ated
Under socilors 2116 and 2122 of the Call condition of any person in order to obtain exceeding \$20,000. Socilors 1143 and 32	Itomia Unemploymere Insurance Code, it is a vi disability insurance benefite, wheeher for the m IUS require additional administrative penalities.	slasion for any individual who, w aker or for any other person, and	vibi Intern ko defraud, falsely canifiles the modica is punishable by imprisonment and/or a fine no	
DE 2501FC Rev. 5 (12-20)	Page	3 of 4		

Claim for Paid Family Leave (PFL) Care Benefits (DE 2501FC), cont'd

8

Page 3 is the Physician/Practitioner's Certification, Part D.

To avoid delays in claim processing:

- 1. Enter the **Receipt Number** from your Paid Family Leave Care claim in the top right corner.
- 2. Have the care recipient's physician/practitioner complete all applicable information.
- 3. Obtain a signature from the care recipient's physician/practitioner prior to uploading or mailing the form.

Note: You may also provide your **Receipt Number** to your care recipient's physician/practitioner so they can submit the medical certificate through SDI Online. Talk to the physician/practitioner about their process for submitting a PFL claim. They do not all follow the same process. 89

1	2	3	4	5	6	7	8	9	10	11	12	13
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Submit Paid Family Leave Care Claim Attachments

State of California	SDI Home	Inbox	New Claim	Draft	Profile	History
Home						
Message Center						
Check the message center Inbox below to rev Inbox [New: 0 , Total: 0]	view messages and take req	uired actions as neede	ed.			
Personal Information						
Full Name:	John Doe		EDD Custome	er Account Number:	123456789	
Mailing Address:	123 Main St			Phone Number:	916-555-1212	
	Sacramento, CA 958	314				
Residence Address:	123 Main St Sacramento, CA 958	314 314	(Cell Phone Number:	916-555-1213	

To submit your completed and signed *Claim for Paid Family Leave (PFL) Care Benefits* (DE 2501FC) form, return to your SDI Online account **Home** screen.

Select New Claim from the main menu bar.

Note: This form must be received within 10 days from the date you submitted your online claim.

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Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

9

Note: It may be necessary to send some documents via US Postal Service.

Apply for Disability Insurance Benefits

Disability Insurance

Apply for Paid Family Leave Benefits

Paid Family Leave Bonding Submit Electronic Paid Family Leave Bonding Attachment Paid Family Leave Care Submit Electronic Paid Family Leave Care Attachment Paid Family Leave Military Assist Submit Electronic Paid Family Leave Military Assist Attachment

Saved Drafts

To open and complete a form that you saved, select the Form Name. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the Delete button.

Select the **Submit Electronic Paid Family Leave Care Attachment** link under the Apply for Paid Family Leave Benefits header.

1	2	3	4	5	6	7	8	9	10	11	
Forn	n Attac	hment									
To attach a weeks of t	a file to your succ he date the claim	essfully submitted.	ed Paid Family Le	ave claim form, ch	100se the 'Select	' link under the A	ction field. Most c	laims are proces	sed and a decisi	on is made witl	nin two
lf vou have	e not received an	vthing from PFL	within 10 davs or	if vou have anv ou	lestions vou mav	call 1-877-238-4	373.				
			5								
Selec	t Claim to	o Attach	Documei	nt							
Form Na	me					Su	bmitted Date	Recei	pt Number	Ac	tion
DE 2501F	, Claim for Paid F	amily Leave (PFI	L) Benefits - Care	for Sick		10	-24-2018	R1000	00000033445	Se	lect
DE 2501F	, Claim for Paid F	amily Leave (PF	L) Benefits - Care	for Sick		10	-24-2018	R1000	00000033448	Se	lect
					Cano	cel					

Verify the **Receipt Number** on the screen with the number you received when you filed the online portion of the claim.

If it matches, click the **Select** link from the **Action** column to attach a document to your claim.

1 Z S 4 S 0 7 0	9	10	12	15
Attachment * Indicates Required Field				
Identifying Information for Previously Submitted Paid Family Leave Initial Care Claim Your Social Security Number: XXX-XX-XXXX Date you requested to have your Paid 08-01-2018 Form Receipt Number: R10000000033448				
Previously Submitted Attachments for Paid Family Leave Initial Care Claim				
Attachment To be eligible for Paid Family Leave benefits to care for a family member, you must submit a "Doctor's certification for care recipient" and "Care recipient authorization for disclosure of personal health information". These documents must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online care claim. A paper "Doctor's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information" is available to print or download from http://www.edd.ca.gov/pdf_pub_ctr/de2501fc.pdf . Follow the instructions below to attach the completed form electronically or through the mail.				
To attach a document, select the Browse button below. • File size: less than 5MB • File type: PDF,JPG, JPEG, TIF or TIFF				
* Please click the "Browse" button to browse for the document: No file chosen * Do you want to attach more documents? Yes No Previous Cancel Submit	^			

Select the **Browse** button to upload the completed document from your computer.

Note: To upload a document, you must have previously uploaded and saved the document on your computer as a PDF, JPG, JPEG, TIF, or TIFF file. All file sizes must be 5MB or less.

To upload additional documents, select **Yes** and then select **Submit**. This will navigate you back to the **Attachment** screen to continue uploading documents.

When you are done uploading, select No and then select Submit.

1 2 3 4 3 0		12	10
Attachment Confirmation			
Identifying Information for Previously Submitte	ed Paid Family Leave Initial Care Claim		
Your Social Security Number: XXX-XX-XXXX	Date you requested to have your Paid 08-01-2018 Family Leave claim begin:		
Form Receipt Number: R1000000033448			
Previously Submitted Attachments for Paid Fami	ily Leave Initial Care Claim		
File Name	Receipt Number		
Care Recipient Authorization.JPG	R1000000033449		

This screen confirms the attachment(s) were submitted.

