SDI Online Tutorial

Claimant Registration, Online Access, and Claim Filing

Employment Development Department
State of California

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

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

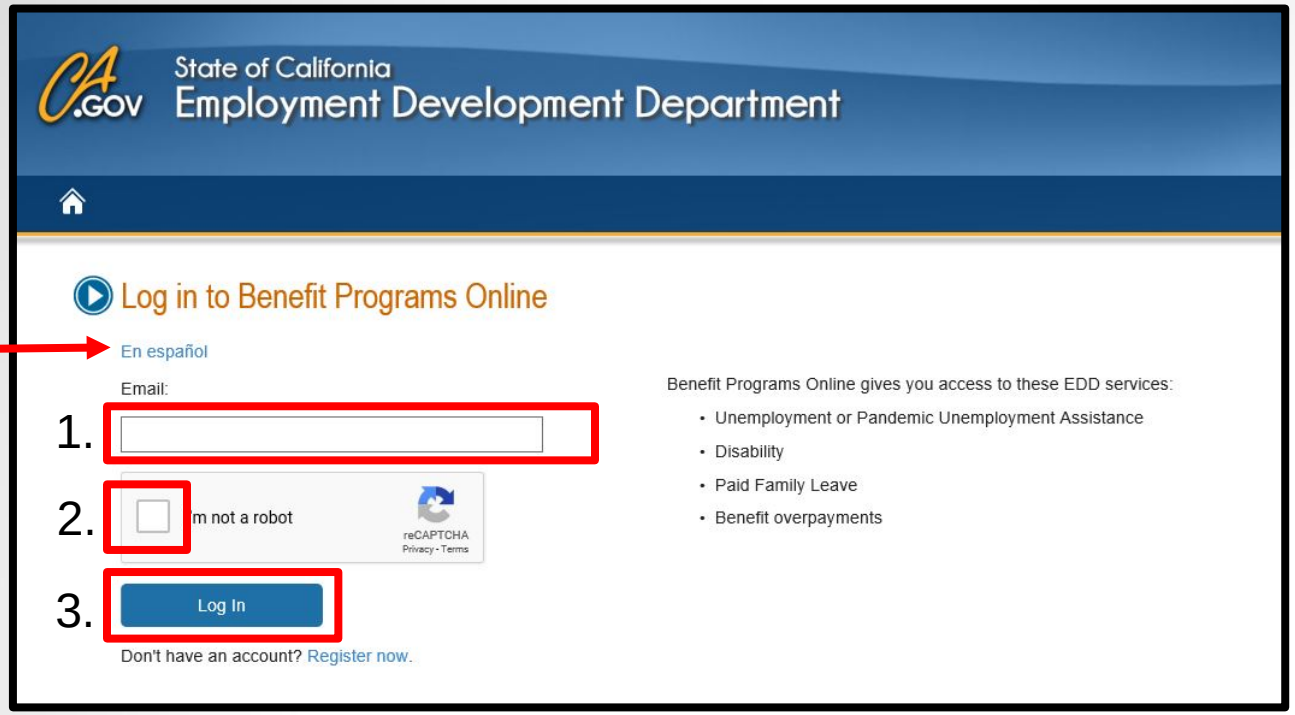
Watch EDD's Benefit Programs Online: Overview and Registration for New Users YouTube video for detailed instructions on how to register a new account.

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

Benefit Programs Online Registration:

1. Visit Benefit Programs Online (edd.ca.gov/BPO) to complete a one-time registration.
2. 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.
8. 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 Register as a Claimant in SDI Online). You will always use Benefit Programs Online to access SDI Online to file a Disability Insurance or Paid Family Leave claim.

Register as a Claimant in SDI Online (Step 2)

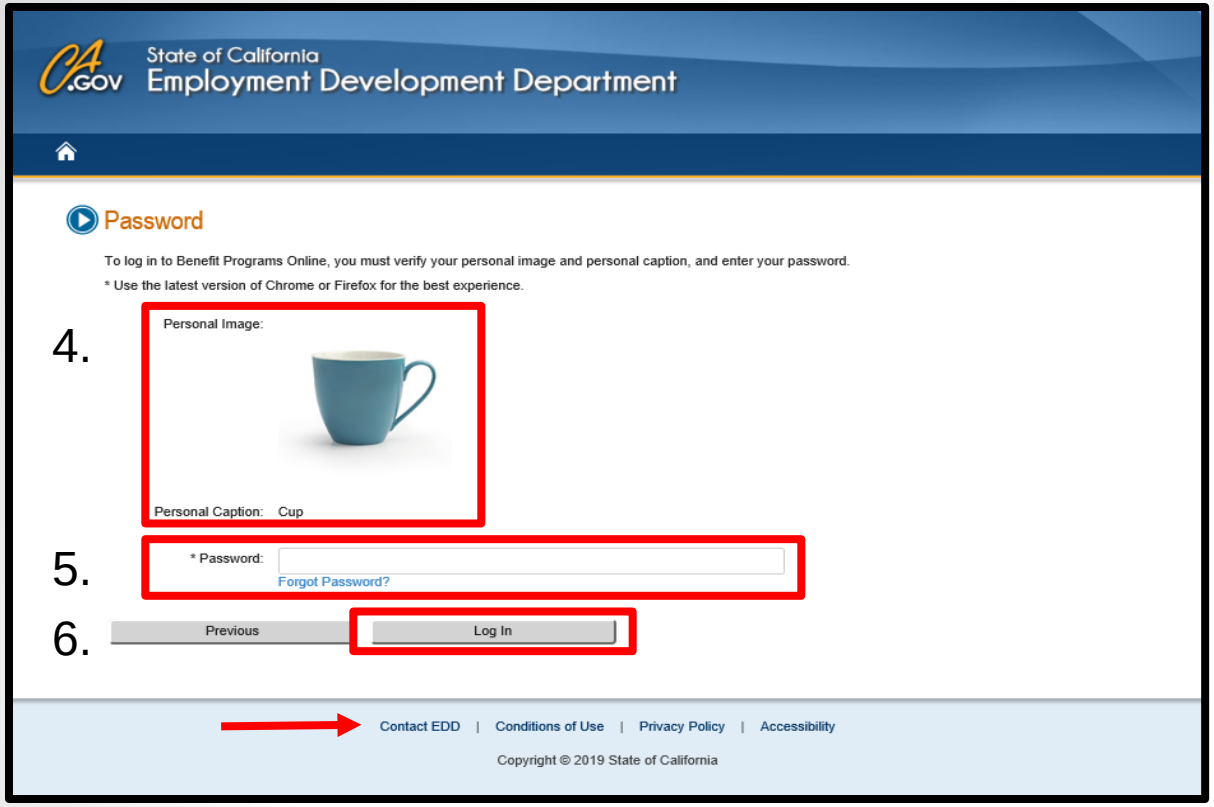


Once you have completed your Benefit Programs Online registration, return to **Benefit Programs Online** and log in to complete the SDI Online registration process.

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.

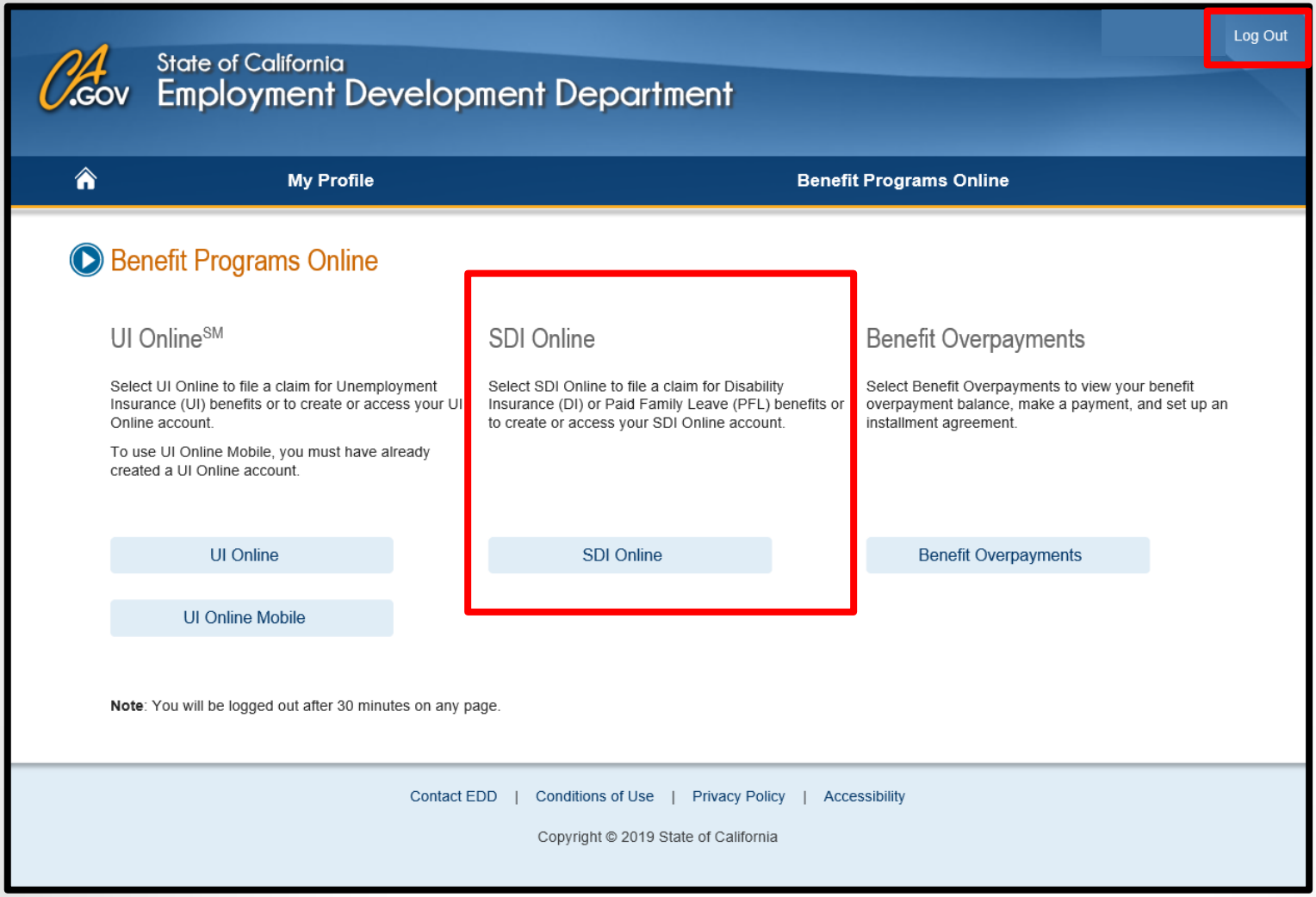


4. Verify your **Personal Image** and **Personal Caption** are correct.

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 Contact EDD (edd.ca.gov/about_edd/contact_edd.htm) for further assistance.

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

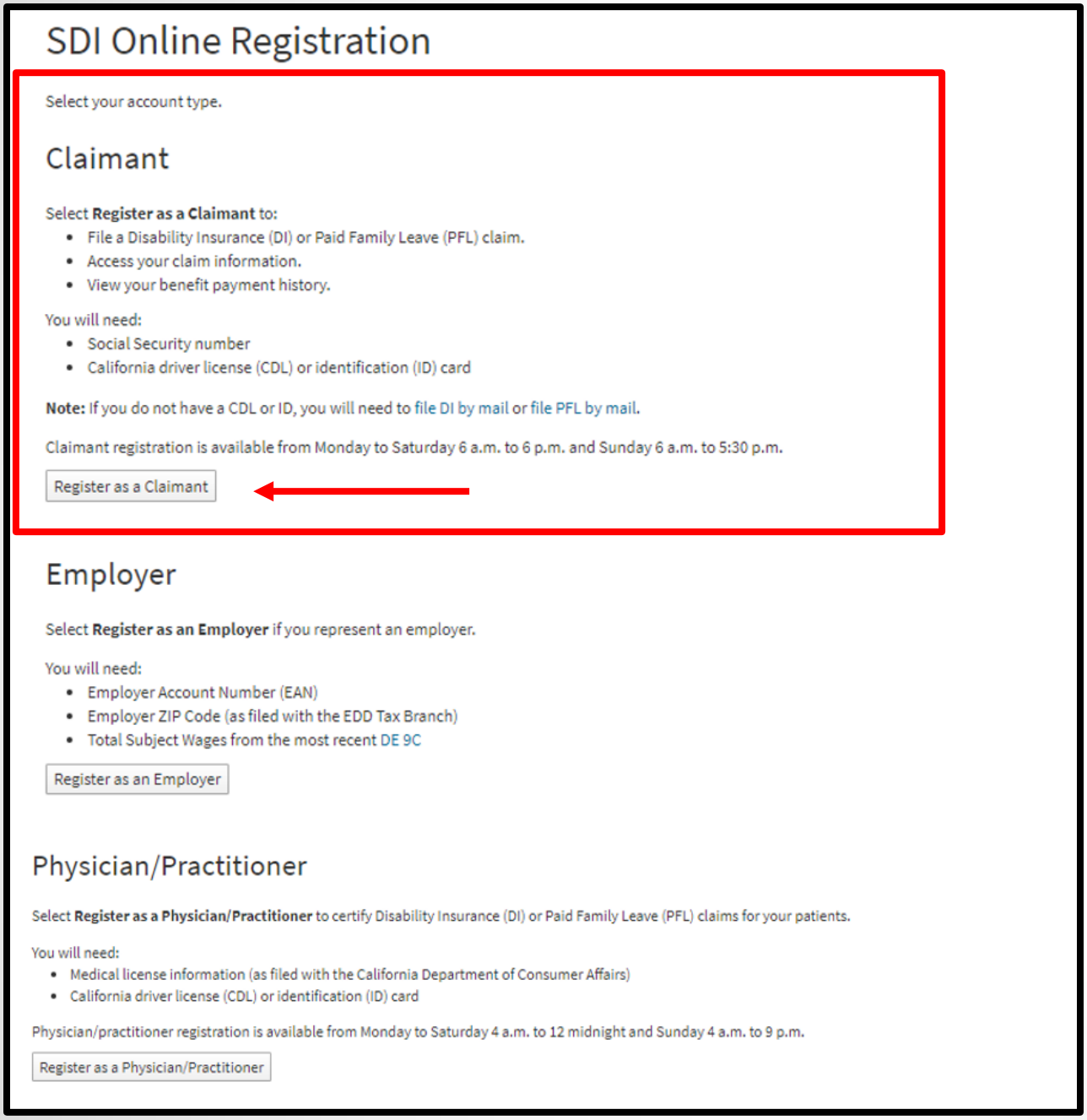
6. Select **Log In**.



To log out of Benefit Programs Online, select the **Log Out** link in the top right hand corner of any screen.

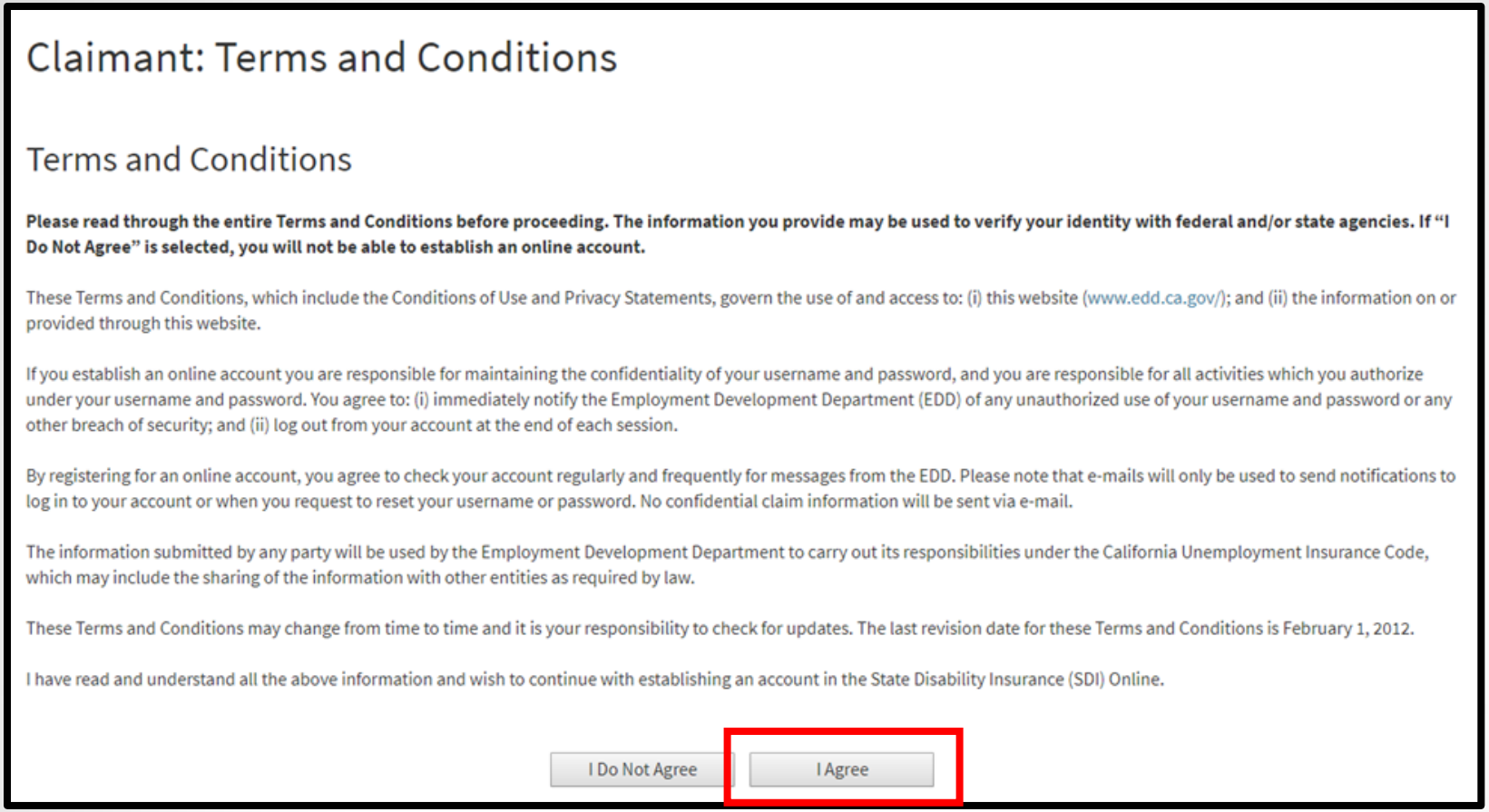
From your Benefit Programs Online account, select the **SDI Online** link to begin your registration for SDI Online.

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.



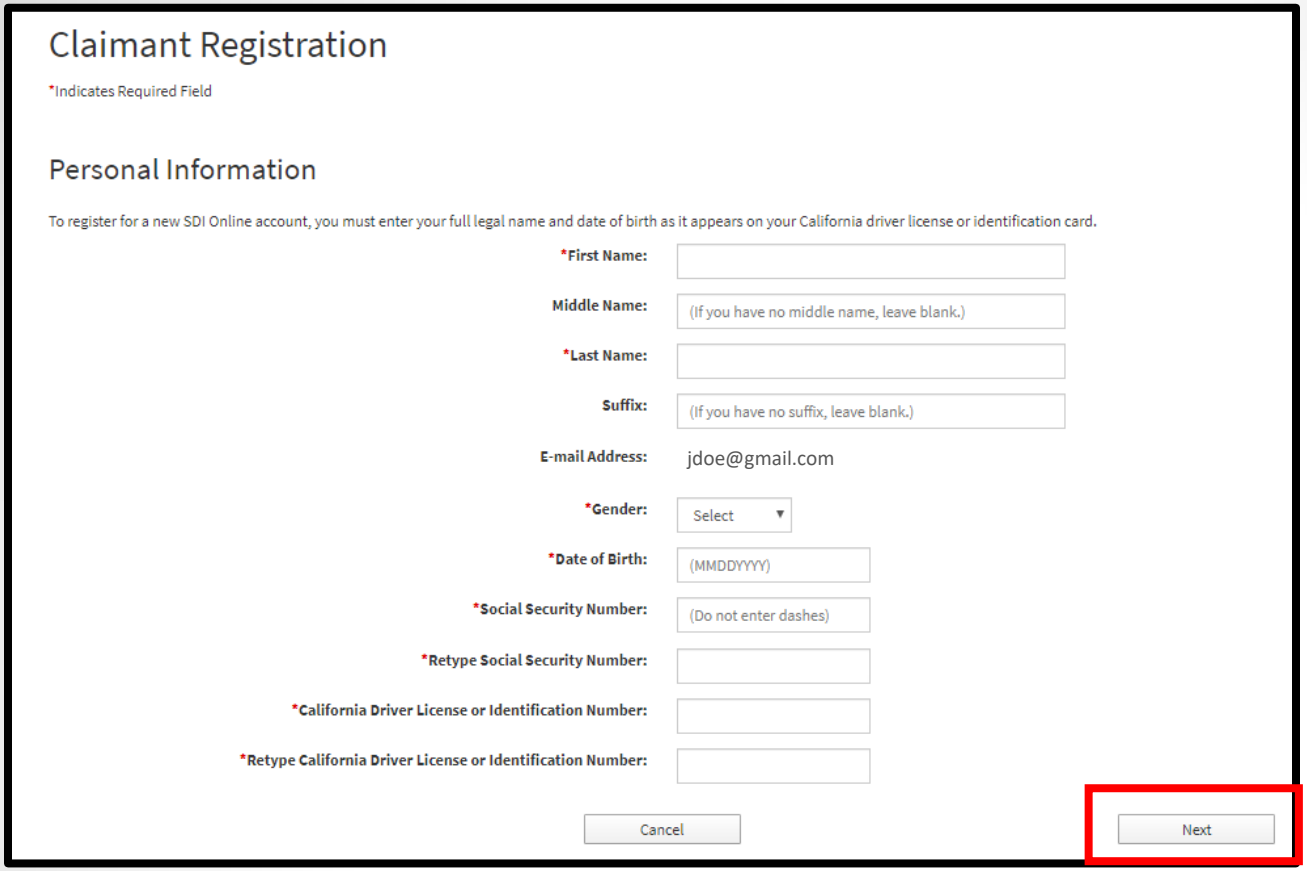
You will be directed to the **SDI Online Registration** account type screen.

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



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

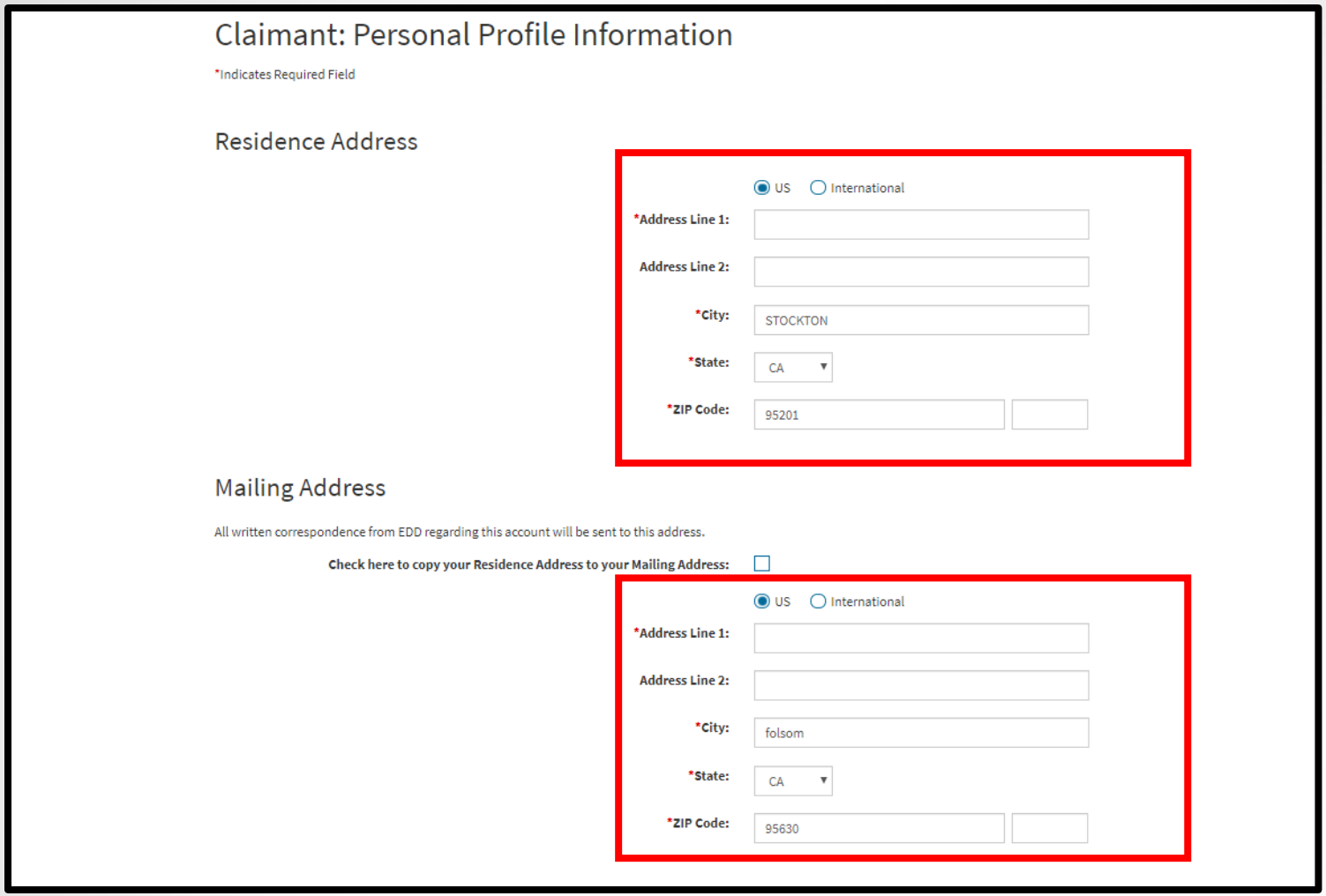
You must agree to these Terms and Condition in order to establish an online account.



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.

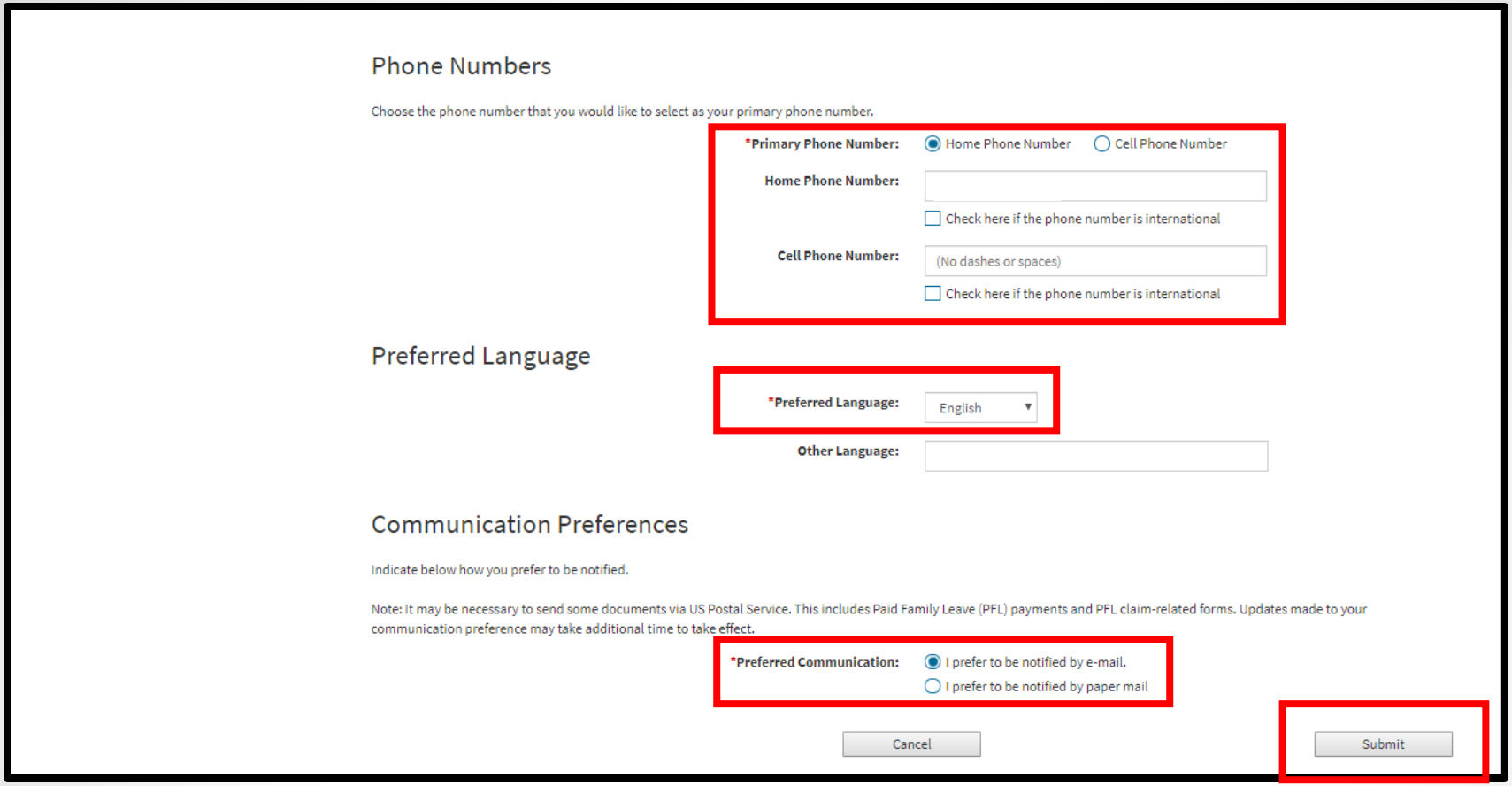
Select **Next**.



Complete and review your:

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

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

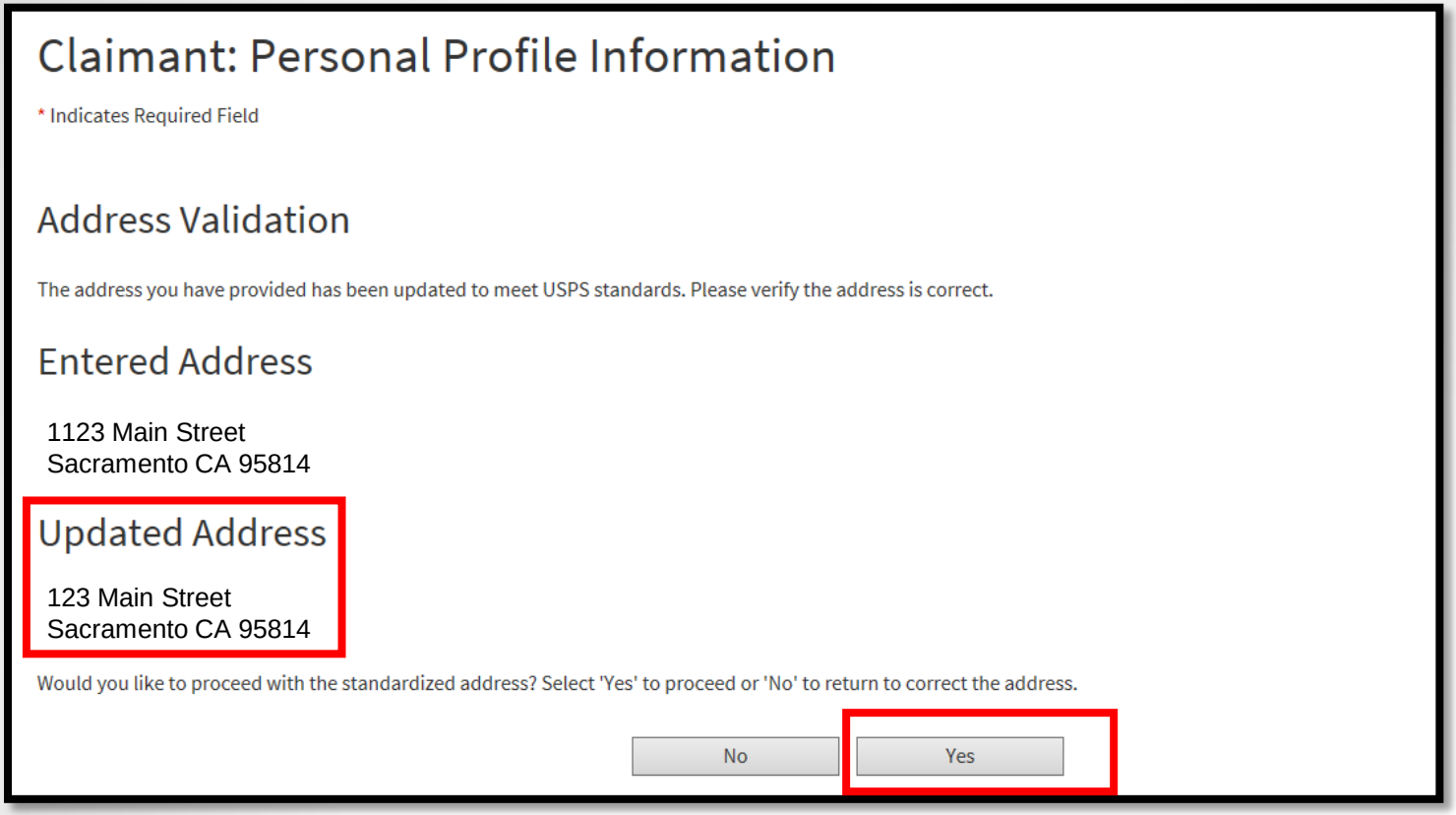


Next, provide your:

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

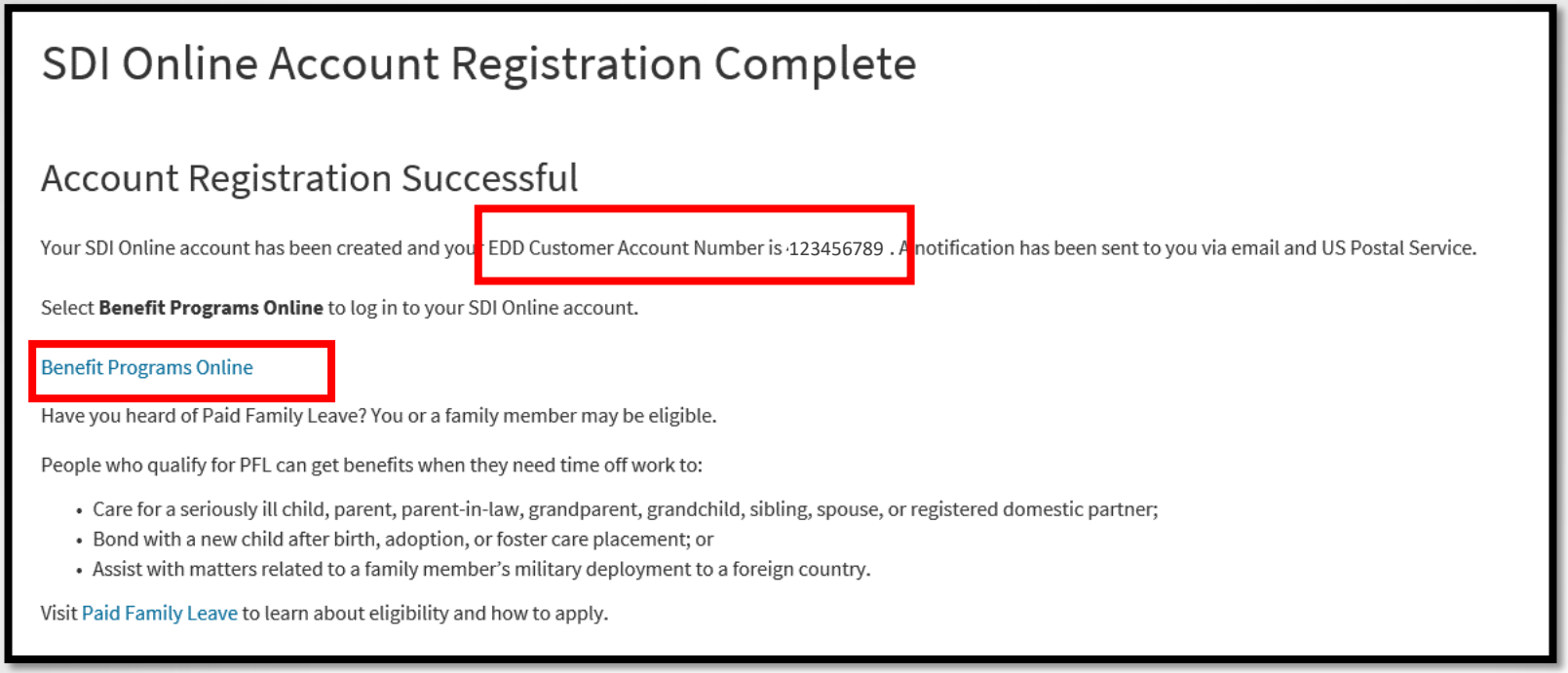
Required fields are marked with a red asterisk (*).

Select **Submit**.



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



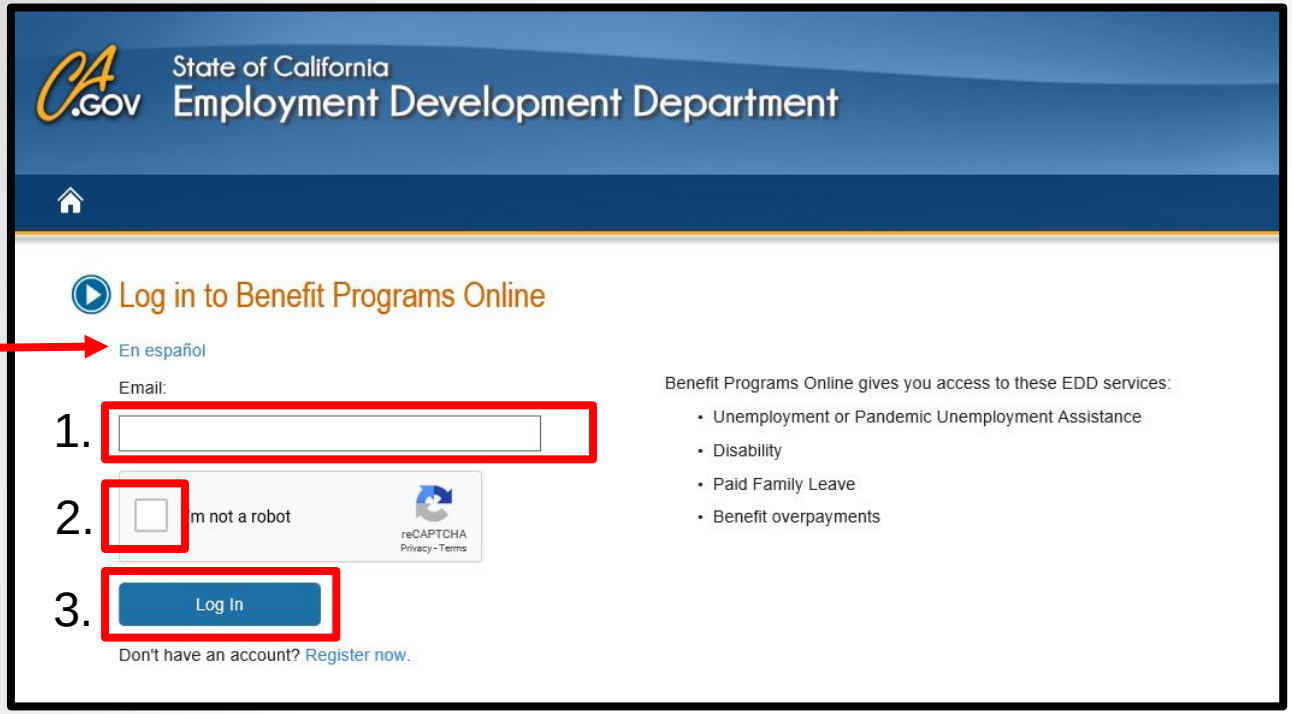
When the above message displays, you have successfully completed your SDI Online account registration.

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.

Access Your SDI Online Account

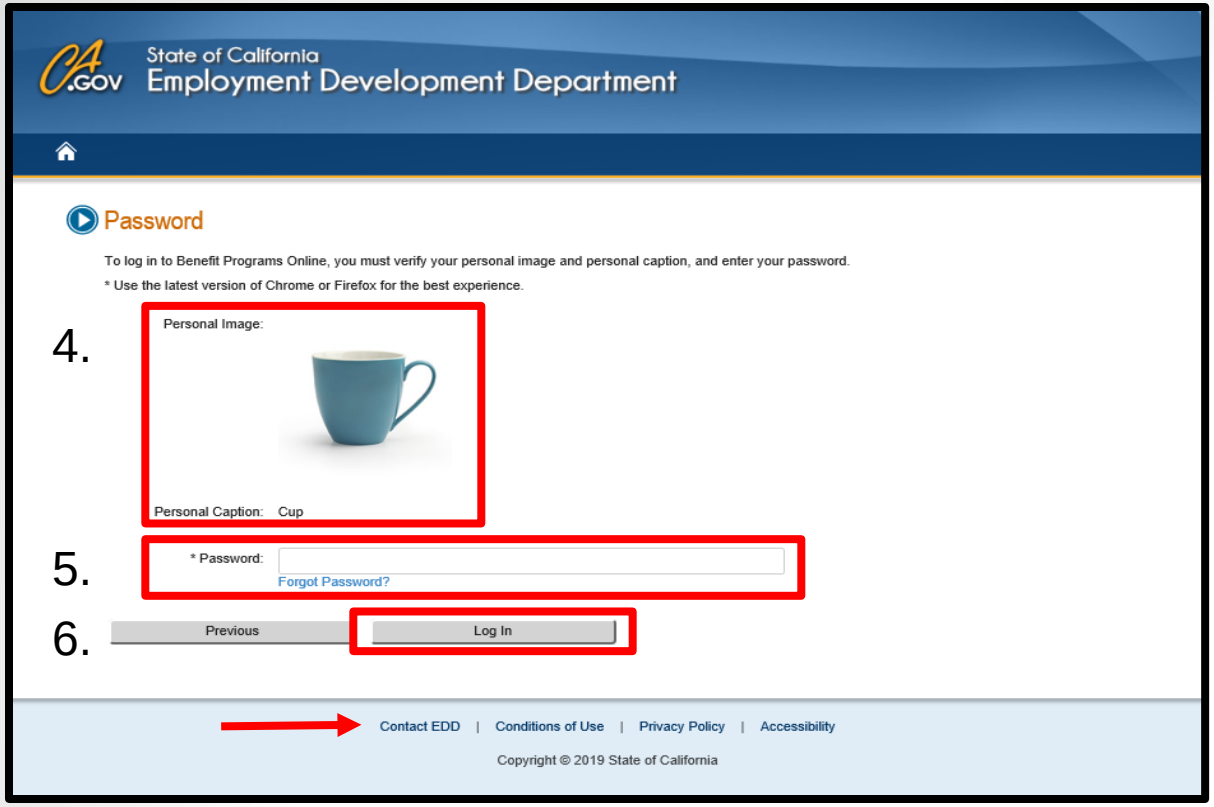


To access your SDI Online account, go directly to Benefit Programs Online (edd.ca.gov/BPO) to log in.

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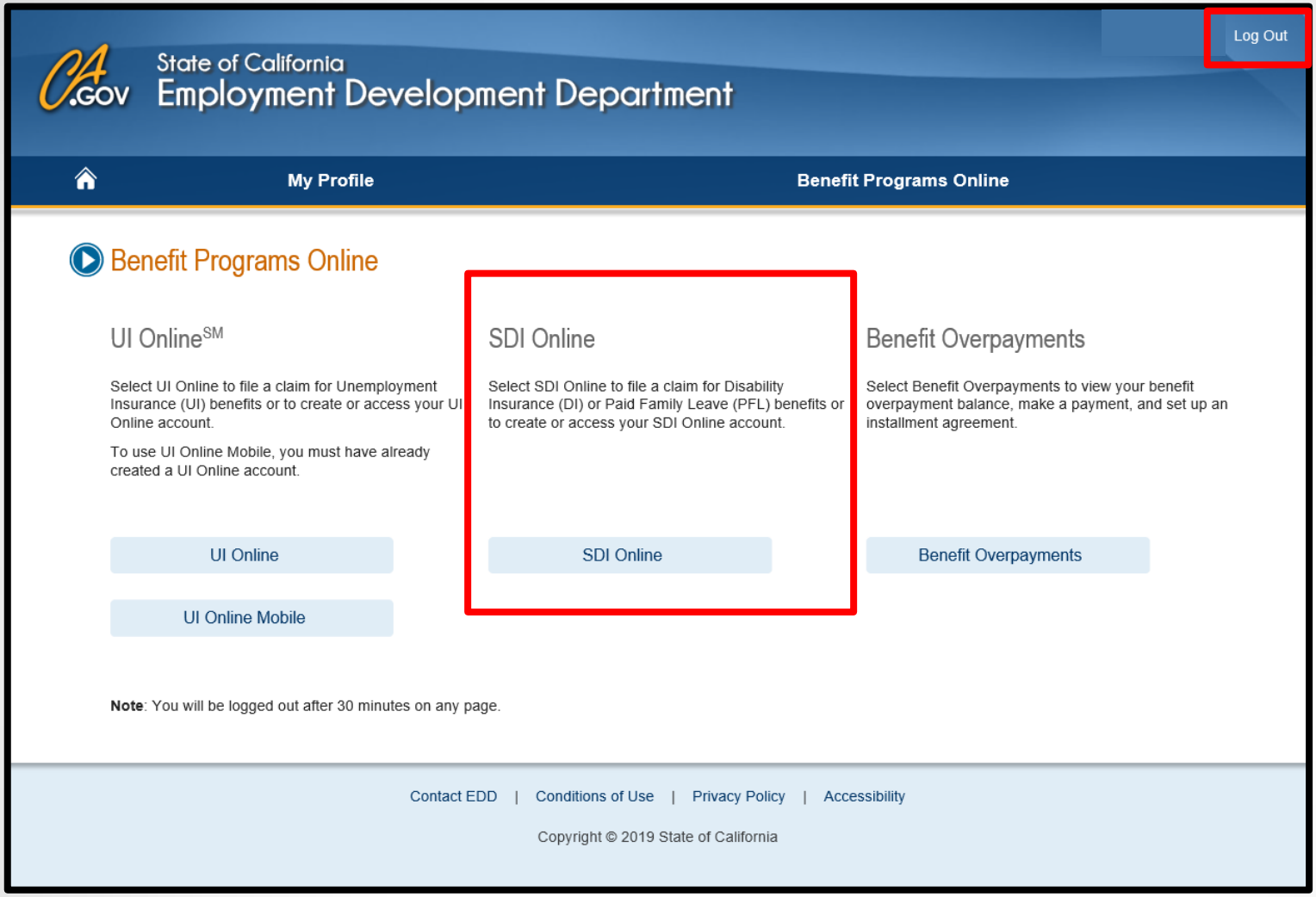
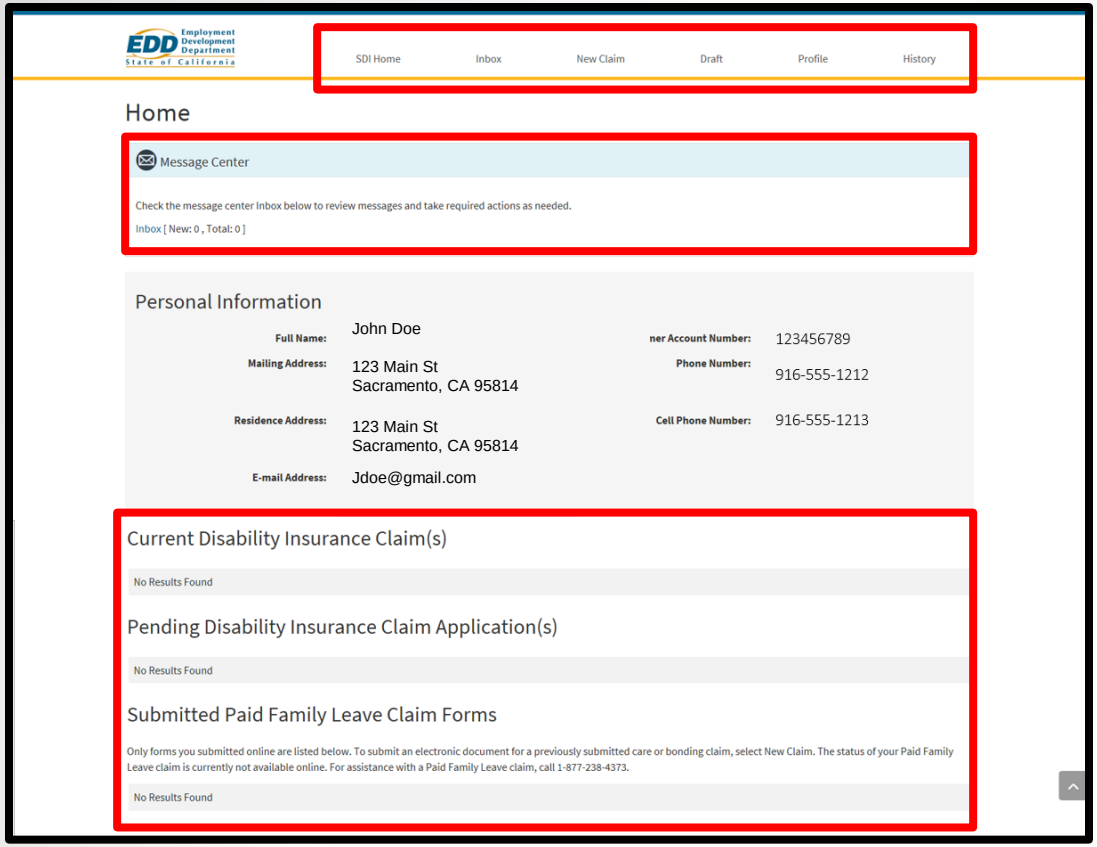
5. Enter the password you created during the Benefit Programs Online registration process.

6. Select **Log In**.



To log out of Benefit Programs Online, select the **Log Out** link in the top right hand corner of any screen.

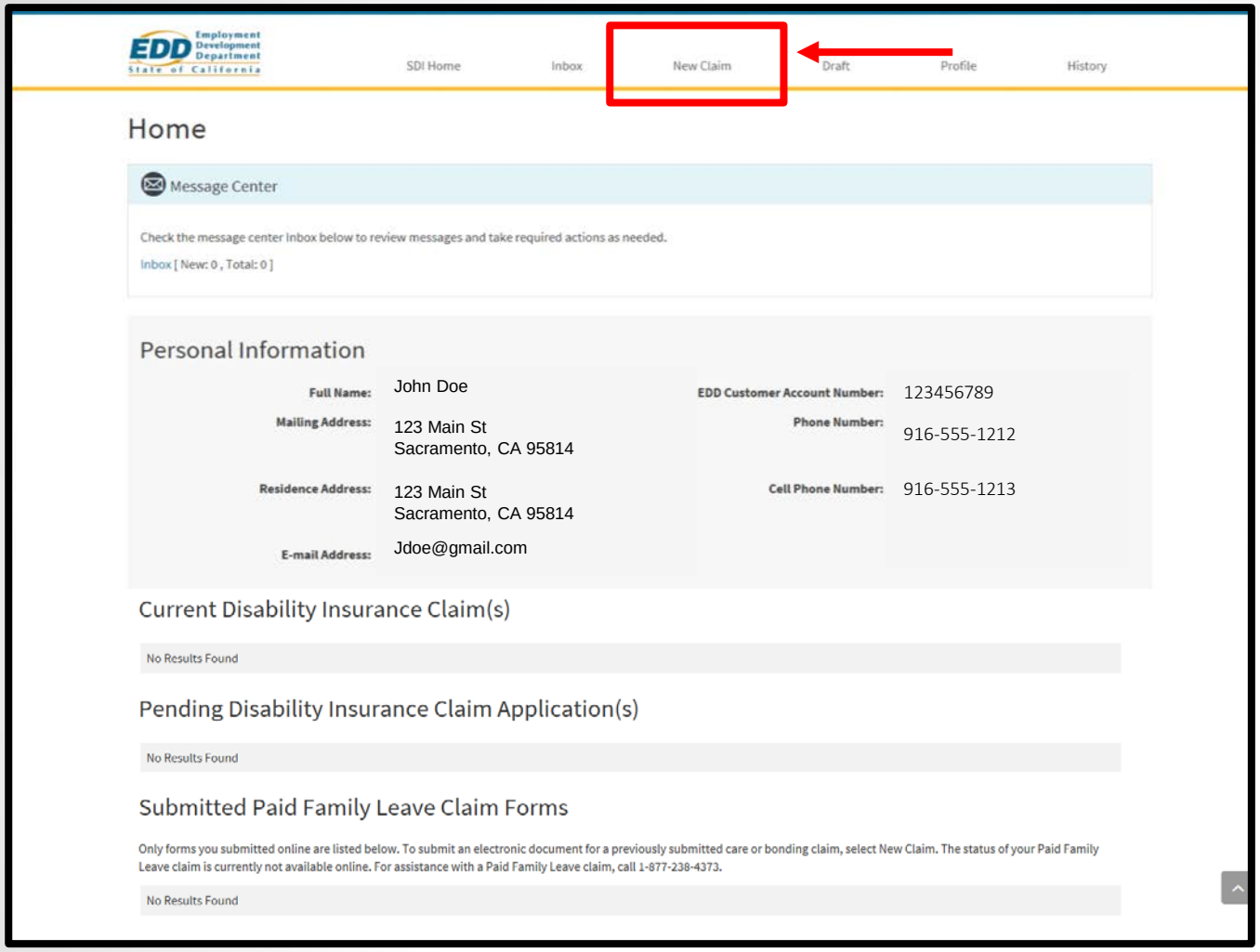
From your Benefit Programs Online account, select the **SDI Online** link to access your SDI Online account **Home** screen.



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.

File a Disability Insurance Claim

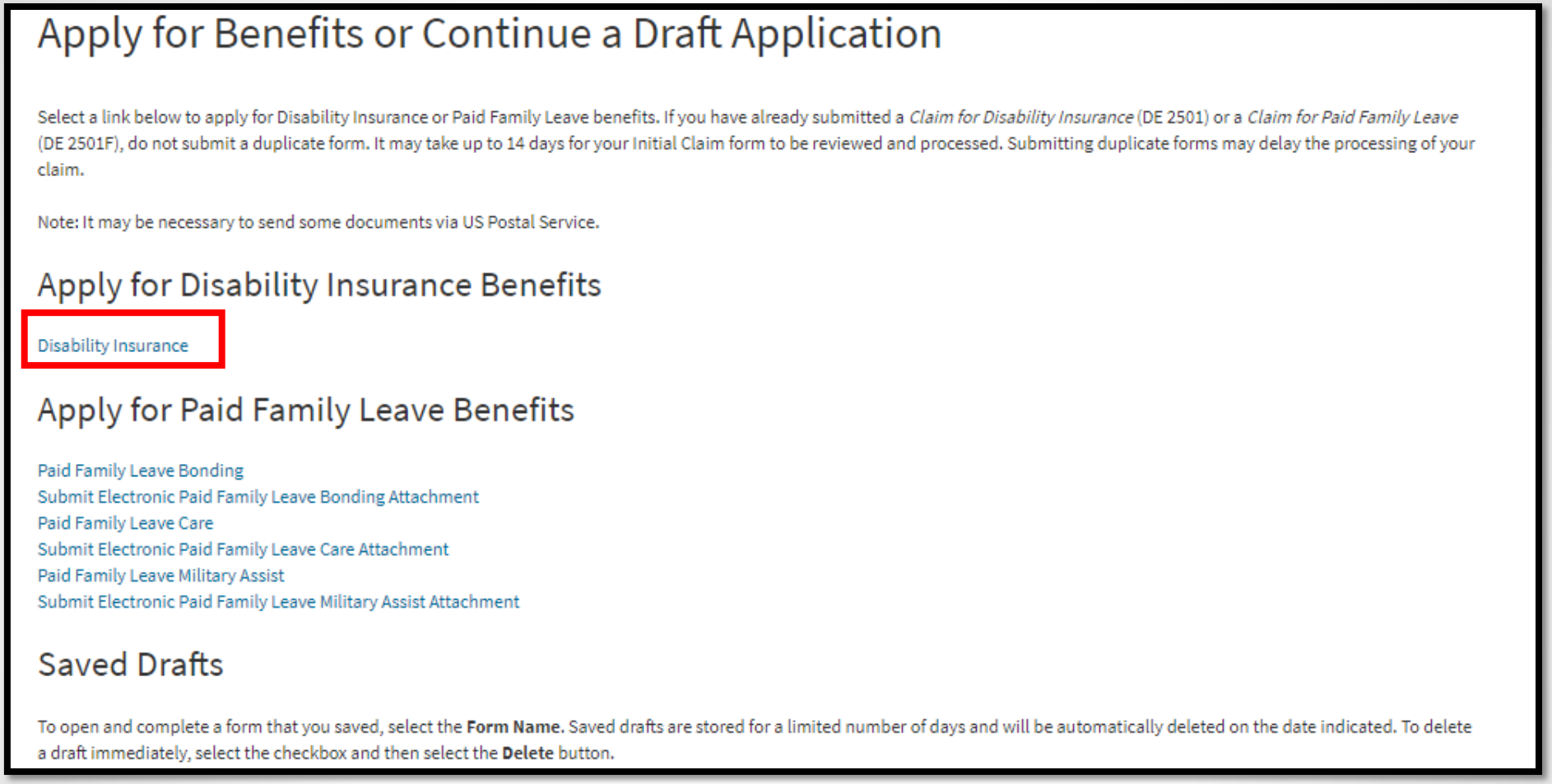


Follow these instructions to begin filing a Disability Insurance claim:

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

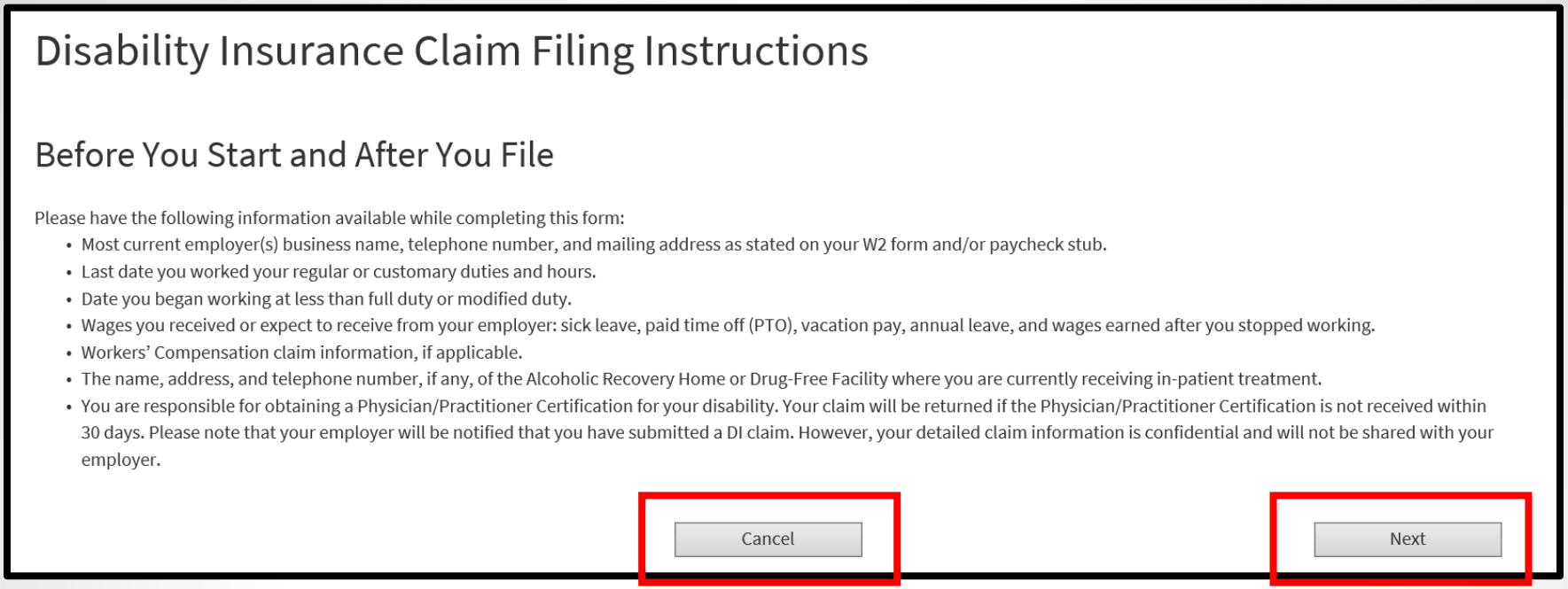
Saved Drafts

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.

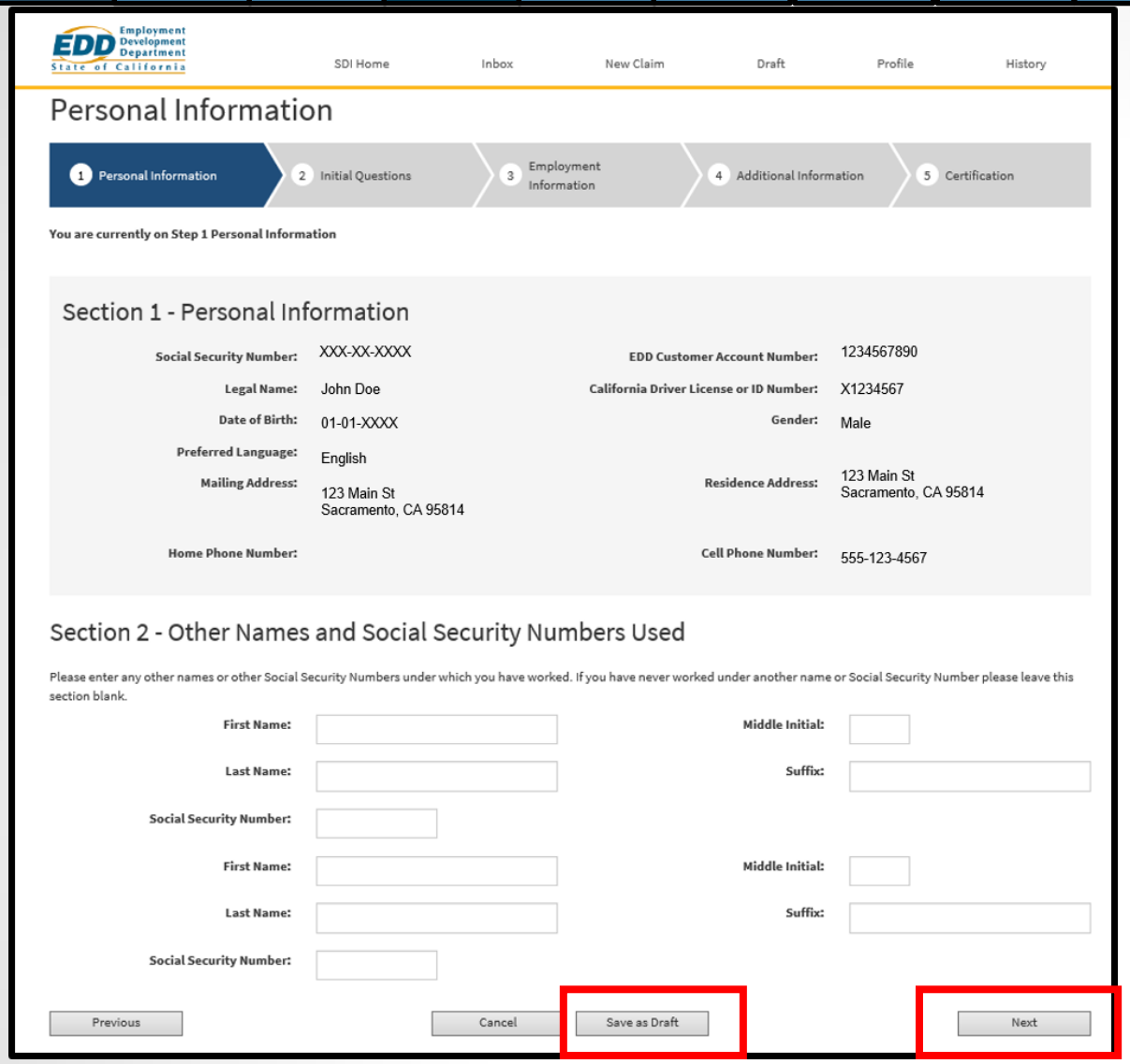
If you have already submitted a claim, do not submit a duplicate claim. It may take up to 14 days for your claim to be reviewed and processed.



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.



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

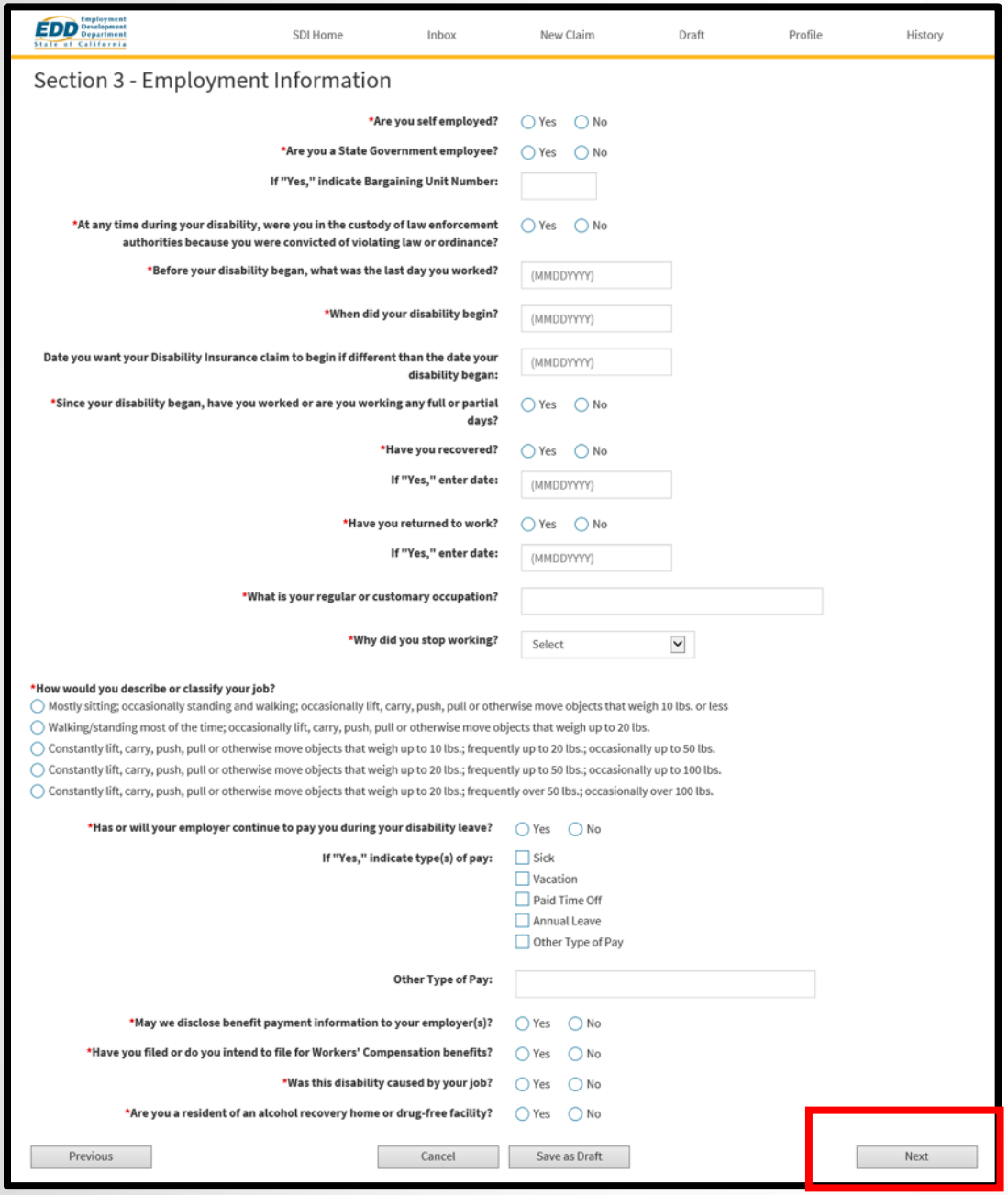
Verify the information in **Section 1** and complete any open fields in **Section 2**, as appropriate.

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.

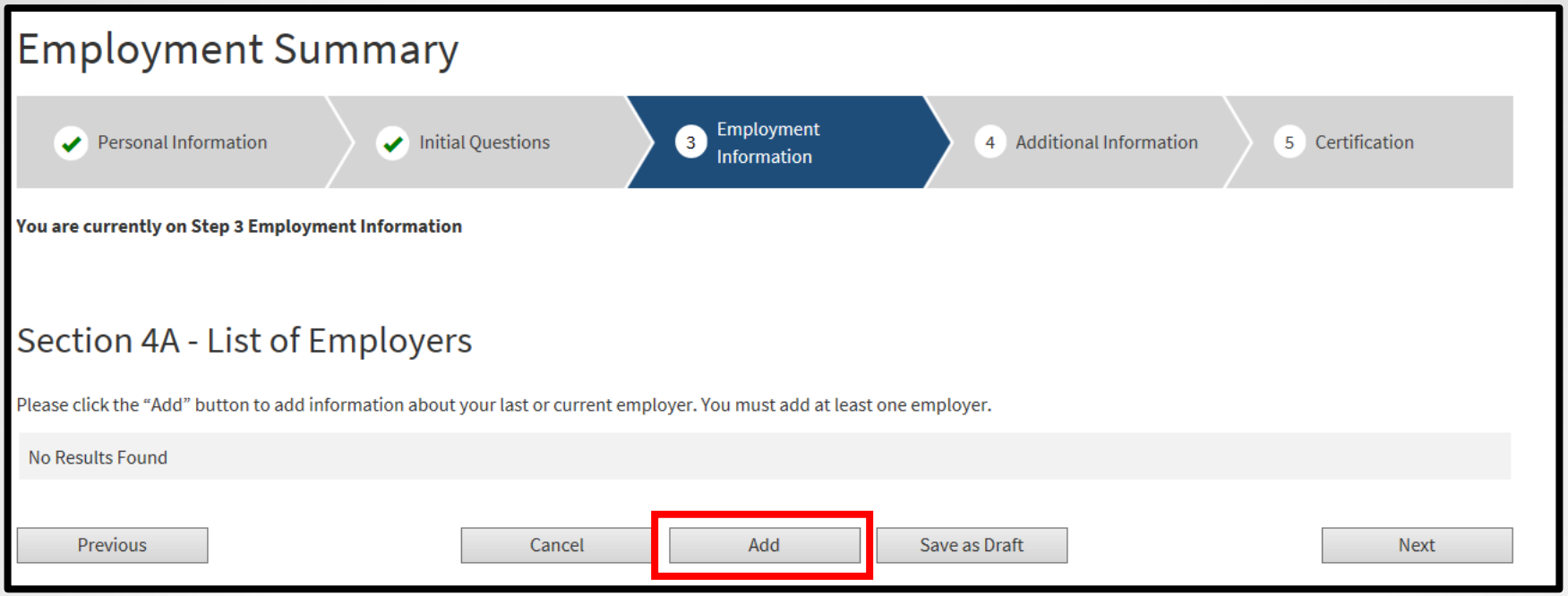


Complete **Section 3 - Employment Information.**

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

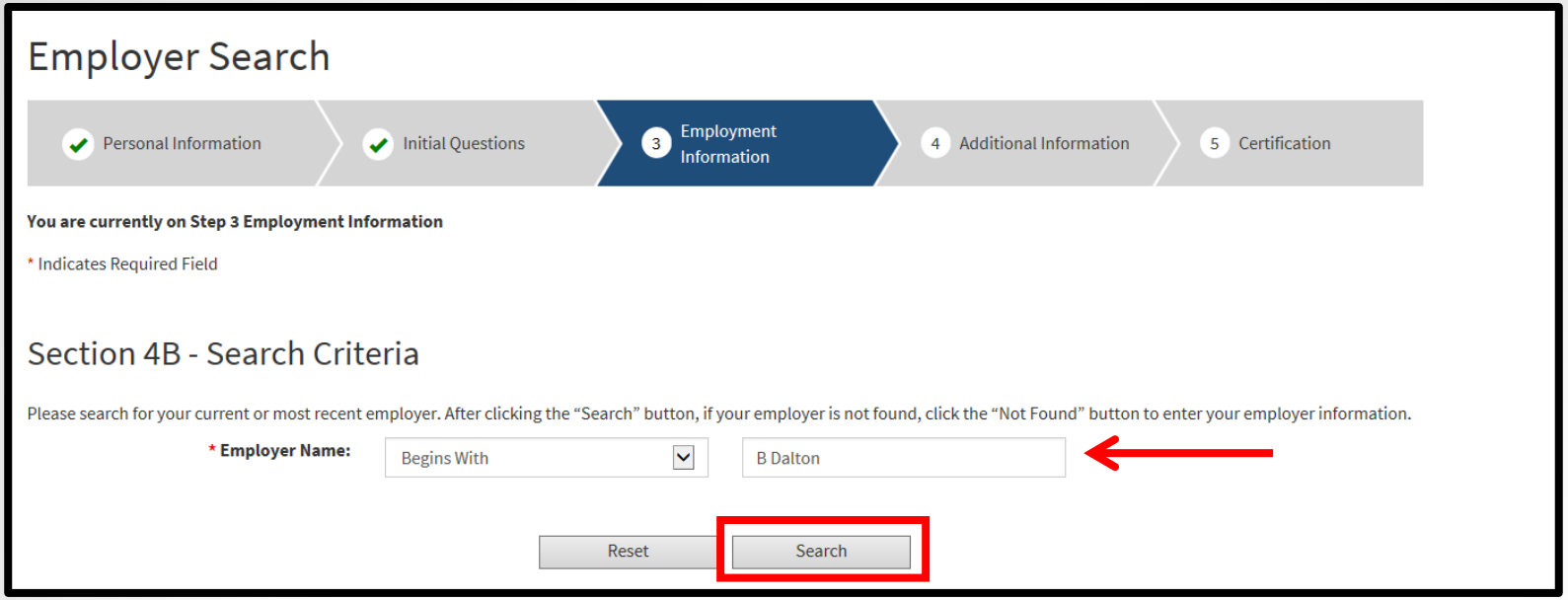
Please confirm all dates and information you enter are correct before proceeding to avoid a possible delay or loss in benefits.

Select **Next**.



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

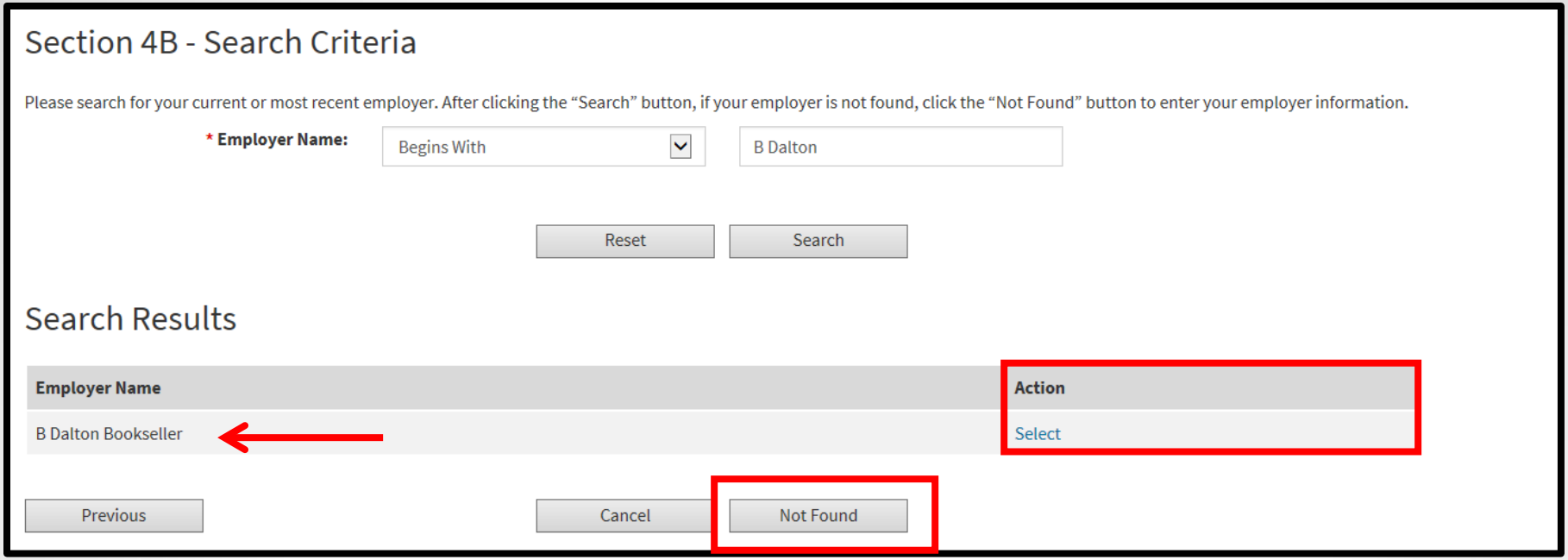
You must add at least one employer.



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

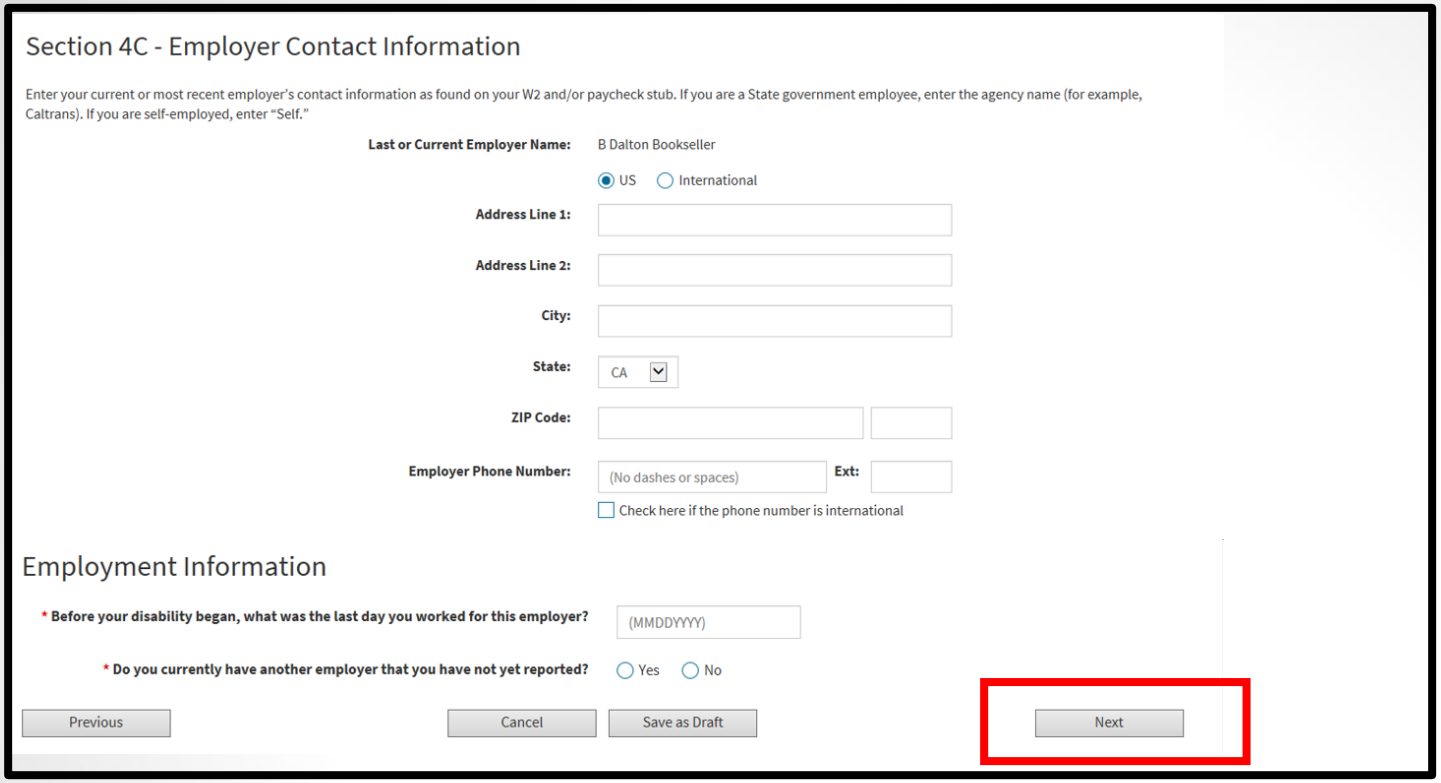
Enter your employer’s name as stated on your W-2 or paystub.

Select **Search** to proceed.



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.

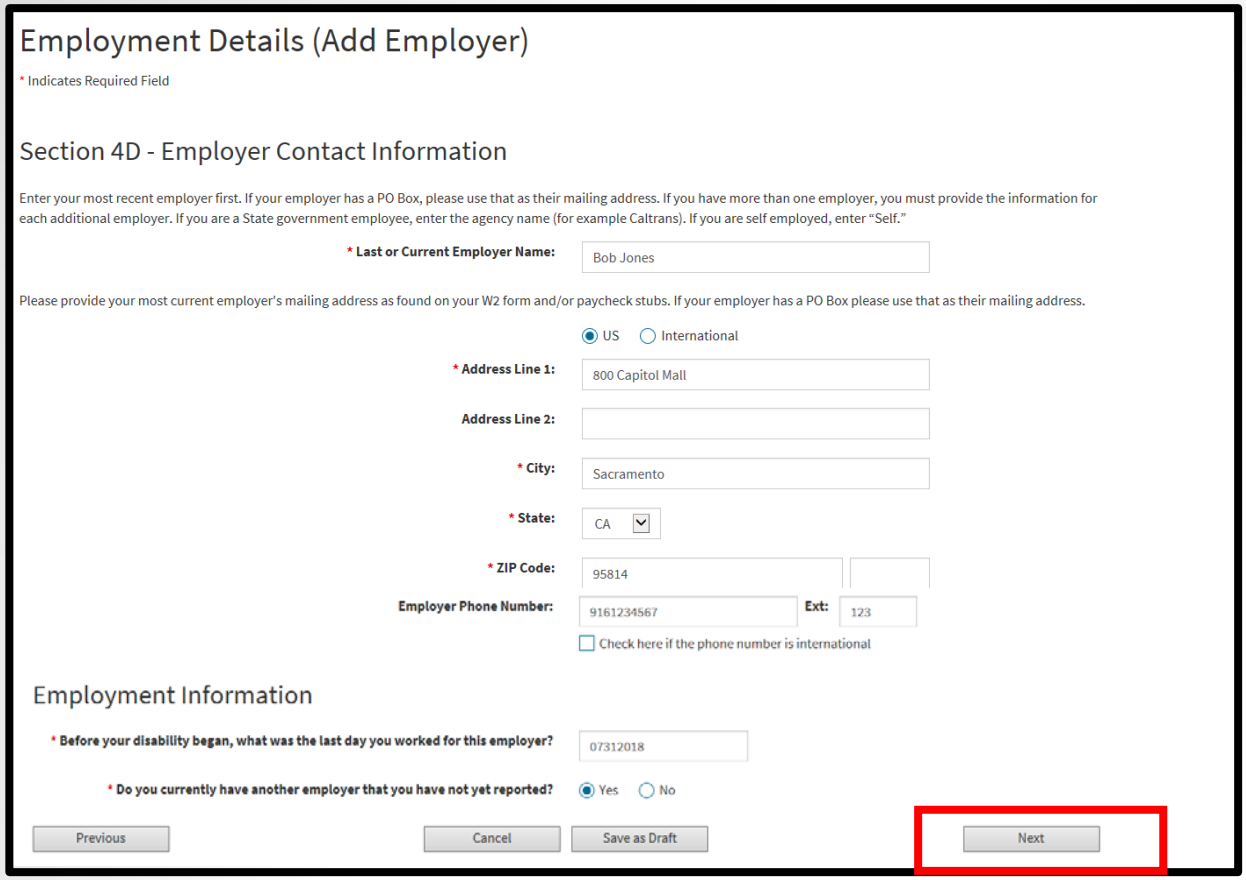


If you selected your employer from the search results in Section 4B, you will be asked to complete the **Employer Contact Information** and **Employment Information** sections (if you selected **Not Found** in Section 4B, please skip to the next slide).

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**.

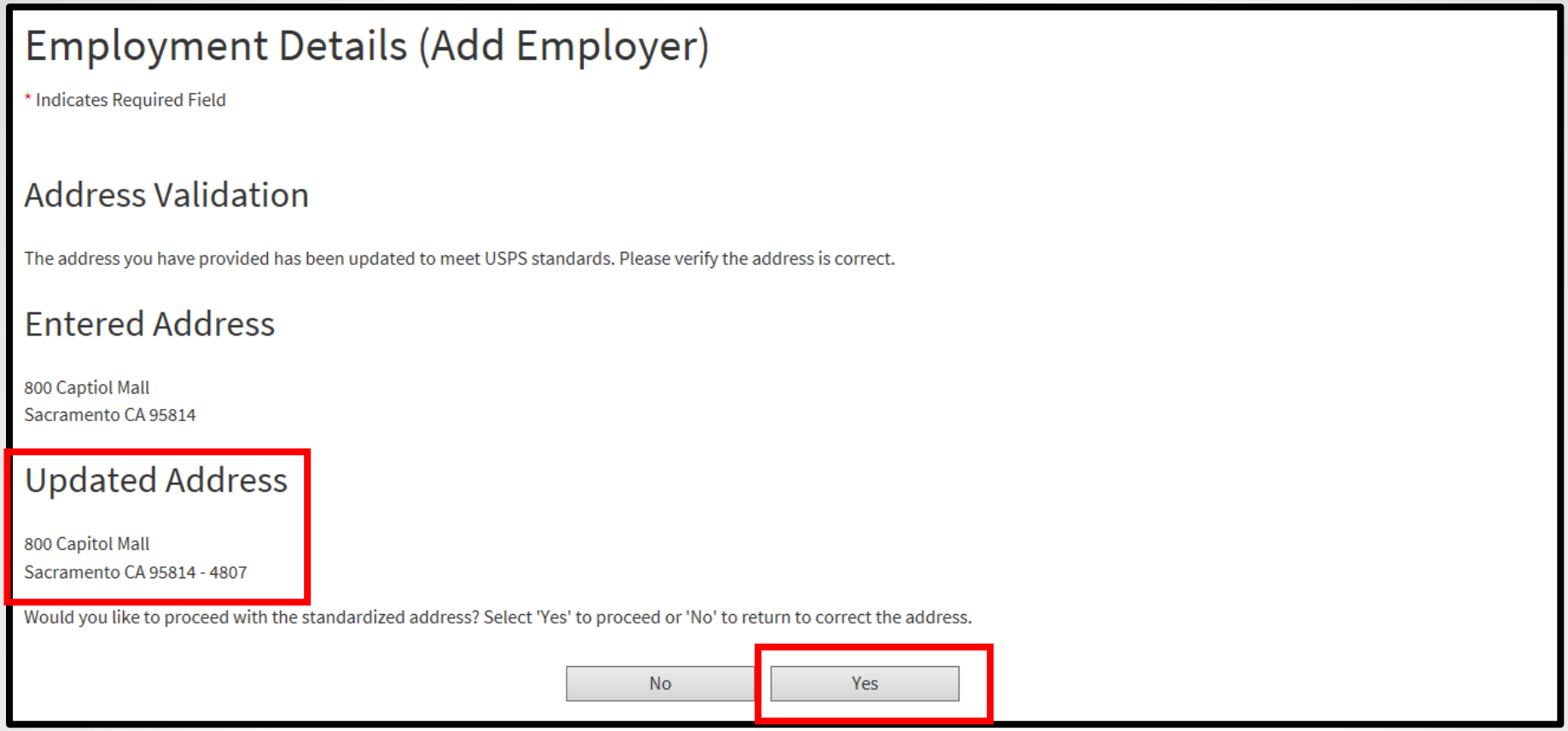


If you selected **Not Found** in Section 4B, you will add your most current employer's business name, phone number, and mailing address as stated on your W-2 or paystub under **Section 4D – Employer Contact Information**.

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

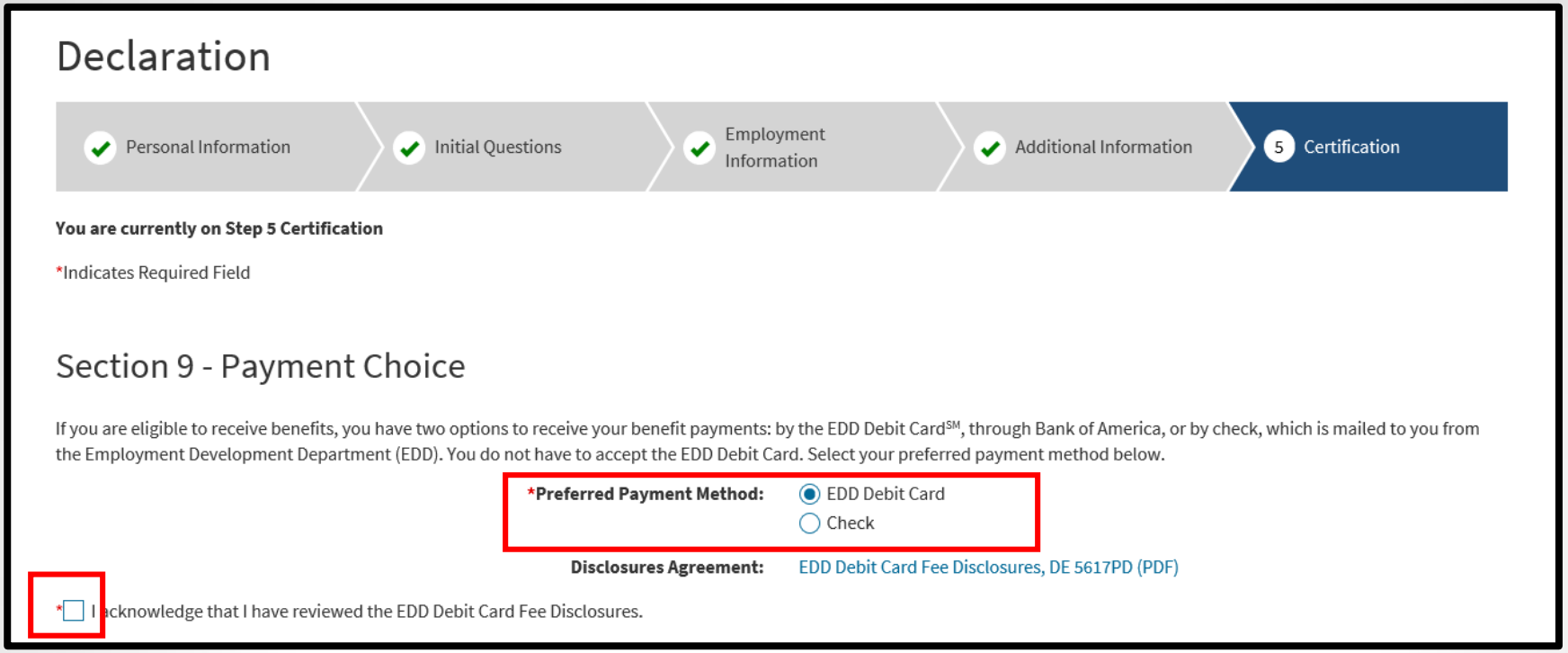
To enter additional employers, select **Yes** to "Do you currently have another employer that you have not yet reported?"

Select **Next**.



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

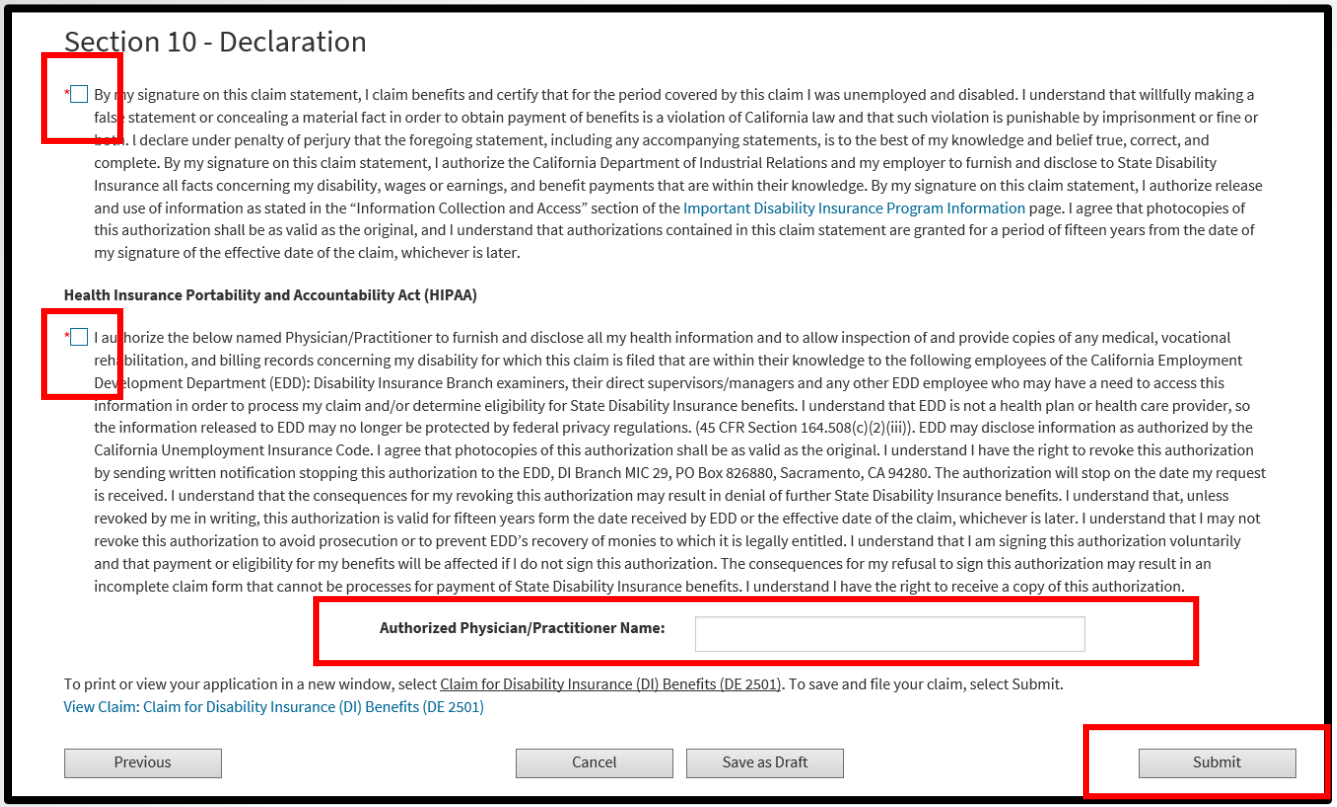
- Confirm the **Updated Address** section is correct by selecting **Yes**.
- Select **No** to go back to the previous screen and re-enter the address.



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.

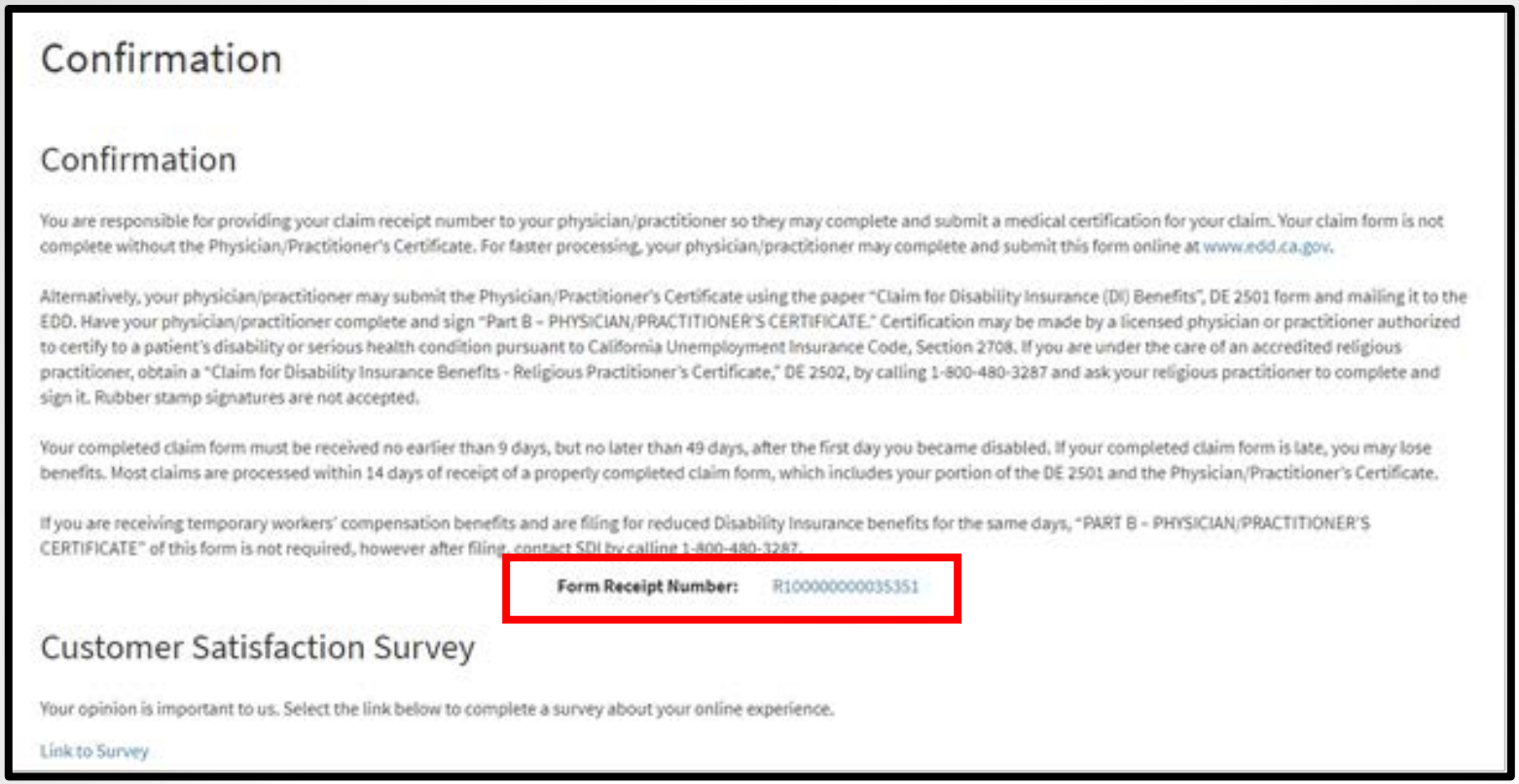


In **Section 10 – Declaration**, select both check boxes to authorize an electronic signature and release of information, and enter the name of your physician/practitioner in the open field. Both boxes must be selected to complete your claim.

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).



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.

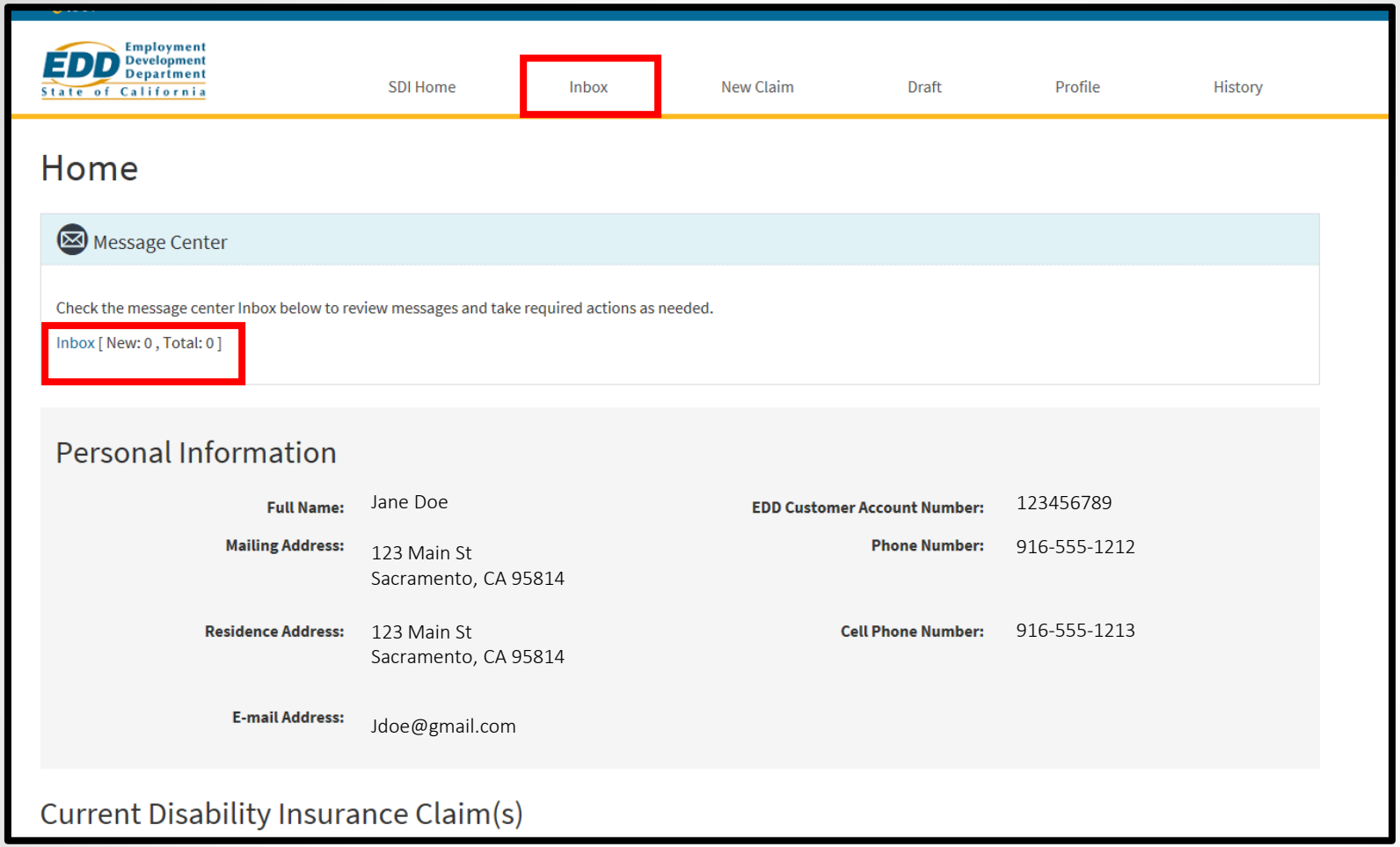
File a Paid Family Leave Bonding Claim – New Mother

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

- 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 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 section of the tutorial.