Save the **Receipt Number(s)** for future reference.

Your Paid Family Leave Care claim is complete once you upload the "Statement of Care Recipient" and "Physician/Practitioner's Certification" portions of the DE 2501FC.

Please allow up to 14 days for the EDD to process your claim.

1	2	3	4	5	6	7	8	9	10	11	12	13
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File a Paid Family Leave Military Assist Claim

between the state of	2 3	4 3	0		0	 10	
<image/> Year And the Andrew State							
Number Note Note Date Pedde Medry Home Image: Contract Operation Image: Message Center Check the message center induces below to review messages and take required actions as needed. Image: Message Center Image: Message	Employment Development Department						
Home	state of California	SDI Home Inbox	New Claim Draft	Profile	History		
Wessage center Uncert the message center inhom betwee wessages and take required actions as needed. Items (Heere 0, Totale 0) Personal Information If will Name: Wailing Address: 23 Main S1 24 Main S1 25 Main S1 26 Main S1 26 Main S1 26 Main S1 27 Main S1 28 Main S1 28 Main S1 28 Main S1 29 Main S1 29 Main S1 20 Main S2 20 Main S1 20	Home						
Check the message center those below to review messages and take required actions as needed. those { New 0 , Totati 0 } Personal Information If will Names: John Doe ED Custemer Account Number: 123466789 Mailing Address: John Doe Phone Number: 123466789 Mailing Address: John Doe Phone Number: 123466789 Mailing Address: John Doe Phone Number: 123465789 Mailing Address: John Doe Phone Number: 123465789 Mailing Address: John Doe Mailing Address: John Doe Phone Number: 12646789 Mailing Address: John Doe Mailing Address: John St. Sacramento, CA 95814 Mailing Address: John St. Sacramento, Mailing Address: John St. John St. John St. Jo	📾 Message Center						
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Personal Information Full Name: John Doe EDD Customer Account Number: 23456789 Halling Address: 23 Main St 916-555-1212 Bread Commento, CA 95814 2018 Phone Number: 916-555-1213 Bread Commento, CA 95814 2018 Phone Number: 916-555-1213 Bread Madress: John Go @gmail.com 916-555-1213 Current Disability Insurance Claim(s) 500 @gmail.com 916-555-1213 Current Disability Insurance Claim(s) 500 @gmail.com 500 @gmail.com Pending Disability Insurance Claim Application(s) 500 @gmail.com 500 @gmail.com No Results Found 500 @gmail.com 500 @gmail.com 500 @gmail.com Descults Found 500 @gmail.com 500 @gmail.com 500 @gmail.com No Results Found 500 @gmail.com 500 @gmail.com 500 @gmail.com No Results Found 500 @gmail.com 500 @gmail.com 500 @gmail.com	Check the message center Inbox below to rev Inbox [New: 0 , Total: 0]	riew messages and take required actions as nee	aded.				
Personal Information Full Name: John Doe EDD Customer Account Number: 123456789 Mailing Addres: John Doe Phone Number: 106-555-1212 Baccramentio, CA 95814 Cell Phone Number: 106-555-1213 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, Cascramentio, CA 95814 Baccramentio, Cascramentio, CA 95814 Baccramentio, CA 95814 Baccramentio, Cascramentio, Ca							
Full Name: John Doe EDD Customer Account Number: 123456789 123 Main St. 23 Main St. 916-555-1212 Sacramento, CA 95814 23 Main St. 916-555-1213 23 Main St. Sacramento, CA 95814 1 Eventl Addresse: Joko @ gmail.com 916-555-1213 Current Disability Insurace Claim (s) No Results Found Pending Disability Insurace Claim Application (s) No Results Found Submitted Paid Family Leave Claim Application (s) Submitted online are listed below. To submit an electronic dor ap reviously submitted case or bonding claim, select New Claim. The status of your Paid family Leave Claim for a previously submitted case or bonding claim, select New Claim. The status of your Paid family Leave Claim Application (s)	Personal Information						
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In the construction Sacramento, CA 95814 Residence Address: 123 Main St Sacramento, CA 95814 E-mail Address: Jdoe @gmail.com Current Disability Insurance Claim(s) No Results Found Pending Disability Insurance Claim Application(s) No Results Found No Results Found Submitted Paid Family Leave Claim Forms Only forms you submitted online are listed below. To submit an electronic document for a previously submitted care or bonding claim, select New Claim. The status of your Paid Family Leave claim and Paid Family Leave claim, call 1-877-228-4375.	Mailing Address:	123 Main St	Phone Numb	916-555-1212			
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No Results Found	No Results Found						

Follow these instructions to begin filing a Paid Family Leave Military Assist claim:

- 1. Access your SDI Online account by logging in to Benefit Programs Online.
- 2. Select the **SDI Online** button to be directed to your SDI Online **Home** screen.
- 3. Select New Claim from the main menu bar on your SDI Online Home screen.

13

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		-										

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

Note: It may be necessary to send some documents via US Postal Service.

Apply for Disability Insurance Benefits

Disability Insurance

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Paid Family Leave Bonding Submit Electronic Paid Family Leave Bonding Attachment Paid Family Leave Care Submit Electronic Paid Family Leave Care Attachment Paid Family Leave Military Assist

Submit Electronic Paid Family Leave Military Assist Attachment

Saved Drafts

To open and complete a form that you saved, select the Form Name. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the Delete button.

Select the **Paid Family Leave Military Assist** link under the Apply for Paid Family Leave Benefits header.

If you are unsure about the type of claim to file for, refer to <u>Types of Claims</u> (edd.ca.gov/Disability/Types_of_Claims.htm) on the EDD website.

1	2 3	4 5	6	7	8 9	10 11	12	13
-								
Paid Family	Leave – Military A	ssist Claim Informatio	on		This screen	provides im	oortant	
Complete this form if you ha	d or will have a loss of wages while assistin	ng with matters related to a family member's militar	y deployment to a foreign country.		information		d roodily	
Note: Do not complete this fe	orm if you are insured by a Voluntary Plan	maintained by your employer. Ask your employer fo	or the proper forms.		mormation	you will need	readily	
Gather Your Inf	formation				available to	file a Paid Fa	amily Lea	ve
Have the following available	while completing this form:				Military Assi	ist claim.		
Personal Informati	on				, í			
Personal Informati • Full name (and other • Date of birth • Gender • Preferred language • Social Security numb • Mailing address • Phone number • Your relation to the m Employment Infor • Occupation • Oate you last worked • Date you verturned to- • Reason(s) why you ha • Bargaining unit numb Most Recent Empl • Name of employer • Mailing address • Phone number	ON Wage Information If you are receiving, or expect or Type of payment receiving Sick leave Sick le	to receive, any payments from your employer(s) ed, such as (but not limited to): d vacation n rt-time or modified duty tcan result in an overpayment, penalties, and disqu tworkers' Compensation during your family leave pri- ne and held in custody during your family leave pri- held tweeks at once or split them over a specified pe- assist claim to begin Qualifying Events You can request PFL benefits for multiple qualifi • Type of qualifying event, such as (but not • Provide/arrange care for the military • Attend courseling • Make financial/legal arrangements • Assist the military member at fi • Represent the military member at fi • Address issues due to the military m Event start and end dates • Contact information for the person or org	alification. beriod od riod of time ving events. You must provide the follow Resources for Spe Child Support Obligat Direct your questions to the Depa Spousal or Parental Si Direct your questions to the Distri	wing for each event: ecial Circumstances ions rtment of Child Support Services at 1-866 upport Obligations ict Attorney's Office administering the cou	Review and on this scree Select Next	gather the inen.	nformatio	٦
	 Letter of impending call or or Documentation approving res 	Reasonable Accommoda	If a person receiving PEL benefits	dias an bair or latal representative should	d renart the death to the DFL office. Renafits are navable	s through date of death if otherwise eligible		
		Call 1-877-238-4373 for required forms and instr	Death of Military Mem	ber	a report the death to the PPL onice. Benefits are payable	through date of death, if otherwise eligible.		
		 Need this form in an alternate format (e.g. Do not understand this form or any form p Are prevented from completing the form or 	If the military member dies, report	rt the death to the PFL office. You are eligi	ble to receive benefits to take care of any business relate	d to their death.		
		Need to choose a representative to sign for Are an authorized representative filing on	Job Benefits and Prot	ection Programs				
		For individuals with disabilities requesting auxil	i The Family and Medical Leave Act	: (FMLA) and California Family Rights Act (CFRA) offer job-protected leave to eligible employees for	· certain family and medical reasons.		
			 To contact FMLA, call 1-866- To contact CFRA, call 1-800- 	-487-9243 or visit the Department of Labo -884-1684 or visit the Department of Fair B	r. mployment and Housing.			
			For more information about Paid	Family Leave, visit the EDD website.				
					Cancel	Nex	:	99

Military	/ Assist Claim Ir	nstructions									
Indicates Requi	red Field										
Read and unders	stand the following information befor	re completing this form.	Thi								
Requirer	nents		on								
Your Respo	onsibilities										
/ou must:	Ineligibility		l Lea								
Read thes Include ve	You must not be:										
 File your Report in You 	Claiming or receiving U Receiving Workers' Con In custody of law enfor	Inemployment Insurance (UI) or Disability Insurance (DI) benefits. mpensation benefits at a weekly rate equal to or greater than the PFL benefit rate. rement authorities because you were convicted of a crime	Re								
◦ You ◦ You ◦ The	You can apply for benefits ever why.	entern building because you are eligible. If you are ineligible for all or part of a period claimed, the EDD will notify you of the ineligible period and the reason(s)									
f you are not su	Disqualification										
Basic Eligi	The PFL office will consider a	Il available information before disqualifying your claim. If the PFL office denies your claim, you will receive a written notice stating the reason(s) why.									
/ou must: • Have a fai	Do not deliberately report in percent penalty. The penalty	Reporting incorrect or incomplete information to collect or increase your benefits violates the California Unemployment Insurance Code and is punishable by im \$20,000, or both. The EDD actively prosecutes fraud, and claimants who are caught will face criminal prosecution to the fullest extent of the law.	iprisonment, a fine up to								
Have had Be emplo	Benefits	Your Rights									
 Have earn Have sub 	Benefit Amount	Confidentiality									
 Be the sp Certify the 	Carefully decide the date you paid one-seventh of your we	Carefully decide the date yo paid one-seventh of your we Information about your claim will be kept confidential, except for the purposes allowed by law. The EDD will not disclose or provide copies of medical information to medical providers.									
	How Bonofits Aro E	Inspection									
	now benefits Are P	You have the right to inspect any of your personal records maintained by the EDD, except for:									
	Atter your claim is processed requirements, a payment wi continued benefits. If payme	 Medical or psychological records where knowledge of the contents might be harmful to the subject. Records of active criminal, civil, or administrative investigations. 									
	Note: The majority of claims	Call 1-877-238-4373 to request a copy of your records. If the EDD denies you access, you can mail a request to review the denial to:									
	Taxability of Benef	Employment Development Department Information Security Office, MIC 33 PO Box 826880									
	PFL benefits are subject to fe PFL benefits are not subject	Sacramento, CA 94280-0001									
	Overpayment	Coll 1.877/38/4378 to correct your records if you believe they are not accurate relevant timely or complete. If the EDD refuses your request, you can mail a requ	uest to review the denial to:								
	If you receive PFL benefits yo waived. Otherwise, you mus from 25 to 100 percent until	Employment Development Department Information Security Office, MIC 33									
	Fraud	PO Box 826880 Sacramento, CA 94280-0001									
		Appeal									
		You have the right to appeal any overpayment, penalty, or disqualification. Instructions on how to appeal will be provided on any appealable document you rece	eive.								
		Agree Before Continuing									
		I understand these instructions for submitting a military assist claim. If I don't provide complete and accurate information, my benefits can be delayed or de report incorrect or incomplete information to collect or increase my benefits, the EDD will disqualify my claim and I can face criminal prosecution.	nied. If I deliberately								
		Previous	Nevt								
		Callect	Incat								

This screen provides instructions on how to file a Paid Family _eave Military Assist claim.