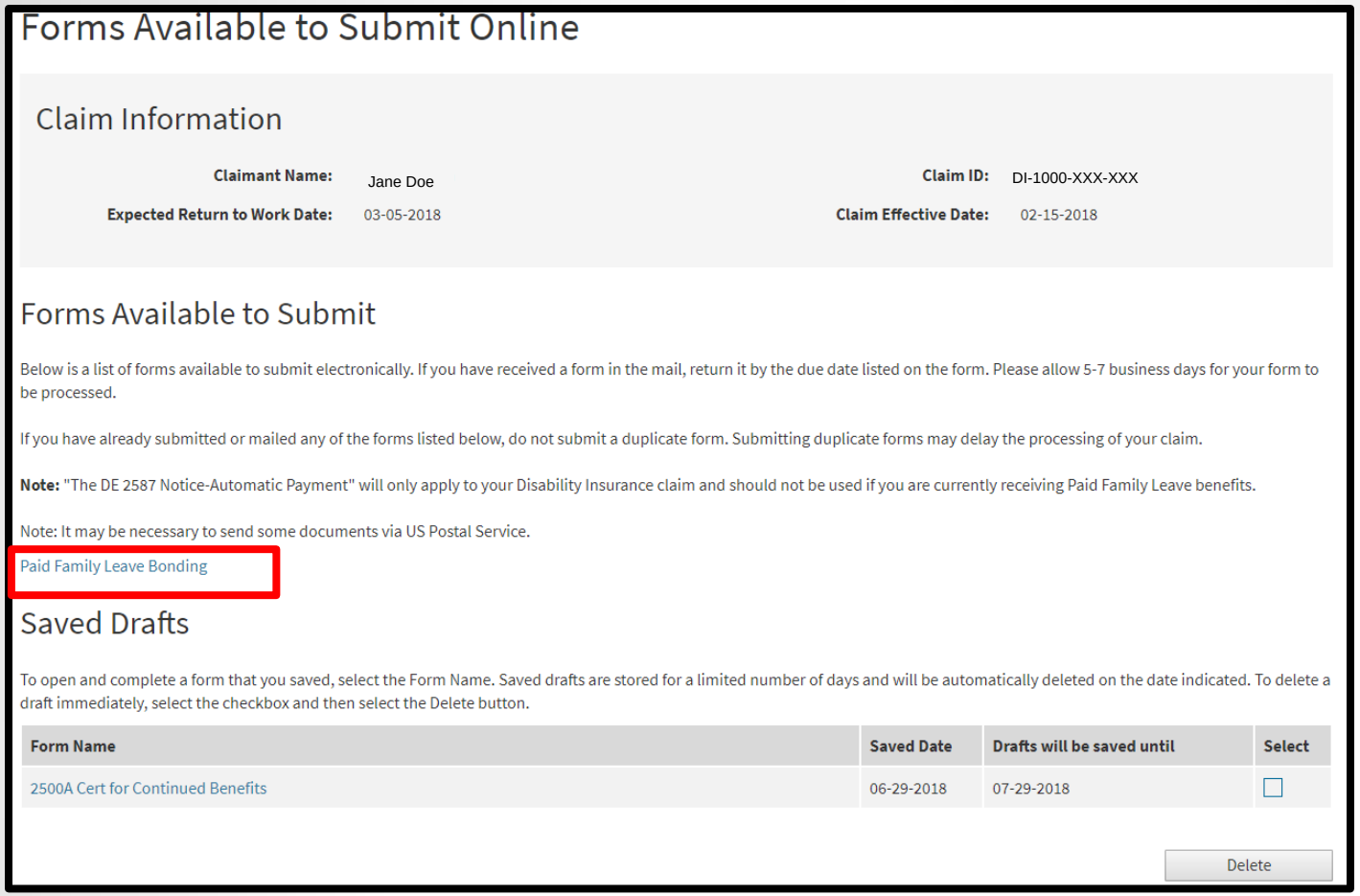


Follow these instructions to begin filing a Paid Family Leave - New Mother claim:

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.**



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

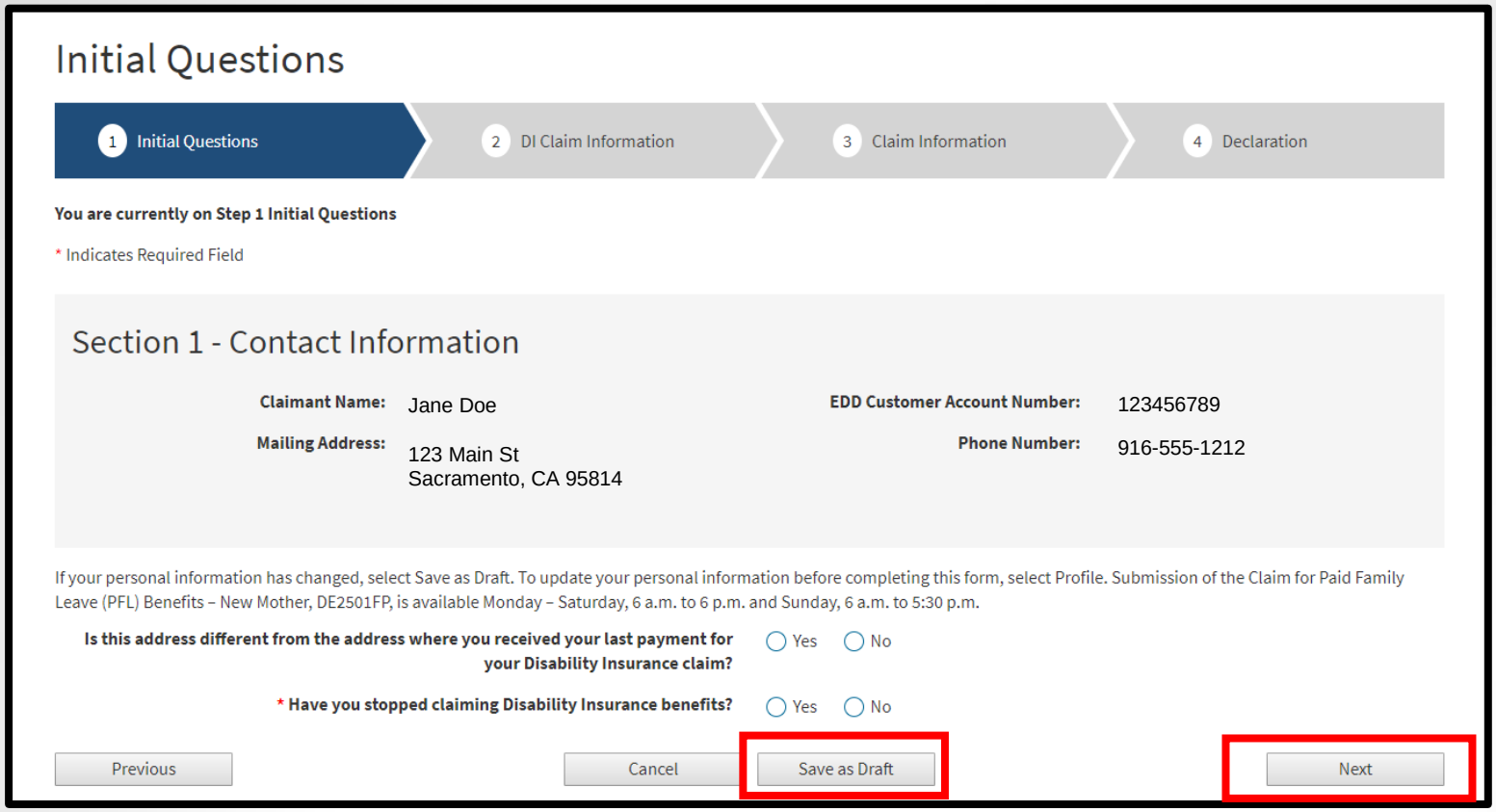
Submit your claim no earlier than the first day your family leave begins, but no later than 41 days after your family leave begins, or you may lose benefits.

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.

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.



Note:

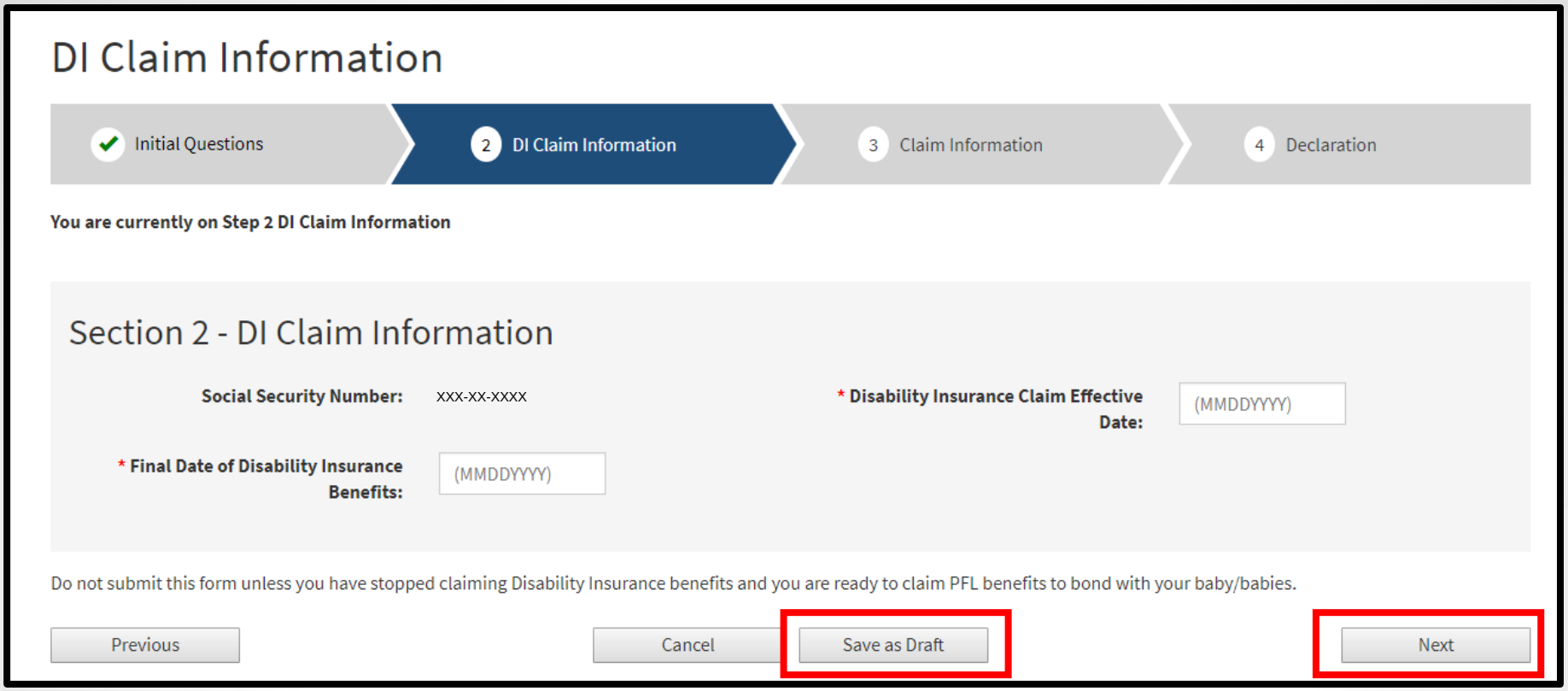
- Select **Save as Draft** at any point in the process to complete the form at a later time.
- Select **Previous** to return to the previous screen.

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.

Select **Next** to proceed.

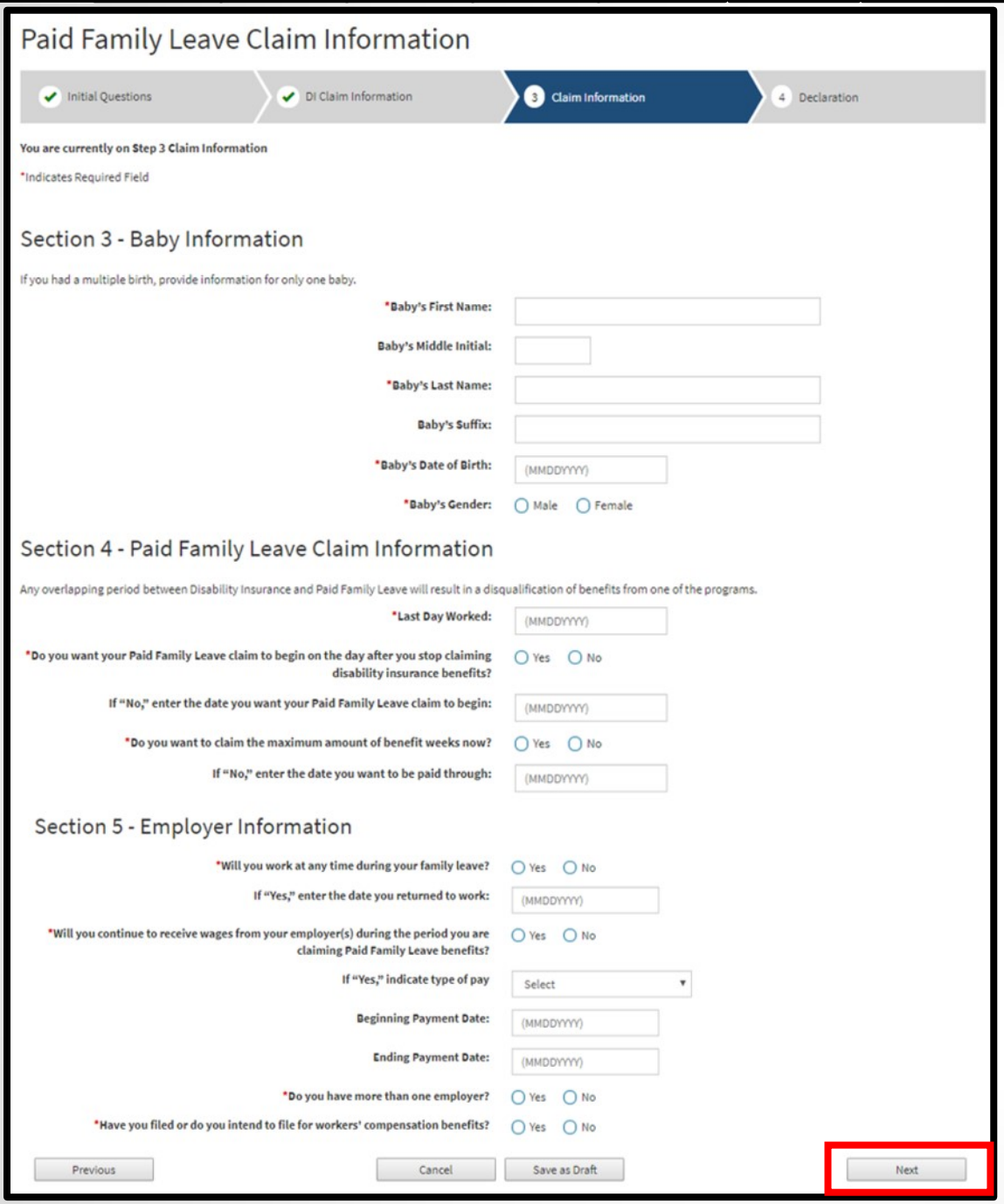


As a reminder, do not file for Paid Family Leave Bonding benefits unless you have fully recovered and have been issued your final Disability Insurance payment.

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.



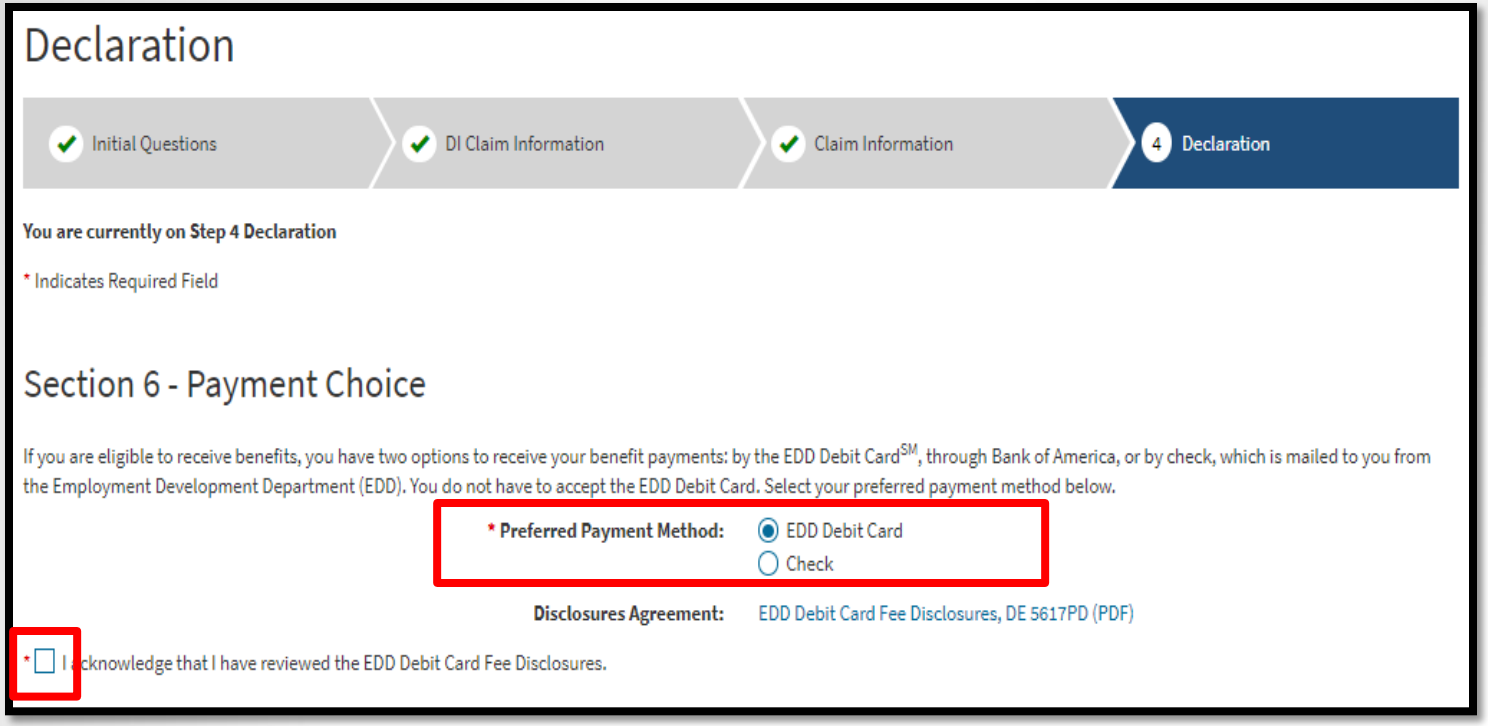
You must complete the following sections:

- **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 (*).

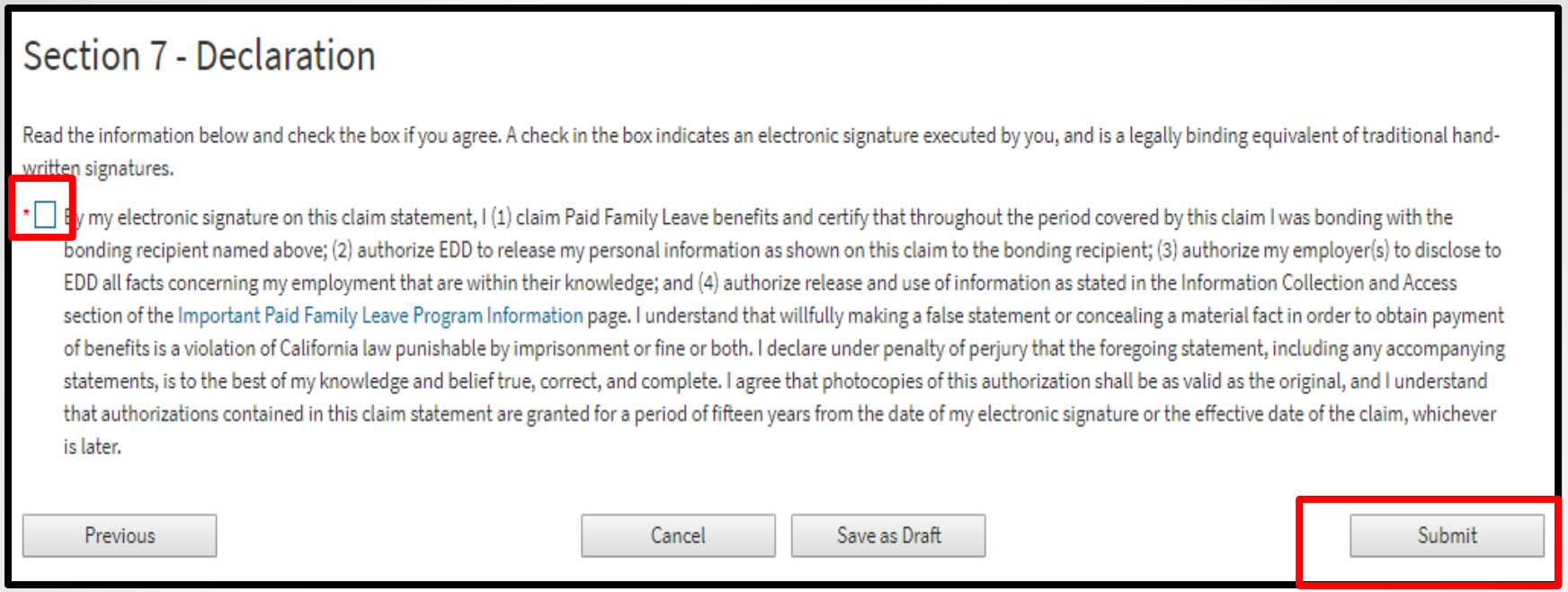
Select **Next** to proceed.



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.

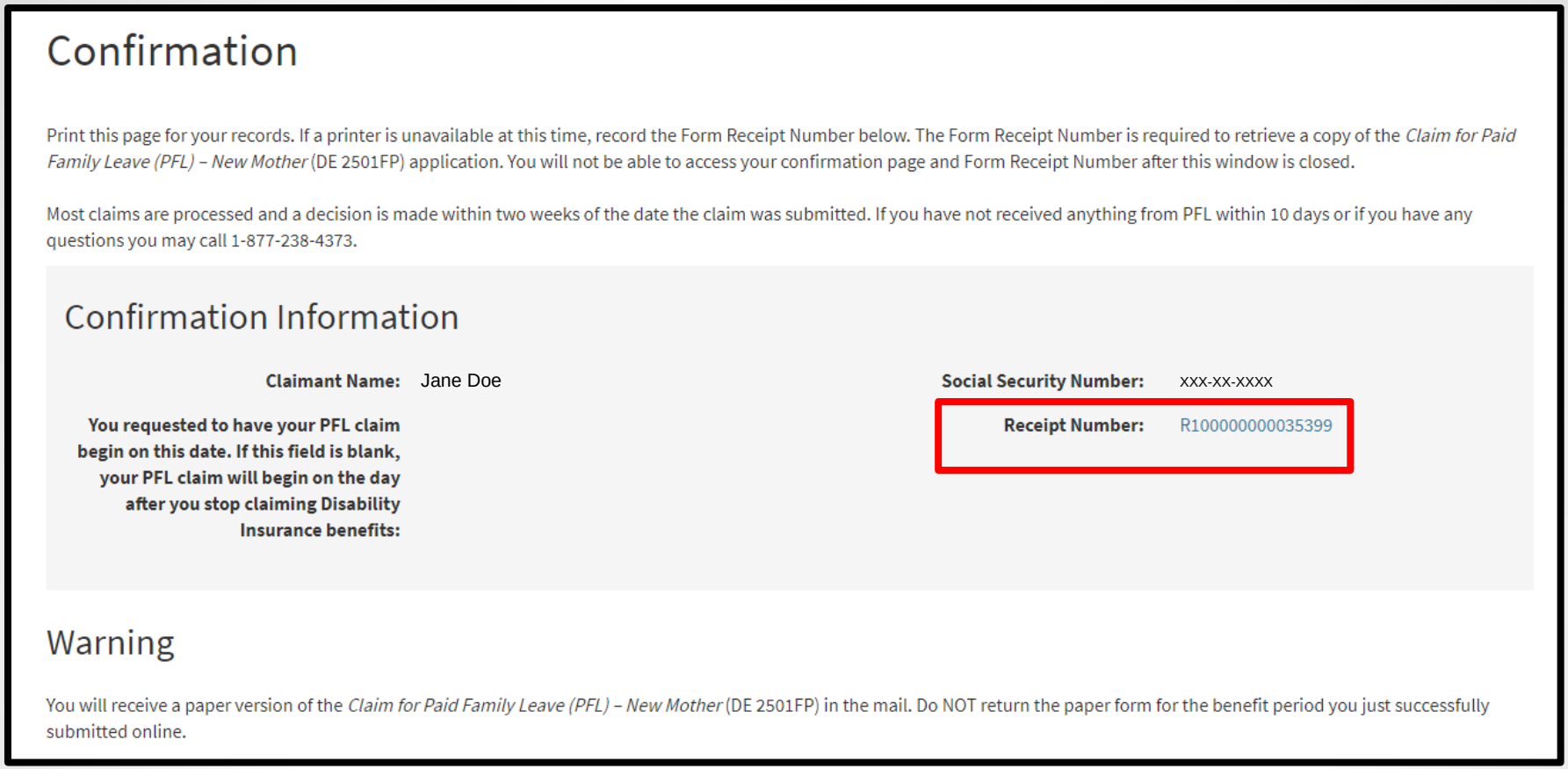
If your preferred payment method is the EDD Debit Card, you may view the disclosure agreement by selecting the ***EDD Debit Card Fee Disclosures*** **(DE 5617PD) (PDF)** link.

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



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.



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 *Claim for Paid Family Leave (PFL) – New Mother* (DE 2501FP) 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 Information

Claimant Name: Jane Doe

Social Security Number: xxx-xx-xxxx

Receipt Number: R100000000035399

You requested to have your PFL claim begin on this date. If this field is blank, your PFL claim will begin on the day after you stop claiming Disability Insurance benefits:

Warning

You will receive a paper version of the *Claim for Paid Family Leave (PFL) – New Mother* (DE 2501FP) in the mail. Do NOT return the paper form for the benefit period you just successfully submitted online.

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 Contact the EDD (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

- The last date you work
- Whether you returned
- Information concernin
- Information as to whe
  and a false statement
- Whether you have clai
- Whether you were you
- The date you want you

FILING A DRAFT

Saves your entered informat

To retrieve your saved draft(

All available information will
reduced, you will receive a w

After You Have Filed Your Application

WHEN YOUR CLAIM IS SUCCESSFULLY SUBMITTED

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.

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.

YOUR RIGHTS

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 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 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.

SPECIAL CIRCUMSTANCE 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.

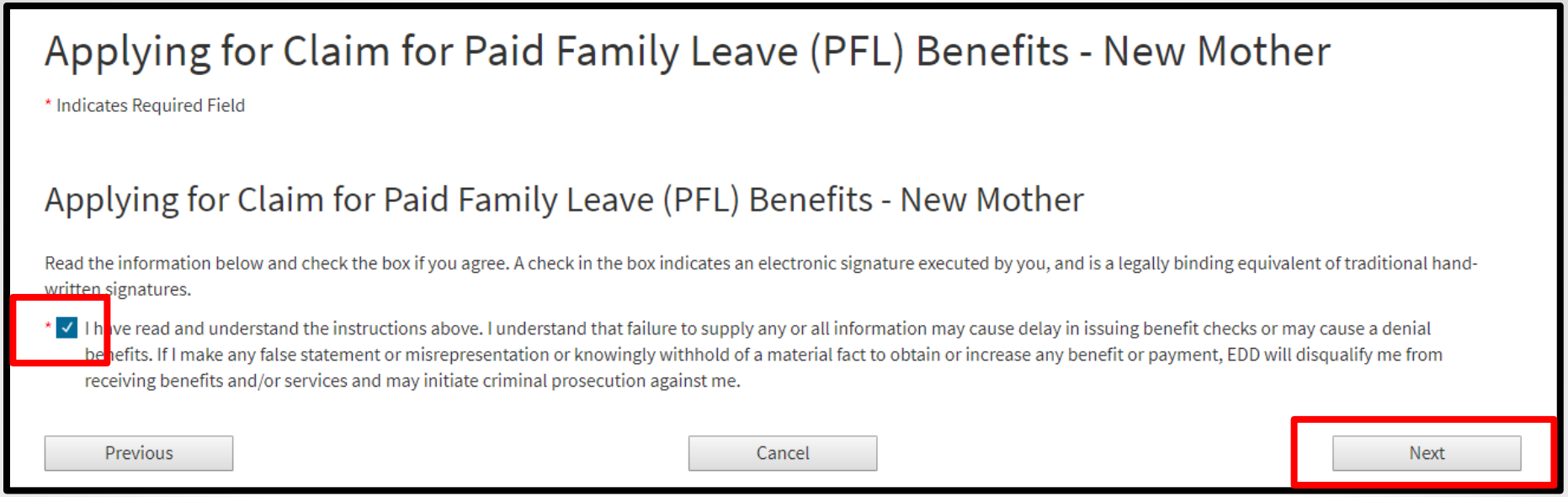
Job Benefits and Protection Programs. Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) offer job protected leave to "eligible" employees for certain family and medical reasons. Contact FMLA at 866-487-9243 or the Department of Labor Web site: https://www.dol.gov/whd/fmla or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

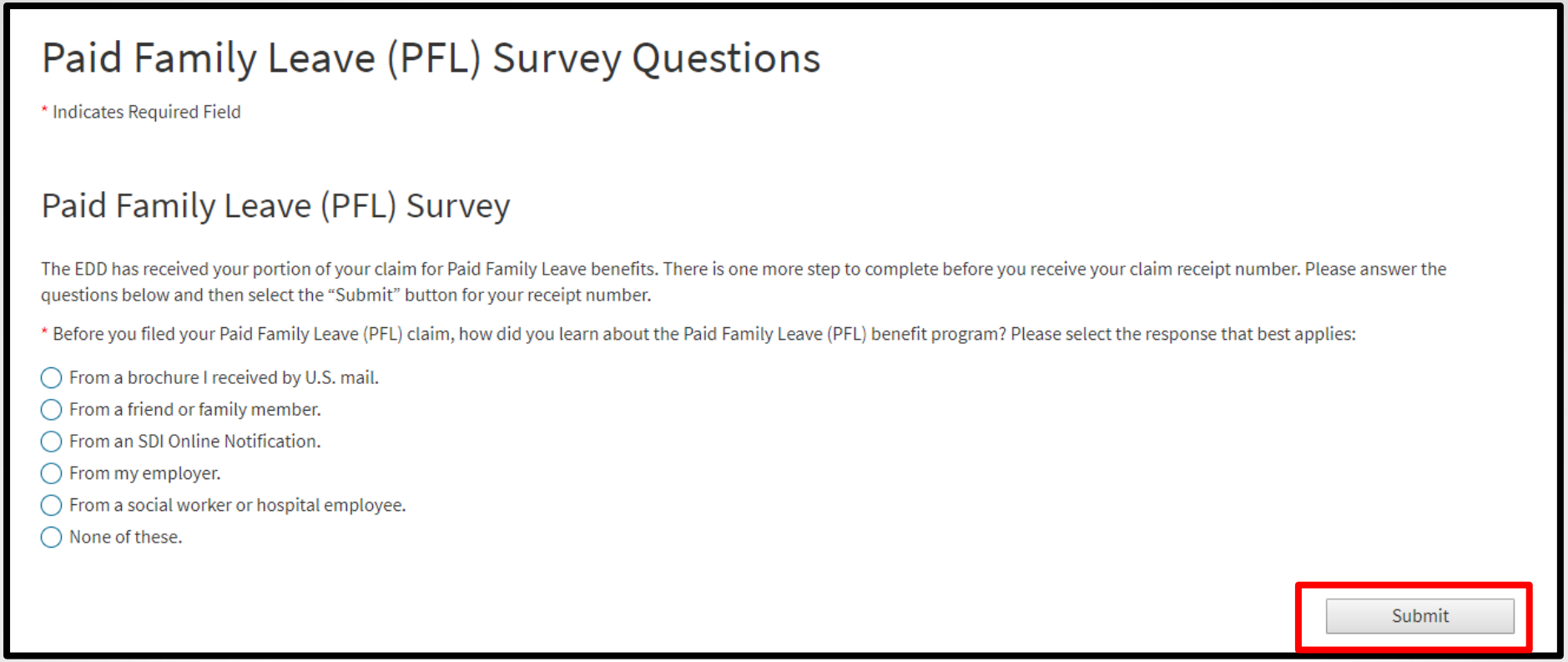
Cancel Next

Read all information carefully. Select **Next**.



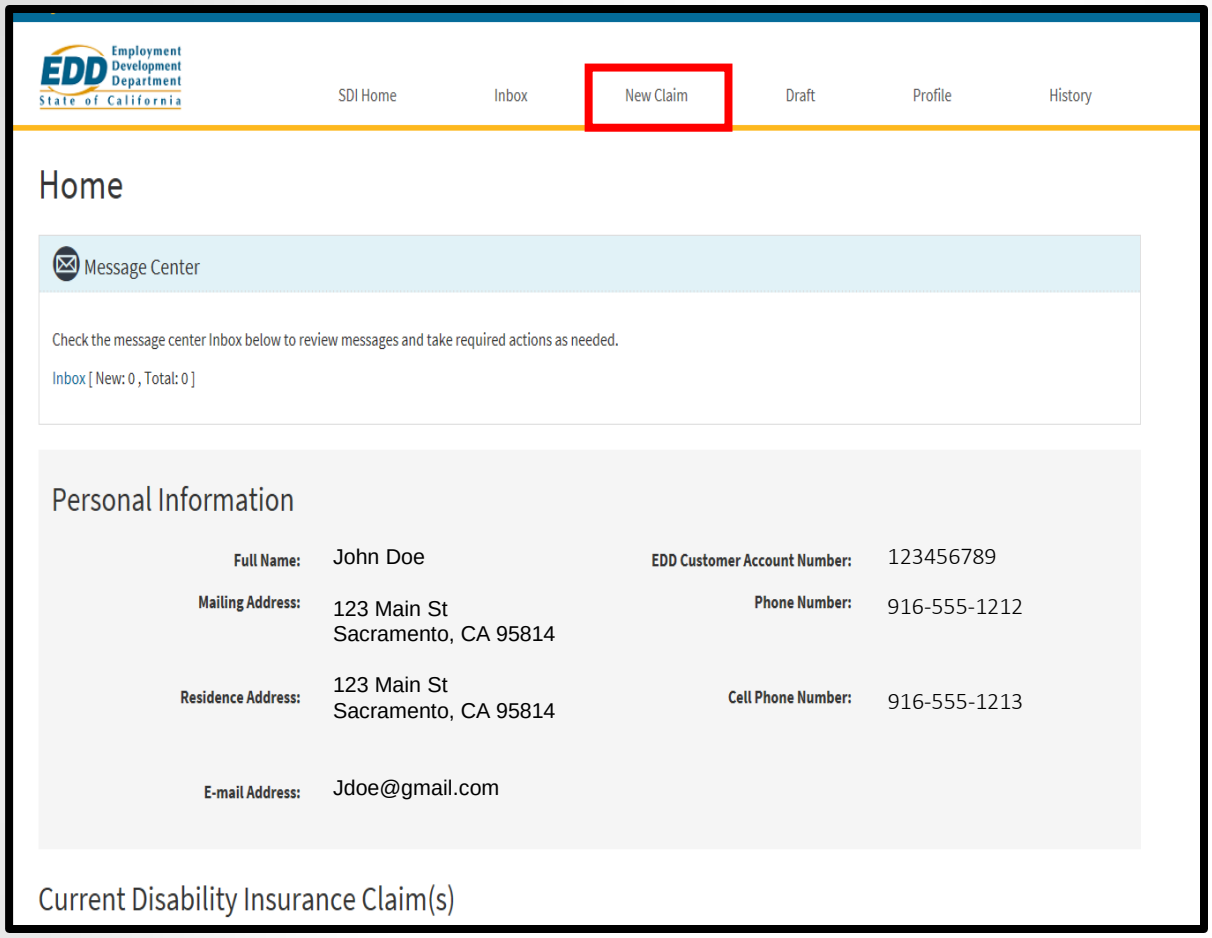
Select the box to authorize an electronic signature.

Select **Next**.



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



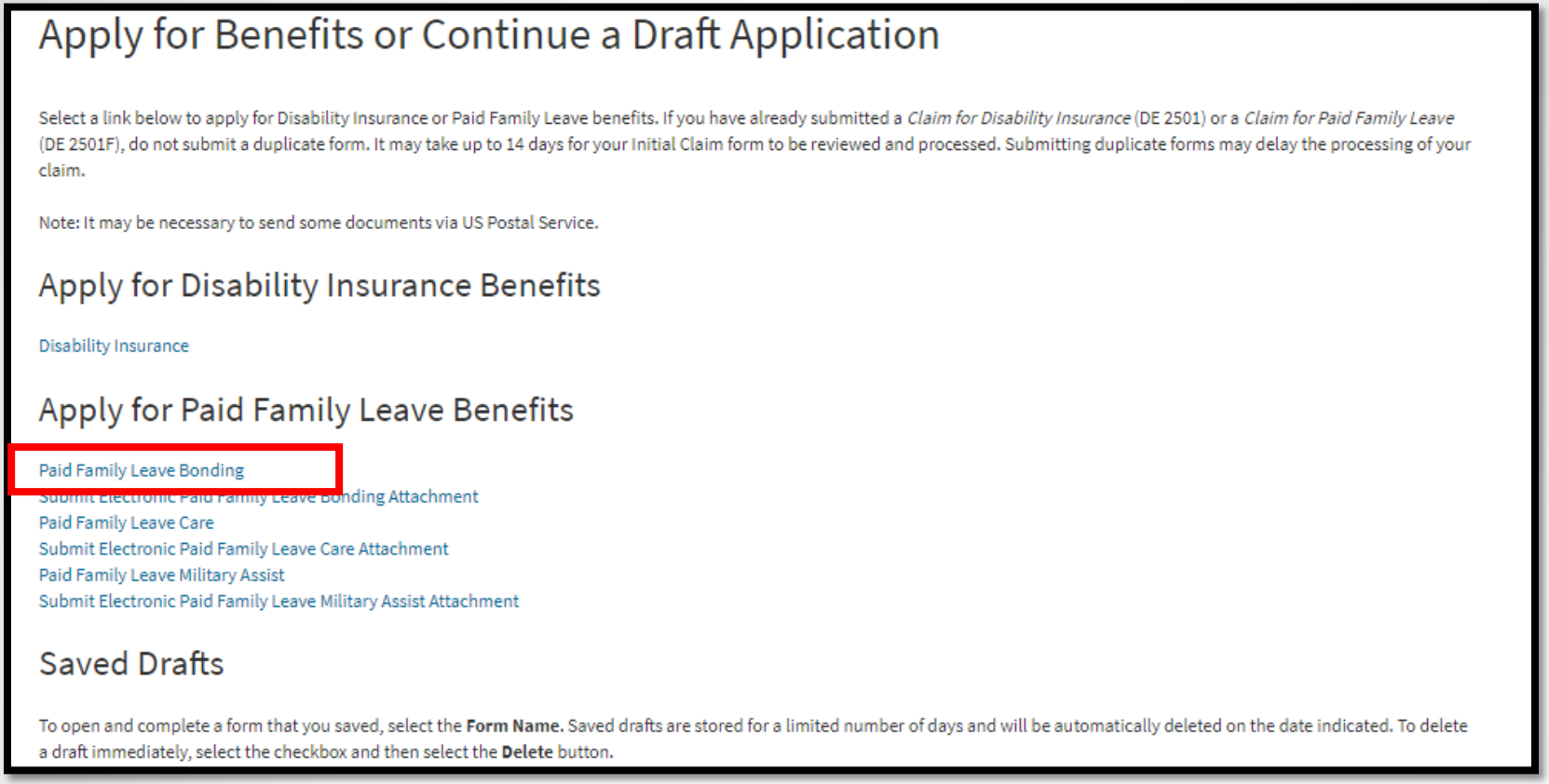
Follow these instructions to begin filing a Paid Family Leave claim for new mothers (not transitioning from Disability Insurance), new fathers, foster care, or adoptive parents:

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.

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 Submit Additional Paid Family Leave Bonding Attachments section of this tutorial.



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 Types of Claims (edd.ca.gov/Disability/Types_of_Claims.htm) on the EDD website.

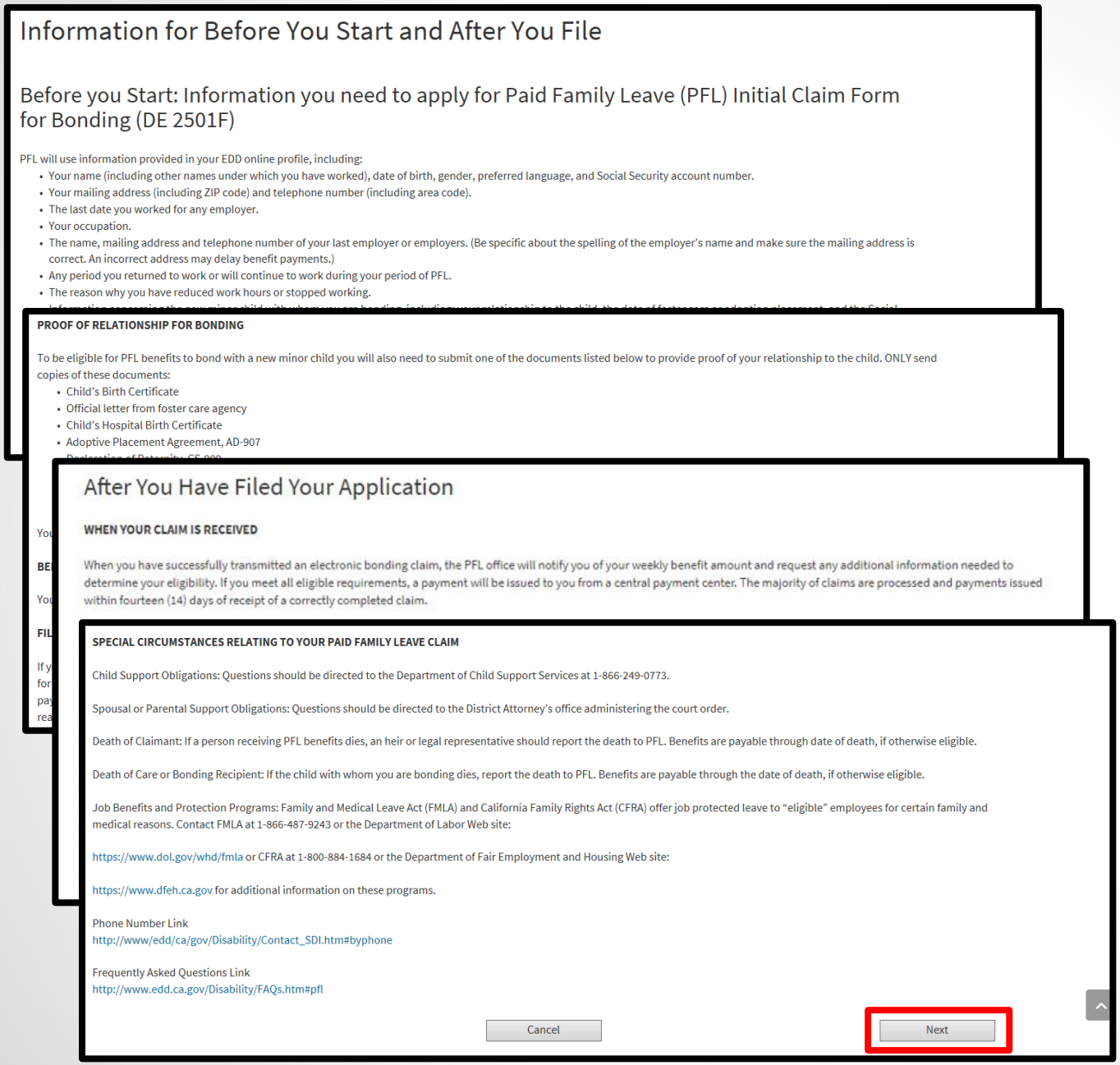
You must answer the prescreening questions:

- 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 (*).

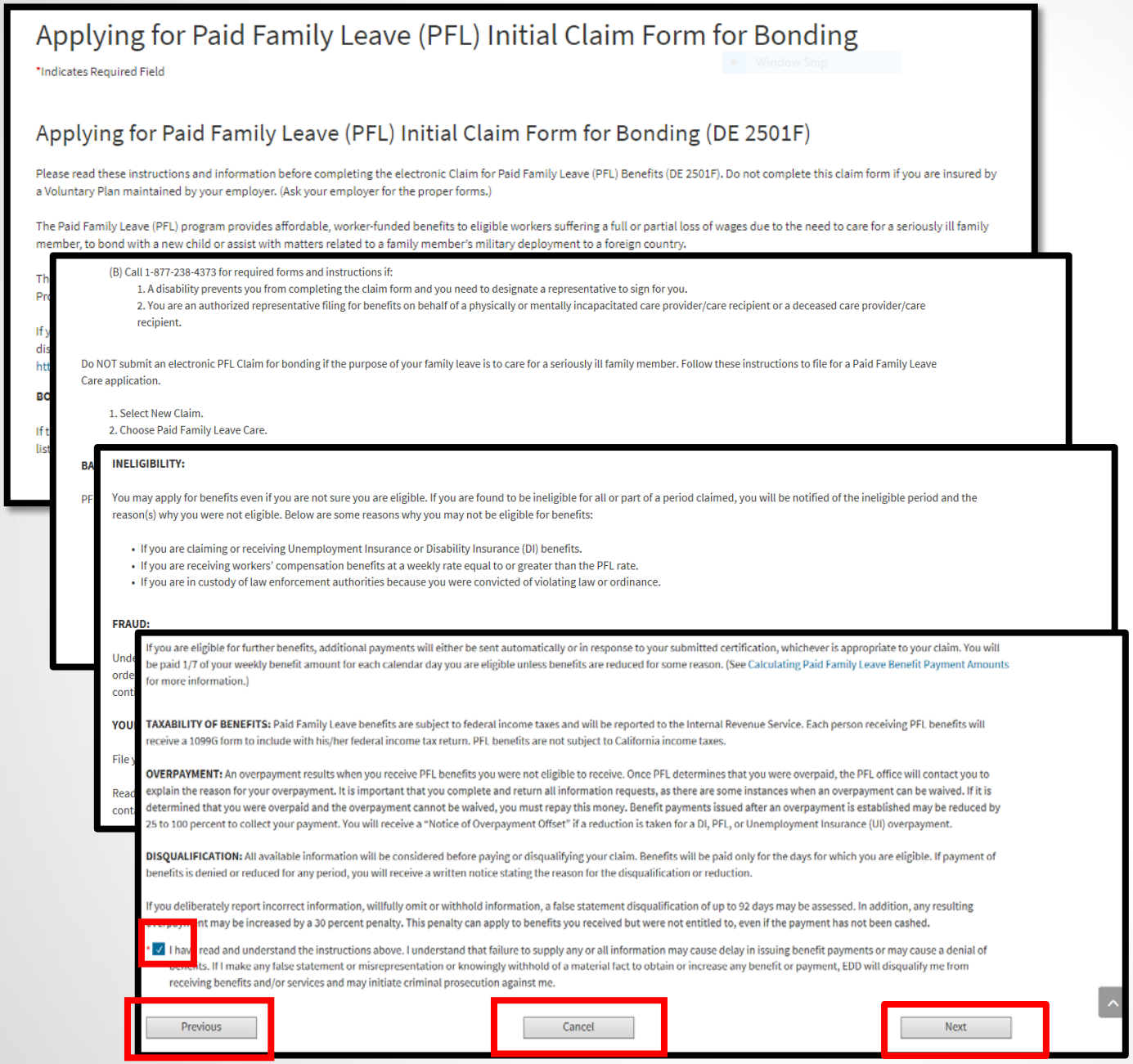
Note: Selecting **Cancel** at any time during this process will cancel the claim and return you to your SDI Online Home screen.



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**.



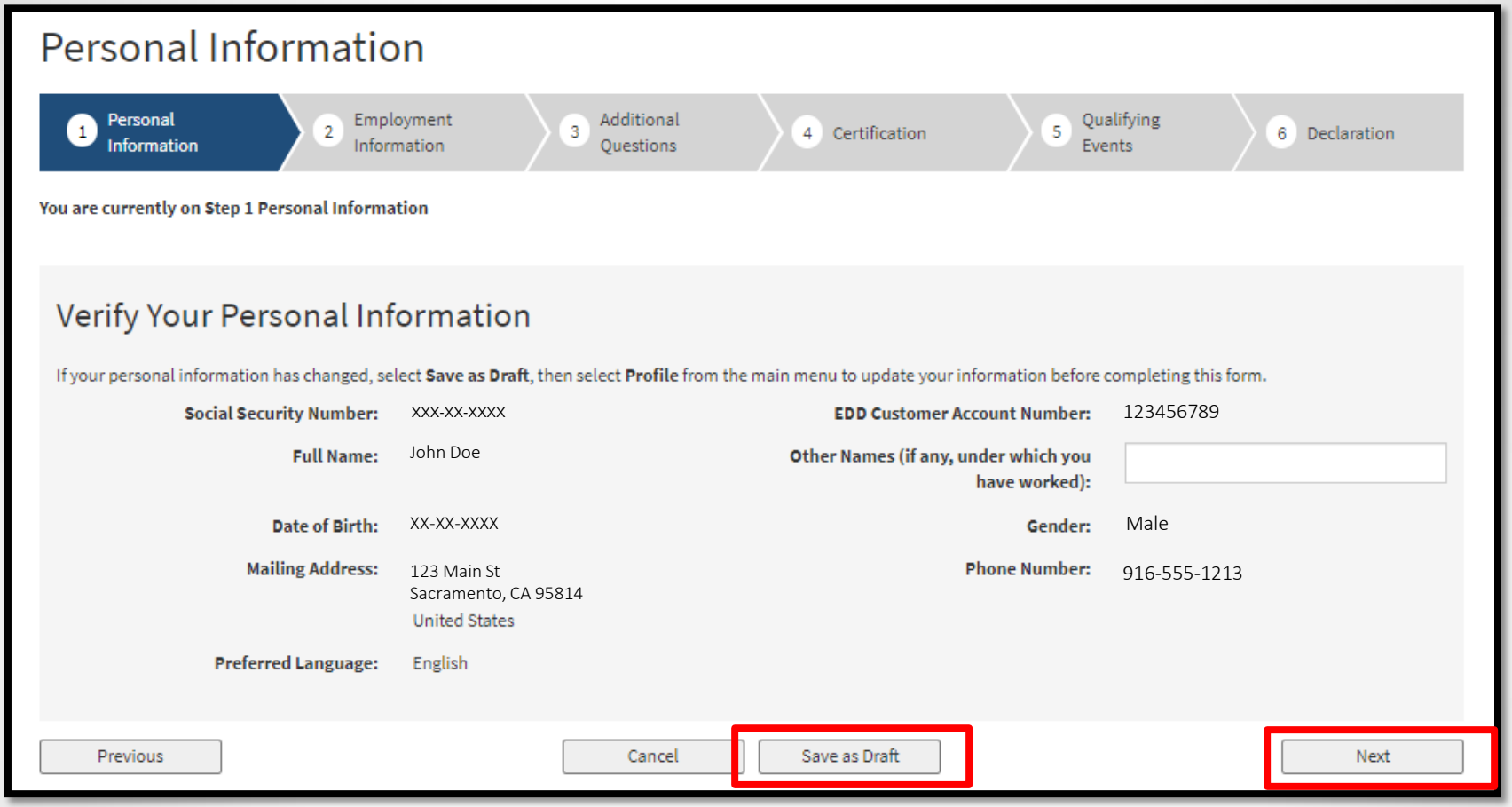
This screen provides additional information about filing a Paid Family Leave Bonding claim.

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

Select **Next** to proceed.