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Review and select Next.

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	+ <u> </u>		
Personal Information Personal Information	ation Additional Questions	4 Certification 5 Qual	ifying ts 6 Declaration
You are currently on Step 1 Personal Informa	tion		
Section 1 - Personal Info	ormation		
Social Security Number:	XXX-XX-XXXX	EDD Customer Account Number:	123456789
Full Name:	John Doe	Other Names (if any, under which you have worked):	
Date of Birth:	XX-XX-XXXX	Gender:	Male
Mailing Address:	123 Main St Sacramento, CA 95814	Phone Number:	916-555-1212
Preferred Language:			
If your personal information has changed, selec	t Save as Draft. To update your person	al information before completing this form, select Profi	le.
Previous	Cancel	Save as Draft	Next

The SDI Online system will automatically populate certain portions of the Paid Family Leave claim form.

Verify the information is correct. If your personal information has changed, select **Save as Draft** and update your SDI Online account profile.

Employment Details			Corre
Personal Information 2 Employment 3 Additional Questions	4 Certification 5 Qualifyin Events	g 6 Declaration	Empl
You are currently on Step 2 Employment Information			Infori
* Indicates Required Field			enteri
			currei
Section 2 - Employer Information			busin
Enter your current employer. If unemployed, enter your most recent employer.			phone
* Name of Your Employer	:		mailir
* Occupation	:		stated
* Are you a state government employee	? OYes No		navet
If "Yes", Indicate Bargaining Unit Number	:		paysi
* May we disclose benefit payment information to your employer(s):	? 🔿 Yes 🔵 No		Dogu
* Do you have more than one employer	? OYes ONo		Requ
* Reason for reducing work hours or stopping work	Care for Family Member O Other		marke
Employer Mailing Address			asteri
	US International		
* Address Line 1:			Selec
Address Line 2:			
* City:			
* State:			
* ZIP Code:			
Employer Phone Number:	(No dashes or spaces) Ext:		
	Check here if the phone number is international		
Previous Cancel	Save as Draft	Next	

Complete Section 2 -Employer Information by entering your most current employer's business name, phone number, and mailing address as stated on your W-2 or paystub.

12

13

10

Required fields are marked with a red asterisk (*).

1 2 3 4 5	6 7 8 9	10	11	12	
Additional Questions					
Personal Information Employment Additional Questions	4 Certification 5 Qualifying Events 6 Declaration				
You are currently on Step 3 Additional Questions *Indicates Required Field					
Paid Family Leave Information					
*Date you last worked:	(MMDDYYYY)				
The date you want your Paid Family Leave (PFL) benefits to begin cannot be before the date the	military member was notified of covered active duty status.				
*Date you want your PFL claim to begin:	(MMDDYYYY)				
[*] Do you want to claim the maximum amount of benefit weeks now?	O Yes O No				
If "No," enter the date you want to be paid through:	(MMDDYYYY)				
Date you returned to work:	(MMDDYYYY)				
Or date you plan to return to work:	(MMDDYYYY)				
*Did you or will you work at any time during your family leave period?	O Yes O No				
If you have or will receive any type of pay from your employer(s) during your family leave period, select the type of pay:	Sick Employer Required Vacation Other Type of Pay				
If "Other Type of Pay," specify the type:	Select 🗸				
*Have you claimed or do you plan to claim Workers' Compensation during your family leave period?	◯ Yes ◯ No				
*At any time during your Paid Family Leave, were you in the custody of law enforcement authorities because you were convicted of violating a law or ordinance?	Yes No				
Previous Cancel	Save as Draft Next				

Complete the **Paid Family Leave Information** section and confirm all dates are correct to avoid a possible delay or loss of benefits.

Required fields are marked with a red asterisk (*).

1	2	3	4	5	6	7	8	9	10	11	12	13
						· · · · · · · · · · · · · · · · · · ·						

Military Assist Certification		
Personal Information Employment Questions	Certification (5) Qualifying Events	6 Declaration
You are currently on Step 4 Certification		
*Indicates Required Field		
Your Information		
"The Military Member is your:	Select 🗸	
If "Other," please specify:		
Militan Manufactoria Information		
Military Member's Information		
"Military Member's First Name:		
Military Member's Middle Initial:		
*Military Member's Last Name:		
Military Member's Suffix:		
*Military Member's Date of Birth:	(MMDDYYYY)	
*Military Member's Gender:	O Male O Female	
"Last four digits of Military Member's Social Security Number:		
*Date Military Member was notified of covered active duty status:	(MMDDYYYY)	
*Covered active duty start date:	(MMDDYYYY)	
Covered active duty end date (if known):	(MMDDYYYY)	
Military Member's Mailing Address		
	US O International	
*Address Line 1:		
Address Line 2:		
*City:		
*State:	CA 🛩	
"ZIP Code:		
Supporting Military Documentation		
After you file this claim, you must submit an approved supporting military document to receiv	e PFL benefits,	
*Select the type of military document you will submit:	 Covered active duty orders Letter of impending call or order to covered active duty Documentation approving rest and recuperation leave 	
Instructions for submitting a supporting military document will be provided on the Confirmat	ion page.	
Previous	Save as Draft	Next

Complete the following sections:

- Your Information
- Military Member's
 Information
- Military Member's Mailing Address
- Supporting Military
 Documentation

Make sure the information you are entering is about the military member you are assisting.

Required fields are marked with a red asterisk (*).

Instructions on how to submit supporting military documentation after submitting your online claim will be provided on the confirmation screen.

Qualifying Ev	ents								
Personal	Employment	Additional		Quali	iying				
Information	Information	Questions	Certification	Event		6 Declaration			
You are currently on Step 5 Qu	alifying Events								
*Indicates Required Field									
Add Event									
Enter a qualifying quant if your	re requesting DEL benefits for a	ultiple quests enter each que	t separately. You can add up	to eight events					
Enter a qualitying event. Il you a	•Wh	at is your qualifying event?	 Provide/arrange childe 	care for the military m	ember's child				
			Provide/arrange care for the military member's parent Attend counseling Make financial/legal arrangements Assist the military member during rest and recuperation leave						
			Attend a military even Represent the military Address issues due to Other	t member at federal, s the military member':	tate, or local age s death	ncies			
		If "Other," please specify:							
		*Event Start Date:	(MMDDYYYY)						
		*Event End Date:	(MMDDYYYY)						
Event Details									
Event Details									
Provide the following informatic	on related to the qualifying even	*Name or Organization:							
		Address Line 1:							
		Address Line 2:							
		fiter							
		city:							
		State:	ca 🗸						
		ZIP Code:							
		*Phone Number:	(No dashes or spaces)	Ext:					
			Check here if the phor	ne number is internat	ional				
		Email Address:							
	*Descr	ribe your qualifying event:	(May characters is 355)						
			(max citaracters is 200)						
u can add mars surety as 1					ĥ				
u can add more events on the n	ext page.								
Previous		Cancel	Save as Draft			Next			

Complete the following sections:

10

- Add Event
- Event Details

Make sure you are entering information about the qualifying event you will attend.

If you are requesting PFL Military Assist benefits for multiple events:

- Enter each event separately.
- You can add up to eight events.
- Instructions to add additional events are located on the next slide.

Required fields are marked with a red asterisk (*).

Select Next to proceed.

List of Qualifying Events									
Personal Information	Additional Questions	Certification	5 Qualifyin Events	ng 6 De	claration				
You are currently on Step 5 Qualifying Events									
*Indicates Required Field									
Your Events Select Add to enter another qualifying event. If you are finished adding events, select Next to continue.									
Qualifying Event	Name	or Organization	Event Start Date	Event End Date	Action				
Provide/arrange care for the military member's parent	Mother	r Jones	MM-DD-YYYY	MM-DD-YYYY	Delete				
Previous	Cancel	Add Save a	as Draft		Next				

To submit more than one event:

• Select Add and enter in additional qualifying event information.

Select **Next** once all events have been submitted.

13

1	2	3	4	5	6	7	8	9	10	11	12	13
De •	Claration Personal Information	Employmen Information	t Ada	ditional estions	 Certification 	Qualifying Events	6 Decla	aration	On the have th preferre	Declaration e option t ed payme	on screer o select y nt metho	n, you your d.
You ar *Indica Pay If you a the Em	e currently on Step 6 D ates Required Field ment Choice are eligible to receive be uployment Development	eclaration 9 nefits, you have two opt t Department (EDD), You	tions to receive your ben u do not have to accept t	hefit payments: by the he EDD Debit Card. Se	EDD Debit Card SM , throu; lect your preferred paym	gh Bank of America, or by ent method below.	r check, which is mailed	to you from	You ma benefit Debit C	y select to payments ard or by	o receive by the E check .	DD
• Dig	knowledge that I have	reviewed the EDD Debit	*Preferred Payr Disclosure t Card Fee Disclosures.	nent Method:	EDD Debit Card Check D Debit Card Fee Disclosu	ires, DE 5617PD (PDF)]		You do EDD Do	not have ebit Card.	to accep	t the
Read t Note: J	A check in the box is a di my signature on this Mi Claim Paid Family La Authorize the EDD to Authorize the EDD to Authorize the releas Understand that wil imprisonment or fin Declare under penal and complete. Agree that photocop Understand that aut whichever is later.	an and check the box if you gital signature executed ilitary Assist Certificatio eave benefits and certifi o release my personal in nyer(s) to disclose all fac e and use of informatio Ifully making a false stat e or both. Ity of perjury that the fo sies of this authorization thorizations contained i	bu agree. I by you and is the legall n and claim statement, I y that, throughout the p information as shown on its concerning my emplo n as stated in the Inform tement or concealing a r regoing statement, inclu n shall be as valid as the n this claim statement a	y binding equivalent t l: eriod covered by this c this claim to the militi vation Collection and A material fact in order t uding any accompanyi original. re granted for a period	o a traditional handwritte claim, I was assisting a mi ary member I am assistin their knowledge to the E access section on the <i>Cla</i> o obtain payment of ben ng statements or docum d of 15 years from the dat	en signature. ilitary member during a o g. IDD. im for Paid Family Leave (efits is a violation of Calif ents, is to the best of my i e of my signature or the o	ualifying event. (<i>PFL) Benefits</i> (DE 2501F ornia law punishable by knowledge and belief tr effective date of the claim	i). / ue, correct, m,	lf your p method you ma agreem Debit C (DE 56	oreferred is the ED y view the ent by se Card Fee 17PD) (Pl	payment D Debit e disclosu lecting th Disclosu DF) link.	Card, ure ne EDD Ires
	Previous			Cancel	Save as Draft			Submit				

Select both check boxes to acknowledge you have reviewed the disclosure agreement and to provide a digital signature.

Select Submit to proceed.

Paid Family Leave (PFL) Survey Questions

* Indicates Required Field

Paid Family Leave (PFL) Survey

The EDD has received your portion of your claim for Paid Family Leave benefits. There is one more step to complete before you receive your claim receipt number. Please answer the questions below and then select the "Submit" button for your receipt number.