Note:

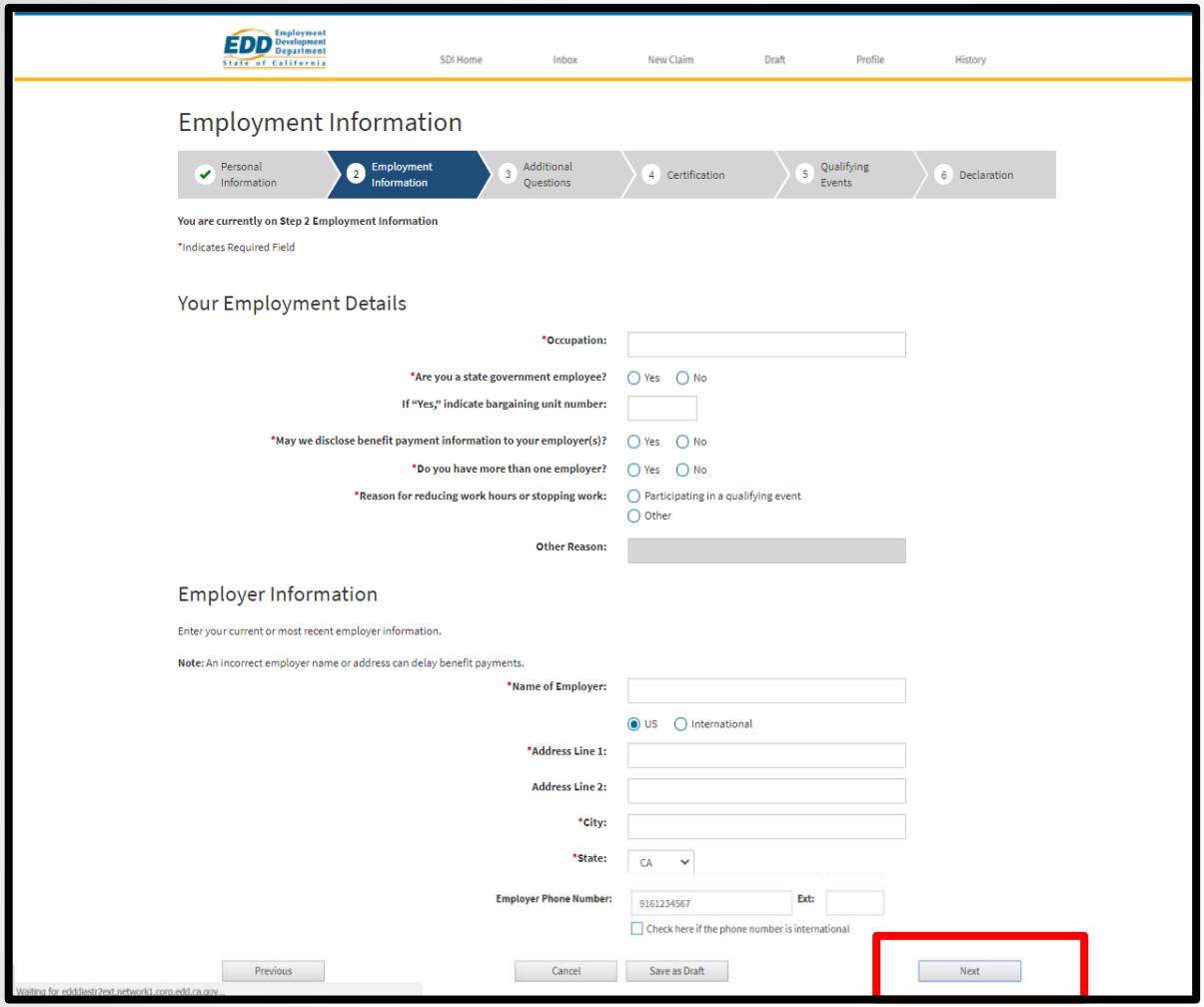
- Select **Save as Draft** at any point in the process to complete the form at a later time.
- Select **Previous** to return to the previous screen.



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.

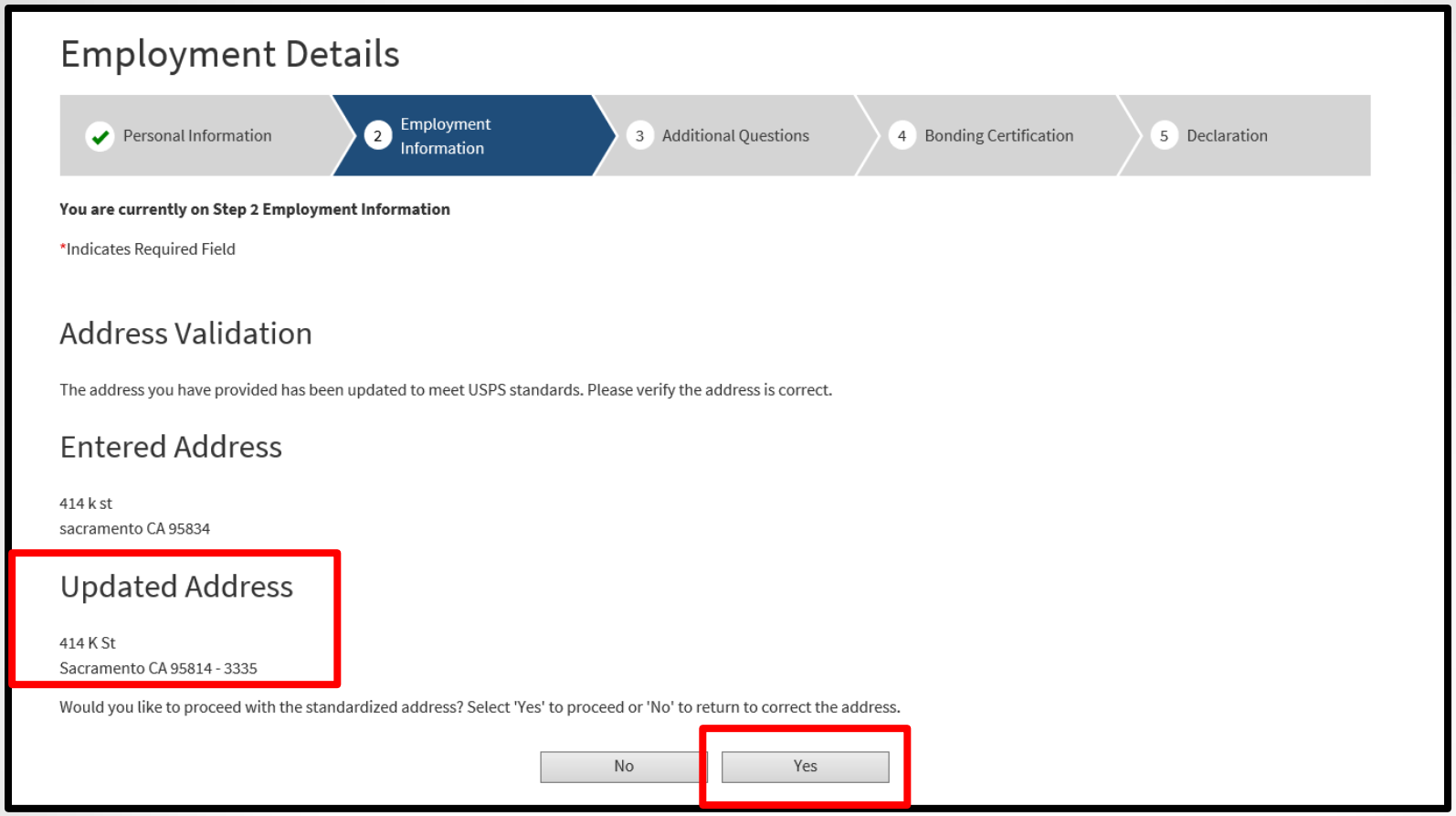
Select **Next** to proceed.



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

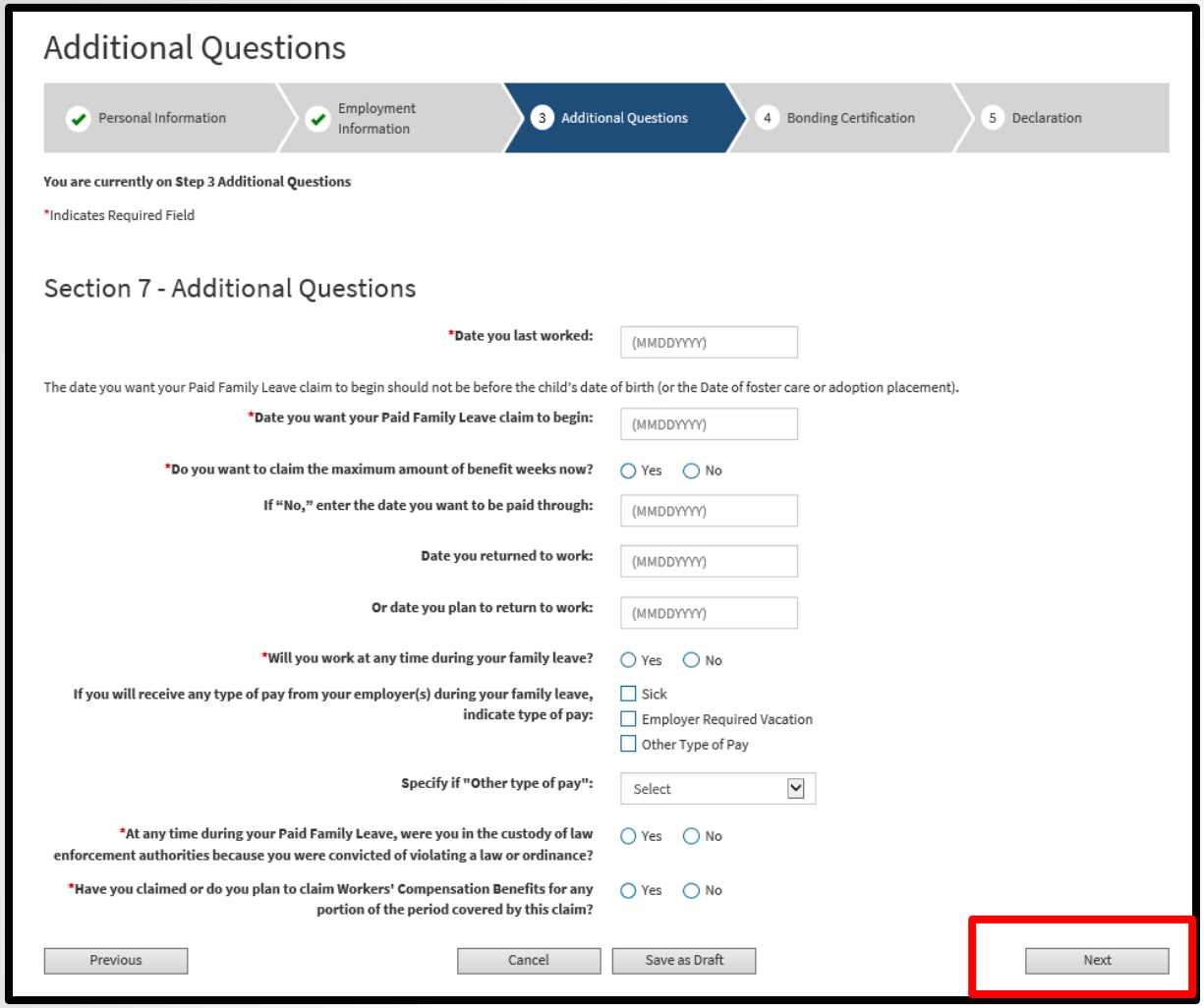
Add your most current employer's business name, phone number, and mailing address as stated on your W-2 or paystub.

Select **Next** to proceed.



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

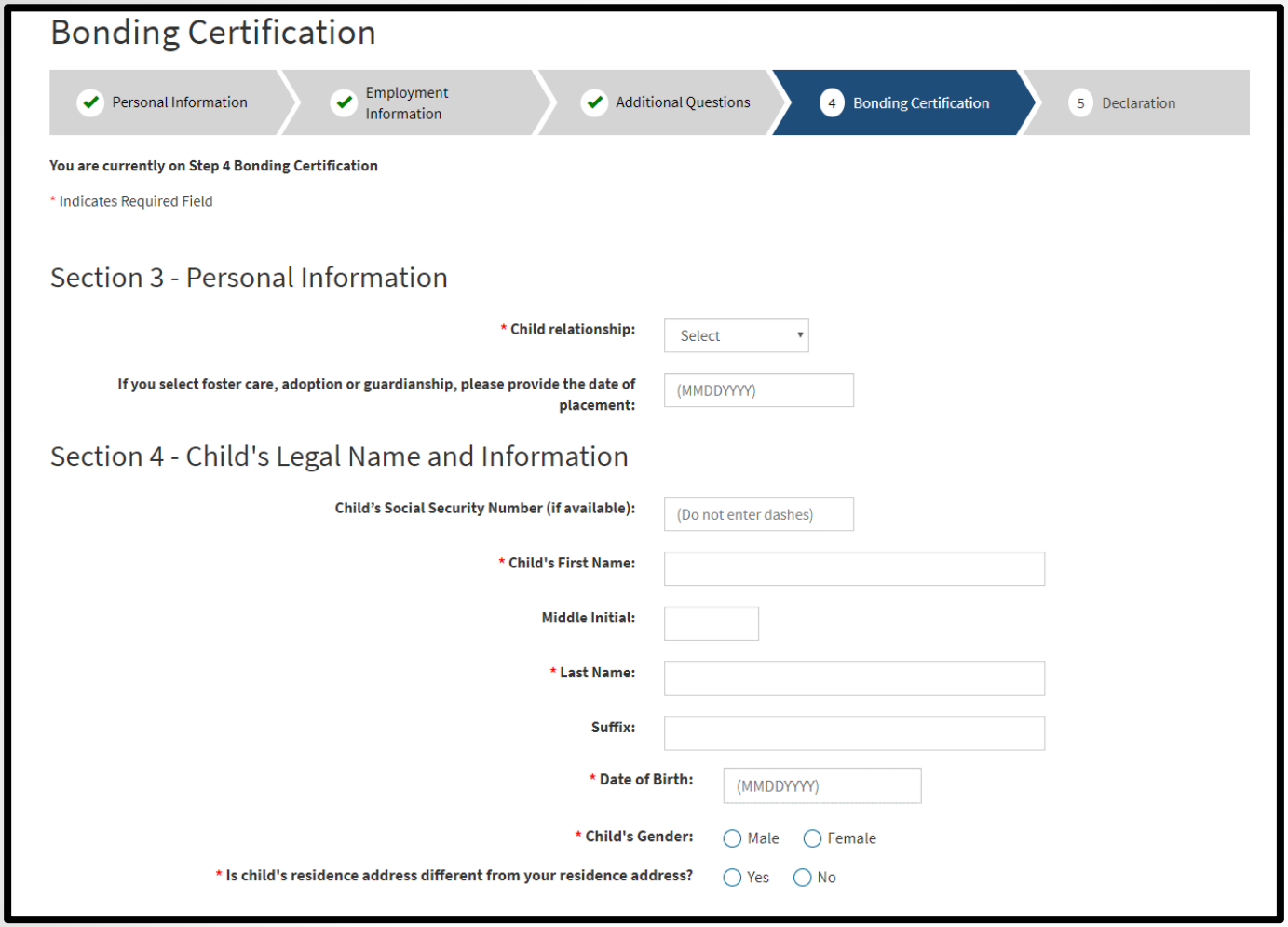
- Confirm the **Updated Address** section is correct by selecting **Yes**.
- Select **No** to go back to the previous screen and re-enter the address.



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 (*).

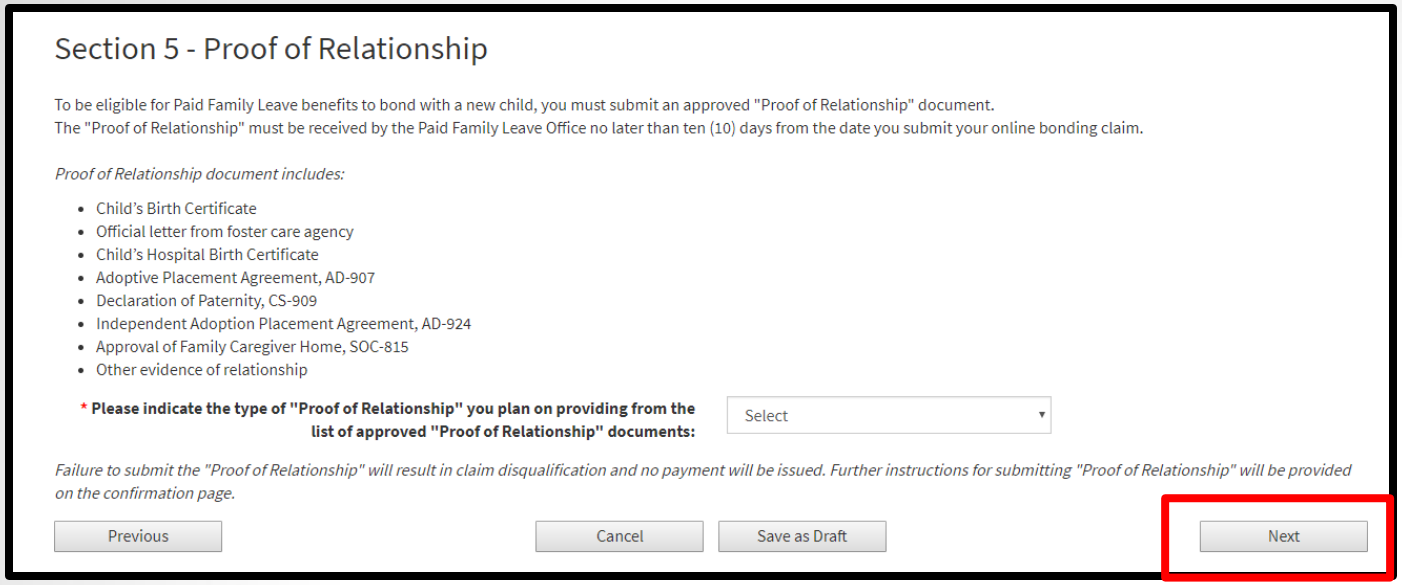
Select **Next** to proceed.



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.

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

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



The accepted "Proof of Relationship" document options are:

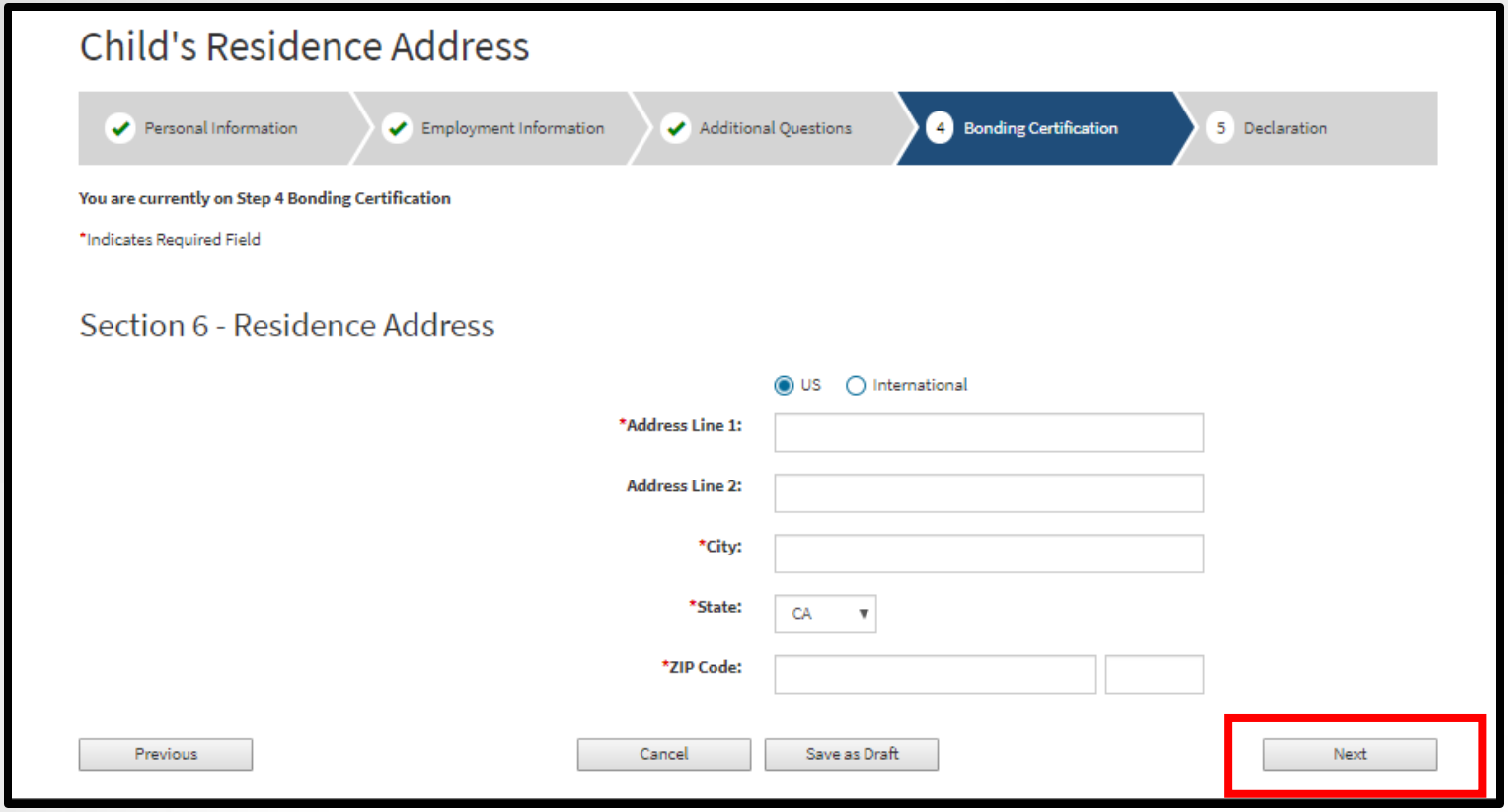
- Child's Birth Certificate
- Official Letter from foster care agency
- Child's Hospital Birth Certificate
- Adoptive Placement Agreement, AD-907
- Declaration of Paternity, CS-909
- Independent Adoption Placement Agreement, AD-924
- Approval of Family Caregiver Home, SOC-815
- Other Evidence of relationship

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.

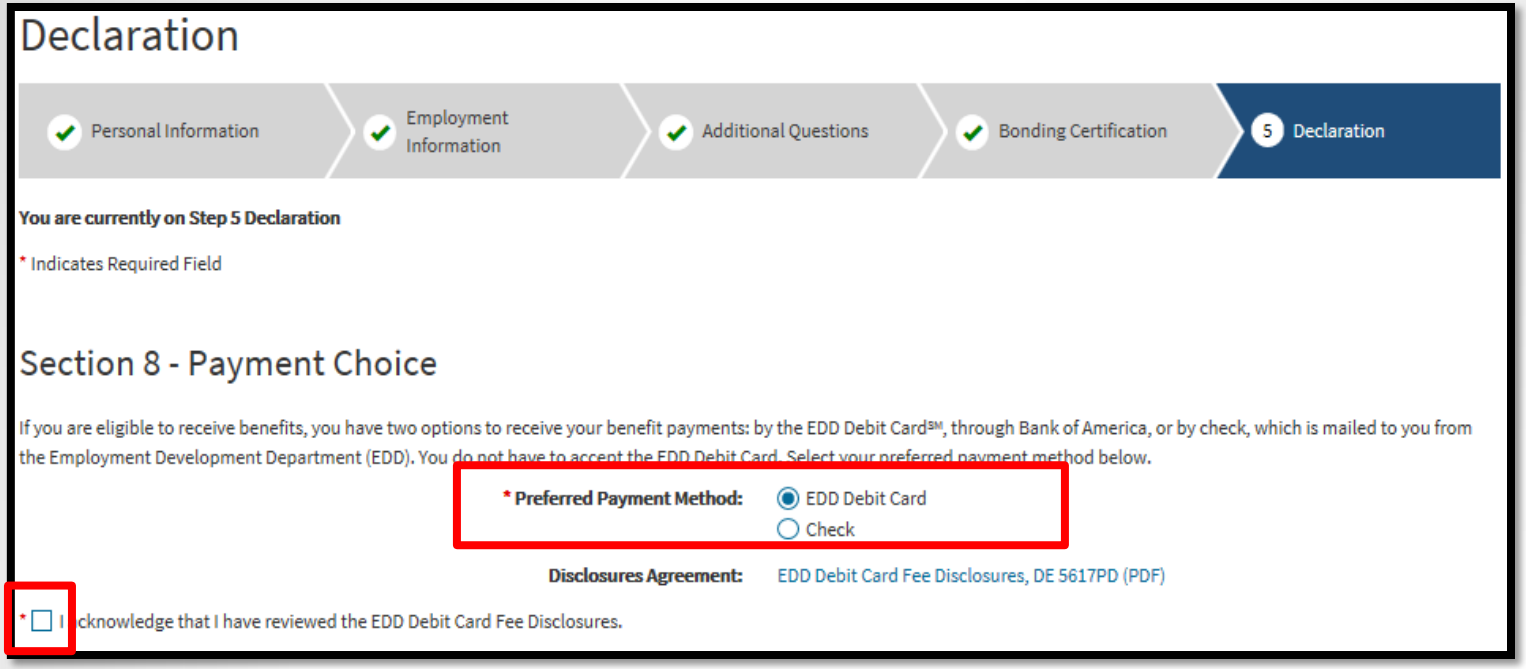


If you selected **Yes** to "Is the child's residence address different from your resident address?" in **Section 4 – Child's Legal Name and Information**, you must enter the child's residential address information here**.**

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.

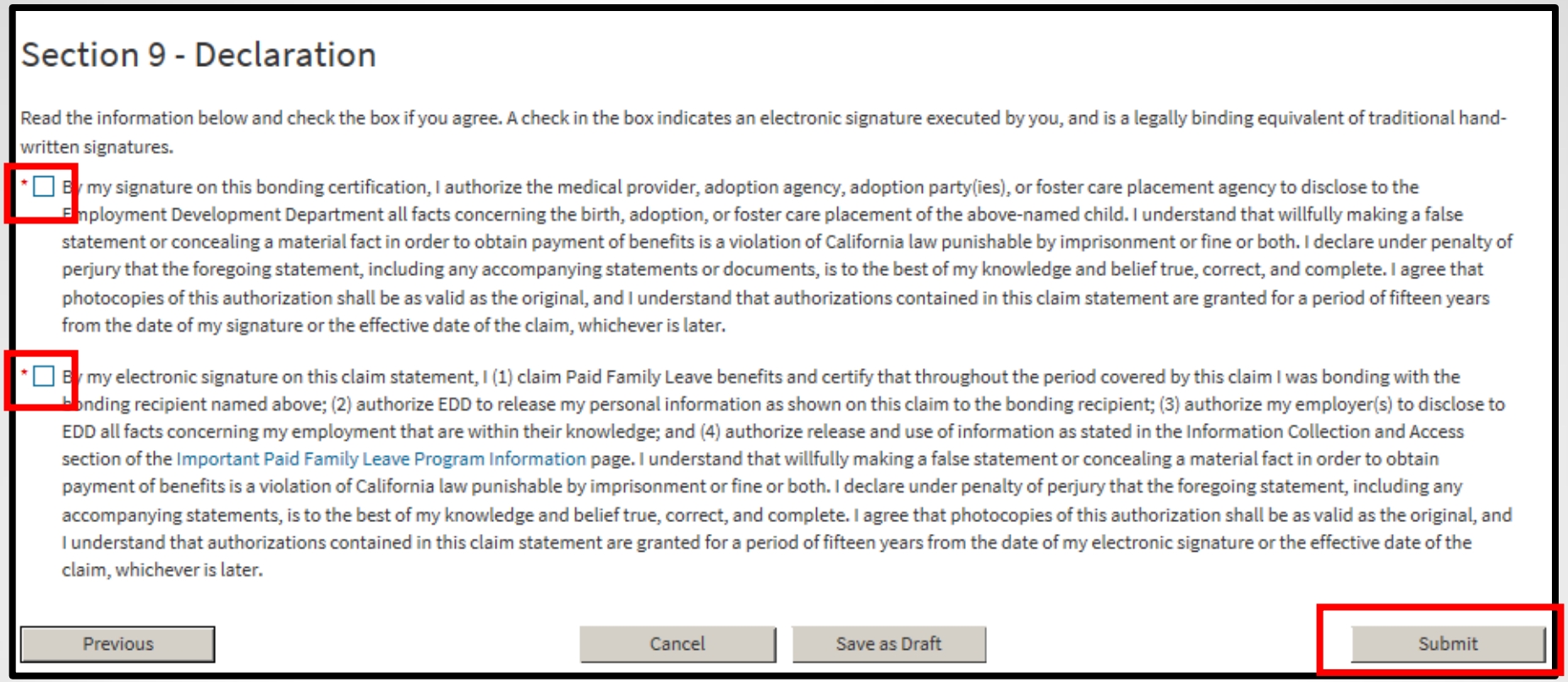
Select **Next** to proceed.



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.

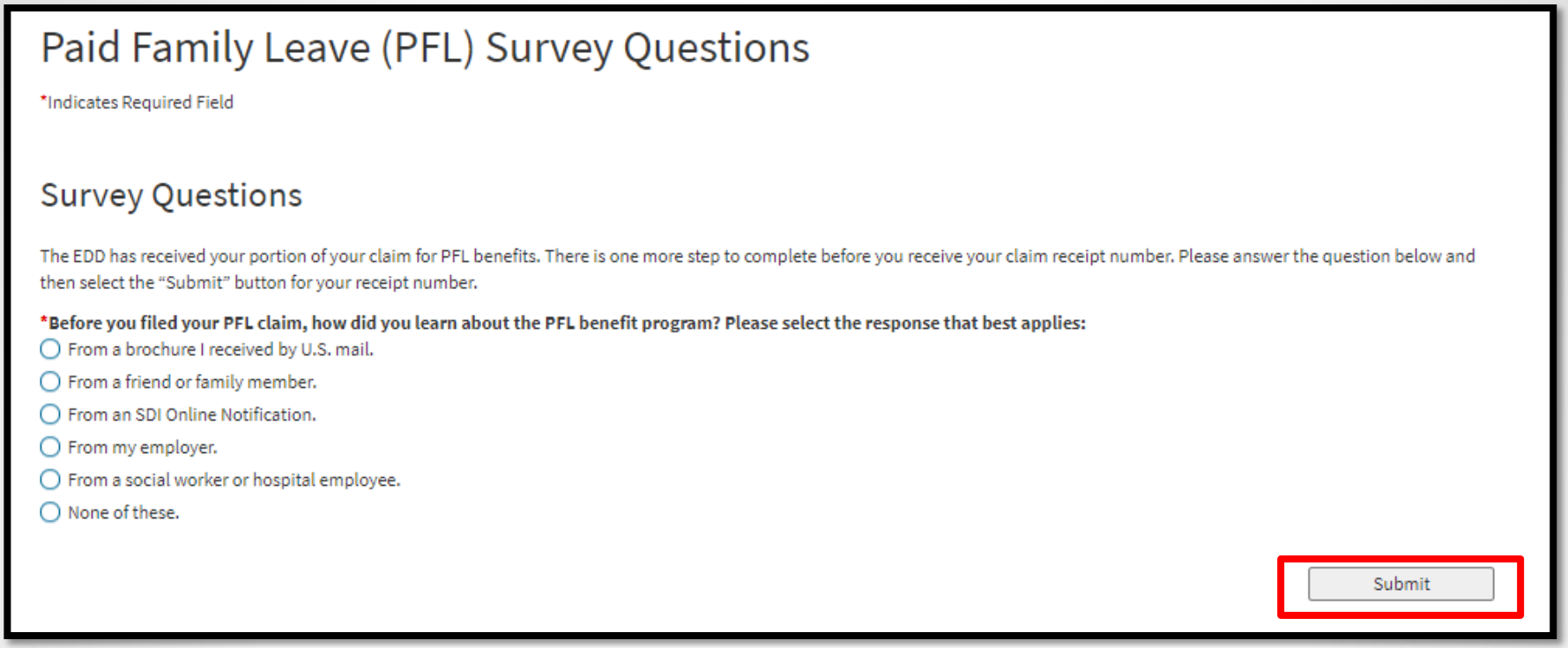
Select the check box below to acknowledge you have reviewed the disclosure agreement.



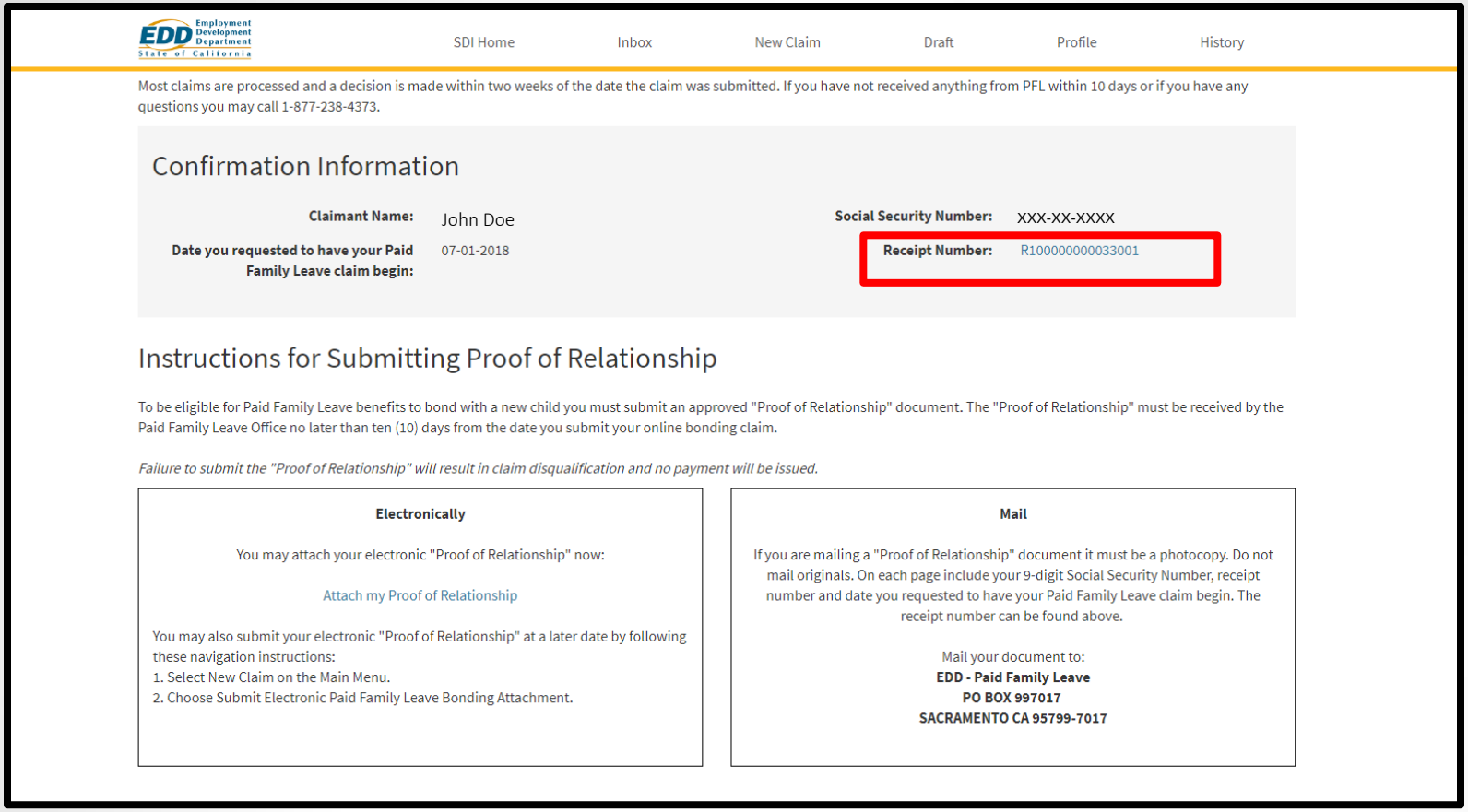
Select both check boxes to authorize an electronic signature and the release of your information.

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

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



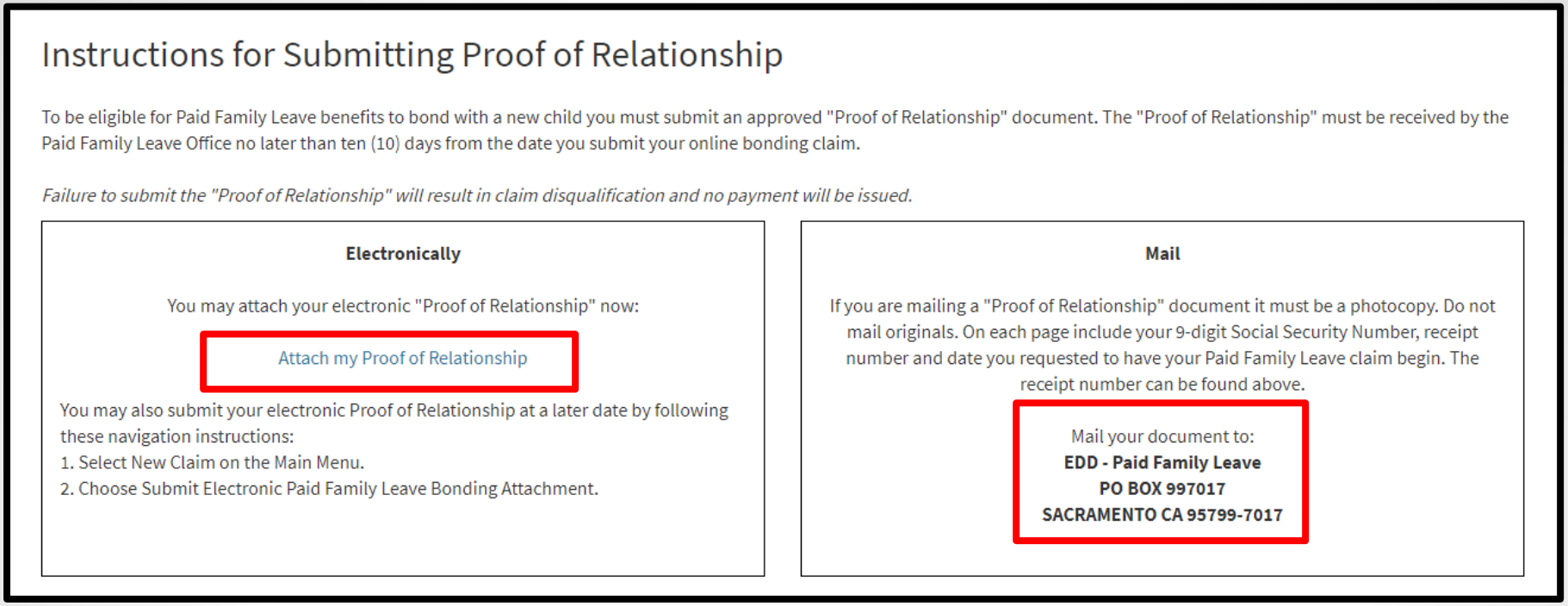
Complete the survey and select **Submit** to proceed to the next step.



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.



Instructions for Submitting Proof of Relationship

To be eligible for Paid Family Leave benefits to bond with a new child you must submit an approved "Proof of Relationship" document. The "Proof of Relationship" must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online bonding claim.

Failure to submit the "Proof of Relationship" will result in claim disqualification and no payment will be issued.

Electronically

You may attach your electronic "Proof of Relationship" now:

Attach my Proof of Relationship

You may also submit your electronic Proof of Relationship at a later date by following these navigation instructions:
1. Select New Claim on the Main Menu.
2. Choose Submit Electronic Paid Family Leave Bonding Attachment.

Mail

If you are mailing a "Proof of Relationship" document it must be a photocopy. Do not mail originals. On each page include your 9-digit Social Security Number, receipt number and date you requested to have your Paid Family Leave claim begin. The receipt number can be found above.

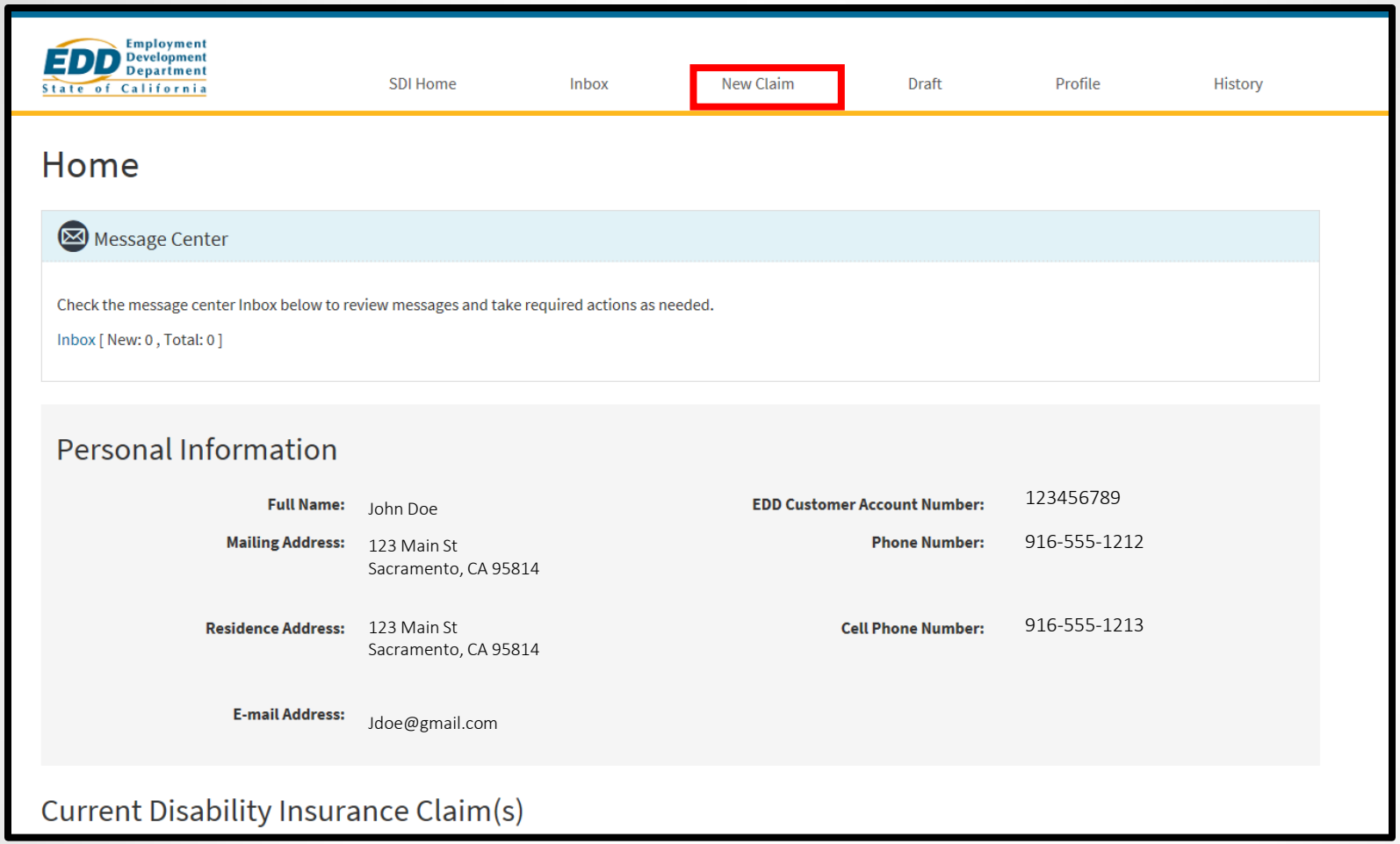
Mail your document to:
EDD - Paid Family Leave
PO BOX 997017
SACRAMENTO CA 95799-7017

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 Submit Paid Family Leave Bonding Claim Attachments section of this tutorial for additional instructions.

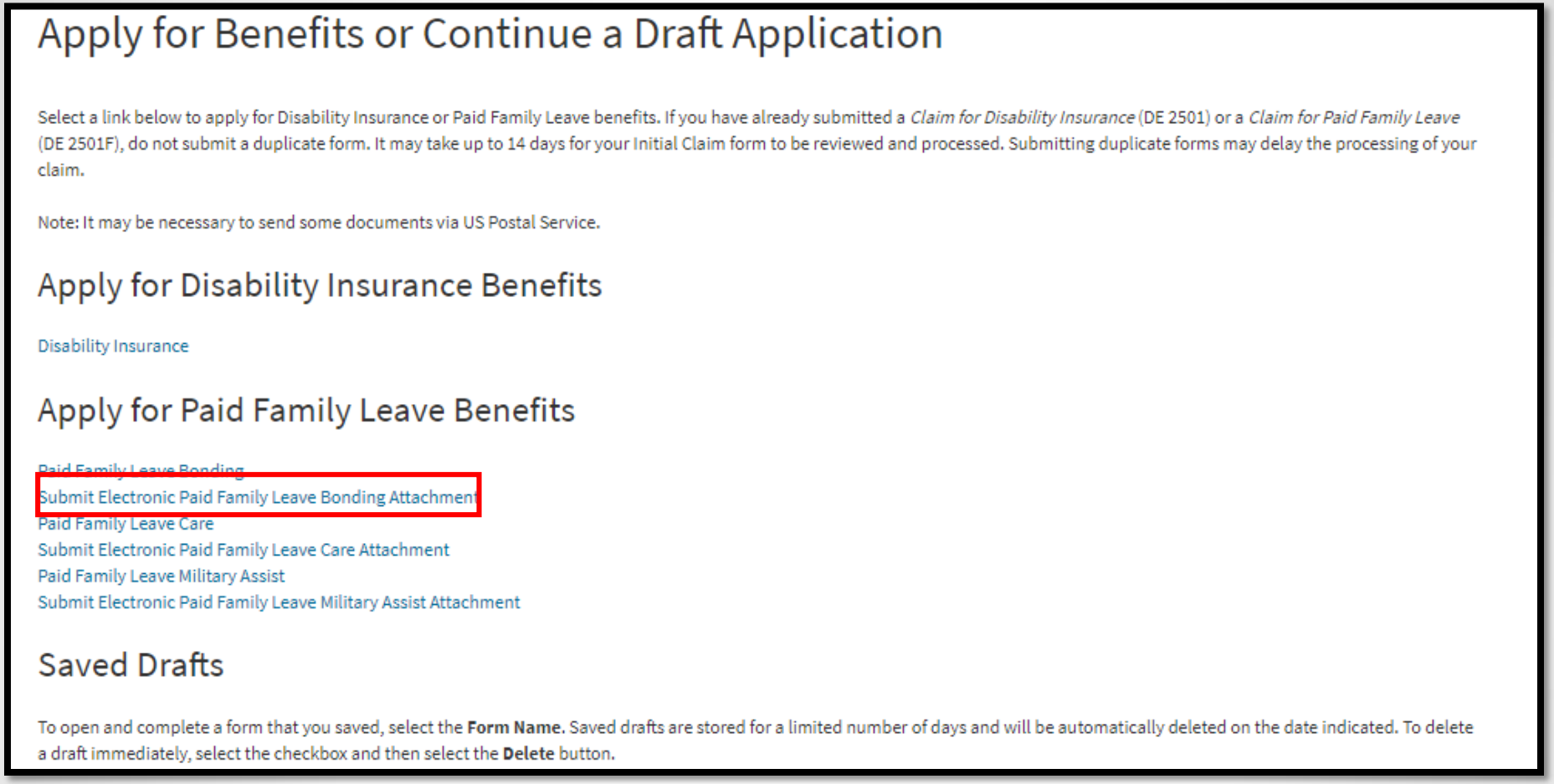
- To submit by mail, send your proof of relationship to the address on the screen. Send photocopies of your documents, do not mail originals. On each page include your 9-digit Social Security number, **Receipt Number**, and your requested claim start date.

Submit Paid Family Leave Bonding Claim Attachments

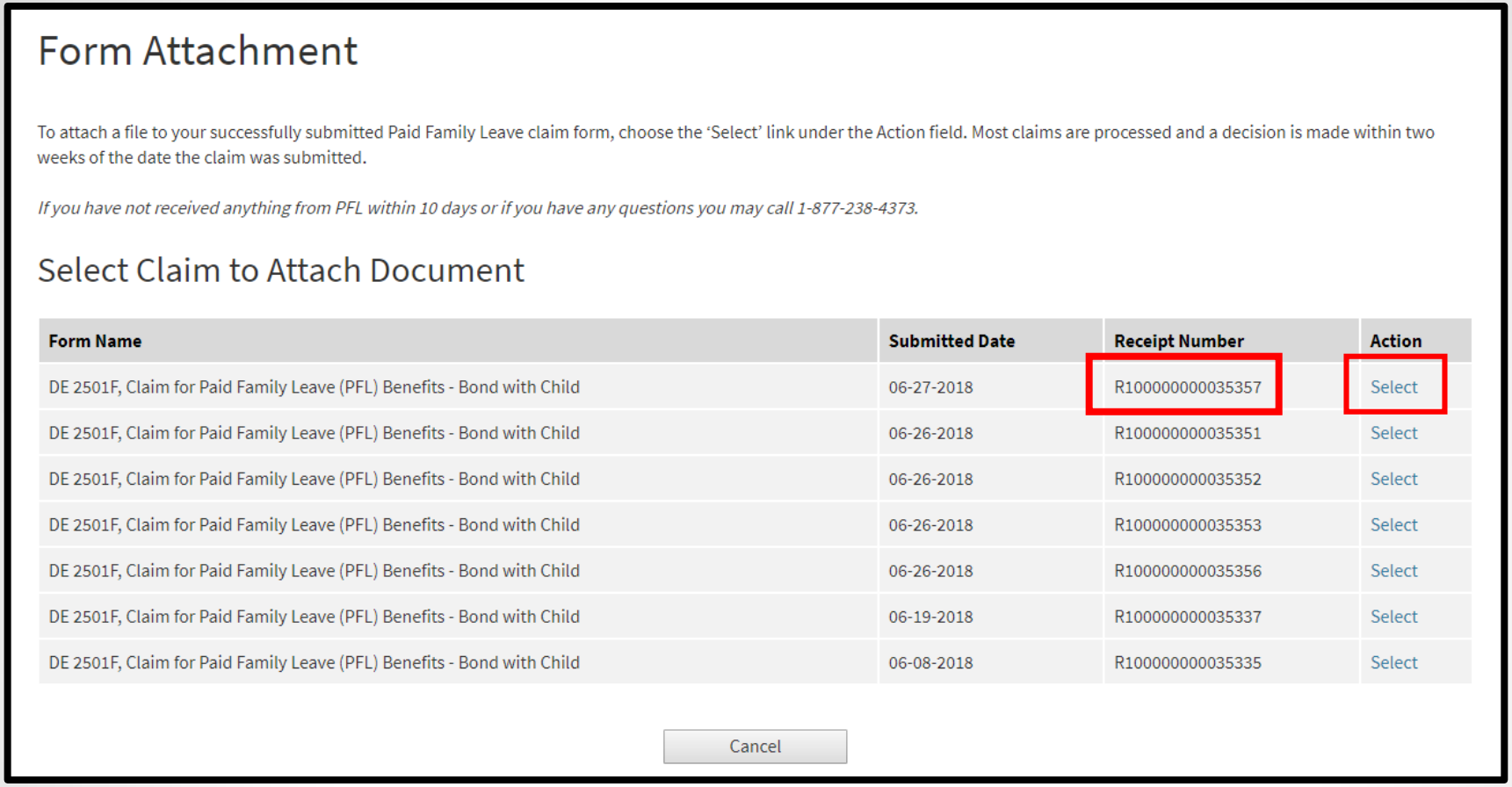


To submit your “Proof of Relationship” document or if you need to submit more than one document (e.g. birth certificates for twins or to resubmit a previous document):

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



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.

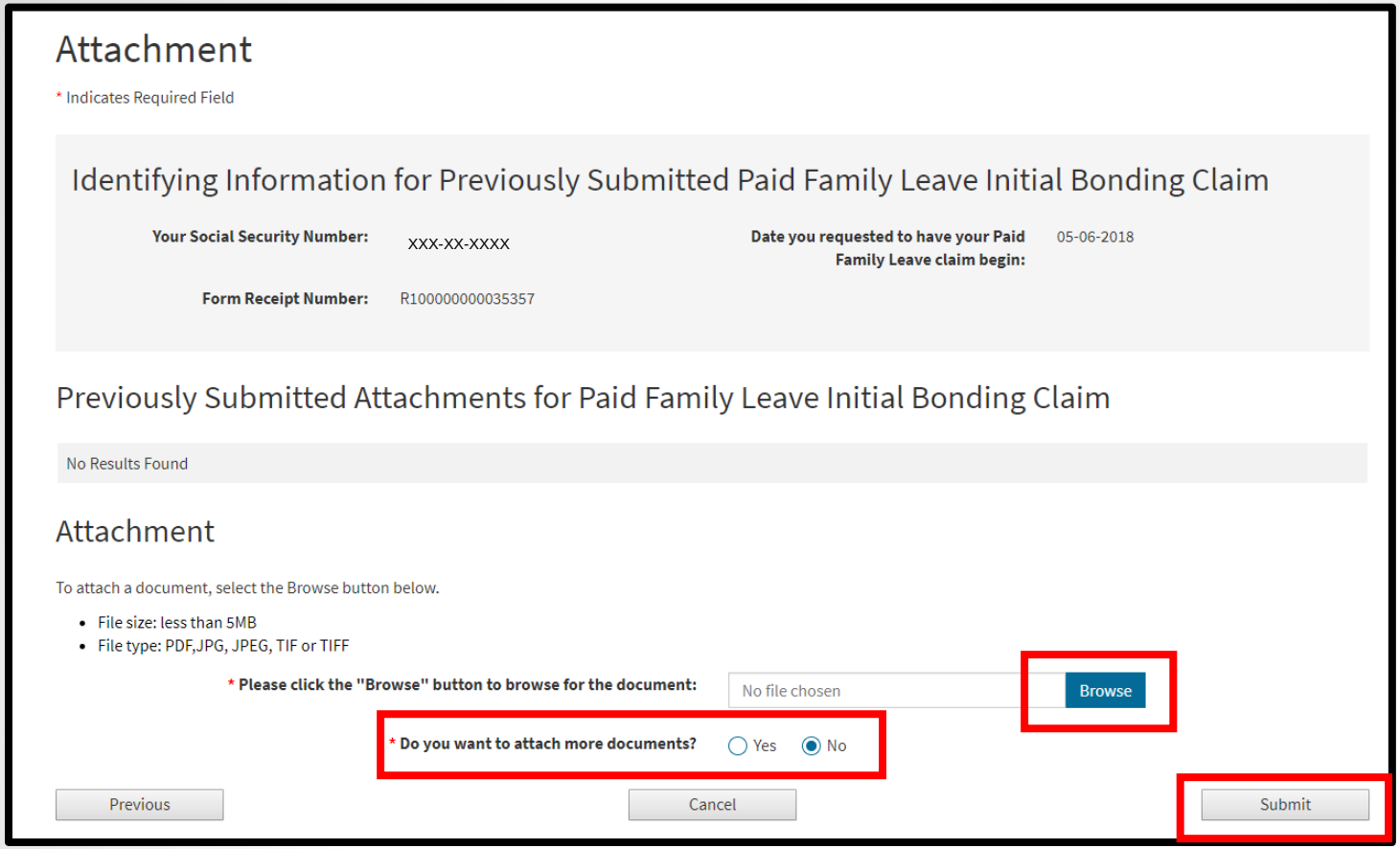
Select Claim to Attach Document

Form Name	Submitted Date	Receipt Number	Action
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Bond with Child	06-27-2018	R100000000035357	Select
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Bond with Child	06-26-2018	R100000000035351	Select
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Bond with Child	06-26-2018	R100000000035352	Select
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Bond with Child	06-26-2018	R100000000035353	Select
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Bond with Child	06-26-2018	R100000000035356	Select
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Bond with Child	06-19-2018	R100000000035337	Select
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Bond with Child	06-08-2018	R100000000035335	Select

Cancel

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

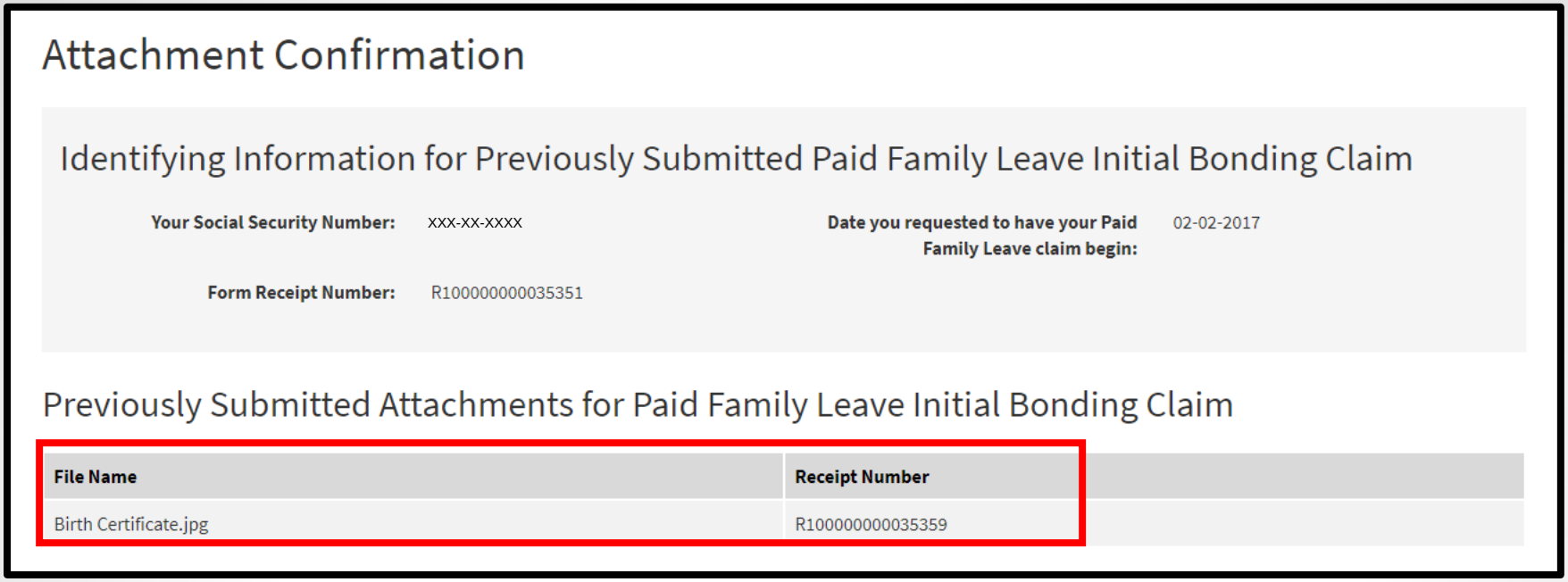
If it matches your claim, choose the **Select** link from the **Action** column to attach a form to your claim.



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

Date you requested to have your Paid Family Leave claim begin: 02-02-2017

Form Receipt Number: R100000000035351

Previously Submitted Attachments for Paid Family Leave Initial Bonding Claim

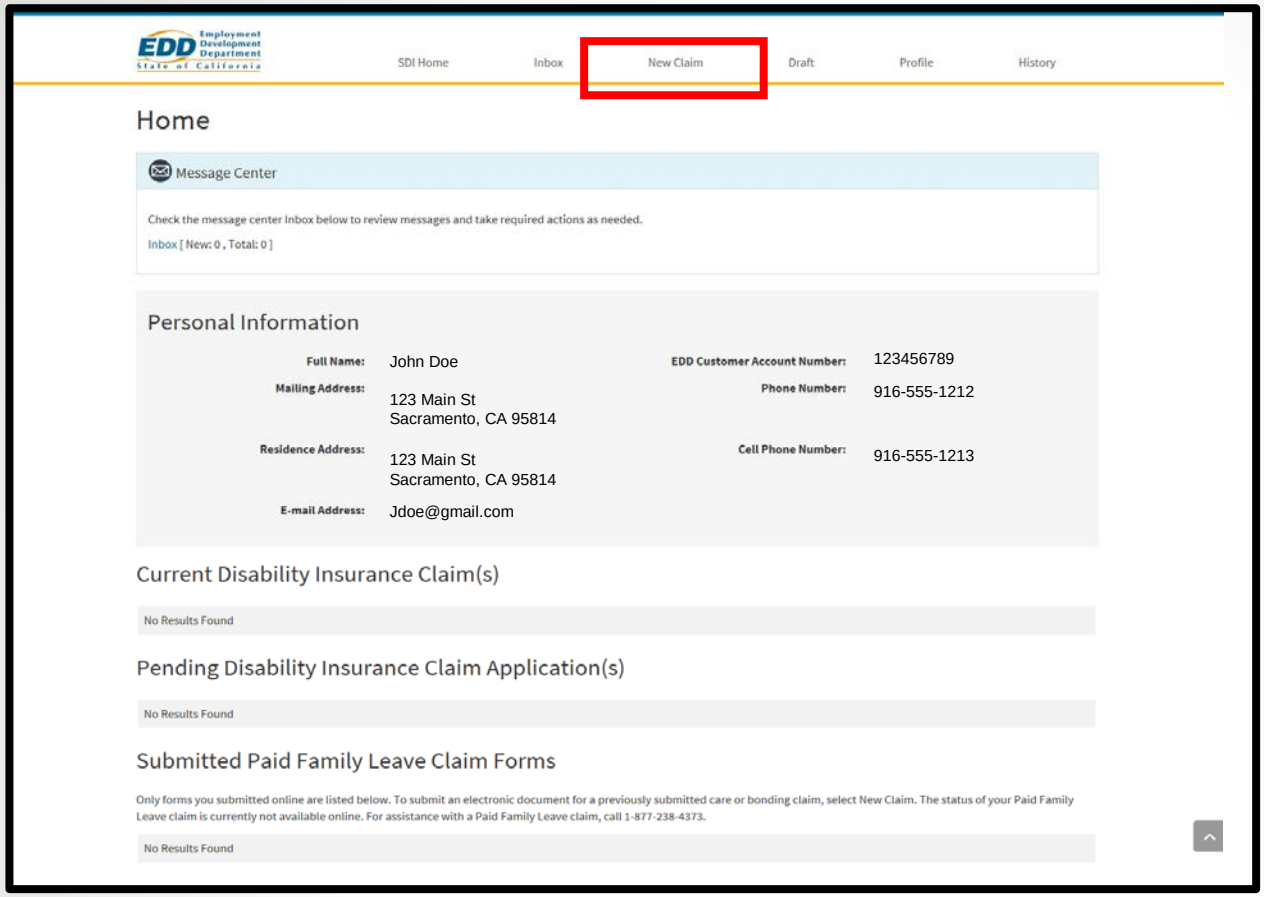
File Name	Receipt Number
Birth Certificate.jpg	R100000000035359

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.

File a Paid Family Leave Care Claim

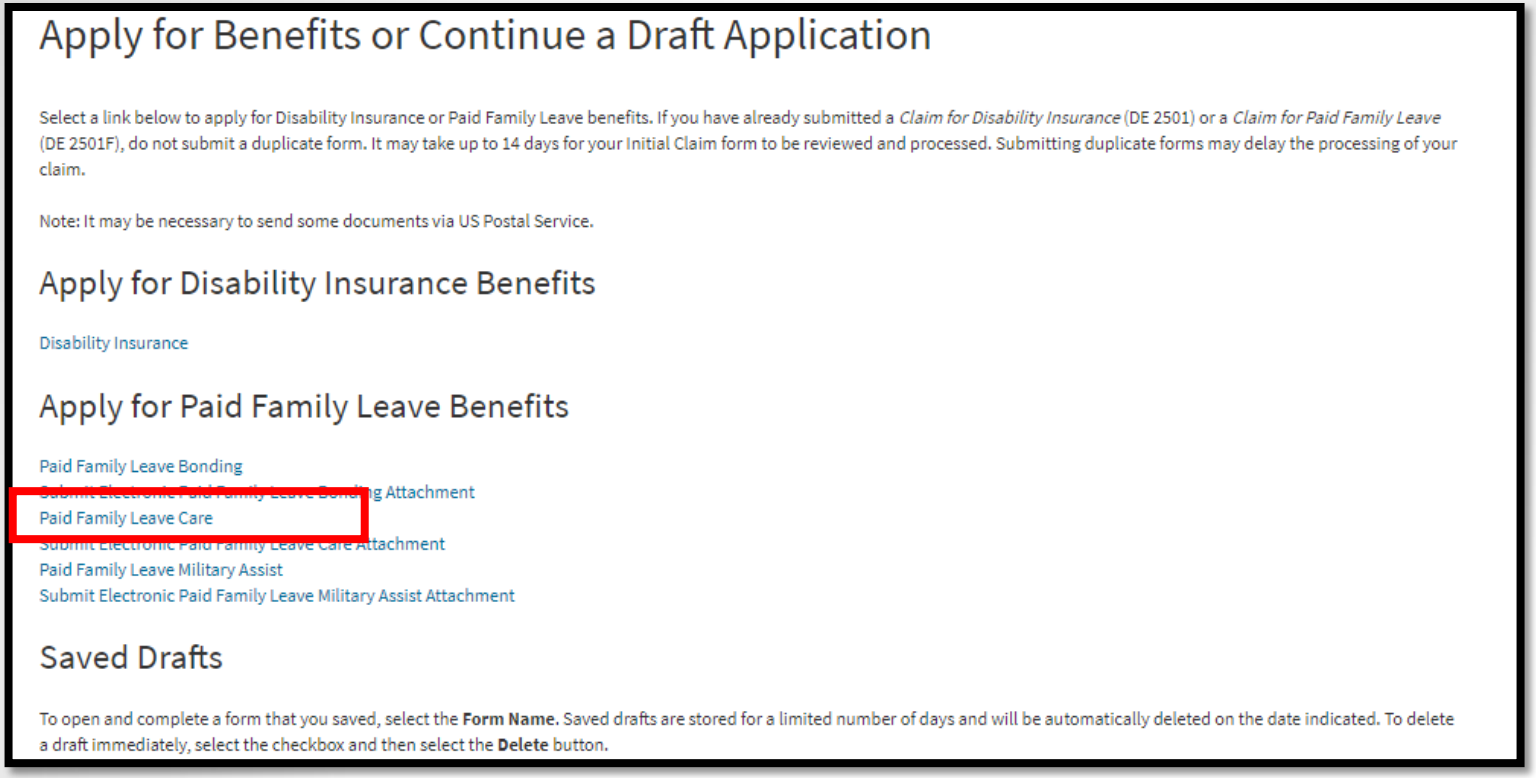


Follow these instructions to begin filing a Paid Family Leave Care claim:

1. Access your SDI Online account by logging in to **Benefit Programs Online**.

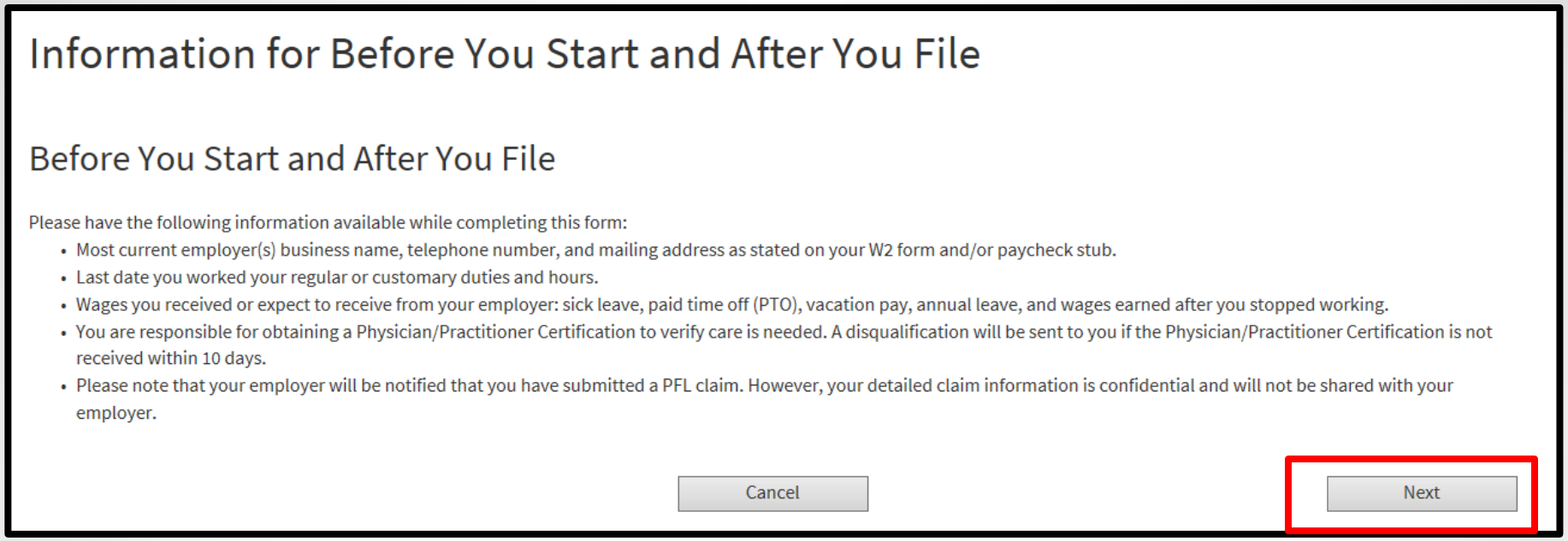
2. Select the **SDI Online** button to be directed to your SDI Online **Home** screen.

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



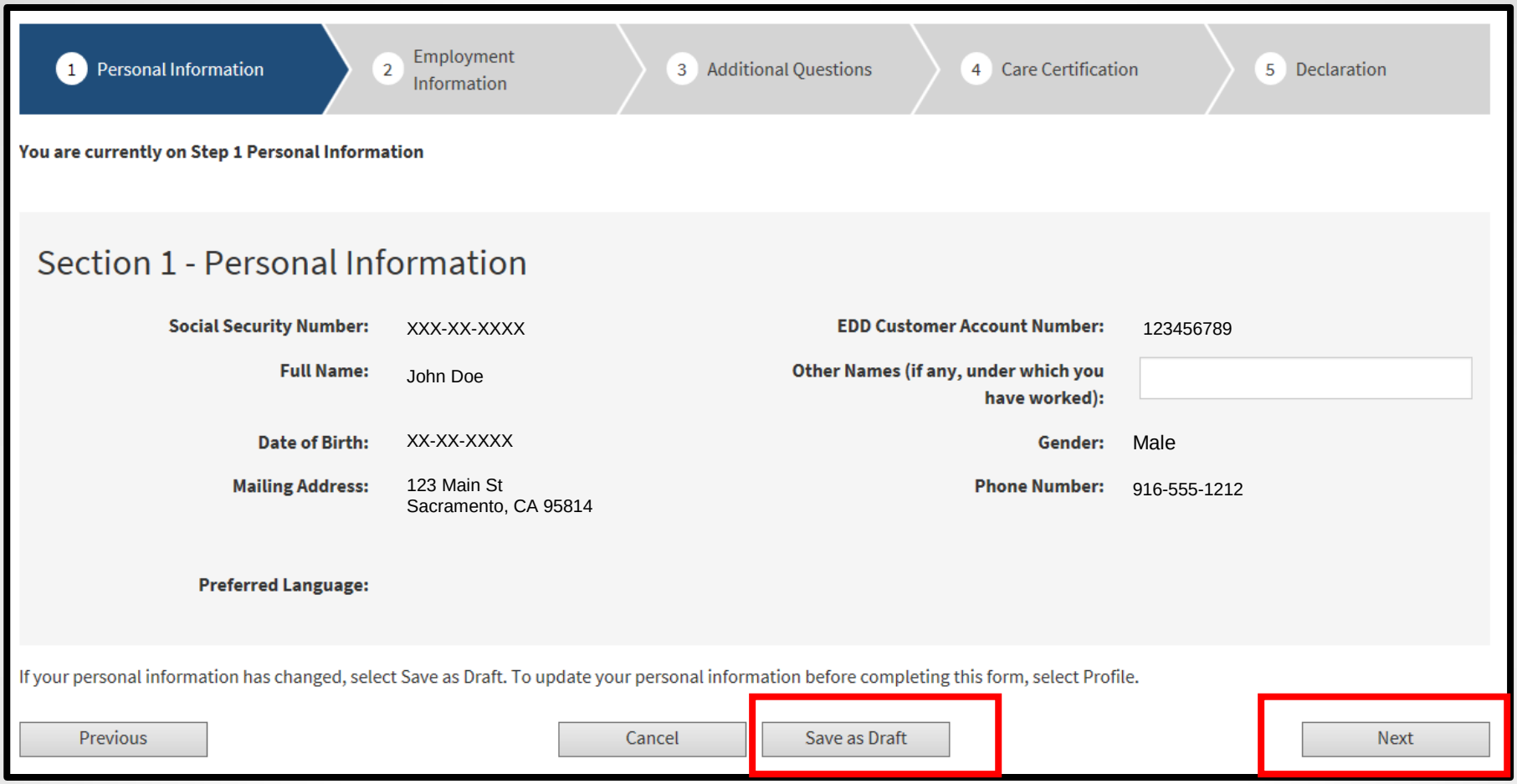
To apply for Paid Family Leave Care benefits, select the **Paid Family Leave Care** link located under the Apply for Paid Family Leave Benefits header.

- 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 Types of Claims (edd.ca.gov/Disability/Types_of_Claims.htm) on the EDD website.



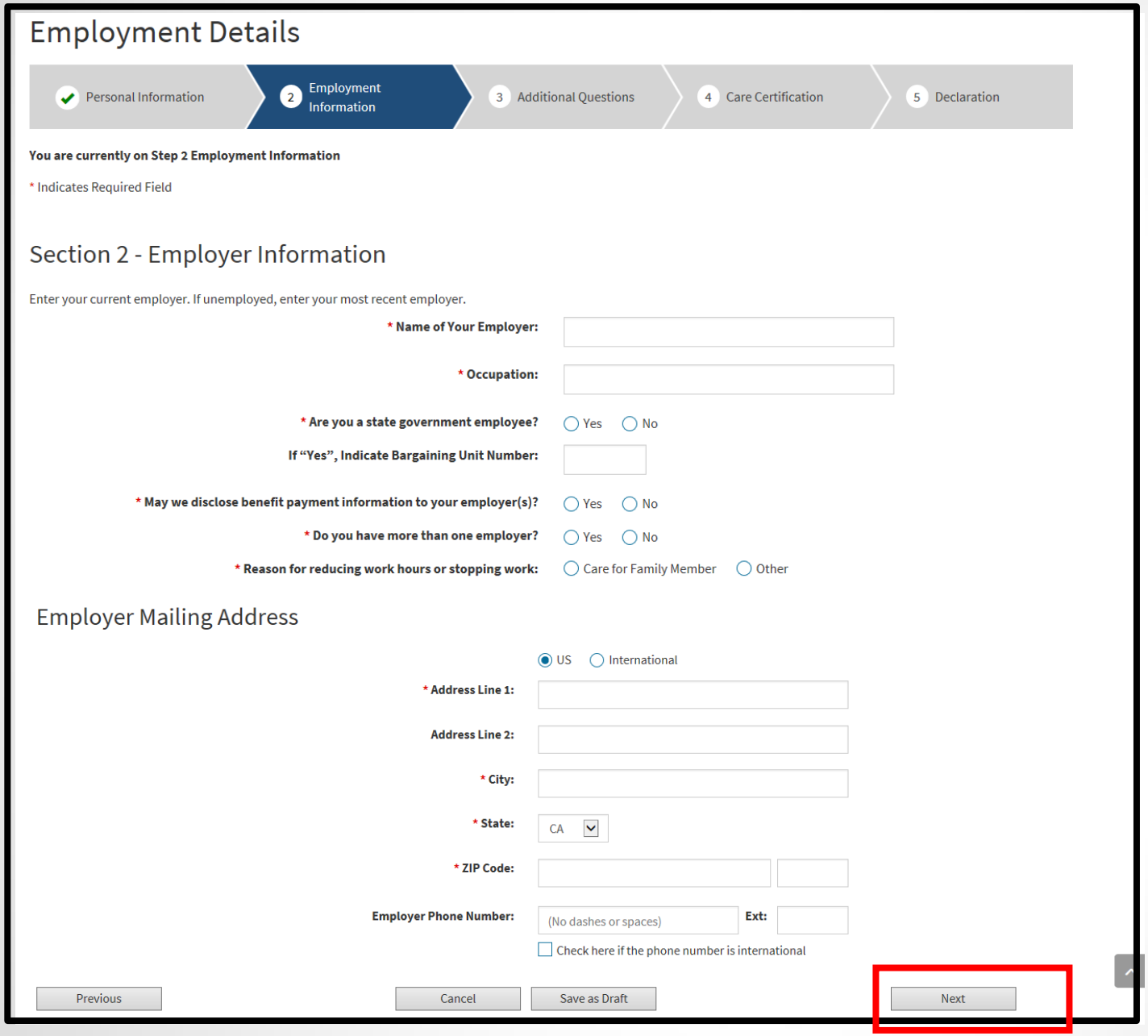
This screen provides important information you will need readily available to file a Paid Family Leave Care claim.

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



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

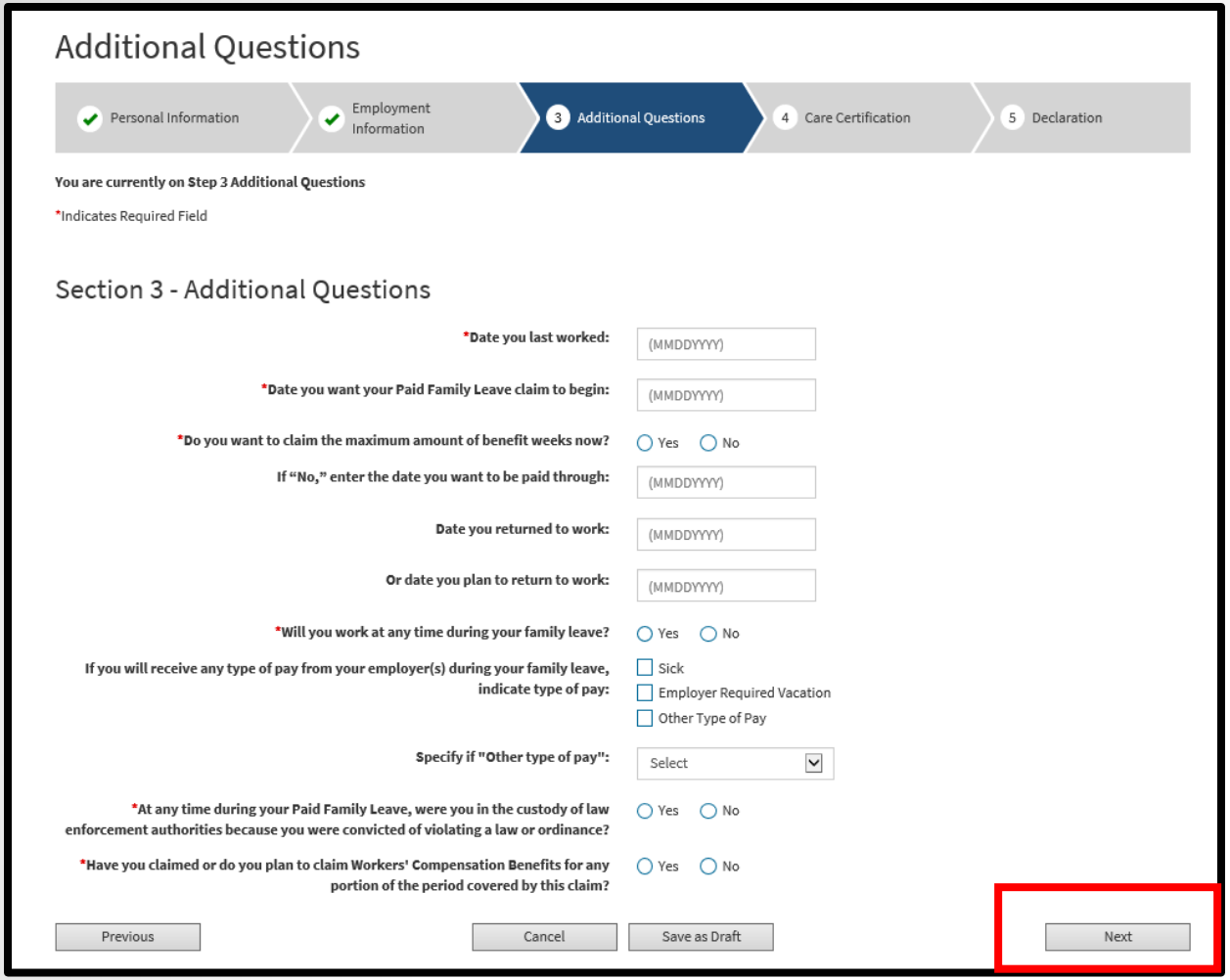
- Verify the information is correct. If your personal information has changed, select **Save as Draft** and update your SDI Online account profile.
- Select **Next** to proceed.



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.

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

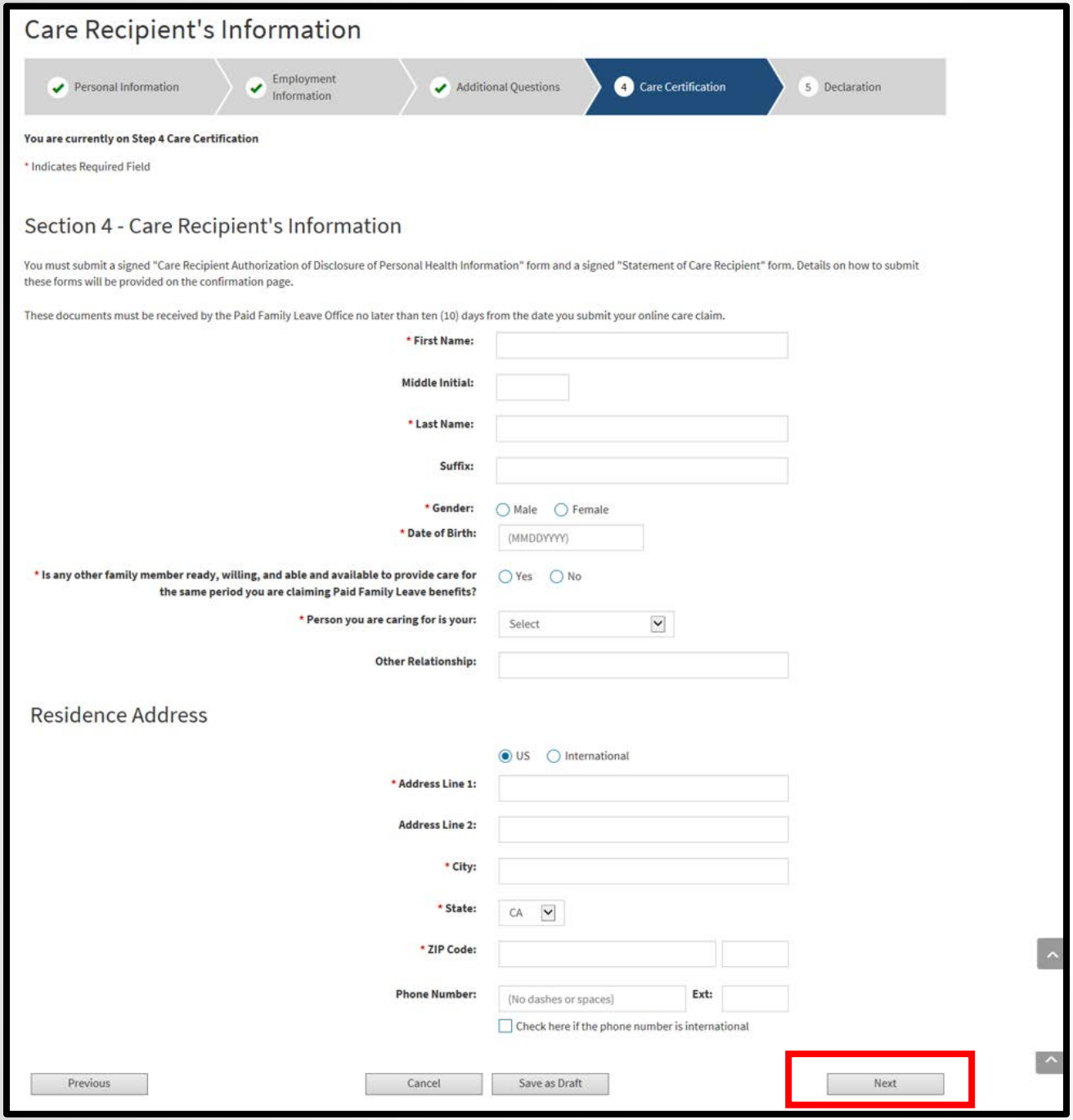
Select **Next** to proceed.



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 (*).

Select **Next**.

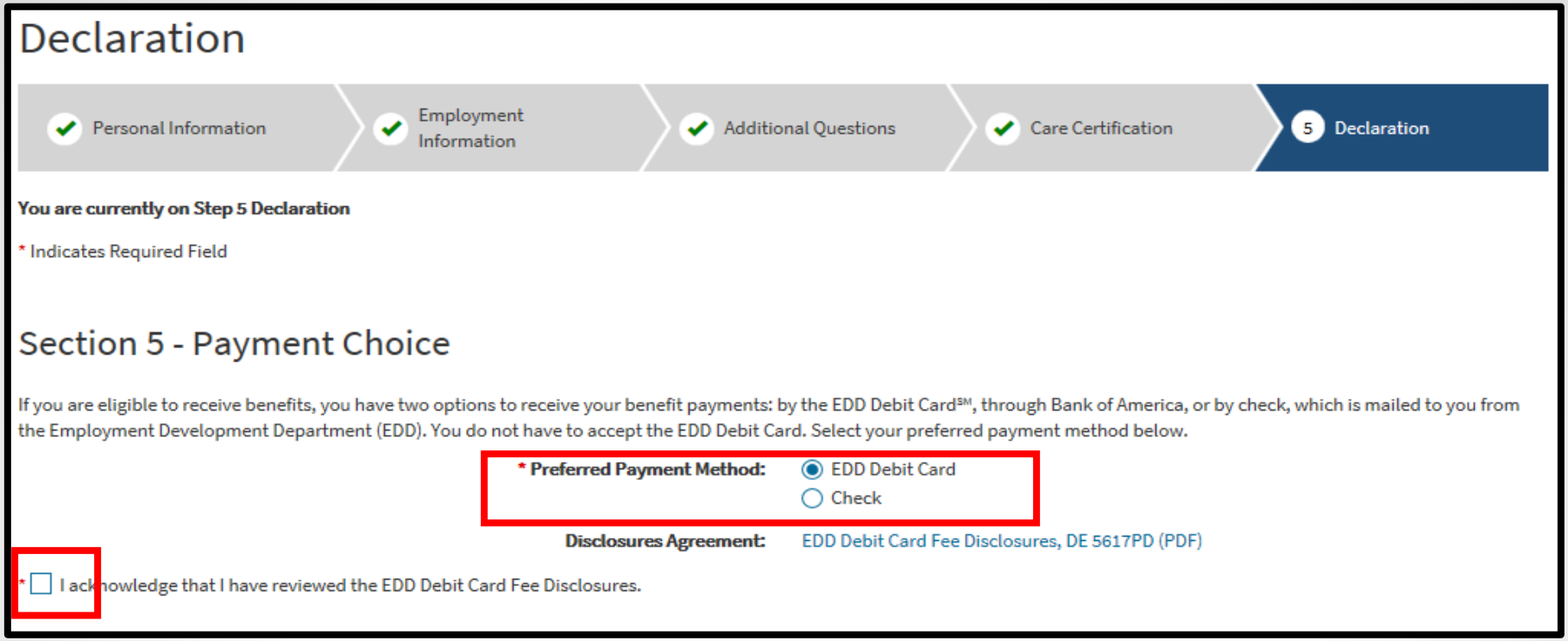


Complete **Section 4 - Care Recipient's Information** and **Residence Address** with information about the person you are caring for.

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 (*).

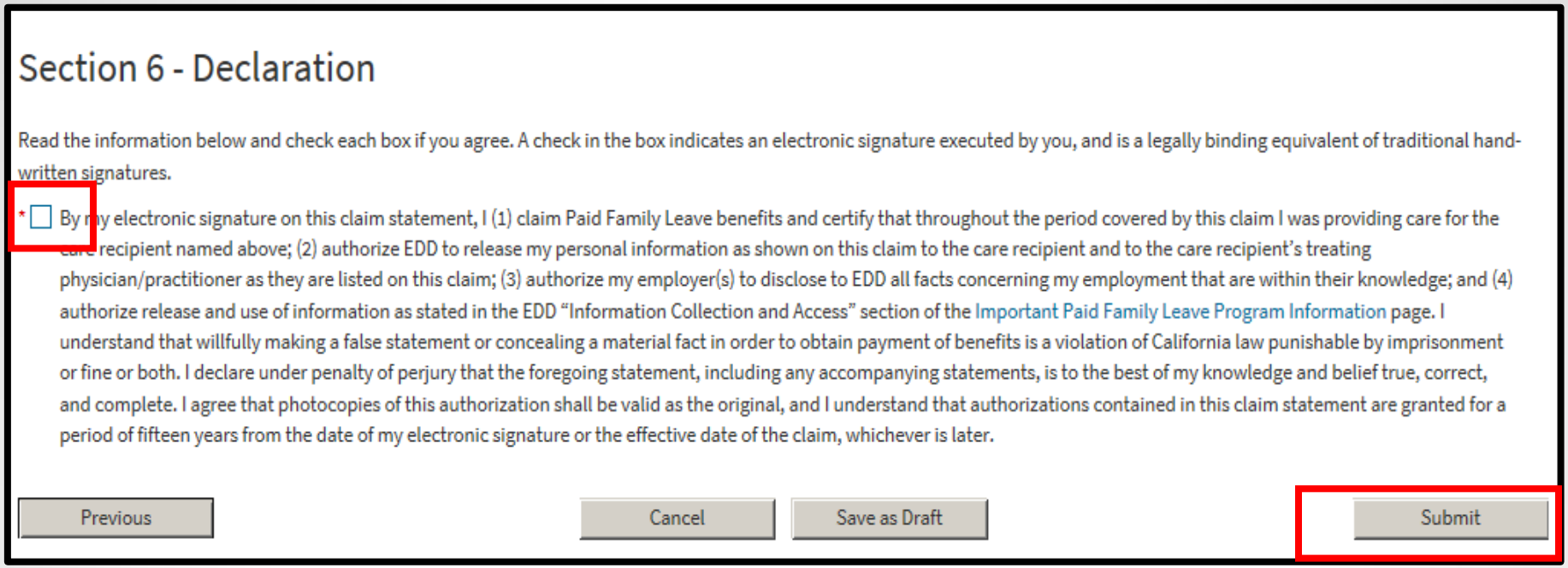
Select **Next**.



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.

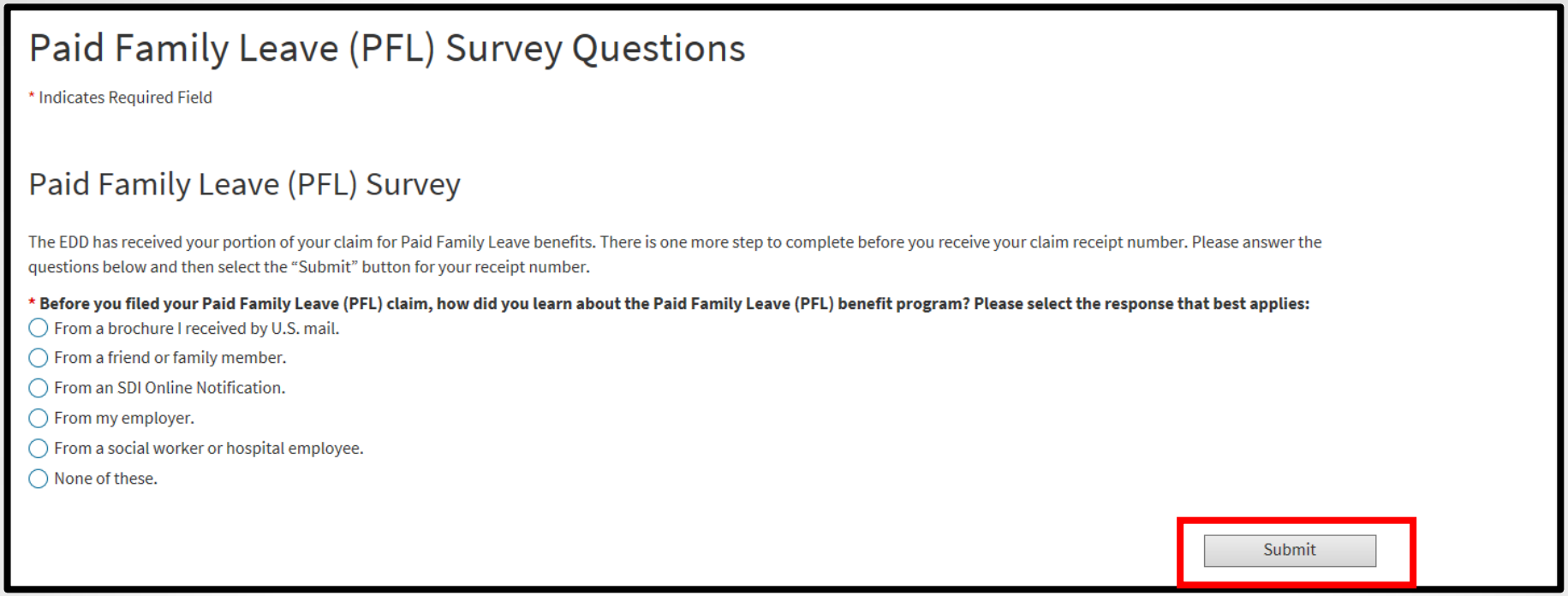


On **Section 6 – Declaration**, select the check box to authorize an electronic signature. You must select this box to complete your claim.

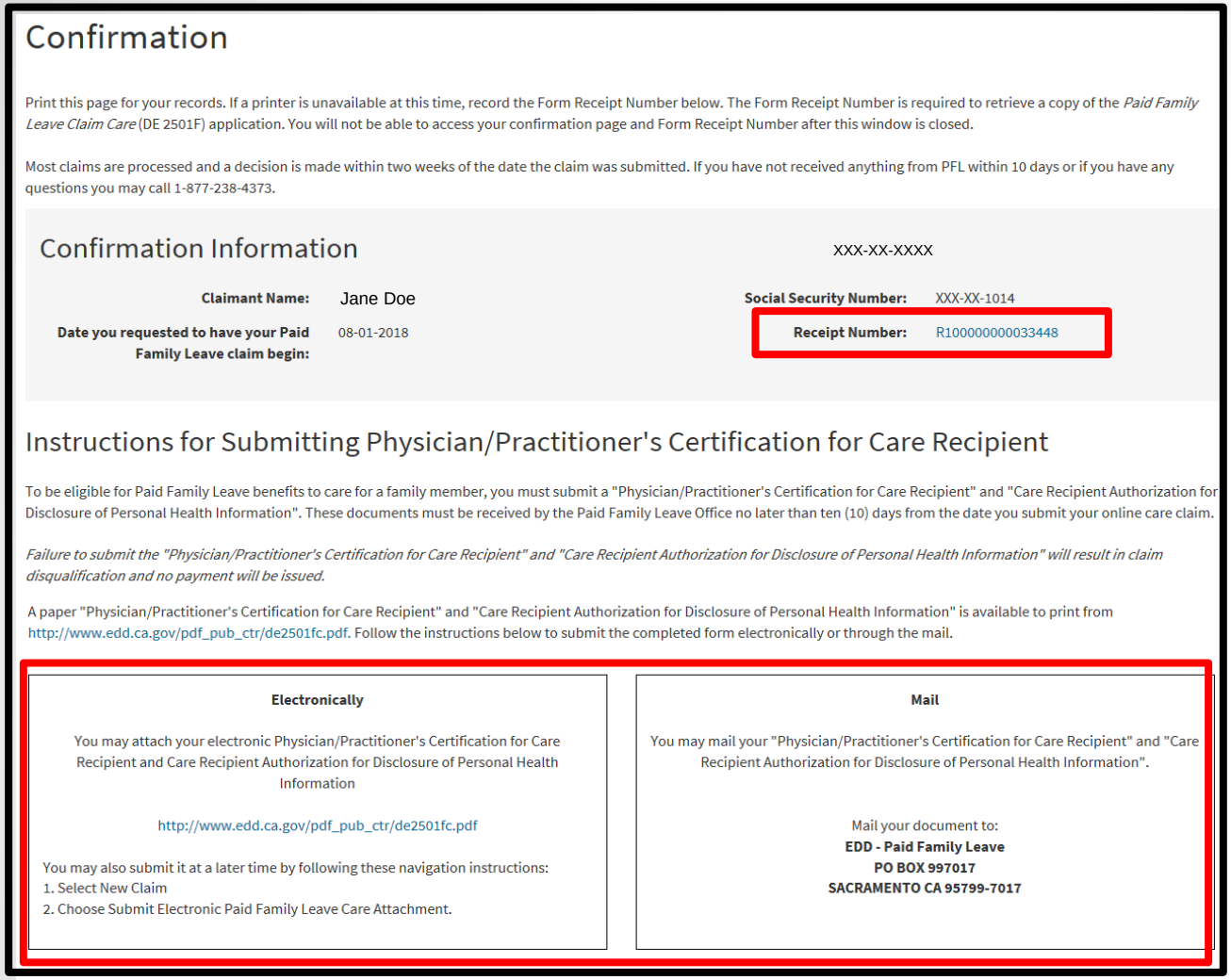
Select **Submit** to send the online portion of your claim to the EDD.

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.



Complete the survey and select **Submit**.



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 Information

XXX-XX-XXXX

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: R100000000033448

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

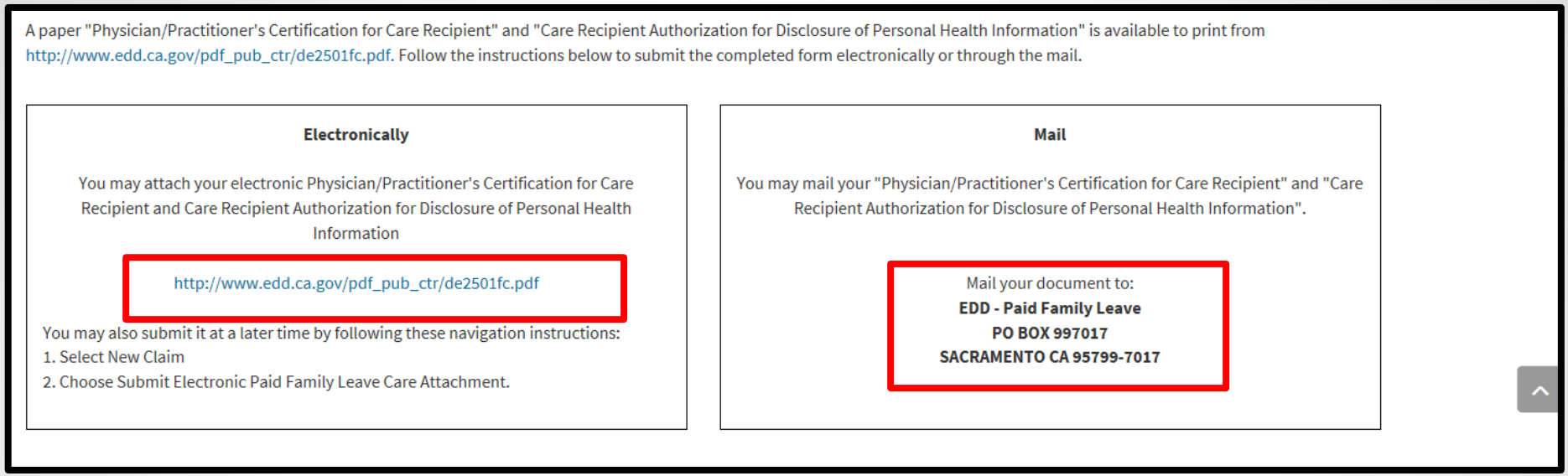
You may mail your "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information".

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.

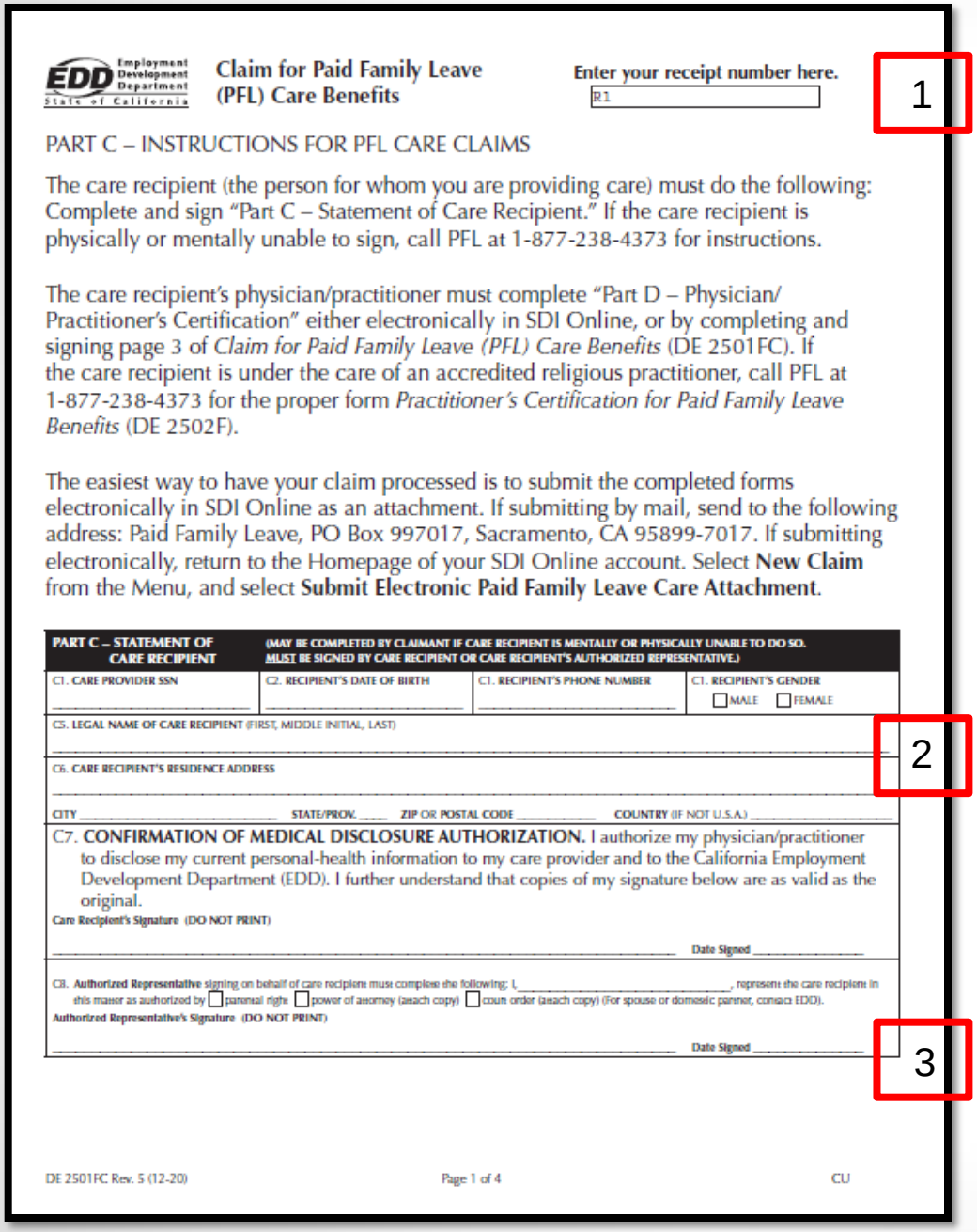


On the **Confirmation** screen, select the link to print a PDF copy of the *Claim for Paid Family Leave (PFL) Care Benefits* (DE 2501FC) form. It is your responsibility to ensure all forms are completed and signed by all parties and submitted to the EDD within 10 days.