* Before you filed your Paid Family Leave (PFL) claim, how did you learn about the Paid Family Leave (PFL) benefit program? Please select the response that best applies:

- From a brochure I received by U.S. mail.
- From a friend or family member.
- From an SDI Online Notification.
- From my employer.
- From a social worker or hospital employee.
- None of these.

Submit

10

Complete the survey and select Submit.
Confirmation	
ou have successfully submitted your PFL claim. Allow two weeks for it to be processed. If yo	ou have any questions, call 1-877-238-4373.
Claim Information	
Claimant Name: John Doe Requested Claim Start Date: 11-07-2021	Social Security Number: XXX-XX-XXXX Receipt Number: R100001000032163
mportant Next Steps ailure to submit your supporting document will result in disqualification, and you will	not receive payment. You must send it within 10 business days electronically or by mail.
mportant Next Steps ailure to submit your supporting document will result in disqualification, and you will Send Electronically	not receive payment. You must send it within 10 business days electronically or by mail.
mportant Next Steps ailure to submit your supporting document will result in disqualification, and you will send Electronically You can attach your supporting document now or at a later date by following these instructions:	not receive payment. You must send it within 10 business days electronically or by mail. Send by Mail Mail a photocopy of your supporting document to:
ailure to submit your supporting document will result in disqualification, and you will Send Electronically You can attach your supporting document now or at a later date by following these instructions: 1. Select New Claim from the main menu.	not receive payment. You must send it within 10 business days electronically or by mail. Send by Mail Mail a photocopy of your supporting document to: EDD - Paid Family Leave PO Box 997017
ailure to submit your supporting document will result in disqualification, and you will Send Electronically You can attach your supporting document now or at a later date by following these instructions: Select New Claim from the main menu. Select the corresponding attachment link.	not receive payment. You must send it within 10 business days electronically or by mail. Send by Mail Mail a photocopy of your supporting document to: EDD - Paid Family Leave PO Box 997017 Sacramento, CA 95799-7017
ailure to submit your supporting document will result in disqualification, and you will Send Electronically You can attach your supporting document now or at a later date by following these instructions: Select New Claim from the main menu. Select the corresponding attachment link.	not receive payment. You must send it within 10 business days electronically or by mail. Send by Mail Mail a photocopy of your supporting document to: EDD - Paid Family Leave PO Box 997017 Sacramento, CA 95799-7017 Do not mail the original document. Include your 9-digit Social Security number, receipt number, and requested claim start date on each page.

On the **Confirmation** screen, you will be assigned a **Receipt Number**.

Save the **Receipt Number** for future reference. You will need this number to upload your additional documentation to the correct online claim.

The **Confirmation** screen will also provide instructions to upload your additional documentation to your Paid Family Leave Military Assist claim.



To complete your Paid Family Leave Military Assist claim, you will need to submit your supporting military documentation and documentation of the qualifying event within 10 days.

To submit your documentation electronically:

- Select the attach your supporting document now link.
- View the <u>Submit Paid Family Leave Military Assist Claim Attachments</u> section of this tutorial for instruction on uploading your documents to your online claim.

To submit your documentation by mail:

- Send copies of your supporting military documentation and documentation of the qualifying event to the address on the screen.
- Do not mail the original documents. Include your 9-digit Social Security number, Receipt Number, and requested claim start date on each page.

1	2	3	4	5	6	7	8	9	10	11	12	13
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Submit Paid Family Leave Military Assist Claim Attachments

2 3 4	5	6	7	8 9	10	11
Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History
Home						
Message Center						
Check the message center Inbox below to rev Inbox [New: 0, Total: 0] Personal Information	iew messages and take re	equired actions as ne	eeded.			
Full Name:	John Doe		EDD Cus	tomer Account Number:	123456789	
Mailing Address:	123 Main St Sacramento, CA 95	5814		Phone Number:	916-555-1212	
Residence Address:	123 Main St Sacramento, CA 95	5814		Cell Phone Number:	916-555-1213	
E-mail Address:	Jdoe@gmail.com					
Current Disability Insura	nce Claim(s)					

To upload the required military documentation and documentation of the qualifying event to your online claim:

- Return to your SDI Online account **Home** screen.
- Select New Claim from the main menu bar.

Note: Your documentation must be received within 10 days from the date you submitted your online claim.

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

Note: It may be necessary to send some documents via US Postal Service.

Apply for Disability Insurance Benefits

Disability Insurance

Apply for Paid Family Leave Benefits

Paid Family Leave Bonding Submit Electronic Paid Family Leave Bonding Attachment Paid Family Leave Care Submit Electronic Paid Family Leave Care Attachment Paid Family Leave Military Assist Submit Electronic Paid Family Leave Military Assist Attachment

Saved Drafts

To open and complete a form that you saved, select the Form Name. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the Delete button.

Select the **Submit Electronic Paid Family Leave Military Assist Attachment** link under the Apply for Paid Family Leave Benefits header.

	2	ა	4	5	6	1	8	9	10		12
ÉD	Employment Development Department California		SDI Home	á	Inbox	New Claim	Dra	R.	Profile	History	
or	n Attac	hment									
Selec	weeks for attack	hments to be pro	ocessed. If you have a	any questions, ci	all 1-877-238-4	1373.					
Allow two Select	o weeks for attach	hments to be pro 1 cessfully submitte	ocessed. If you have a ed will be listed.	any questions, ci	all 1-877-238-4	Date	Submitted	Rece	int Number	Action	_

Verify the **Receipt Number** on the screen with the number you received when you filed the online portion of the claim.

If it matches, choose the **Select** link from the **Action** column to attach a document to your claim.