- 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 Paid Family Leave Forms and Publications (edd.ca.gov/pfl_forms_and_publications.htm).



Employment Development Department
State of California

Claim for Paid Family Leave (PFL) Care Benefits

Enter your receipt number here.
R1

1

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 IF CARE RECIPIENT IS MENTALLY OR PHYSICALLY UNABLE TO DO SO. MUST BE SIGNED BY CARE RECIPIENT OR CARE RECIPIENT'S AUTHORIZED REPRESENTATIVE.)

C1. CARE PROVIDER SSN	C2. RECIPIENT'S DATE OF BIRTH	C3. RECIPIENT'S PHONE NUMBER	C4. RECIPIENT'S GENDER
			☐ MALE ☐ FEMALE

C5. LEGAL NAME OF CARE RECIPIENT (FIRST, MIDDLE INITIAL, LAST)

C6. CARE RECIPIENT'S RESIDENCE ADDRESS

CITY _____ STATE/PROV. ____ ZIP OR POSTAL CODE _____ COUNTRY (IF NOT U.S.A.) _____

2

C7. **CONFIRMATION OF MEDICAL DISCLOSURE AUTHORIZATION.** I authorize my physician/practitioner to disclose my current personal-health information to my care provider and to the California Employment Development Department (EDD). I further understand that copies of my signature below are as valid as the original.

Care Recipient's Signature (DO NOT PRINT)

Date Signed _____

C8. **Authorized Representative** signing on behalf of care recipient must complete the following: I, _____, represent the care recipient in this matter as authorized by ☐ parental right ☐ power of attorney (attach copy) ☐ court order (attach copy) (For spouse or domestic partner, contact EDD).

Authorized Representative's Signature (DO NOT PRINT)

Date Signed _____

3

DE 2501FC Rev. 5 (12-20) Page 1 of 4 CU

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

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

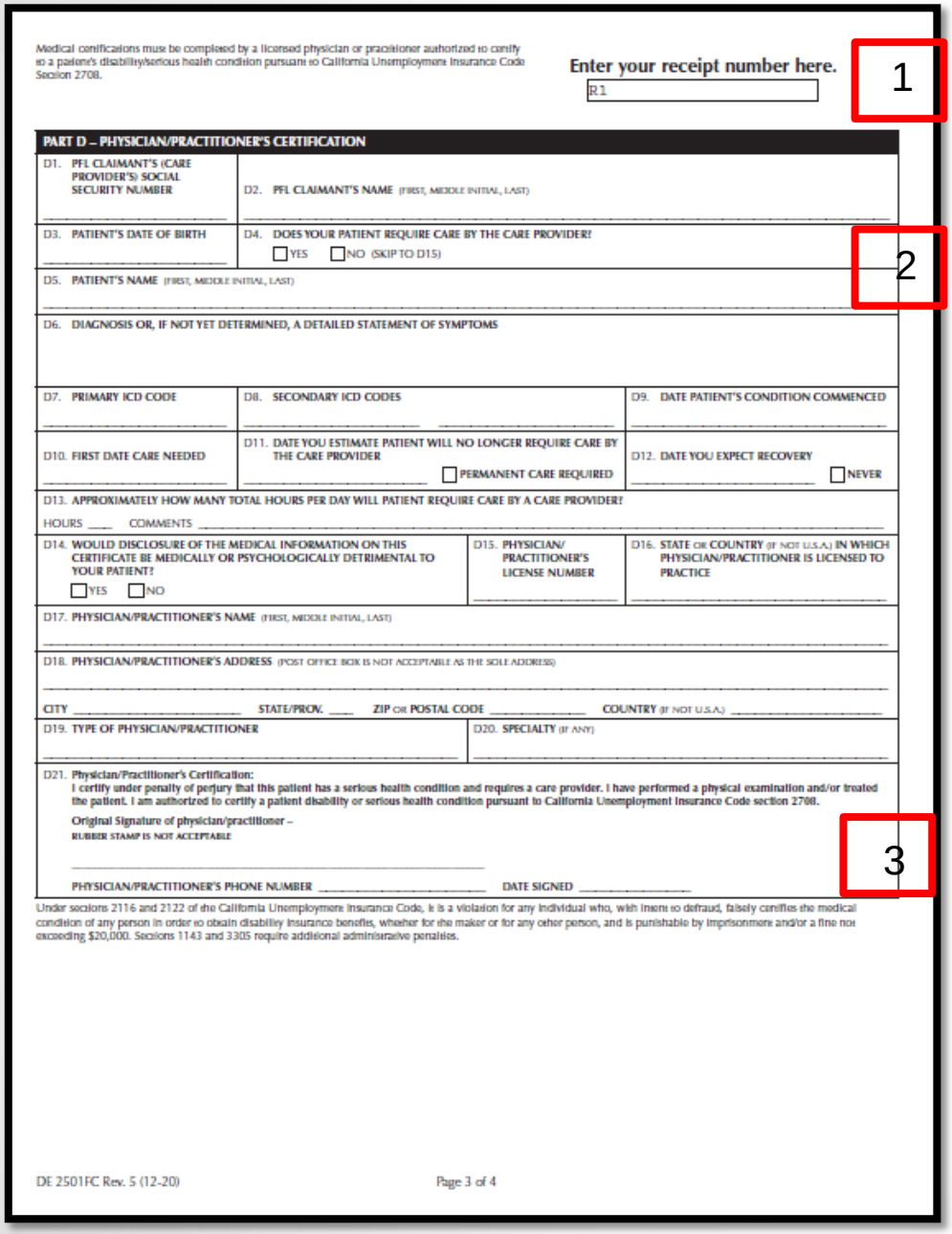
To avoid delays in claim processing:

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 by a licensed physician or practitioner authorized to certify on a patient's disability/serious health condition pursuant to California Unemployment Insurance Code Section 2708.

Enter your receipt number here.
R1

1

PART D – PHYSICIAN/PRACTITIONER'S CERTIFICATION

D1. PFL CLAIMANT'S (CARE PROVIDER'S) SOCIAL SECURITY NUMBER

D2. PFL CLAIMANT'S NAME (FIRST, MIDDLE INITIAL, LAST)

D3. PATIENT'S DATE OF BIRTH

D4. DOES YOUR PATIENT REQUIRE CARE BY THE CARE PROVIDER? ☐ YES ☐ NO (SKIP TO D15)

2

D5. PATIENT'S NAME (FIRST, MIDDLE INITIAL, LAST)

D6. DIAGNOSIS OR, IF NOT YET DETERMINED, A DETAILED STATEMENT OF SYMPTOMS

D7. PRIMARY ICD CODE

D8. SECONDARY ICD CODES

D9. DATE PATIENT'S CONDITION COMMENCED

D10. FIRST DATE CARE NEEDED

D11. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CARE PROVIDER ☐ PERMANENT CARE REQUIRED

D12. DATE YOU EXPECT RECOVERY ☐ NEVER

D13. APPROXIMATELY HOW MANY TOTAL HOURS PER DAY WILL PATIENT REQUIRE CARE BY A CARE PROVIDER?
HOURS ____ COMMENTS

D14. WOULD DISCLOSURE OF THE MEDICAL INFORMATION ON THIS CERTIFICATE BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL TO YOUR PATIENT? ☐ YES ☐ NO

D15. PHYSICIAN/ PRACTITIONER'S LICENSE NUMBER

D16. STATE OR COUNTRY (IF NOT U.S.A.) IN WHICH PHYSICIAN/PRACTITIONER IS LICENSED TO PRACTICE

D17. PHYSICIAN/PRACTITIONER'S NAME (FIRST, MIDDLE INITIAL, LAST)

D18. PHYSICIAN/PRACTITIONER'S ADDRESS (POST OFFICE BOX IS NOT ACCEPTABLE AS THE SOLE ADDRESS)

CITY ____ STATE/PROV. ____ ZIP OR POSTAL CODE ____ COUNTRY (IF NOT U.S.A.) ____

D19. TYPE OF PHYSICIAN/PRACTITIONER

D20. SPECIALTY (IF ANY)

D21. Physician/Practitioner's Certification:
I certify under penalty of perjury that this patient has a serious health condition and requires a care provider. I have performed a physical examination and/or treated the patient. I am authorized to certify a patient disability or serious health condition pursuant to California Unemployment Insurance Code section 2708.

Original Signature of physician/practitioner –
RUBBER STAMP IS NOT ACCEPTABLE

3

PHYSICIAN/PRACTITIONER'S PHONE NUMBER ____ DATE SIGNED ____

Under sections 2116 and 2122 of the California Unemployment Insurance Code, it is a violation for any individual who, with intent to defraud, falsely certifies the medical condition of any person in order to obtain disability insurance benefits, whether for the maker or for any other person, and is punishable by imprisonment and/or a fine not exceeding $20,000. Sections 1143 and 3305 require additional administrative penalties.

DE 2501FC Rev. 5 (12-20) Page 3 of 4

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

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

To avoid delays in claim processing:

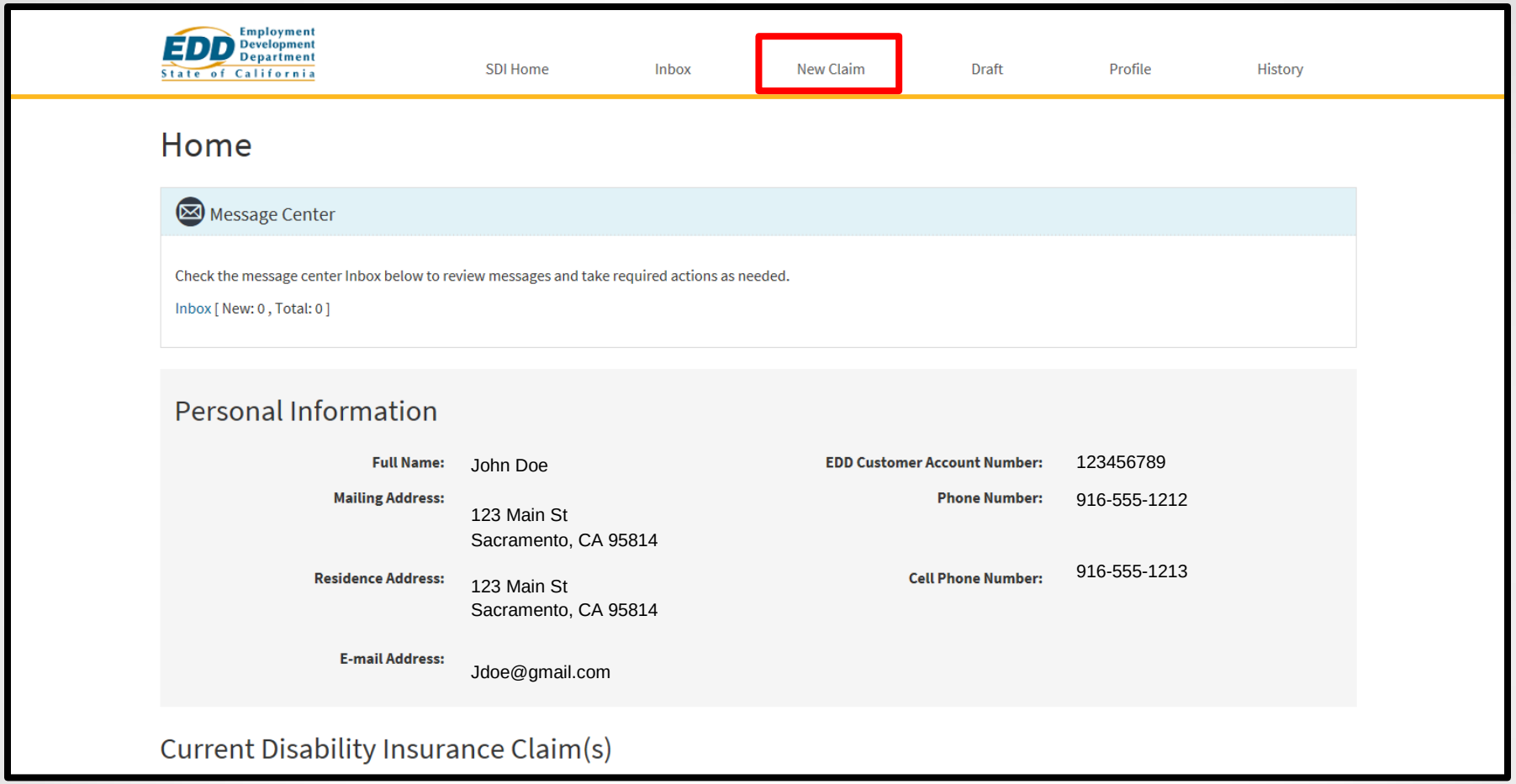
1. Enter the **Receipt Number** from your Paid Family Leave Care claim in the top right corner.

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.

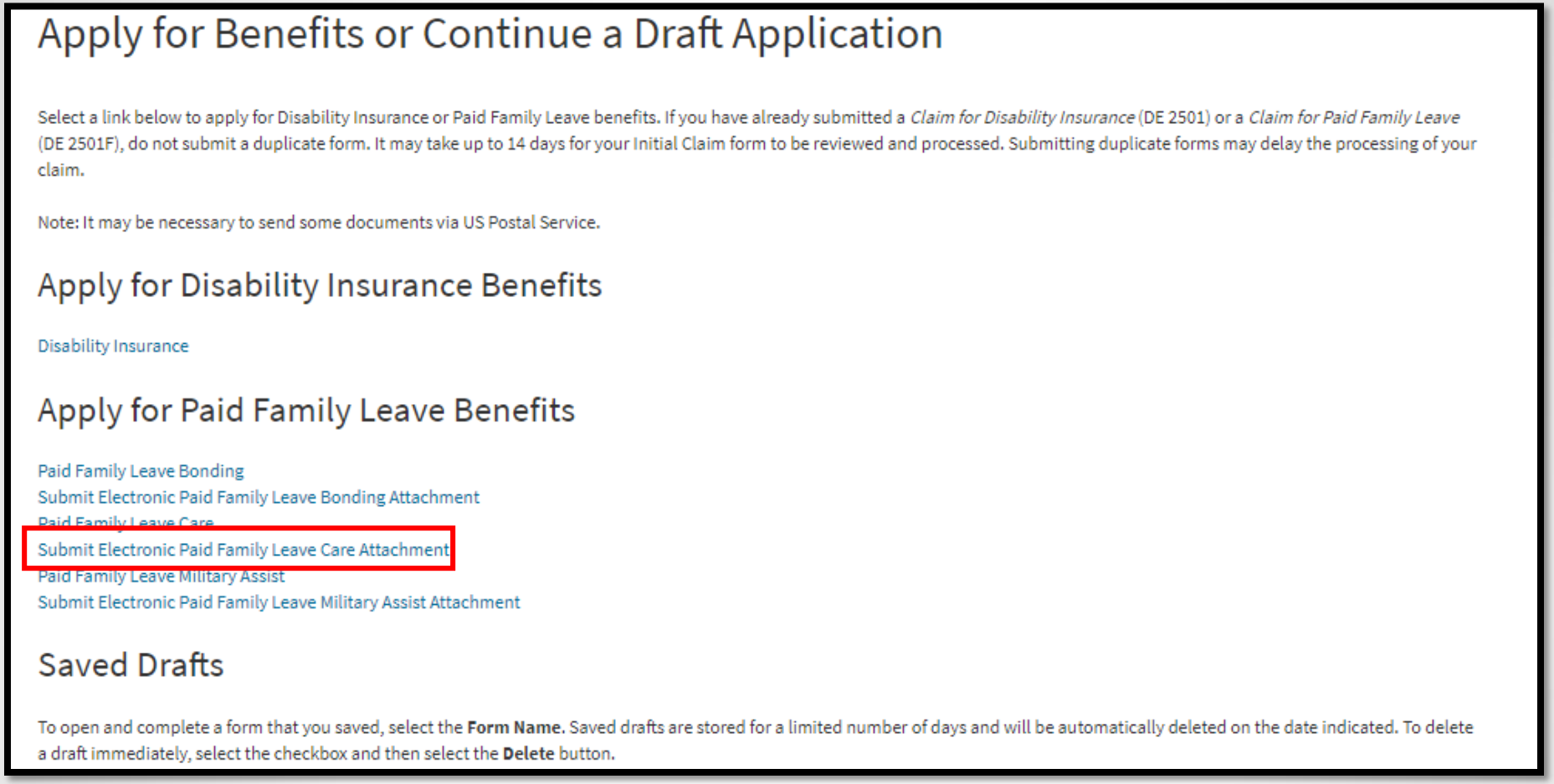
Submit Paid Family Leave Care Claim Attachments



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.



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

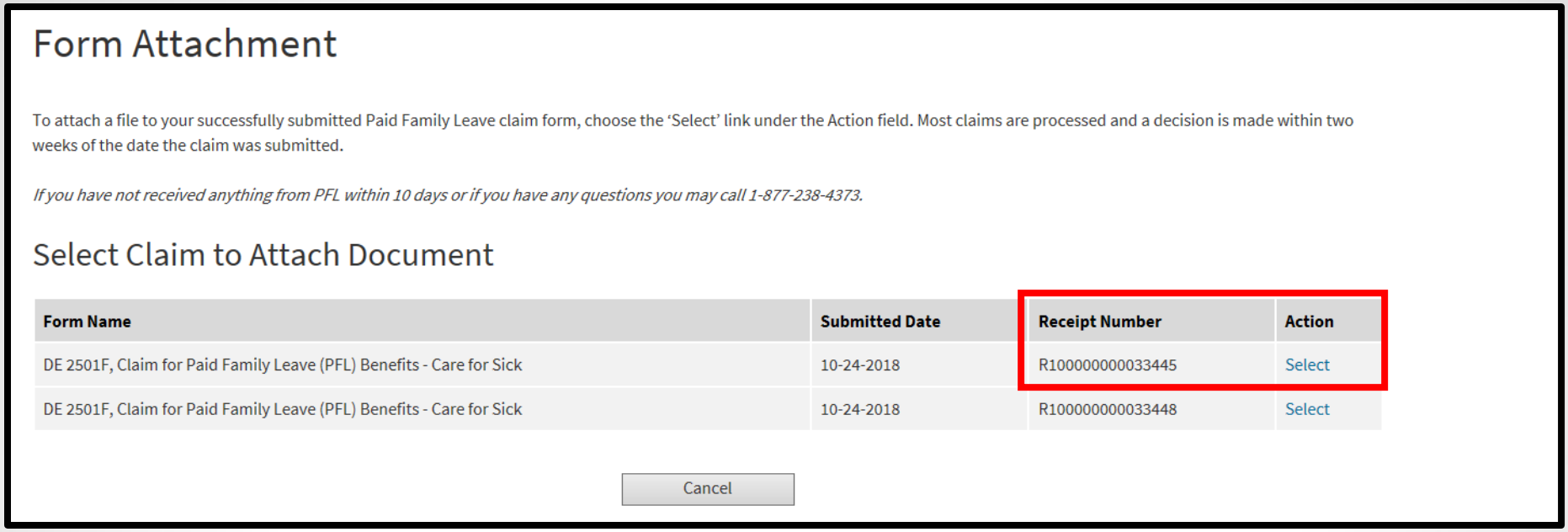
Apply for Paid Family Leave Benefits

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 Care 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.

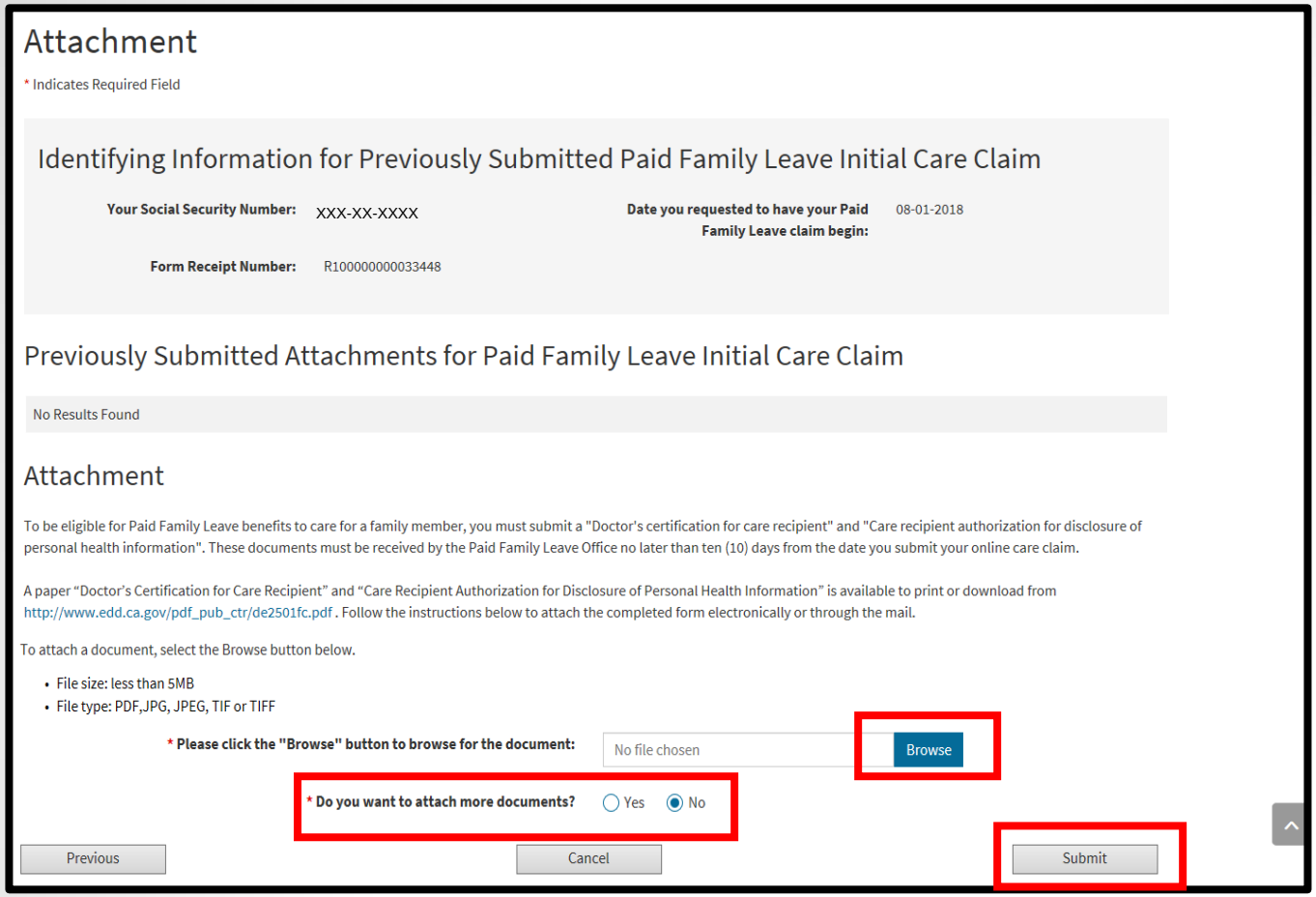
Select Claim to Attach Document

Form Name	Submitted Date	Receipt Number	Action
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Care for Sick	10-24-2018	R100000000033445	Select
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Care for Sick	10-24-2018	R100000000033448	Select

Cancel

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.

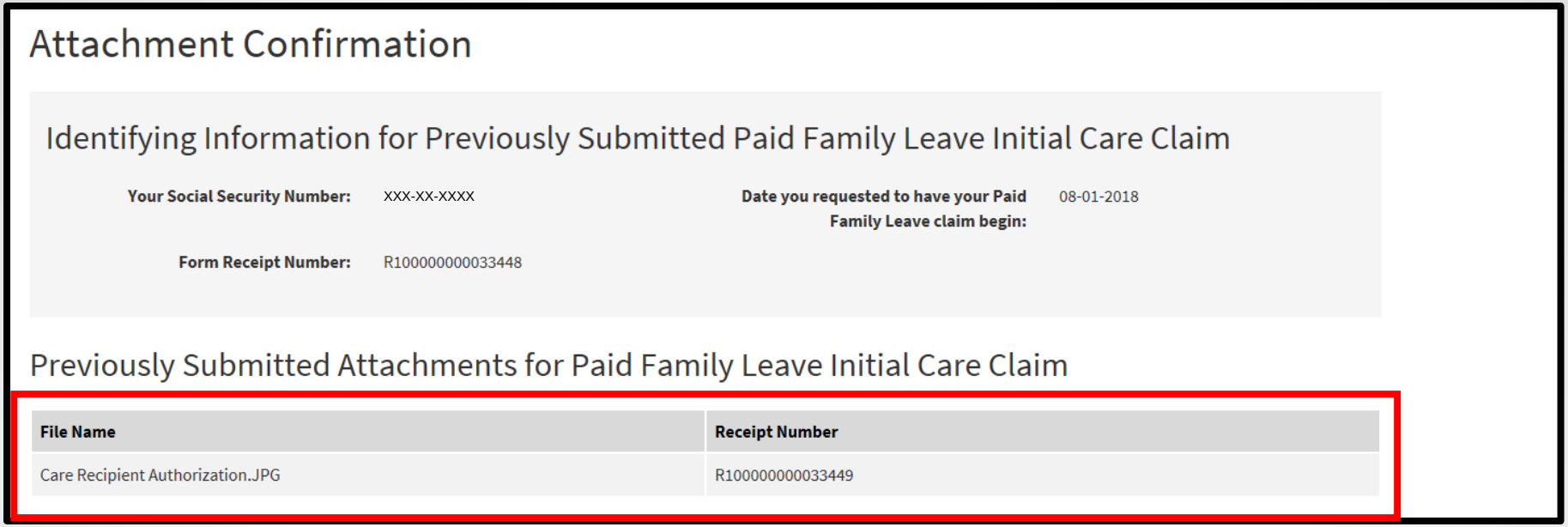


Select the **Browse** button to upload the completed document from your computer.

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.**



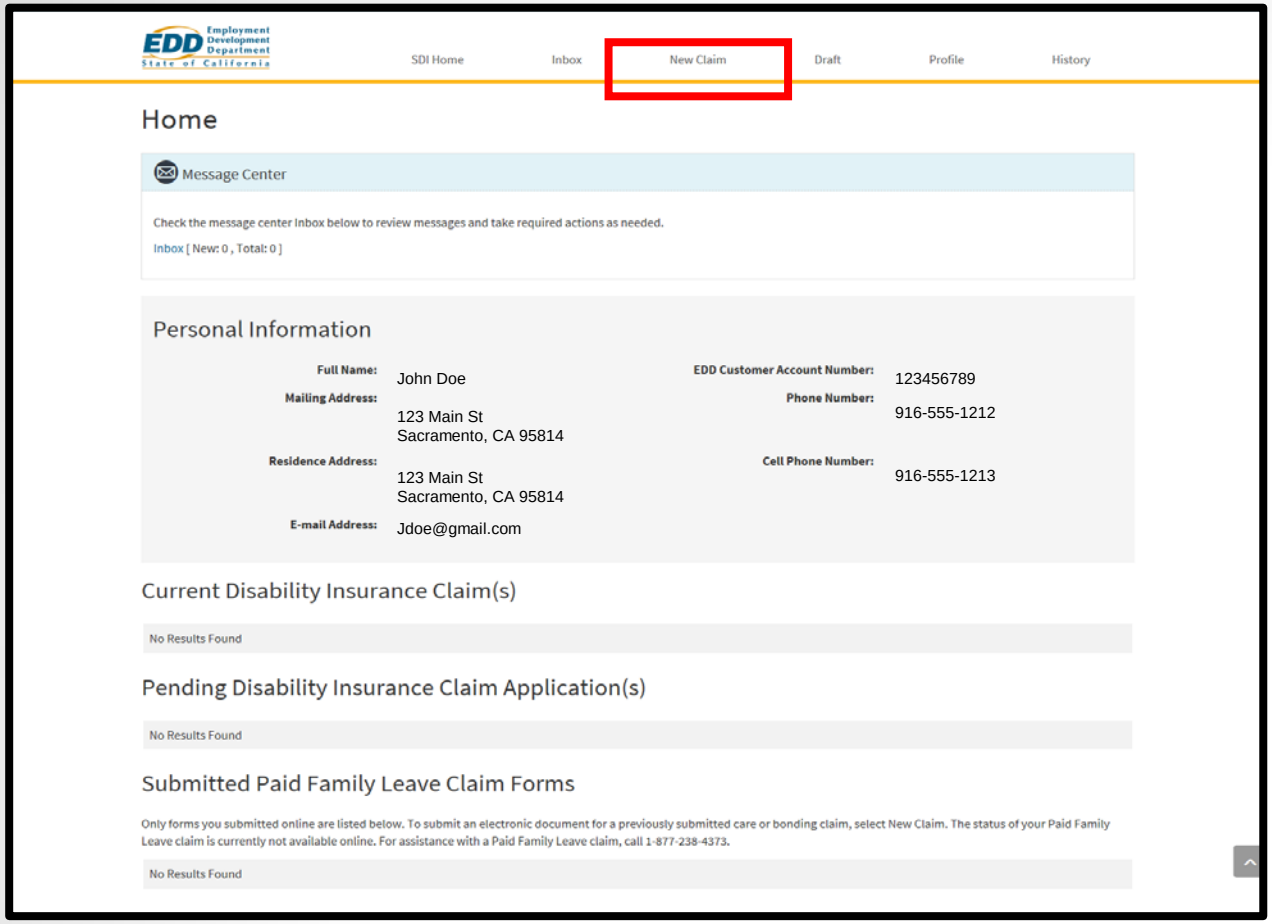
This screen confirms the attachment(s) were submitted.

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.

File a Paid Family Leave Military Assist Claim

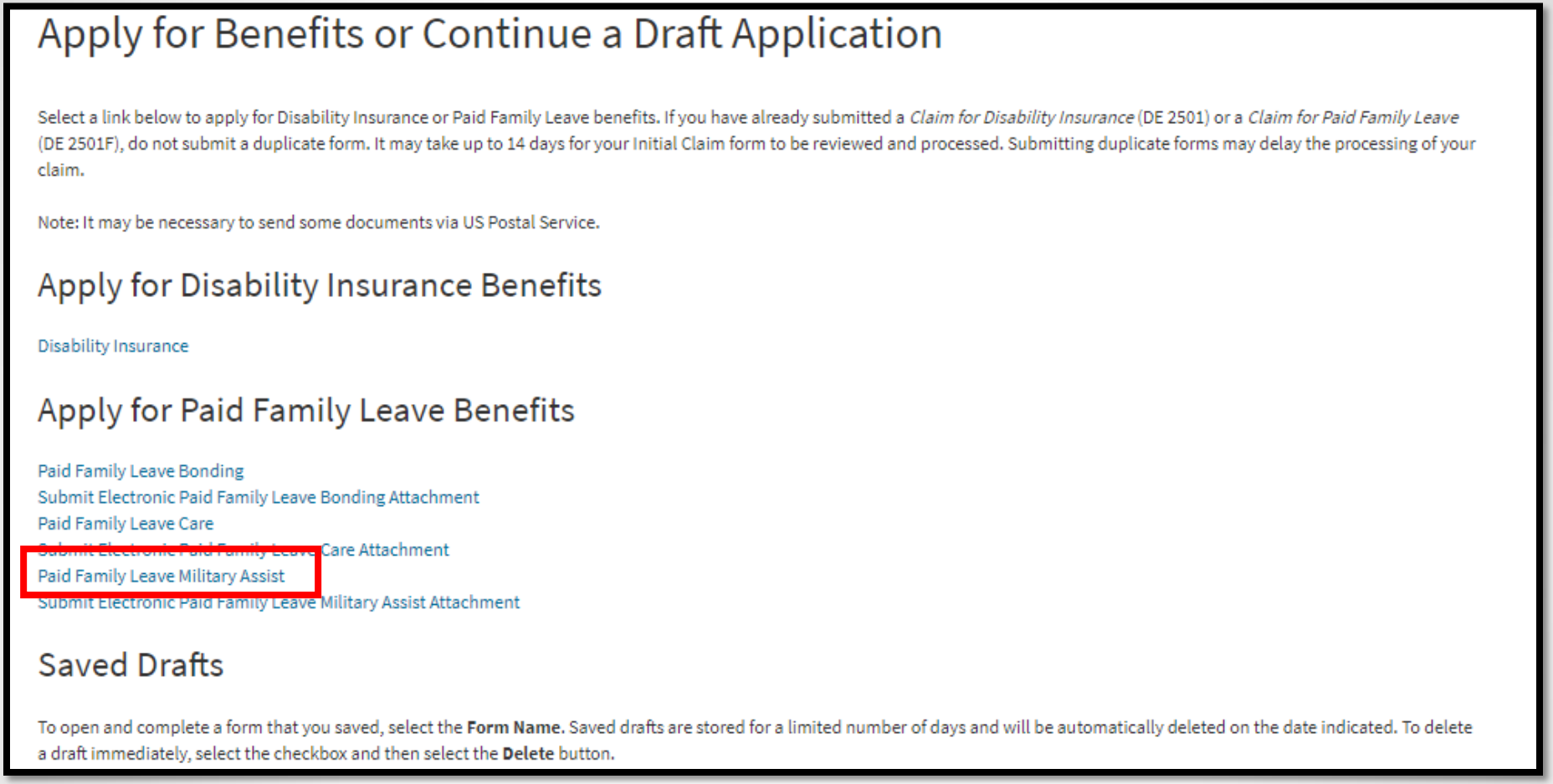


Follow these instructions to begin filing a Paid Family Leave Military Assist claim:

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.



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

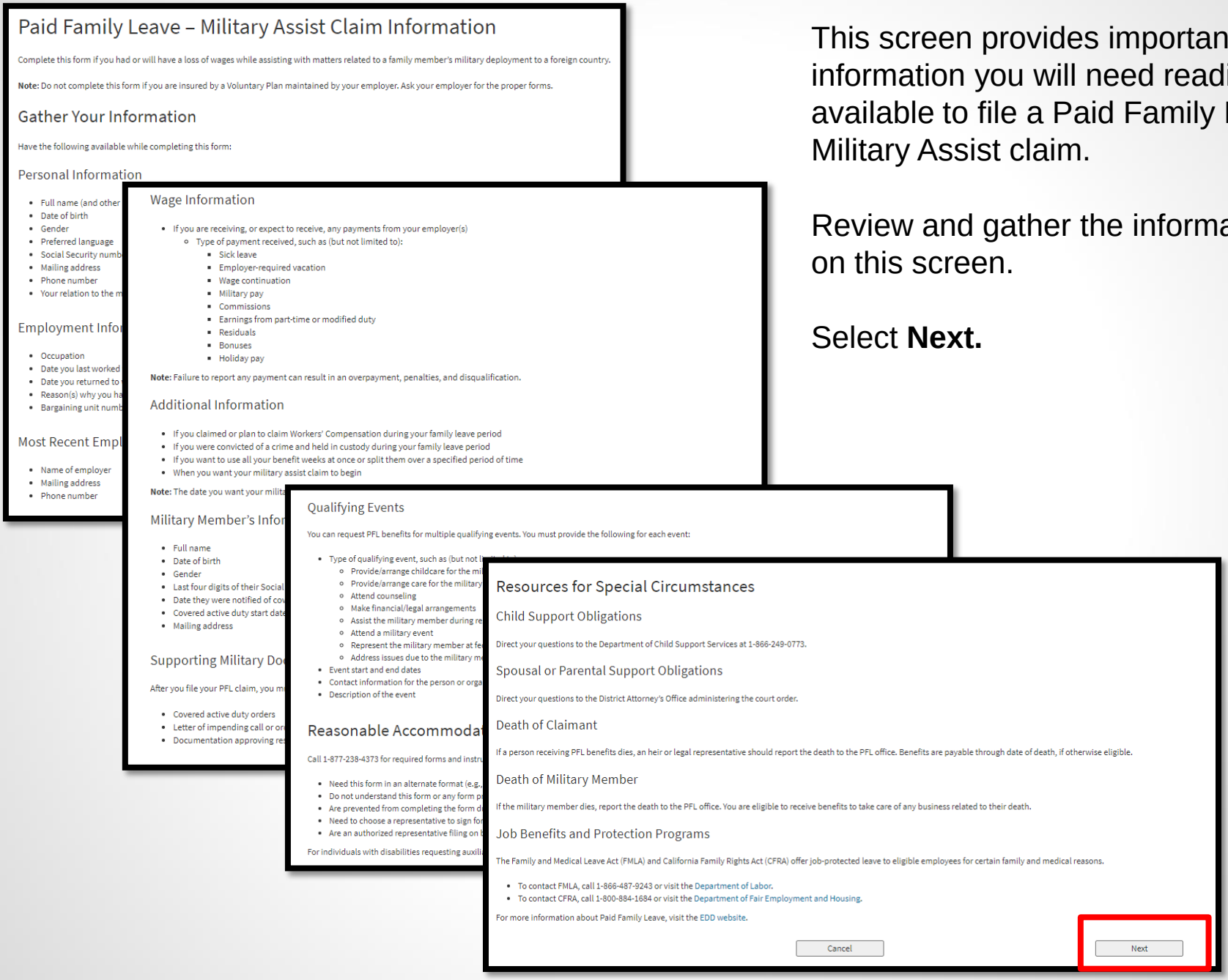
Paid Family Leave Bonding
Submit Electronic Paid Family Leave Bonding Attachment
Paid Family Leave Care
Submit Electronic Paid Family Leave Care Attachment
Paid Family Leave Military Assist
Submit Electronic Paid Family Leave Military Assist Attachment

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 **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 Types of Claims (edd.ca.gov/Disability/Types_of_Claims.htm) on the EDD website.



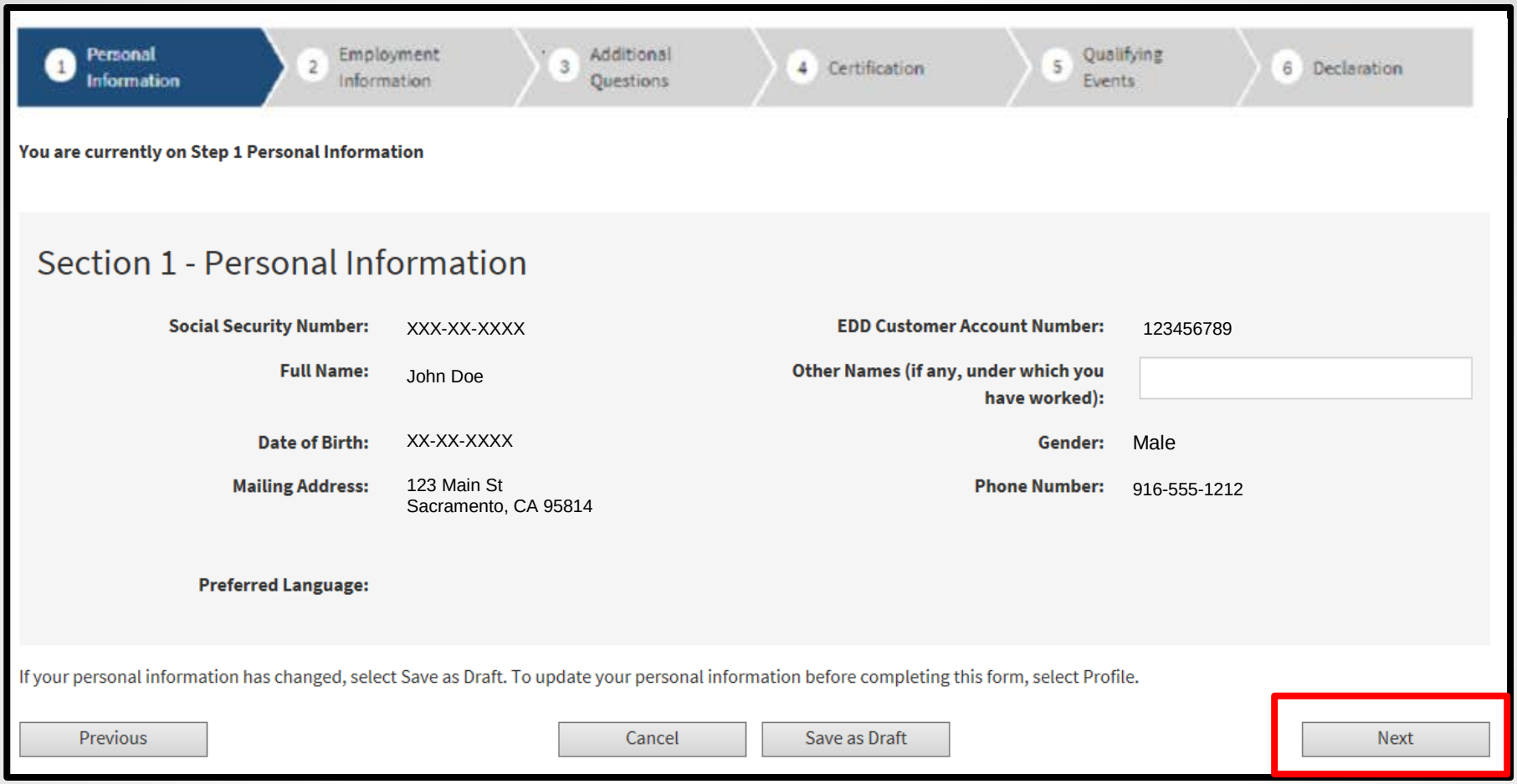
This screen provides important information you will need readily available to file a Paid Family Leave Military Assist claim.

Review and gather the information on this screen.

Select **Next.**

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

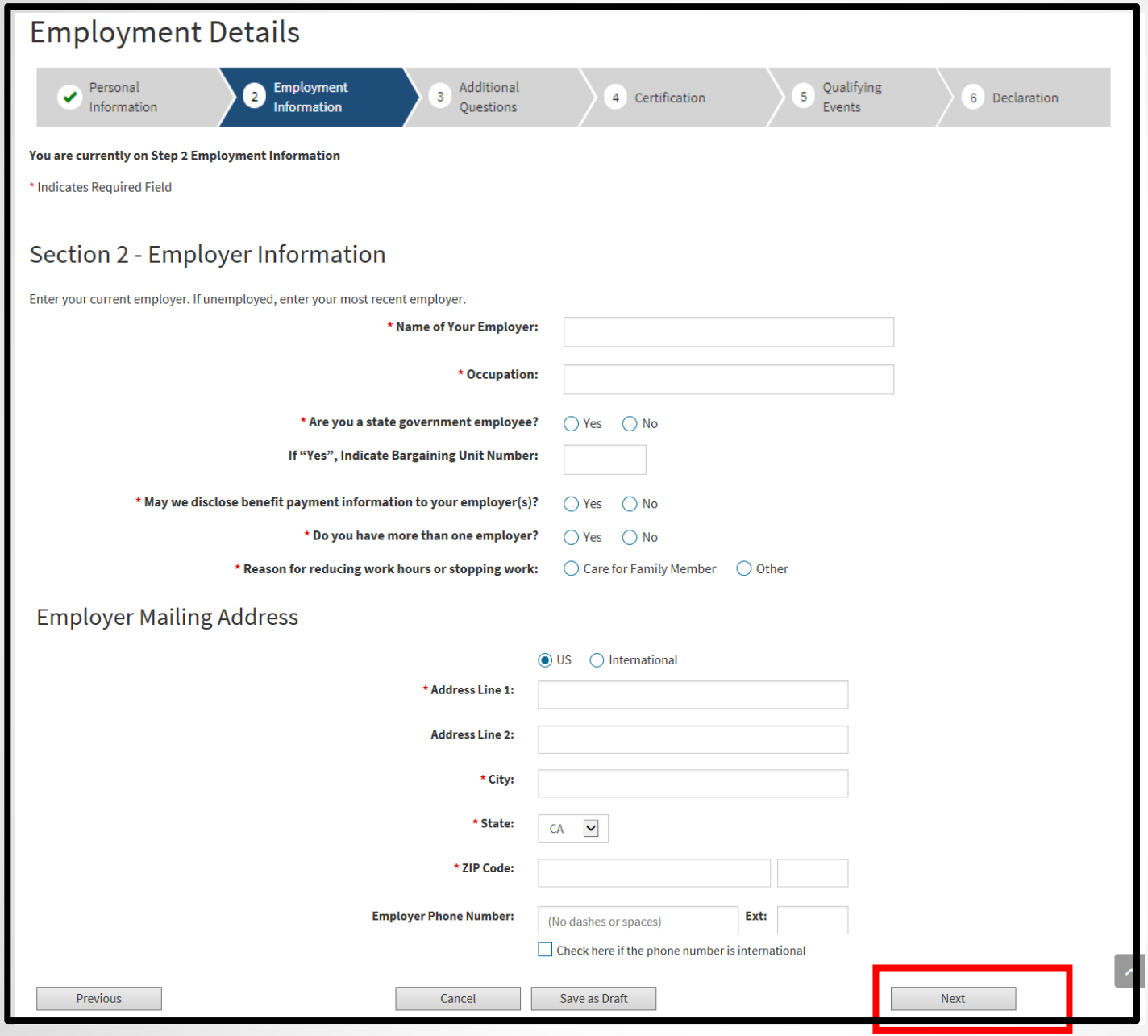
Review and select **Next.**



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.

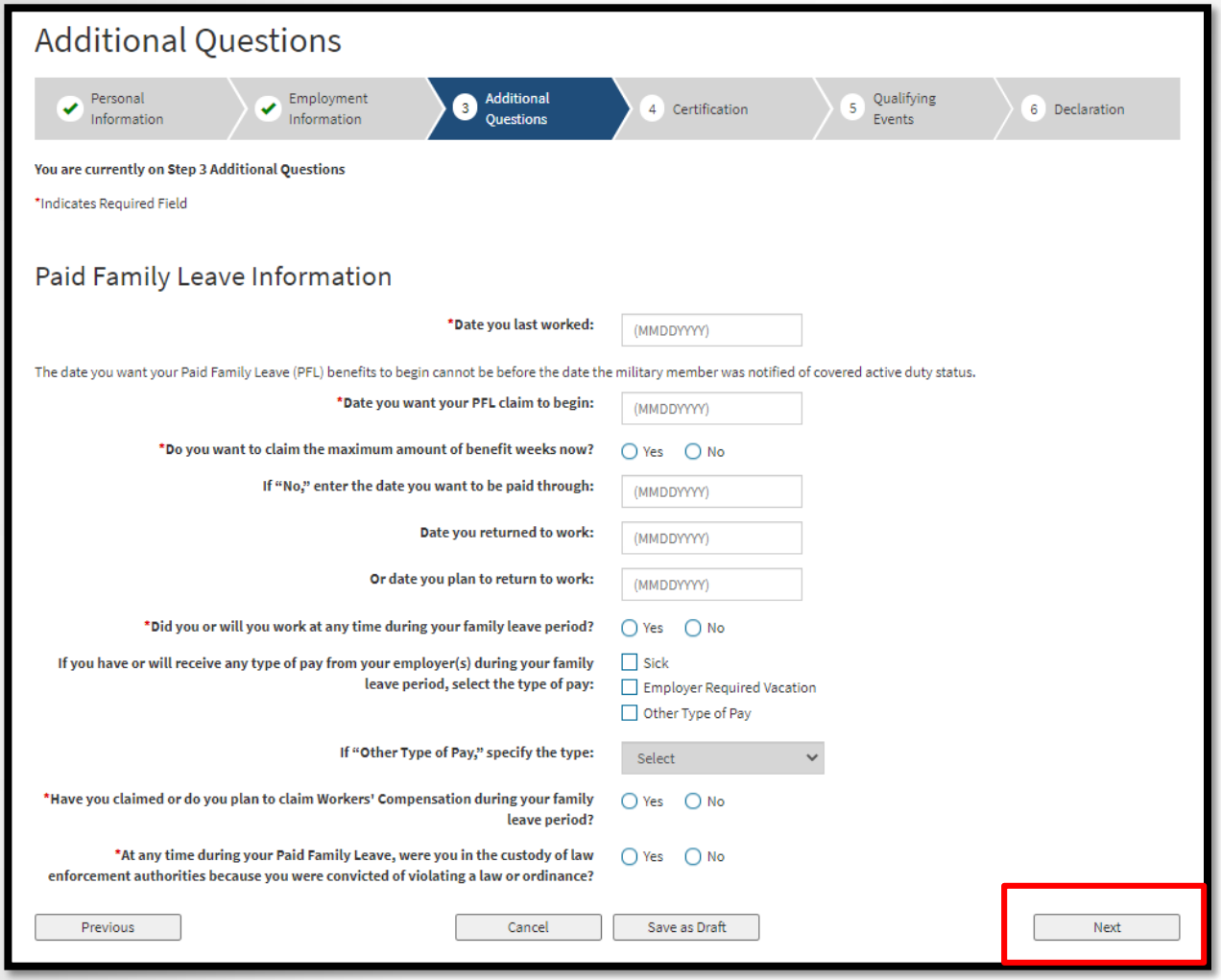
Select **Next** to proceed.



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.

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

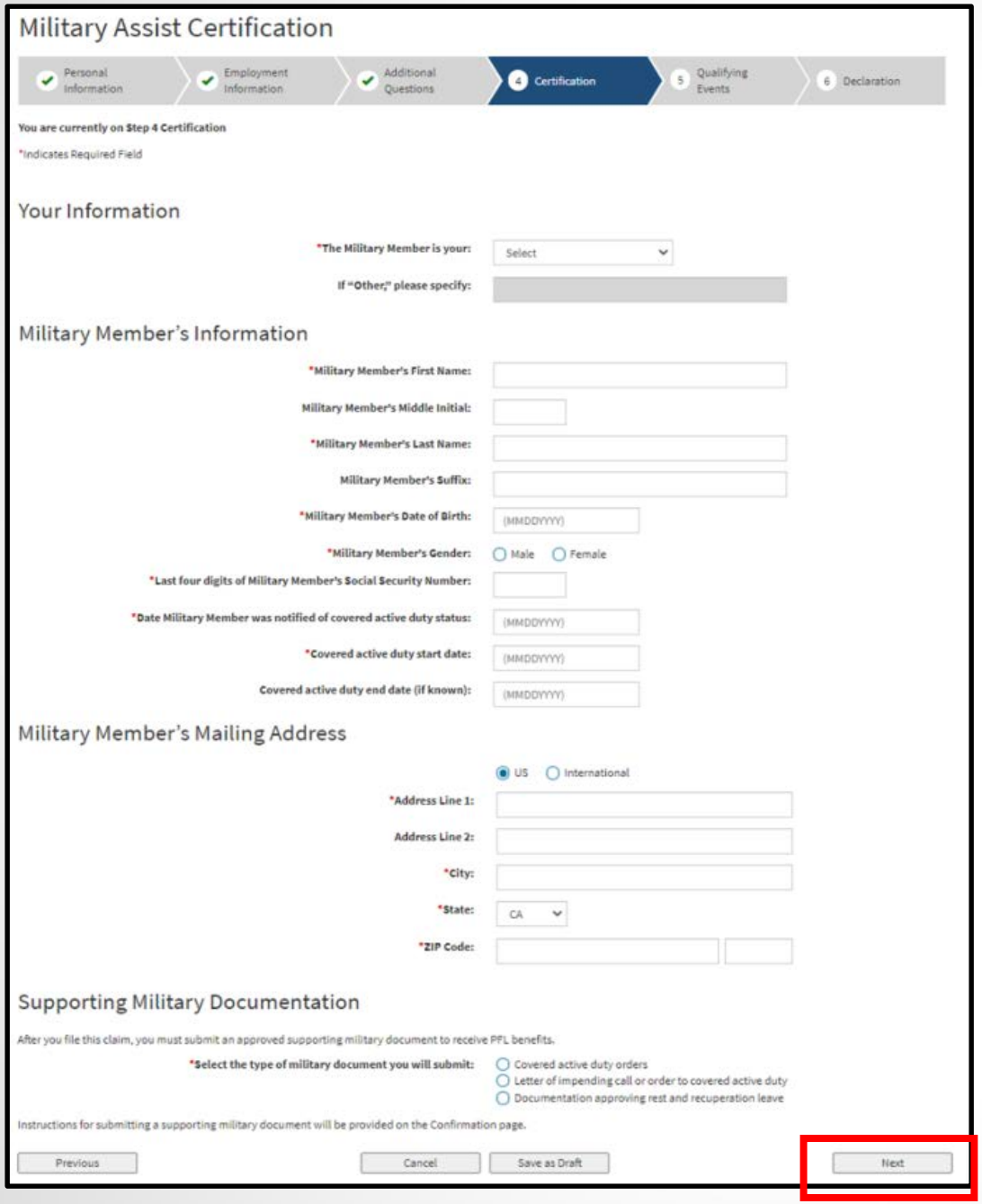
Select **Next**.



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 (*).

Select **Next**.



Complete the following sections:

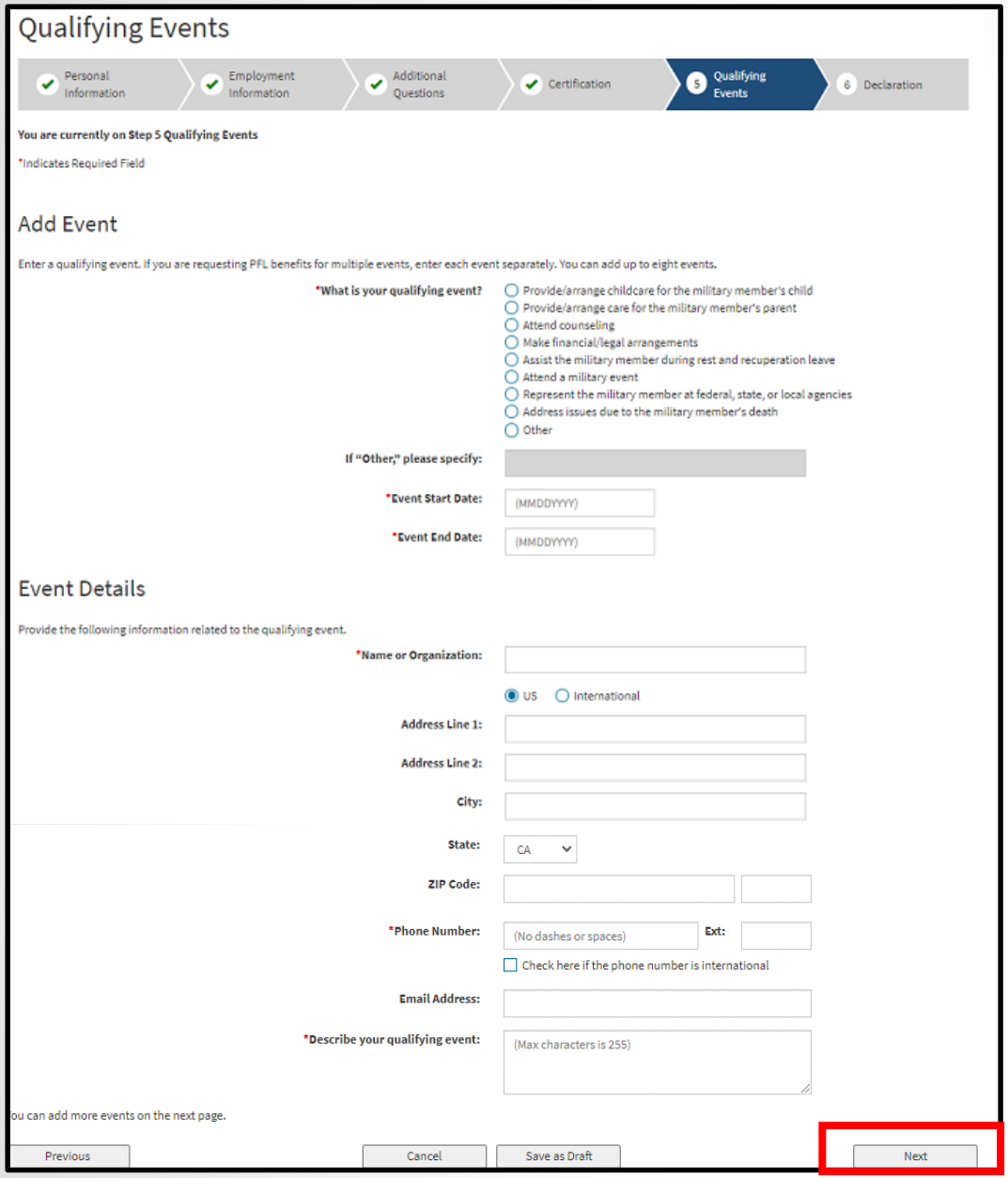
- **Your Information**
- **Military Member's Information**
- **Military Member's Mailing Address**
- **Supporting Military Documentation**

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.

Select **Next**.



Complete the following sections:

- **Add Event**
- **Event Details**

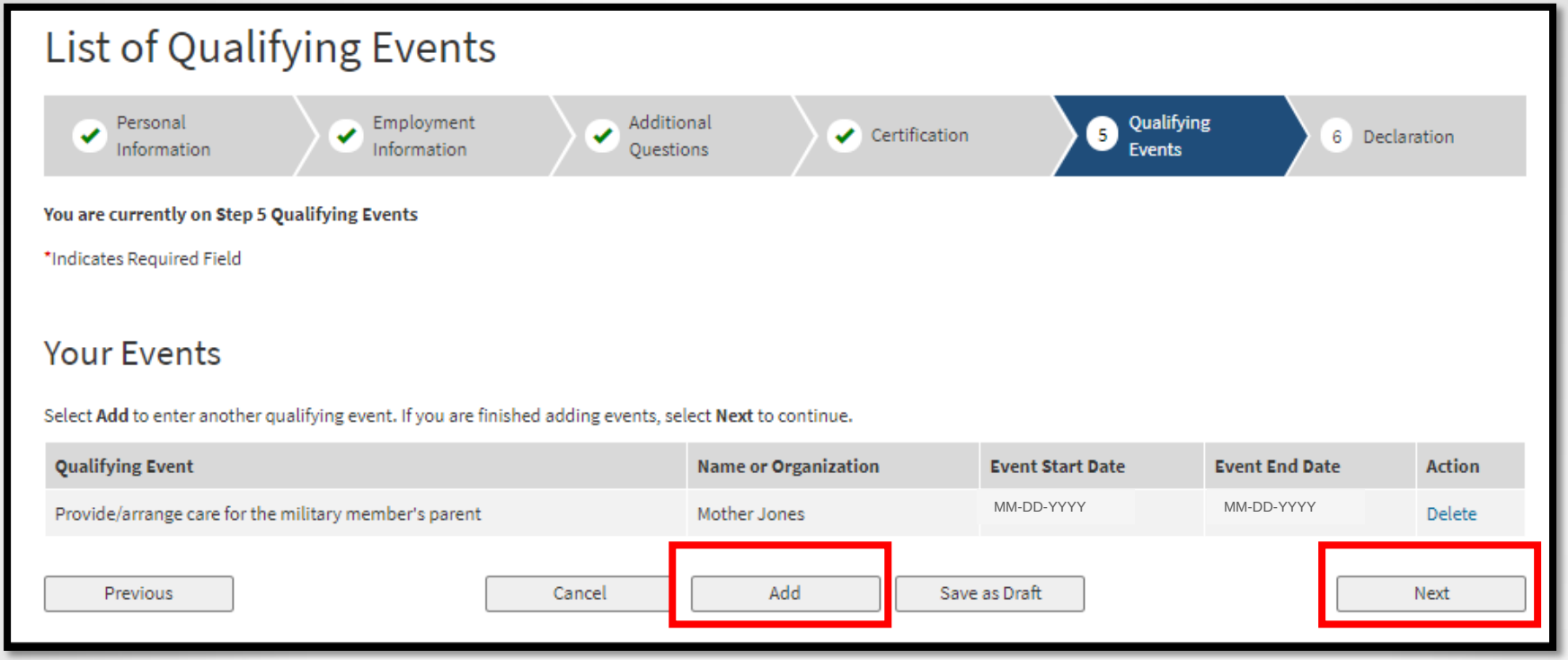
Make sure you are entering information about the qualifying event you will attend.

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 (*).

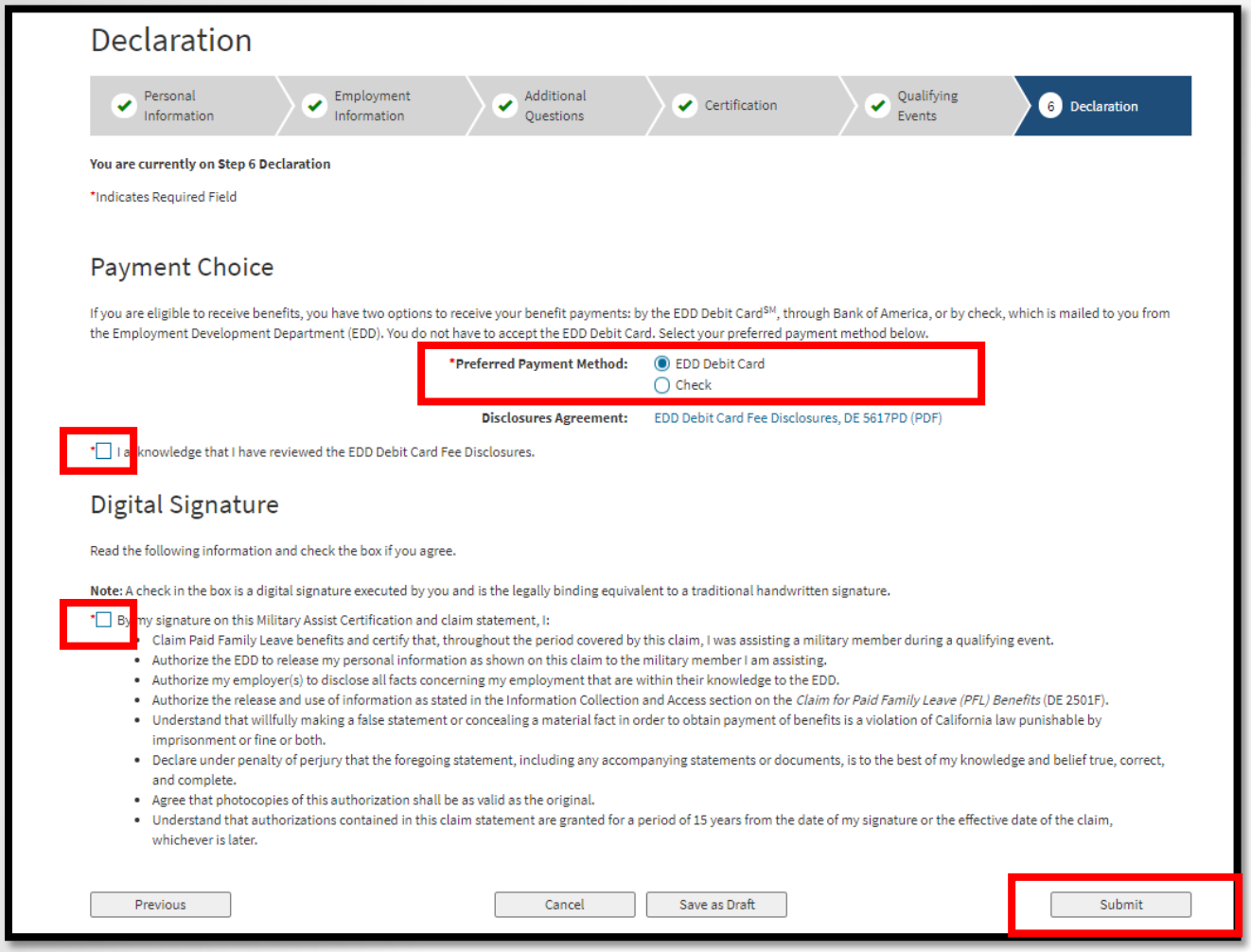
Select **Next** to proceed.



To submit more than one event:

- Select **Add** and enter in additional qualifying event information.

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



On the Declaration screen, you have the option to select your preferred payment method.

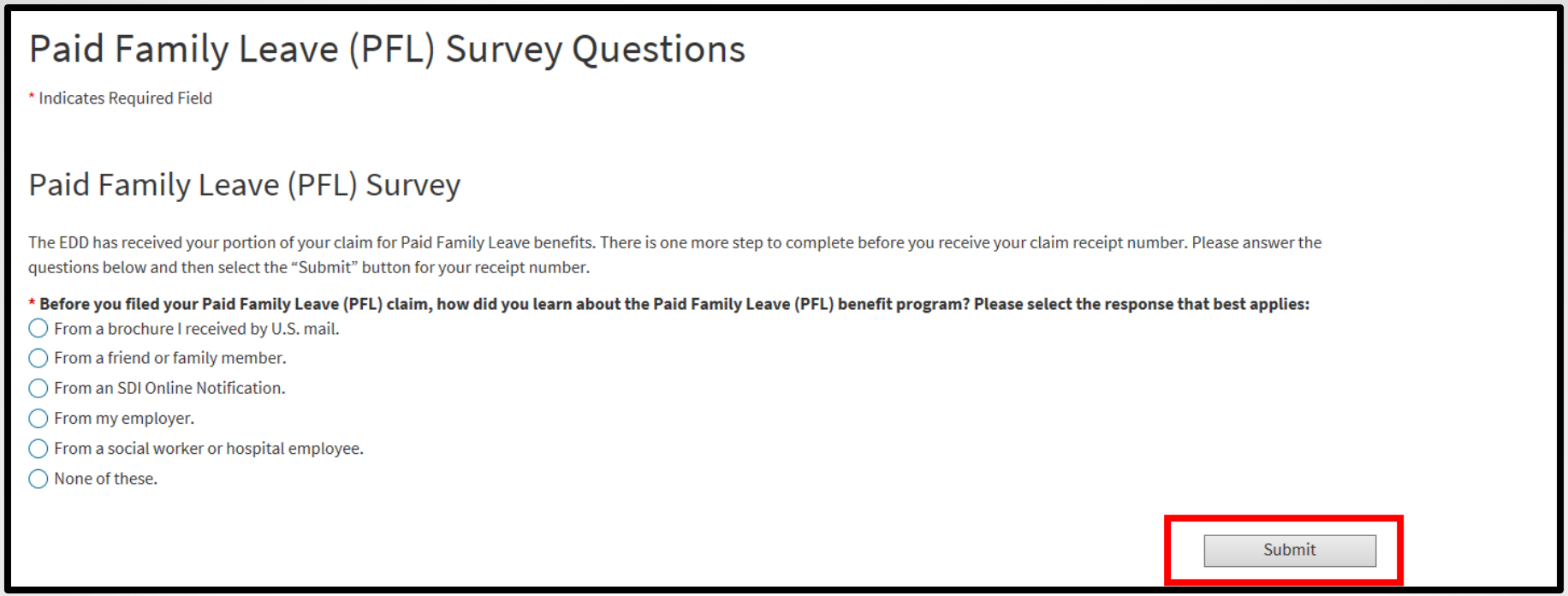
You may select to receive benefit payments by the **EDD Debit Card** or by **check**.

You do not have to accept the EDD Debit Card.

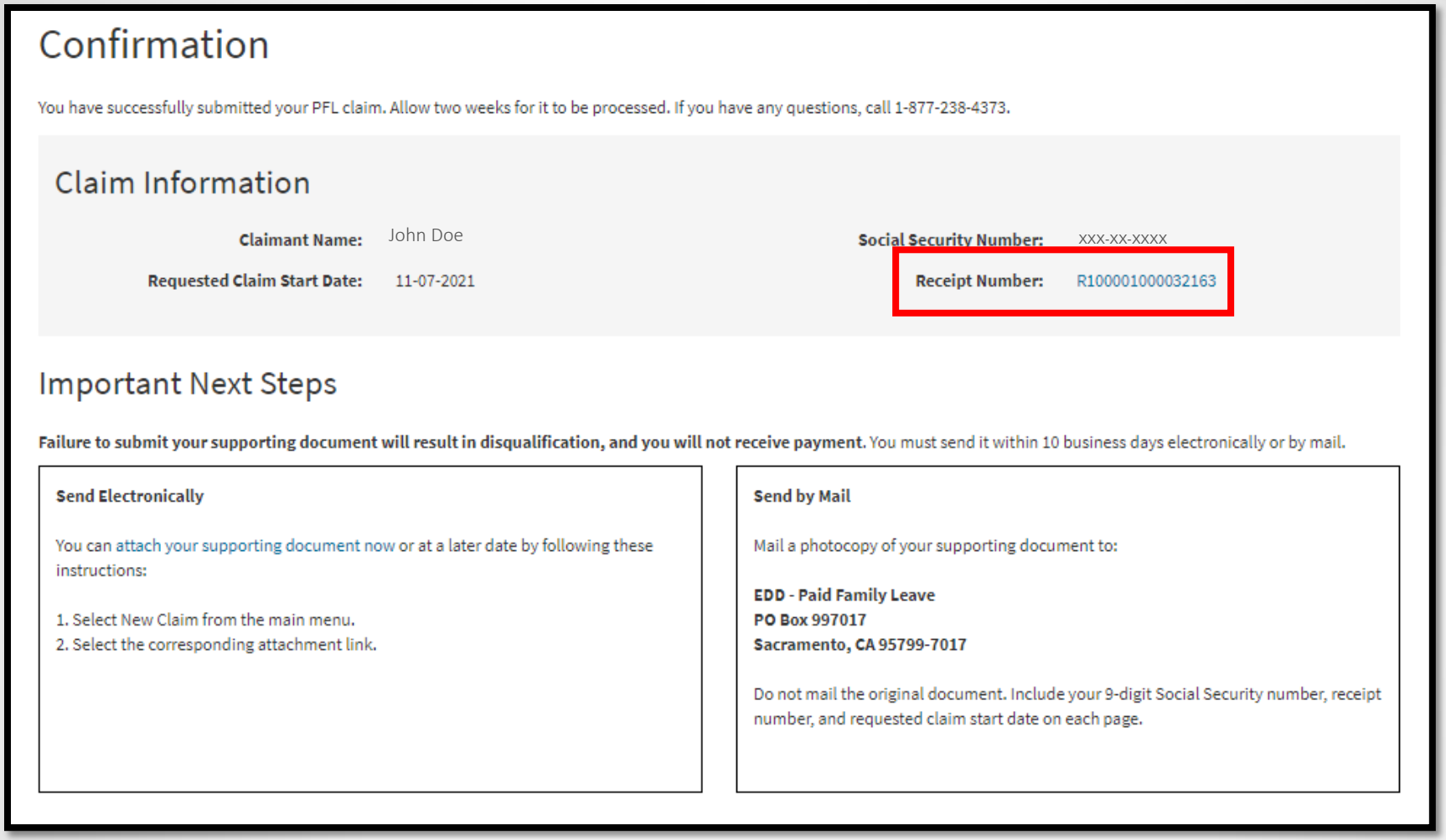
If your preferred payment method is the EDD Debit Card, you may view the disclosure agreement by selecting the ***EDD Debit Card Fee Disclosures*** **(DE 5617PD) (PDF)** link.

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

Select **Submit** to proceed.



Complete the survey and select **Submit**.



Confirmation

You have successfully submitted your PFL claim. Allow two weeks for it to be processed. If you 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

Important Next Steps

Failure 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.

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.
2. Select the corresponding attachment link.

Send by Mail

Mail a photocopy of your supporting document to:

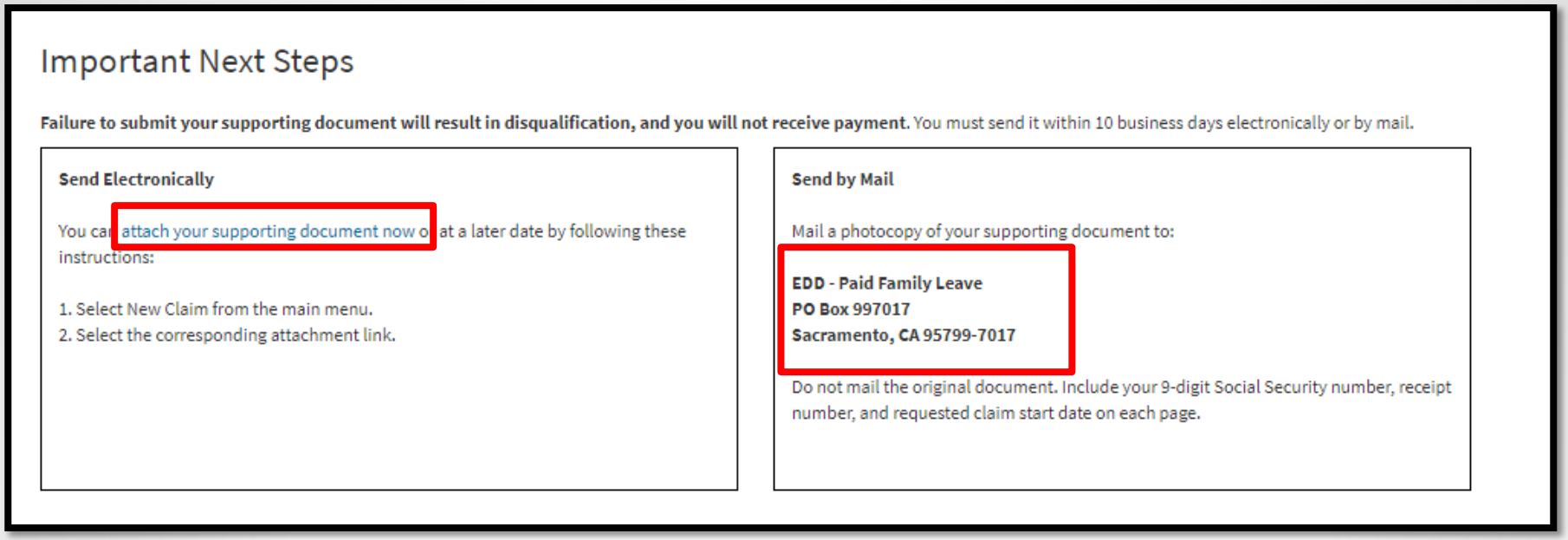
EDD - Paid Family Leave
PO Box 997017
Sacramento, CA 95799-7017

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.

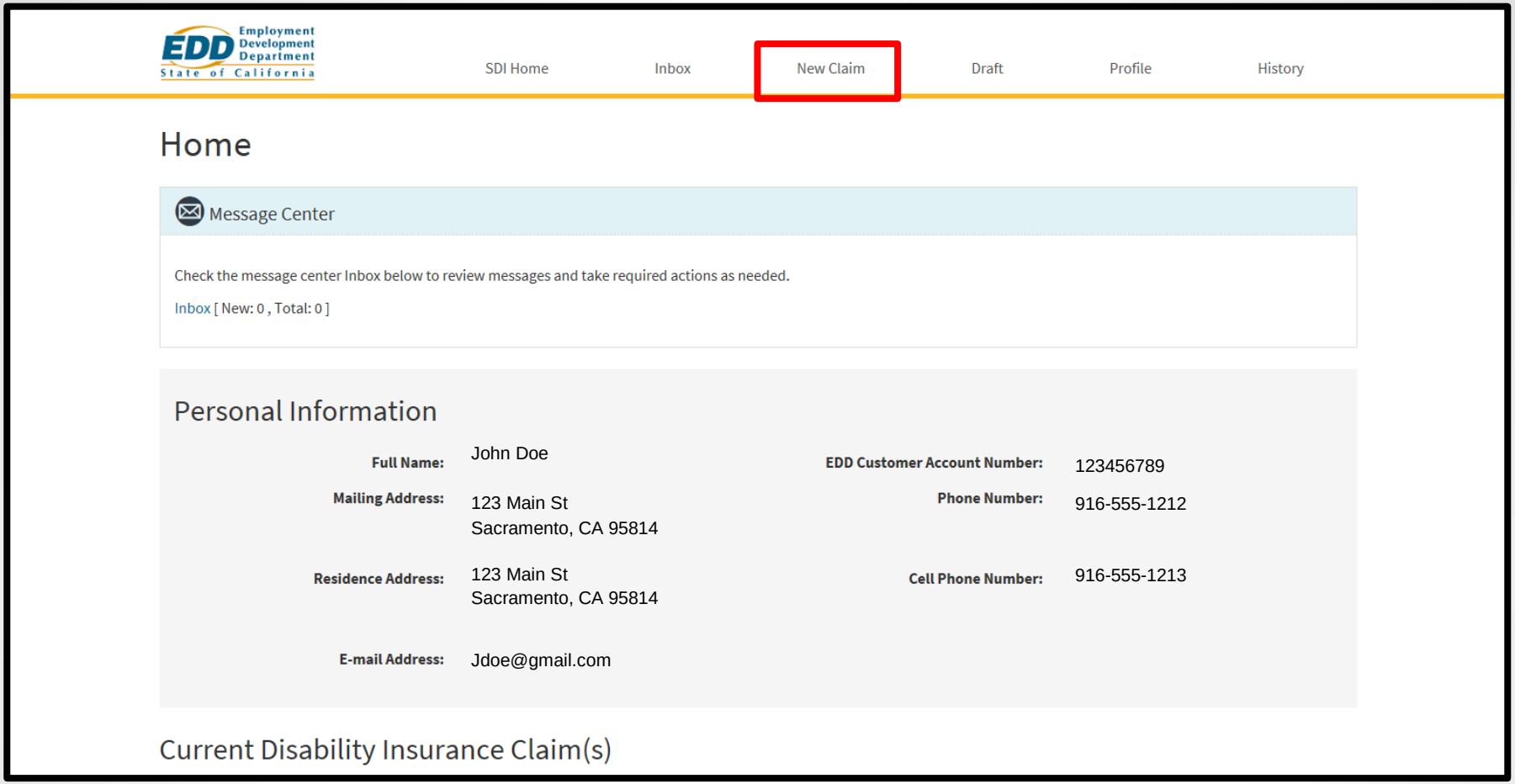
To submit your documentation electronically:

- Select the **attach your supporting document now** link.
- View the Submit Paid Family Leave Military Assist Claim Attachments 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.

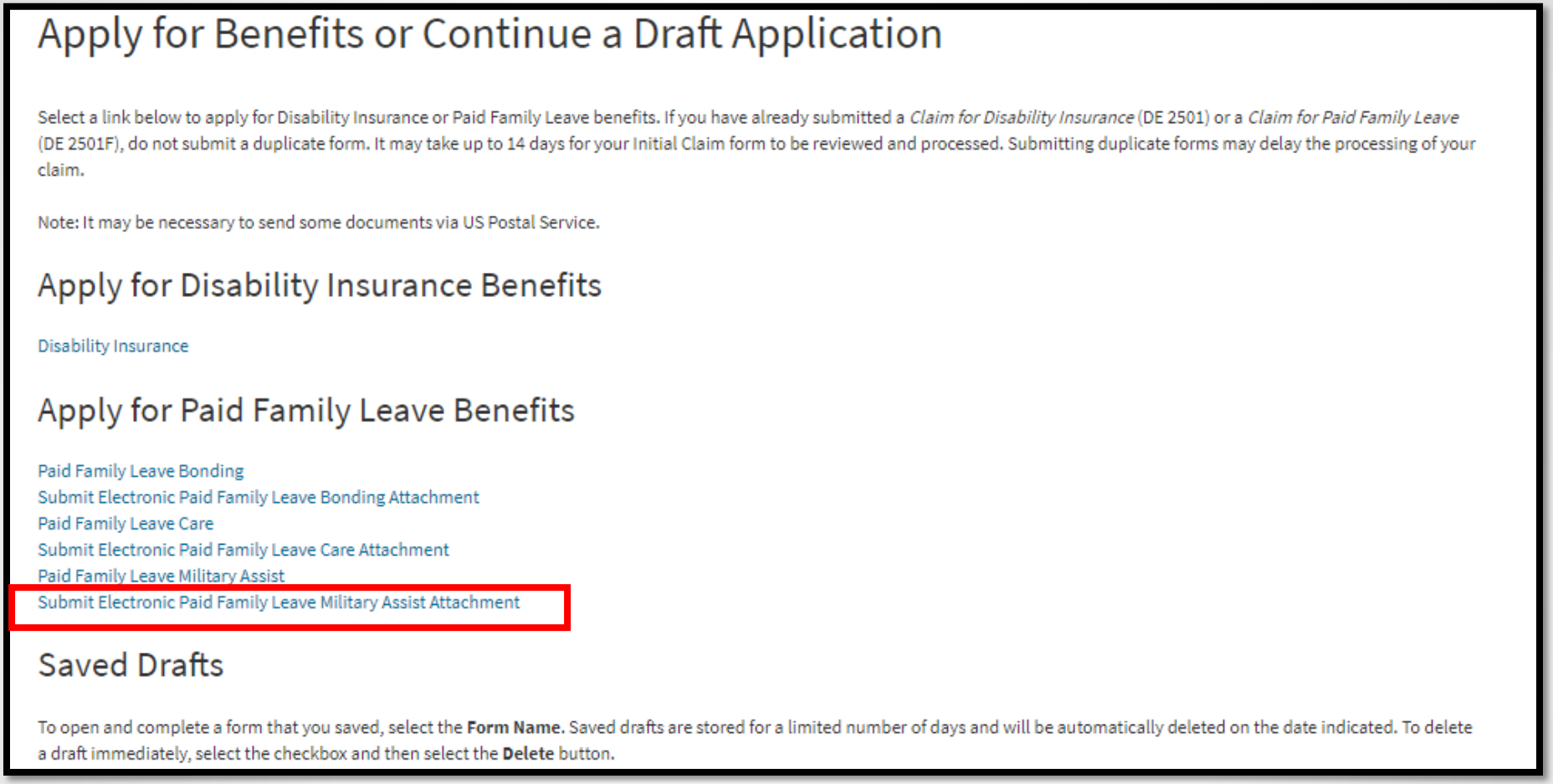
Submit Paid Family Leave Military Assist Claim Attachments



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

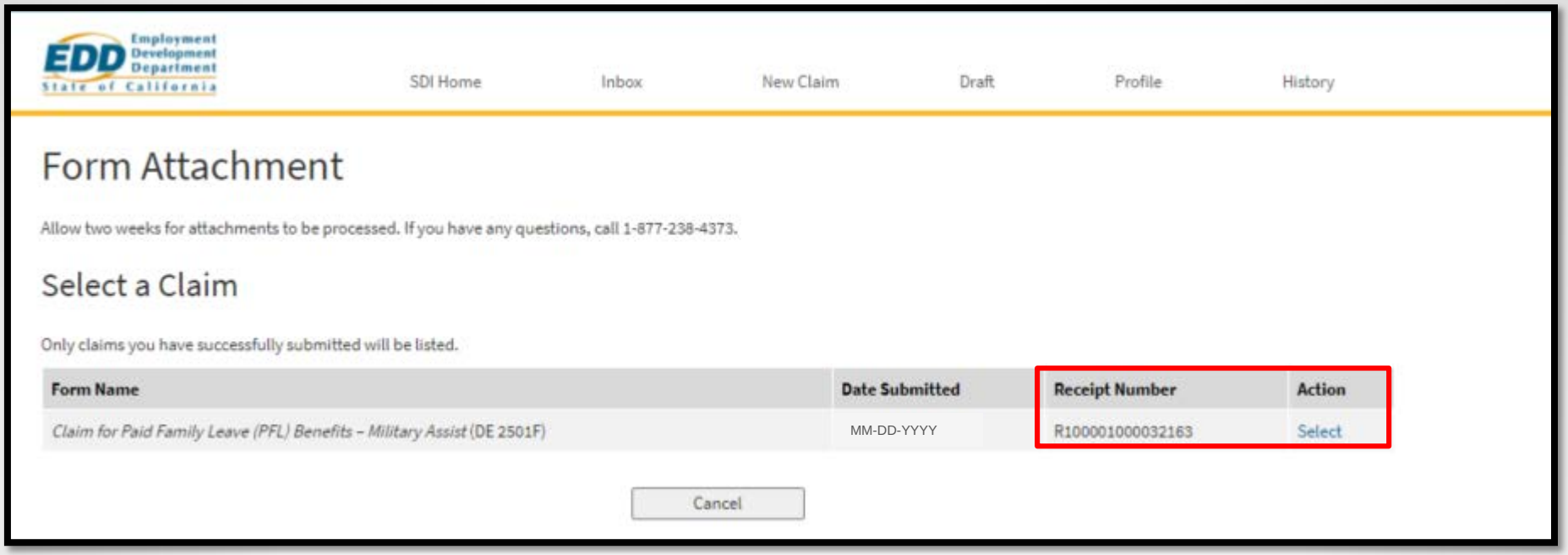
Apply for Paid Family Leave Benefits

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

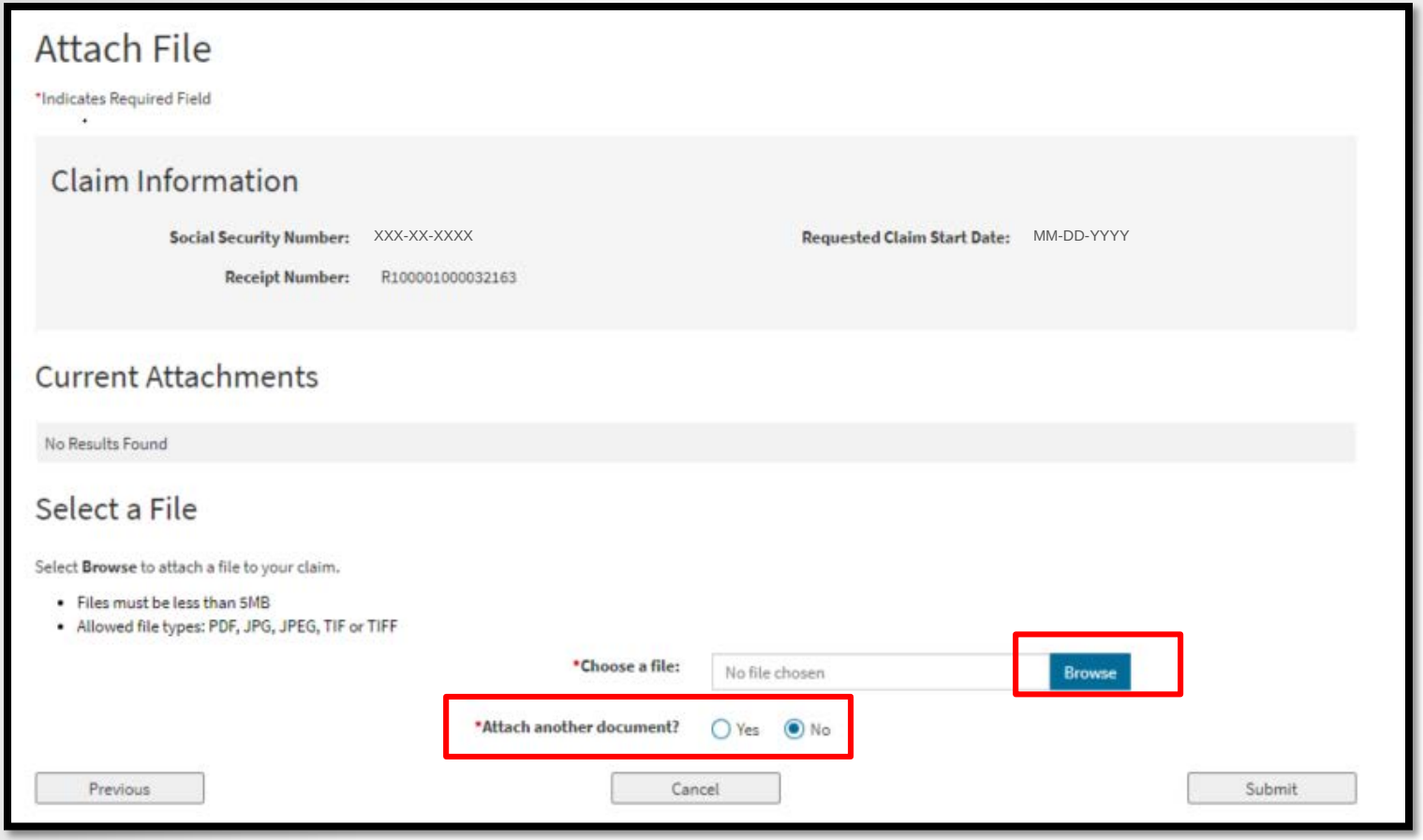
To open and complete a form that you saved, select the **Form Name**. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the **Delete** button.

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



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.

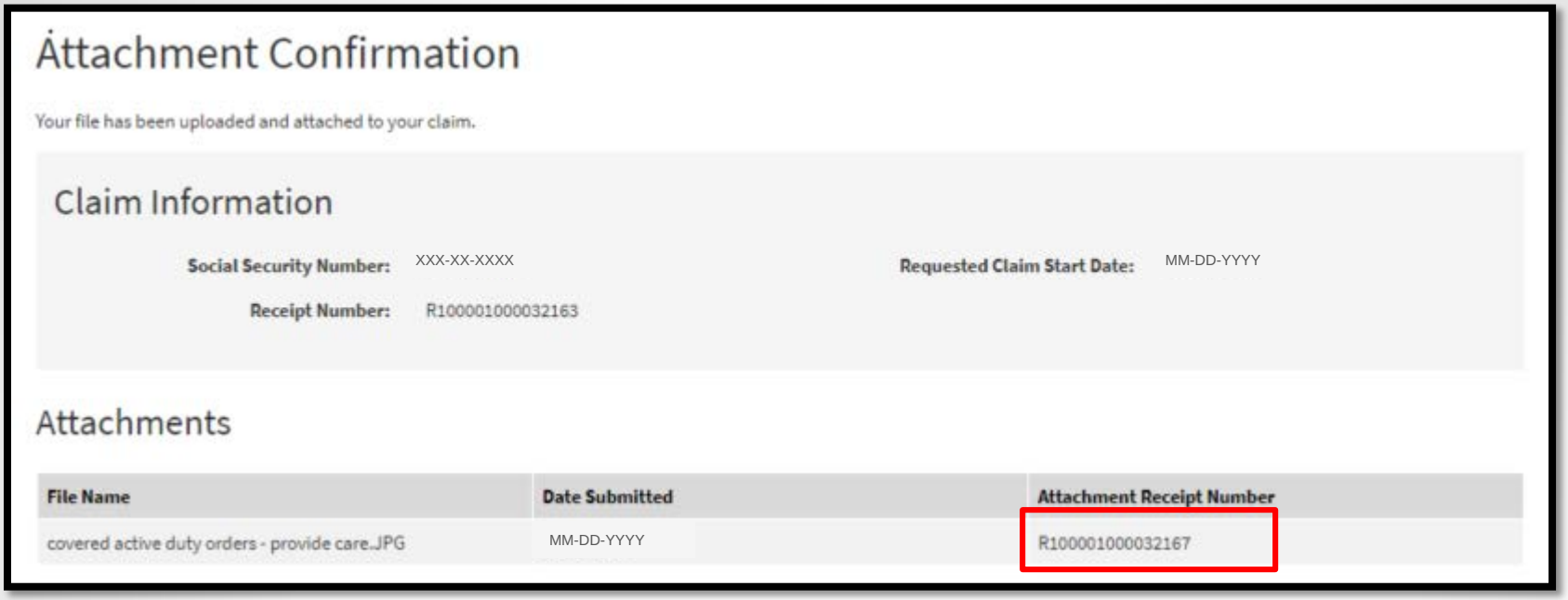


Select the **Browse** button to upload a document from your computer.

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.**



Attachment Confirmation

Your file has been uploaded and attached to your claim.

Claim Information

Social Security Number: XXX-XX-XXXX

Requested Claim Start Date: MM-DD-YYYY

Receipt Number: R100001000032163

Attachments

File Name	Date Submitted	Attachment Receipt Number
covered active duty orders - provide care.JPG	MM-DD-YYYY	R100001000032167

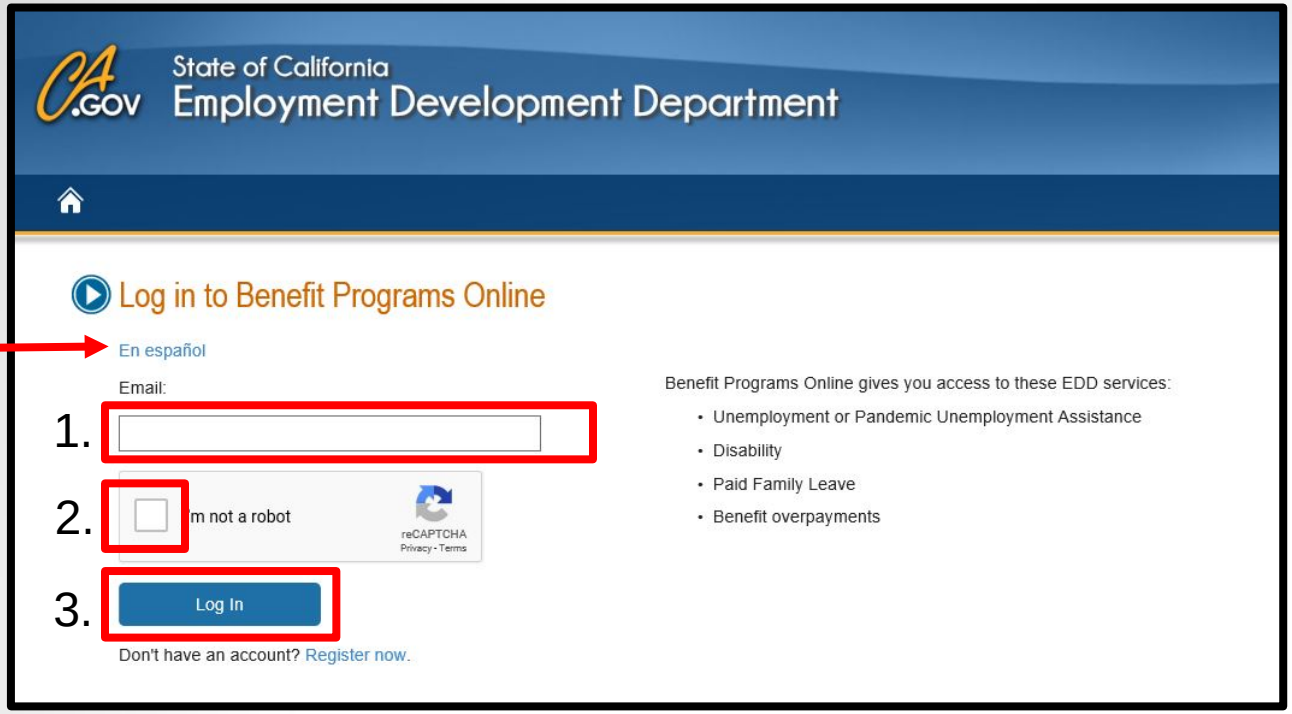
This screen confirms that the attachment(s) have been submitted.

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.

Update My Benefit Programs Online Profile -

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

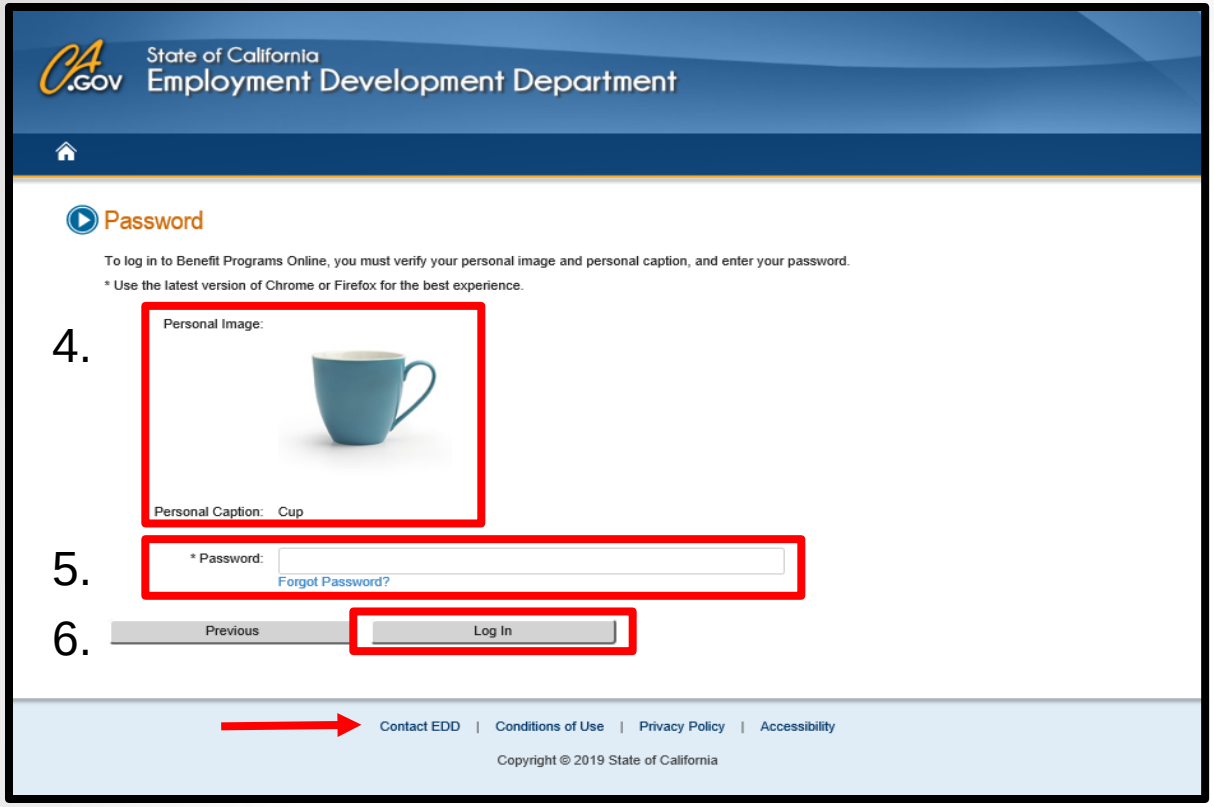


Visit Benefit Programs Online (edd.ca.gov/BPO) to change or update your email, password, security questions, or personal image and caption.

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.

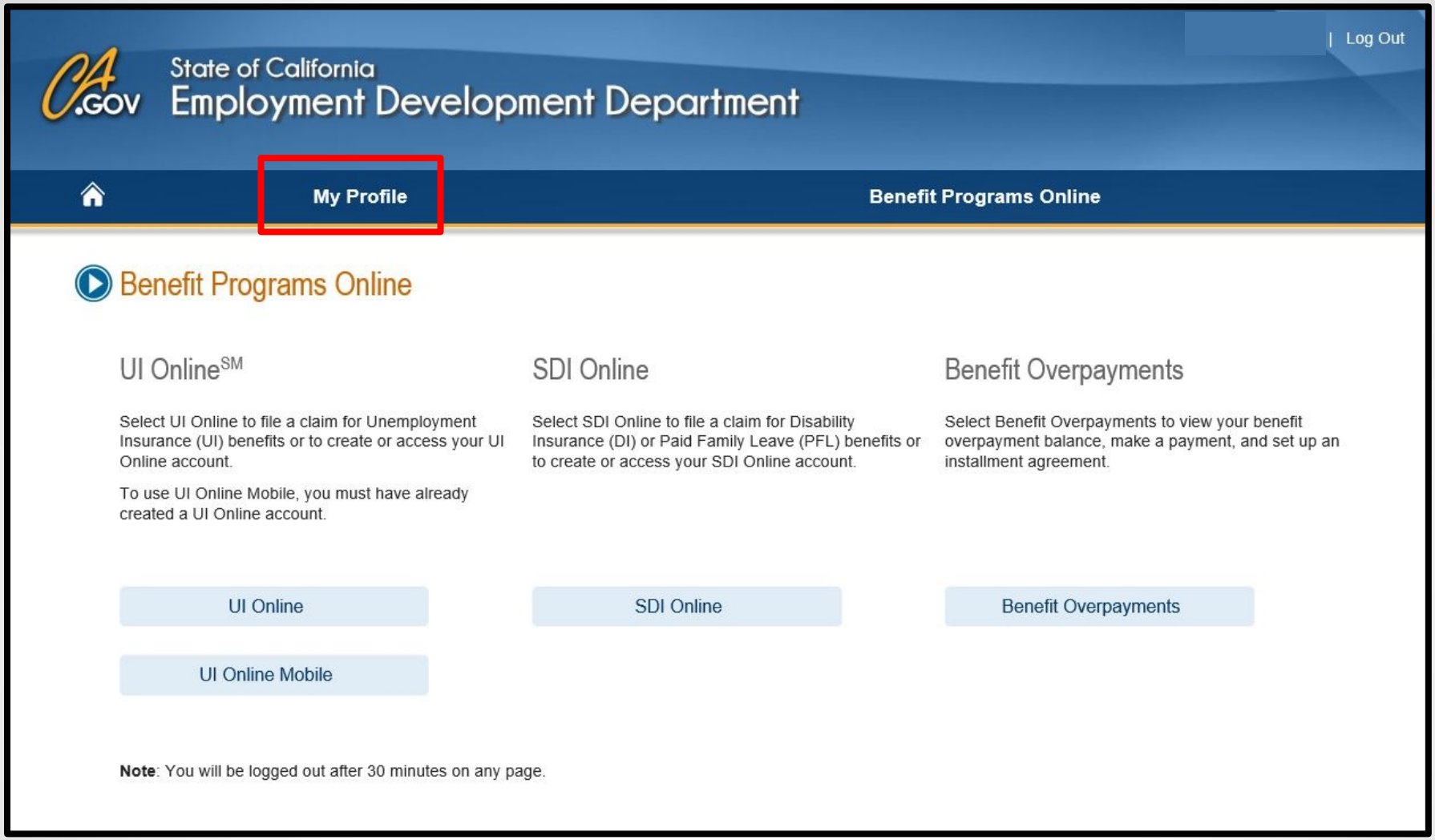


4. Verify your **Personal Image** and **Personal Caption** are correct.

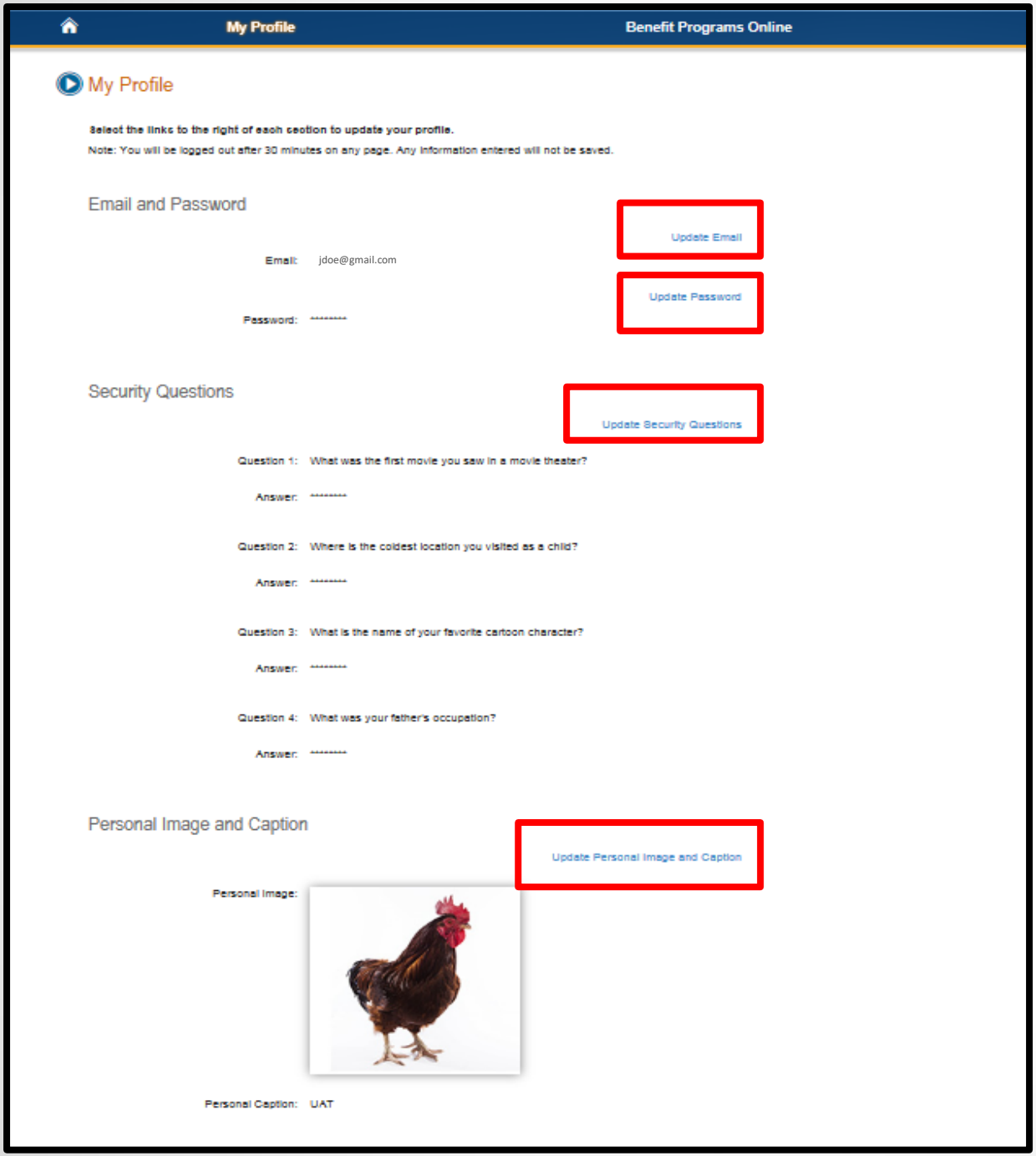
If you do not recognize your personal image and caption, select **Previous** to review the email address entered on the login screen to ensure it is correct. If you are unable to verify your personal image, select Contact EDD (edd.ca.gov/about_edd/contact_edd.htm) for your options on further assistance.