1 2 3	4 5	6	1	8	9	10	11	12
Attach File *Indicates Required Field								
Claim Information Social Security Number: XXX-XX- Receipt Number: R10000	XXXX 1000032163		Requested Claim Star	Date: MM-D	D-YYYY			
Current Attachments								
Select a File								
Select Browse to attach a file to your claim. • Files must be less than 5MB • Allowed file types: PDF, JPG, JPEG, TIF or TIFF								
	*Choose a fi *Attach another documei	nt? O Yes) No	В	rowse			
Previous		Cancel				Submit		

Select the **Browse** button to upload a document from your computer.

Note: To upload a document, you must have previously uploaded and saved the document on your computer as a PDF, JPG, JPEG, TIF, or TIFF file. All file sizes must be 5MB or less.

To upload additional documents, select **Yes** and then select **Submit**. This will navigate you back to the **Attachment** screen to continue uploading documents.

When you are done uploading your documents, select No and then select Submit.

Áttachment Confirmati	on	
Your file has been uploaded and attached to your claim.	ie -	
Claim Information		
Social Security Number: XXX-XX-	XXXX	Requested Claim Start Date: MM-DD-YYYY
Receipt Number: R1000	01000032163	
Attachments		
File Name	Date Submitted	Attachment Receipt Number
covered active duty orders - provide care.JPG	MM-DD-YYYY	R100001000032167

This screen confirms that the attachment(s) have been submitted.

Save the **Receipt Number(s)** for future reference.

Once the supporting military documentation and documentation of the qualifying event are submitted, your military assist claim is complete and should be processed by the EDD within 14 days.

1	2	3	4	5	6	7	8	9	10	11	12	13
				-	-							

Update My Benefit Programs Online Profile -

Email, Password, Security Questions, or Personal Image and Caption



Visit <u>Benefit Programs Online</u> (edd.ca.gov/BPO) to change or update your email, password, security questions, or personal image and caption.

Follow these directions to login to Benefit Programs Online:

- 1. Enter the email address that you used to register.
- 2. Complete the security check.
- 3. Select Log In.

For Spanish, select the En español link.

<i>C</i> .cov 爺	State of California Employment Development Department
Pas ^{To log} * Use	sword i n to Benefit Programs Online, you must verify your personal image and personal caption, and enter your password. the latest version of Chrome or Firefox for the best experience. Personal Image: Personal Caption: Cup
5.	* Password: Forgot Password?
6. –	Previous Log In
	Contact EDD Conditions of Use Privacy Policy Accessibility Copyright © 2019 State of California

4. Verify your Personal Image and Personal Caption are correct.

If you do not recognize your personal image and caption, select **Previous** to review the email address entered on the login screen to ensure it is correct. If you are unable to verify your personal image, select <u>Contact EDD</u> (edd.ca.gov/about_edd/contact_edd.htm) for your options on further assistance.

5. Enter the password you created during the Benefit Programs Online registration process.

6. Select Log In.



From your Benefit Programs Online account, select My Profile.

A My Profile	Benefit Programs Online	Or
Ny Profile		se
Select the links to the right of each se Note: You will be logged out after 30 min	notion to update your profile. Nutes on any page. Any information entered will not be saved.	lin •
Email and Password		•
Email:	i jdoe@gmail.com	
Pessword:	Update Password	
Security Questions	Update Security Questions	Fo
Question 1:	What was the first movie you saw in a movie theater?	up
Answer		inf
Question 2:	Where is the coldest location you visited as a child?	
Answer		
Question 3:	What is the name of your favorite cartoon character?	
Answer		
Question 4:	What was your father's occupation?	
Answer.		
Personal Image and Captio	In Update Personal Image and Caption	
Personal Image:		
Personal Caption:	UAT	

On the **My Profile** screen select one of the following inks:

12

13

Update Email

10

- Update Password
- Update Security Questions
- Update Personal Image and Caption

Follow the instructions to update your profile information.

	Ų			5
Gov Emp	e of California Dioyment De	velopment Depar	tment	Log Out
â	My Profile		Benefit Programs Online	
You have succ	e essfully updated your profil	e. A notification will be sent to your emai	il confirming this update.	
	TASSWOID		Lindate Email	
	Email:	jdoe@gmail.com	opute Linui	
	Password:	******	Update Password	
Security C	Questions			
			Update Security Questions	
	Question 1:	Where did you celebrate your 21st birth	iday?	
	Answer:	****		

A message confirming the change will display at the top of the **My Profile** screen and a notification will be sent to your email confirming the change.

Note: Update your mailing and residence address, phone number, and preferences for language and communication through SDI Online:

- Select Benefit Programs Online
- Select the SDI Online link
- Select Profile from your SDI Online main menu bar

1	2	3	4	5	6	7	8	9	10	11	12	13
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Complete Paper Claim Forms



9

Claim for Disability Insurance (DI) Benefits (DE 2501) SAMPLE Claim for Paid Family Leave (PFL) Benefits (DE 2501F) SAMPLE

The DE 2501 is used to file for Disability Insurance benefits and the DE 2501F is used to file for Paid Family Leave Bonding, Care, or Military Assist benefits. These forms are printed with special red ink so they may be scanned into the SDI Online system. These forms may not be submitted as photocopied versions or faxed to the EDD for processing.

If you have already applied online, do not file a paper claim form. Duplicate claim requests will delay claim processing.



- Use black ink only.
- Type or write clearly **within** the boxes provided.
- Complete and review your portion of the form:
 - **Disability Insurance:** Part A of the *Claim for Disability Insurance (DI) Benefits* (DE 2501) and have your physician/practitioner complete Part B.
 - **Paid Family Leave Bonding:** Part A and Part B of the *Claim for Paid Family Leave* (*PFL*) *Benefits* (DE 2501F), and include a "Poof of Relationship" document.
 - Paid Family Leave Care: Part A and Part C of the Claim for Paid Family Leave (PFL) Benefits (DE 2501F), and have the care recipient's physician/practitioner complete Part D.
 - **Paid Family Leave Military Assist:** Part A and Part E of the *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F), and include the required supporting military documentation.
- The EDD does not accept photocopied or faxed forms.
- Mail the completed form to the EDD in the pre-addressed envelope provided.
- Do not mail this form to the EDD if you have already submitted this claim online.



Date Signed

12252015

 SAMPLE, this page for reference only

 Claim for Disability Insurance (DI) Benefits

 Health Insurance Portability and Accountability Act (HIPAA) Authorization

 Claimant Social Security Number
 0 0 0 0 0 0 0 0 0 0

 Claimant Name
 (First)
 (MI)

 Sample 1 e
 Claimant to cla

l authorize

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I understand that EDD is not a health plan or health care provider, so the information released to EDD may no longer be protected by federal privacy regulations. (45 CFR Section 164.508(c)(2)(iii)). EDD may disclose information as authorized by the California Unemployment Insurance Code.

I agree that photocopies of this authorization shall be as valid as the original.

I understand I have the right to revoke this authorization by sending written notification stopping this authorization to EDD, DI Branch MIC 29, PO Box 826880, Sacramento, CA 94280. The authorization will stop on the date my request is received. I understand that the consequences for my revoking this authorization may result in denial of further State Disability Insurance benefits.

I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by EDD or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

I understand that I am signing this authorization voluntarily and that payment or eligibility for my benefits will be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization may result in an incomplete claim form that cannot be processed for payment of State Disability Insurance benefits.

I understand I have the right to receive a copy of this authorization.

Claimant Signature (Do Not Print)
Sample Claimant

Claim for Disability Insurance (DI) Benefits (DE 2501)

Health Insurance Portability and Accountability Act (HIPAA) Authorization, page 7.

You must sign and date the Health Insurance Portability and Accountability Act (HIPAA) Authorization and provide the name of your physician/practitioner.

Note: Pages 1-6 includes information and instructions for filing your Disability Insurance claim and EDD Debit Card Fee Disclosures. Please review all information before completing your paper claim form.

Page 7 of 13



4

Claim for Disability Insurance (DI) Benefits (DE 2501)

Part A - Claimant's Statement, pages 8-10.

Pages 8, 9, and 10 – You must complete all applicable information. Do not forget to sign page 10.

Page 10 also includes checkboxes to request to receive benefit payments by check or debit card.

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PARTE	- PHYS	ICIAN/	RACT	тю	IER's	CE	RTIFIC	CATE																	- 10-										
B1. PA	RENT'S	SOCIAL	SECU	RITY	NUM	8ER	0	0	0	0	0	0	0	0) ()		82	PA	TIEN	rs	FILE	NUN	BE	a (5	9 -	-	6	4	2	-	3	8	
83. IF'	YOU KN	OW THE	PATIE	NT'S	ELEC	TRO	ONIC	RECE	EIPT	NUN	IBE	R, E	NT	ERI	T HE	ERE:	8		F	B4. F	ATE		S DA	TE ()F BI	RTH	0								
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s a	m p	NAME 1	9	(FIRS	η)				(MI)		(LA:	ST) 1	a	i	. 1	n a	alı	n t	-	T	1		Ι	Ι	K	Ι		Ι		Ι	Ι	Ι		1	
6 3		0	2 7	9	3	NSE 0	NUM	BER			B7	ST/	ATE	OR	col	JNTF	RY (I	F NO	ru.	SA)1	THAT	riss	UED	LICE	NSE	NU	MBE	REN	TER	EDI	IN B6	Т		Т	F
B8. PH	YSICIA	VPRAC	ппо	NER I	JCEN	SET	YPE	_	_	_		_			1	в	9. 5	PEC	ALT	TY ar	ANT	0	-				-	-	_	_	_	_	_	_	5
MD			3 4 A		Ι		T									t	Ι		I	Í	Ι														1
810. P	HYSICIA	NPRAC	тпо	NER'S	NAM	EAS	SHO	WN C	DN L	ICEN	SE									_	_	_		_	_	_		_	_	_					
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Claim for Disability Insurance (DI) Benefits (DE 2501)

Part B - Physician/Practitioner's Certificate, pages 11-13.

Your physician/practitioner must complete all applicable information including dates and diagnosis/treatment codes. The physician/practitioner must also sign page 13.



Claim for Paid Family Leave (PFL) Benefits (DE 2501F)

PAGE 1

Part A - Statement of Claimant:

 Complete all applicable information, including your personal information, last day worked and employer information. Make sure to sign and date the form.

Part A is required for all Paid Family Leave claim types:

- Bonding
- Care
- Military assist

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for Paid Family Leave (PFL) ts (DE 2501F)

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- Bonding Certification:

ou are filing a bonding claim, must complete this section and the form.

- Statement of Care Recipient:

ou are filing a care claim, you or care recipient must complete section. The care recipient or r authorized representative st sign the form.

ete either Part B or Part C – ver both for one claim.

Part B and Part C are NOT d for military assist claims.

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Claim for Paid Family Leave (PFL) Benefits (DE 2501F)

PAGE 5

Part E – Military Assist Certification:

You must complete all information under Part E, including:

- The military member's personal information
- Dates of covered duty
- Qualifying event information
- Your signature

Note: Part E is NOT required for bonding or care claims. It is only required for military assist claims.

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Claim for Paid Family Leave (PFL) Benefits (DE 2501F)

PAGE 6

Part E - Qualifying Event for Leave Documentation:

If you're requesting family leave to meet with a third party, you must include:

- Third party contact information.
- Description of the event, including dates.

Make sure to complete all required pages and sign the claim form before mailing to the EDD for processing.

Note: The Qualifying Event for Leave Documentation is NOT required for bonding or care claims.

Visit <u>State Disability Insurance</u> (edd.ca.gov/disability) for more information. For additional help call Disability Insurance at 1-800-480-3287 or Paid Family Leave at 1-877-238-4373.

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 1-866-490-8879. TTY users, please call the California Relay Service at 711.