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

6. Select **Log In**.



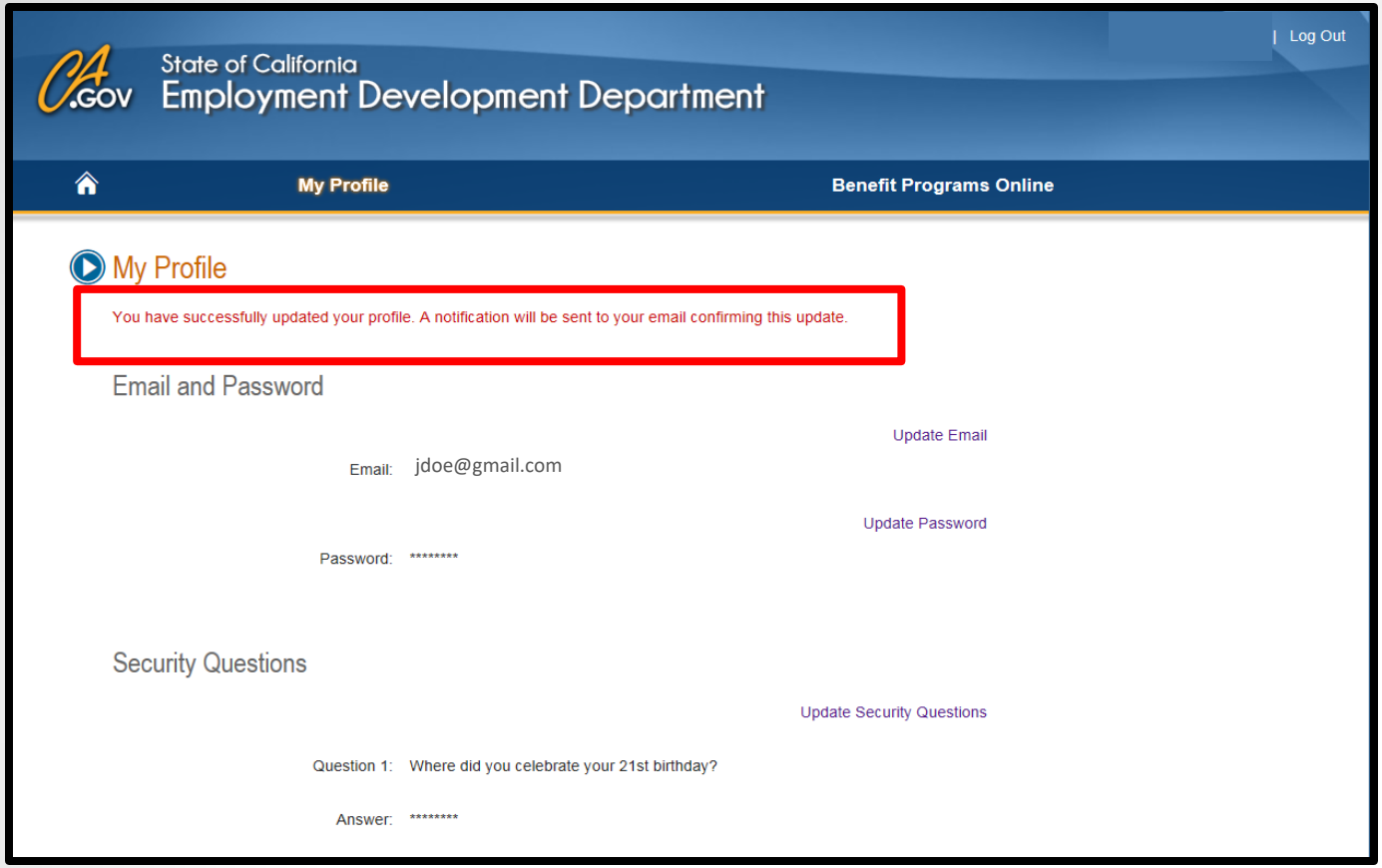
From your Benefit Programs Online account, select **My Profile.**



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

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

Follow the instructions to update your profile information.

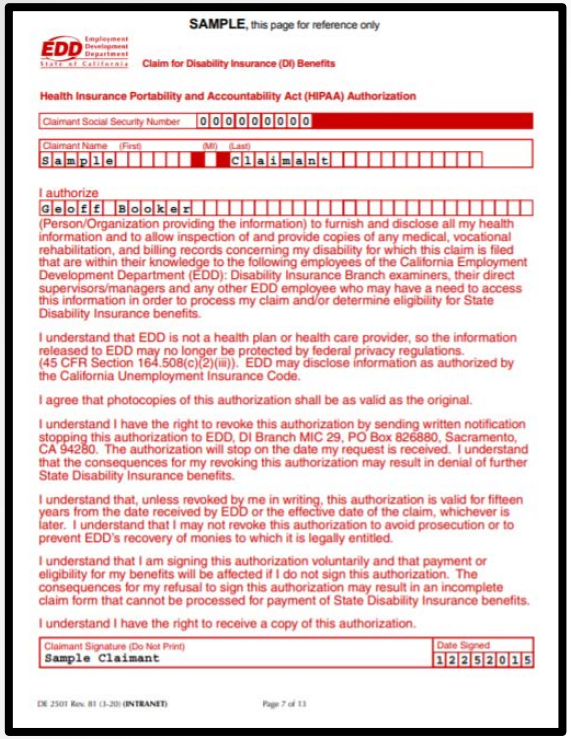


A message confirming the change will display at the top of the **My Profile** screen and a notification will be sent to your email confirming the change.

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

Complete Paper Claim Forms



SAMPLE, this page for reference only

EDD Employment Development Department State of California

Claim for Disability Insurance (DI) Benefits

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Claimant Social Security Number: 000000000

Claimant Name (First) (MI) (Last): Sample Claimant

I authorize: Geoff Booker

(Person/Organization providing the information) to furnish and disclose all my health information and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability for which this claim is filed that are within their knowledge to the following employees of the California Employment Development Department (EDD): Disability Insurance Branch examiners, their direct supervisors/managers and any other EDD employee who may have a need to access this information in order to process my claim and/or determine eligibility for State Disability Insurance benefits.

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.

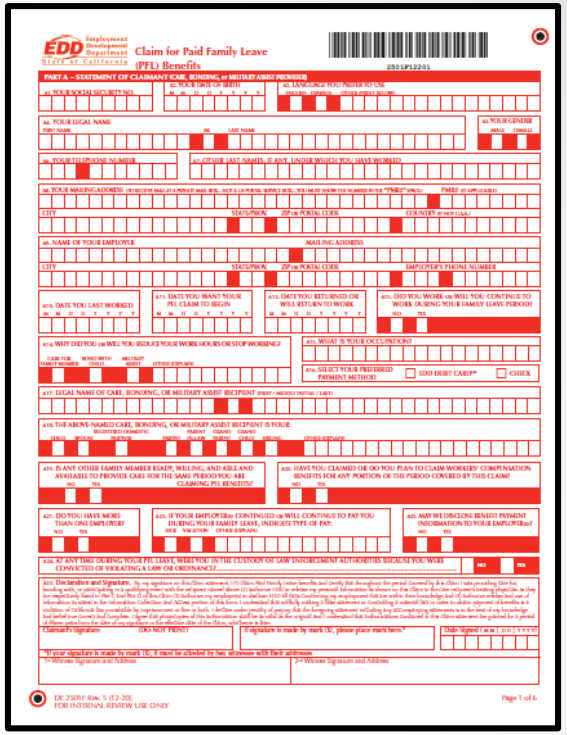
I understand that I am signing this authorization voluntarily and that payment or eligibility for my benefits will be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization may result in an incomplete claim form that cannot be processed for payment of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

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

Claimant Signature (Do Not Print): Sample Claimant — Date Signed: 12/25/2015

DE 2501 Rev. 81 (3-20) (INTRANET) Page 7 of 13

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



EDD Employment Development Department State of California

Claim for Paid Family Leave (PFL) Benefits

2501F12201

PART A – STATEMENT OF CLAIMANT (CARE, BONDING, or MILITARY ASSIST PROVIDER)

DE 2501F Rev. 5 (12-20) FOR INTERNAL REVIEW USE ONLY

Page 1 of 6

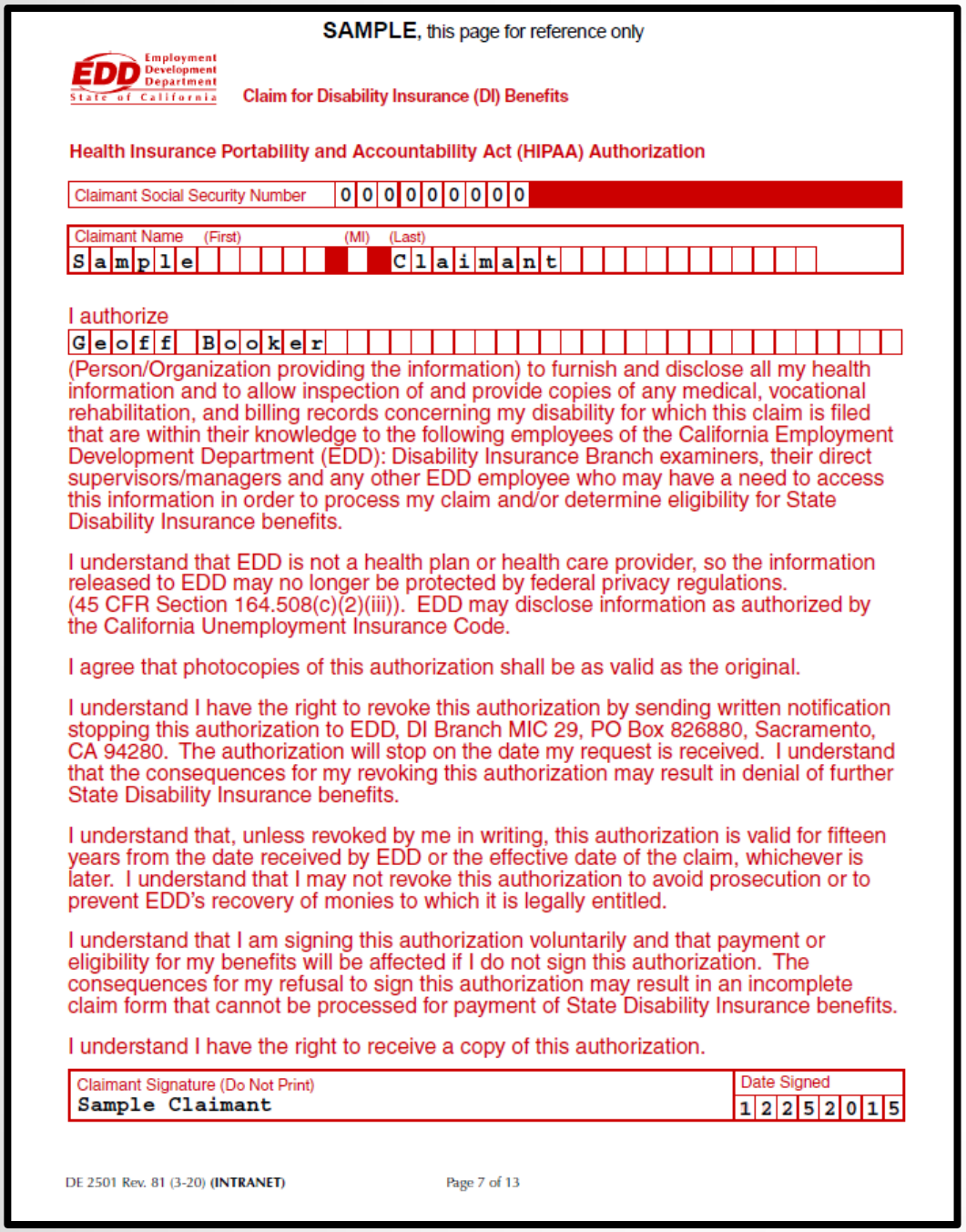
Claim for Paid Family Leave (PFL) Benefits
(DE 2501F) SAMPLE

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.

To avoid delays in claims processing, complete EDD forms as follows:

- 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.



SAMPLE, this page for reference only

Employment Development Department
State of California

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

Claimant Name (First) (MI) (Last): Sample Claimant

I authorize

Geoff Booker

(Person/Organization providing the information) to furnish and disclose all my health information and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability for which this claim is filed that are within their knowledge to the following employees of the California Employment Development Department (EDD): Disability Insurance Branch examiners, their direct supervisors/managers and any other EDD employee who may have a need to access this information in order to process my claim and/or determine eligibility for State Disability Insurance benefits.

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

Date Signed: 12 25 2015

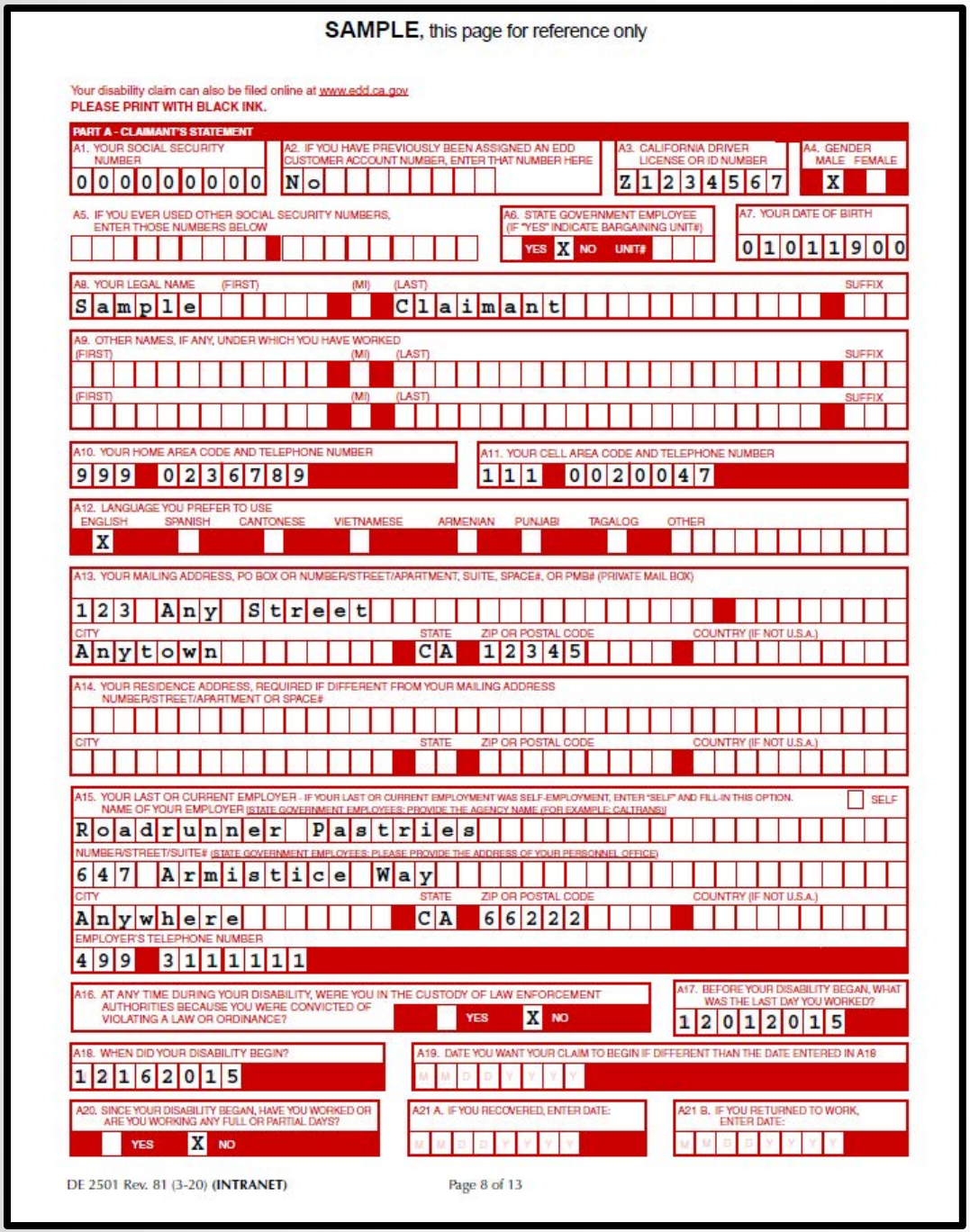
DE 2501 Rev. 81 (3-20) (INTRANET) Page 7 of 13

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.



SAMPLE, this page for reference only

Your disability claim can also be filed online at www.edd.ca.gov
PLEASE PRINT WITH BLACK INK.

PART A - CLAIMANT'S STATEMENT

A1. YOUR SOCIAL SECURITY NUMBER	A2. IF YOU HAVE PREVIOUSLY BEEN ASSIGNED AN EDD CUSTOMER ACCOUNT NUMBER, ENTER THAT NUMBER HERE	A3. CALIFORNIA DRIVER LICENSE OR ID NUMBER	A4. GENDER
000000000	No	Z1234567	MALE X FEMALE

A5. IF YOU EVER USED OTHER SOCIAL SECURITY NUMBERS, ENTER THOSE NUMBERS BELOW	A6. STATE GOVERNMENT EMPLOYEE (IF "YES" INDICATE BARGAINING UNIT#)	A7. YOUR DATE OF BIRTH
	YES X NO UNIT#	01011900

A8. YOUR LEGAL NAME (FIRST) (MI) (LAST) SUFFIX
Sample Claimant

A9. OTHER NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED
(FIRST) (MI) (LAST) SUFFIX
(FIRST) (MI) (LAST) SUFFIX

A10. YOUR HOME AREA CODE AND TELEPHONE NUMBER	A11. YOUR CELL AREA CODE AND TELEPHONE NUMBER
999 0236789	111 0020047

A12. LANGUAGE YOU PREFER TO USE
ENGLISH SPANISH CANTONESE VIETNAMESE ARMENIAN PUNJABI TAGALOG OTHER
X

A13. YOUR MAILING ADDRESS, PO BOX OR NUMBER/STREET/APARTMENT, SUITE, SPACE#, OR PMB# (PRIVATE MAIL BOX)
123 Any Street
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)
Anytown CA 12345

A14. YOUR RESIDENCE ADDRESS, REQUIRED IF DIFFERENT FROM YOUR MAILING ADDRESS
NUMBER/STREET/APARTMENT OR SPACE#
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)

A15. YOUR LAST OR CURRENT EMPLOYER - IF YOUR LAST OR CURRENT EMPLOYMENT WAS SELF-EMPLOYMENT, ENTER "SELF" AND FILL-IN THIS OPTION. ☐ SELF
NAME OF YOUR EMPLOYER (STATE GOVERNMENT EMPLOYEES: PROVIDE THE AGENCY NAME (FOR EXAMPLE: CALTRANS))
Roadrunner Pastries
NUMBER/STREET/SUITE# (STATE GOVERNMENT EMPLOYEES: PLEASE PROVIDE THE ADDRESS OF YOUR PERSONNEL OFFICE)
647 Armistice Way
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)
Anywhere CA 66222
EMPLOYER'S TELEPHONE NUMBER
4993111111

A16. AT ANY TIME DURING YOUR DISABILITY, WERE YOU IN THE CUSTODY OF LAW ENFORCEMENT AUTHORITIES BECAUSE YOU WERE CONVICTED OF VIOLATING A LAW OR ORDINANCE?	A17. BEFORE YOUR DISABILITY BEGAN, WHAT WAS THE LAST DAY YOU WORKED?
YES X NO	12012015

A18. WHEN DID YOUR DISABILITY BEGIN?	A19. DATE YOU WANT YOUR CLAIM TO BEGIN IF DIFFERENT THAN THE DATE ENTERED IN A18
12162015	M M D D Y Y Y Y

A20. SINCE YOUR DISABILITY BEGAN, HAVE YOU WORKED OR ARE YOU WORKING ANY FULL OR PARTIAL DAYS?	A21 A. IF YOU RECOVERED, ENTER DATE:	A21 B. IF YOU RETURNED TO WORK, ENTER DATE:
YES X NO	M M D D Y Y Y Y	M M D D Y Y Y Y

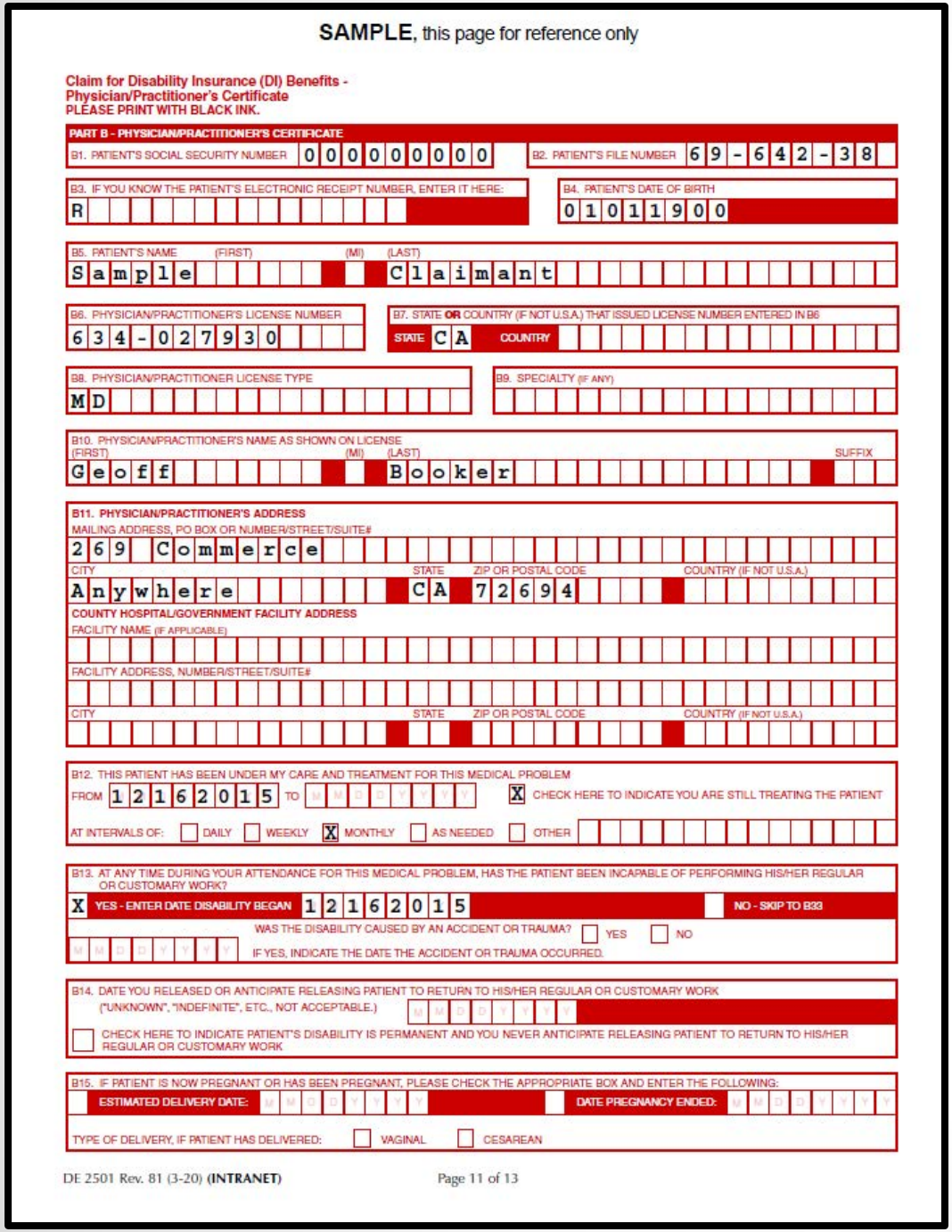
DE 2501 Rev. 81 (3-20) (INTRANET) Page 8 of 13

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.



SAMPLE, this page for reference only

Claim for Disability Insurance (DI) Benefits -
Physician/Practitioner's Certificate
PLEASE PRINT WITH BLACK INK.

PART B - PHYSICIAN/PRACTITIONER'S CERTIFICATE

B1. PATIENT'S SOCIAL SECURITY NUMBER: 000000000

B2. PATIENT'S FILE NUMBER: 69-642-38

B3. IF YOU KNOW THE PATIENT'S ELECTRONIC RECEIPT NUMBER, ENTER IT HERE: R

B4. PATIENT'S DATE OF BIRTH: 01011900

B5. PATIENT'S NAME (FIRST) (MI) (LAST): Sample Claimant

B6. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER: 634-027930

B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED IN B6: STATE CA

B8. PHYSICIAN/PRACTITIONER LICENSE TYPE: MD

B9. SPECIALTY (IF ANY)

B10. PHYSICIAN/PRACTITIONER'S NAME AS SHOWN ON LICENSE (FIRST) (MI) (LAST) SUFFIX: Geoff Booker

B11. PHYSICIAN/PRACTITIONER'S ADDRESS
MAILING ADDRESS, PO BOX OR NUMBER/STREET/SUITE#: 269 Commerce
CITY: Anywhere STATE: CA ZIP OR POSTAL CODE: 72694 COUNTRY (IF NOT U.S.A.)
COUNTY HOSPITAL/GOVERNMENT FACILITY ADDRESS
FACILITY NAME (IF APPLICABLE)
FACILITY ADDRESS, NUMBER/STREET/SUITE#
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)

B12. THIS PATIENT HAS BEEN UNDER MY CARE AND TREATMENT FOR THIS MEDICAL PROBLEM
FROM 12162015 TO [X] CHECK HERE TO INDICATE YOU ARE STILL TREATING THE PATIENT
AT INTERVALS OF: [ ] DAILY [ ] WEEKLY [X] MONTHLY [ ] AS NEEDED [ ] OTHER

B13. AT ANY TIME DURING YOUR ATTENDANCE FOR THIS MEDICAL PROBLEM, HAS THE PATIENT BEEN INCAPABLE OF PERFORMING HIS/HER REGULAR OR CUSTOMARY WORK?
[X] YES - ENTER DATE DISABILITY BEGAN 12162015 [ ] NO - SKIP TO B33
WAS THE DISABILITY CAUSED BY AN ACCIDENT OR TRAUMA? [ ] YES [ ] NO
IF YES, INDICATE THE DATE THE ACCIDENT OR TRAUMA OCCURRED.

B14. DATE YOU RELEASED OR ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR OR CUSTOMARY WORK ("UNKNOWN", "INDEFINITE", ETC., NOT ACCEPTABLE.)
[ ] CHECK HERE TO INDICATE PATIENT'S DISABILITY IS PERMANENT AND YOU NEVER ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR OR CUSTOMARY WORK

B15. IF PATIENT IS NOW PREGNANT OR HAS BEEN PREGNANT, PLEASE CHECK THE APPROPRIATE BOX AND ENTER THE FOLLOWING:
ESTIMATED DELIVERY DATE: DATE PREGNANCY ENDED:
TYPE OF DELIVERY, IF PATIENT HAS DELIVERED: [ ] VAGINAL [ ] CESAREAN

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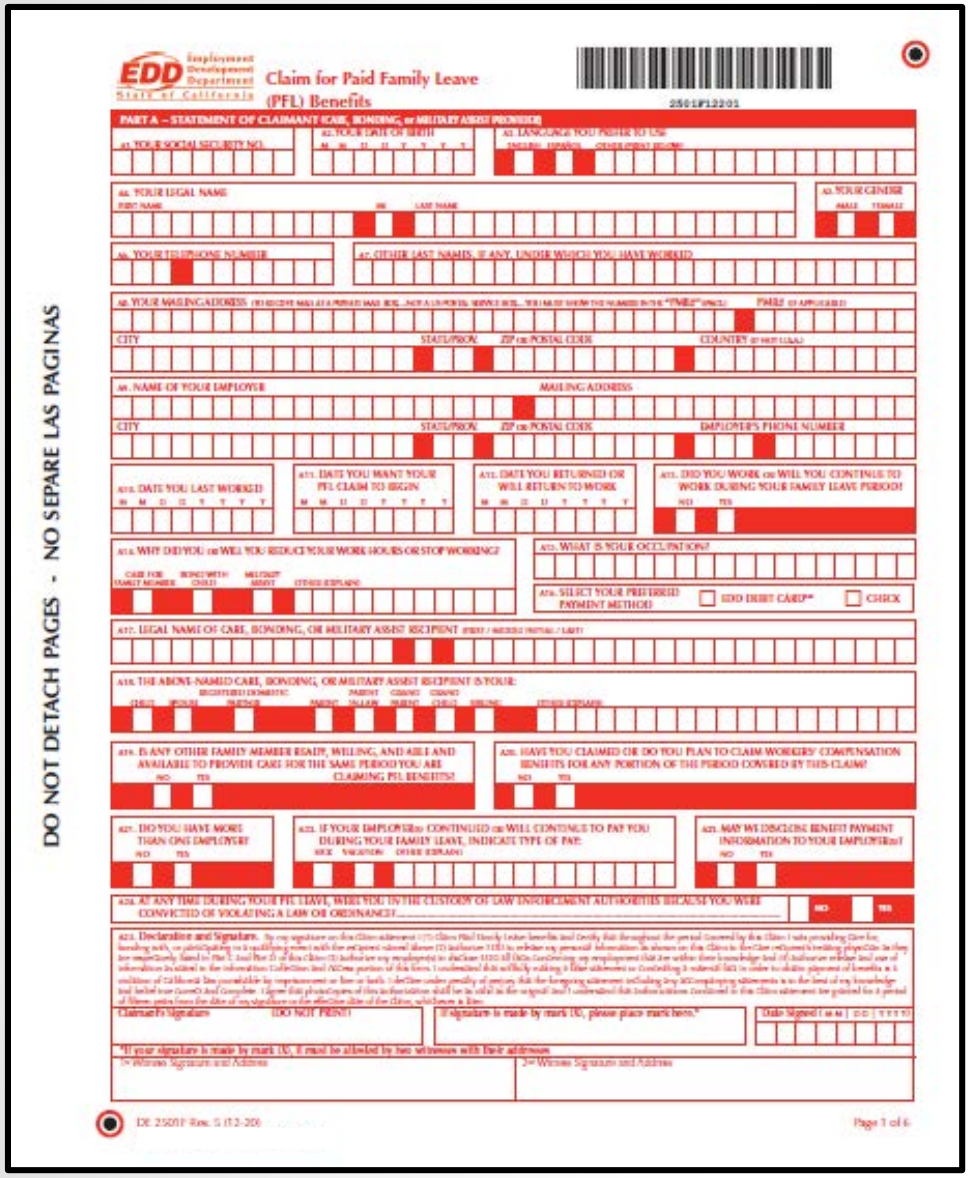
Claim for Disability Insurance (DI) Benefits (DE 2501)

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)

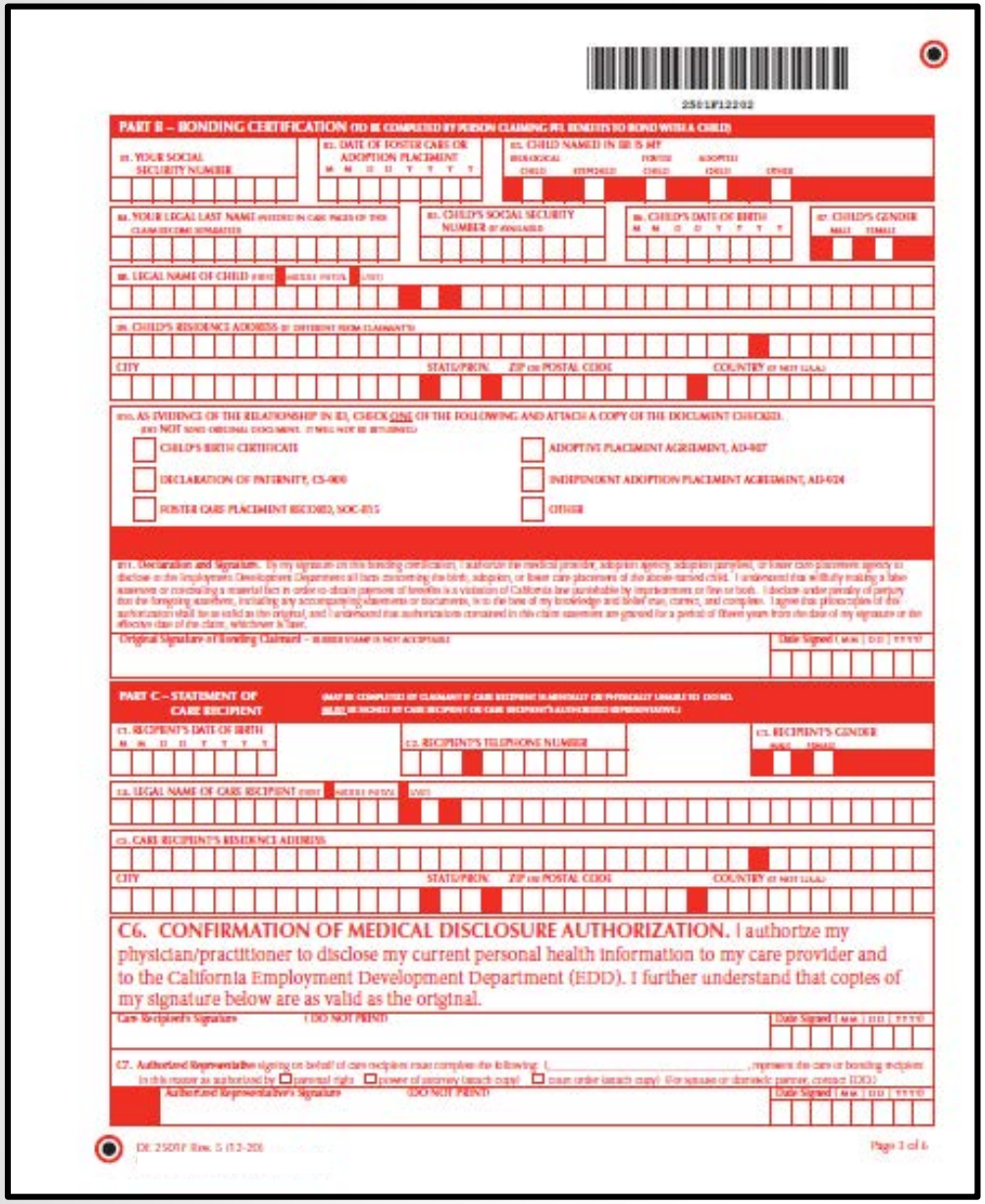
PAGE 1

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



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

PAGE 3

Part B - Bonding Certification:

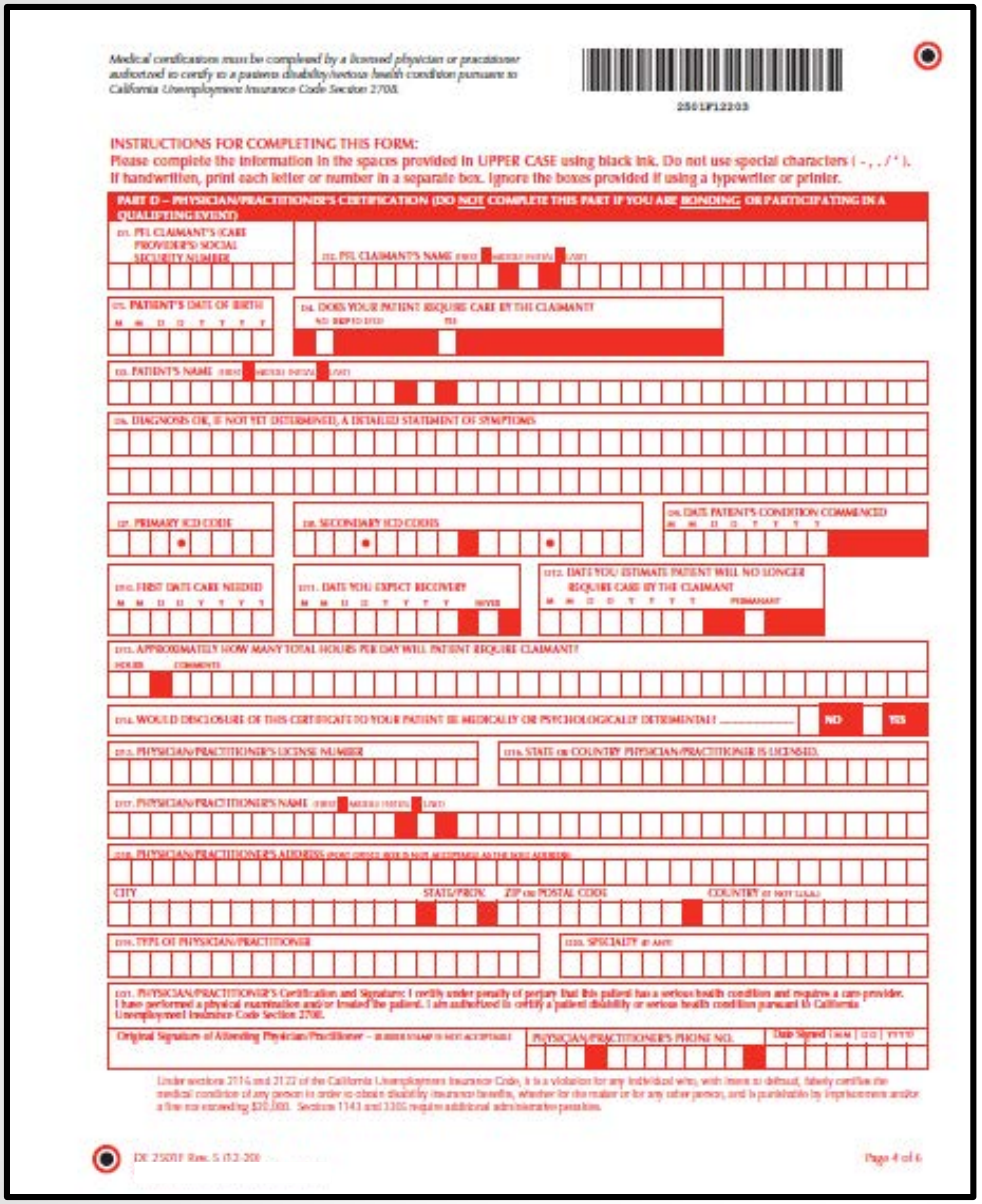
- If you are filing a bonding claim, you must complete this section and sign the form.

Part C - Statement of Care Recipient:

- If you are filing a care claim, you or the care recipient must complete this section. The care recipient or their authorized representative must sign the form.

Complete either Part B or Part C – but never both for one claim.

Note: Part B and Part C are NOT required for military assist claims.



Medical certification must be completed by a licensed physician or practitioner authorized to certify to a patient disability/serious health condition pursuant to California Unemployment Insurance Code Section 2708.

250 EP1 22 03

INSTRUCTIONS FOR COMPLETING THIS FORM:
Please complete the information in the spaces provided in UPPER CASE using black ink. Do not use special characters (- , . / ').
If handwritten, print each letter or number in a separate box. Ignore the boxes provided if using a typewriter or printer.

PART D – PHYSICIAN/PRACTITIONER'S CERTIFICATION (DO NOT COMPLETE THIS PART IF YOU ARE BONDING OR PARTICIPATING IN A QUALIFYING EVENT)

01. PFL CLAIMANT'S (CARE PROVIDER'S) SOCIAL SECURITY NUMBER
02. PFL CLAIMANT'S NAME (FIRST, MIDDLE INITIAL, LAST)
03. PATIENT'S DATE OF BIRTH (M M D D Y Y Y Y)
04. DOES YOUR PATIENT REQUIRE CARE BY THE CLAIMANT? NO / YES
05. PATIENT'S NAME (FIRST, MIDDLE INITIAL, LAST)
06. DIAGNOSIS OR, IF NOT YET DETERMINED, A DETAILED STATEMENT OF SYMPTOMS
07. PRIMARY ICD CODE
08. SECONDARY ICD CODES
09. DATE PATIENT'S CONDITION COMMENCED (M M D D Y Y Y Y)
010. FIRST DATE CARE NEEDED (M M D D Y Y Y Y)
011. DATE YOU EXPECT RECOVERY (M M D D Y Y Y Y) OR / OR PERMANENT
012. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CLAIMANT (M M D D Y Y Y Y) PERMANENT
013. APPROXIMATELY HOW MANY TOTAL HOURS PER DAY WILL PATIENT REQUIRE CLAIMANT? HOURS / COMMENTS
014. WOULD DISCLOSURE OF THIS CERTIFICATE TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL? NO / YES
015. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER
016. STATE OR COUNTRY PHYSICIAN/PRACTITIONER IS LICENSED
017. PHYSICIAN/PRACTITIONER'S NAME (FIRST, MIDDLE INITIAL, LAST)
018. PHYSICIAN/PRACTITIONER'S ADDRESS (POST OFFICE BOX IS NOT ACCEPTABLE AS THE ONLY ADDRESS)
CITY / STATE/PROV / ZIP OR POSTAL CODE / COUNTRY (IF NOT U.S.A.)
019. TYPE OF PHYSICIAN/PRACTITIONER
020. SPECIALTY (IF ANY)
021. PHYSICIAN/PRACTITIONER'S Certification and Signature: I certify under penalty of perjury that this patient has a serious health condition and requires a care provider. I have performed a physical examination and/or treated the patient. I am authorized to certify a patient disability or serious health condition pursuant to California Unemployment Insurance Code Section 2708.
Original Signature of Attending Physician/Practitioner – RUBBER STAMP IS NOT ACCEPTABLE
PHYSICIAN/PRACTITIONER'S PHONE NO.
Date Signed (M M / D D / Y Y Y Y)

Under sections 2714 and 2122 of the California Unemployment Insurance Code, it is a violation for any individual who, with intent to defraud, falsely certifies the medical condition of any person in order to obtain disability insurance benefits, whether for the maker or for any other person, and is punishable by imprisonment and/or a fine not exceeding $20,000. Sections 1143 and 1305 require additional administrative penalties.

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

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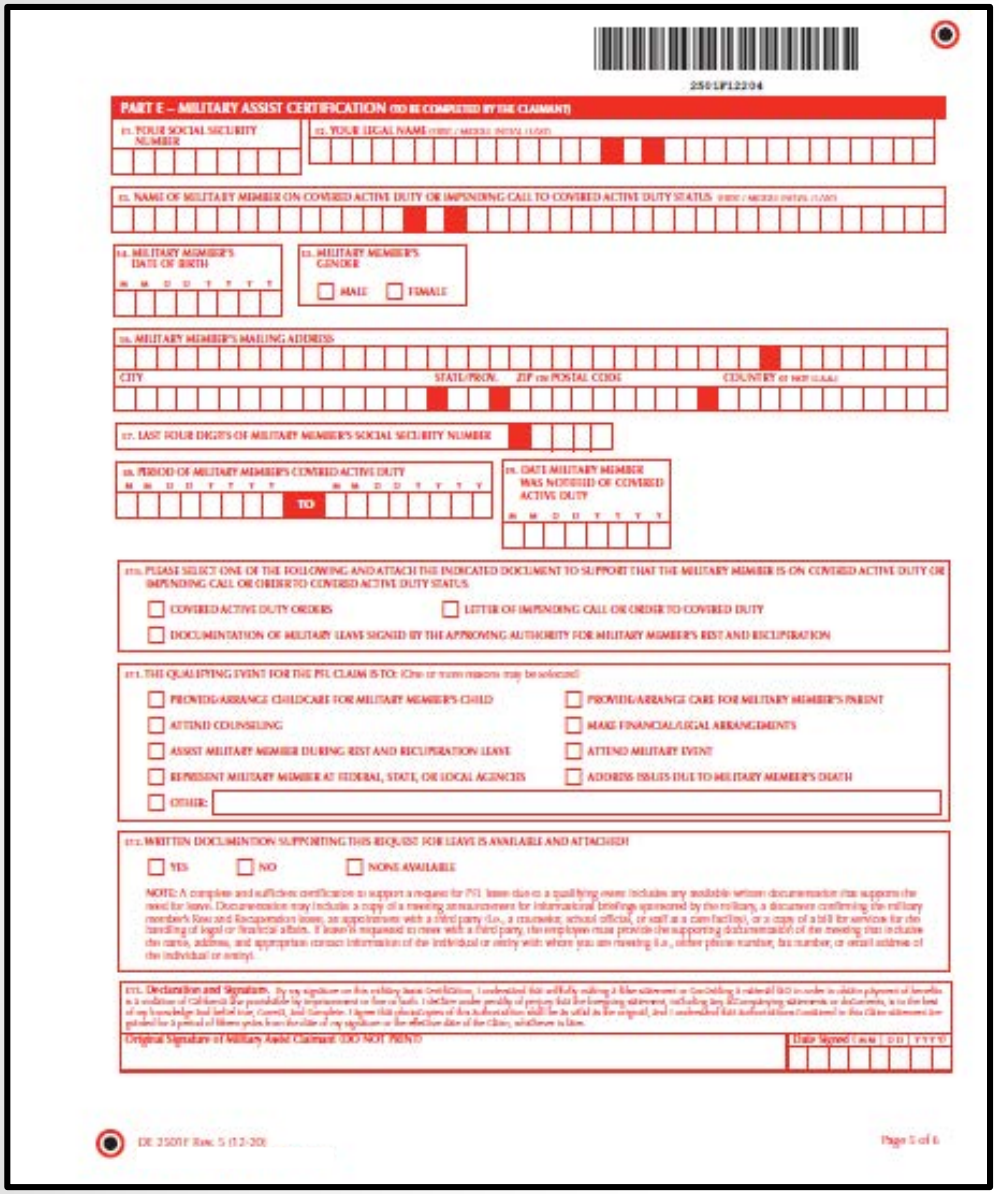
Part D - Physician/Practitioner's Certification:

- Your care recipient's physician/practitioner must complete all patient information for care claims, including dates, diagnosis codes, and signing the bottom of the form.

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

Page 4 is left blank intentionally and not shown in this tutorial. Do NOT remove this page.



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PART E – MILITARY ASSIST CERTIFICATION (TO BE COMPLETED BY THE CLAIMANT)

11. YOUR SOCIAL SECURITY NUMBER

12. YOUR LEGAL NAME (FIRST / MIDDLE INITIAL / LAST)

13. NAME OF MILITARY MEMBER ON COVERED ACTIVE DUTY OR IMPENDING CALL TO COVERED ACTIVE DUTY STATUS (FIRST / MIDDLE INITIAL / LAST)

14. MILITARY MEMBER'S DATE OF BIRTH (M M D D Y Y Y Y)

15. MILITARY MEMBER'S GENDER ☐ MALE ☐ FEMALE

16. MILITARY MEMBER'S MAILING ADDRESS

CITY STATE/PROV. ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)

17. LAST FOUR DIGITS OF MILITARY MEMBER'S SOCIAL SECURITY NUMBER

18. PERIOD OF MILITARY MEMBER'S COVERED ACTIVE DUTY (M M D D Y Y Y Y) TO (M M D D Y Y Y Y)

19. DATE MILITARY MEMBER WAS NOTIFIED OF COVERED ACTIVE DUTY (M M D D Y Y Y Y)

20. PLEASE SELECT ONE OF THE FOLLOWING AND ATTACH THE INDICATED DOCUMENT TO SUPPORT THAT THE MILITARY MEMBER IS ON COVERED ACTIVE DUTY OR IMPENDING CALL OR ORDER TO COVERED ACTIVE DUTY STATUS.

☐ COVERED ACTIVE DUTY ORDERS ☐ LETTER OF IMPENDING CALL OR ORDER TO COVERED DUTY

☐ DOCUMENTATION OF MILITARY LEAVE SIGNED BY THE APPROVING AUTHORITY FOR MILITARY MEMBER'S REST AND RECUPERATION

21. THE QUALIFYING EVENT FOR THE PFL CLAIM IS TO: (One or more reasons may be selected)

☐ PROVIDE/ARRANGE CHILDCARE FOR MILITARY MEMBER'S CHILD ☐ PROVIDE/ARRANGE CARE FOR MILITARY MEMBER'S PARENT

☐ ATTEND COUNSELING ☐ MAKE FINANCIAL/LEGAL ARRANGEMENTS

☐ ASSIST MILITARY MEMBER DURING REST AND RECUPERATION LEAVE ☐ ATTEND MILITARY EVENT

☐ REPRESENT MILITARY MEMBER AT FEDERAL, STATE, OR LOCAL AGENCIES ☐ ADDRESS ISSUES DUE TO MILITARY MEMBER'S DEATH

☐ OTHER:

22. WRITTEN DOCUMENTATION SUPPORTING THIS REQUEST FOR LEAVE IS AVAILABLE AND ATTACHED?

☐ YES ☐ NO ☐ NONE AVAILABLE

NOTE: A complete and sufficient certification to support a request for PFL leave due to a qualifying event includes any available written documentation that supports the need for leave. Documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming the military member's Rest and Recuperation leave, an appointment with a third party (i.e., a counselor, school official, or staff at a care facility), or a copy of a bill for services for the handling of legal or financial affairs. If leave is requested to meet with a third party, the employee must provide the supporting documentation of the meeting that includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., office phone number, fax number, or email address of the individual or entity).

23. Declaration and Signature. By my signature on this military leave Certification, I understand that willfully making a false statement on this Certification is subject to criminal penalties. In addition, 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 statements, including any accompanying statements or documents, 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 original, and I understand that Authorization Continues in this Claim submission for a period of fifteen years from the date of my signature or the effective date of the Claim, whichever is later.

Original Signature of Military Assist Claimant (DO NOT PRINT) Date Signed (M M / D D / Y Y Y Y)

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

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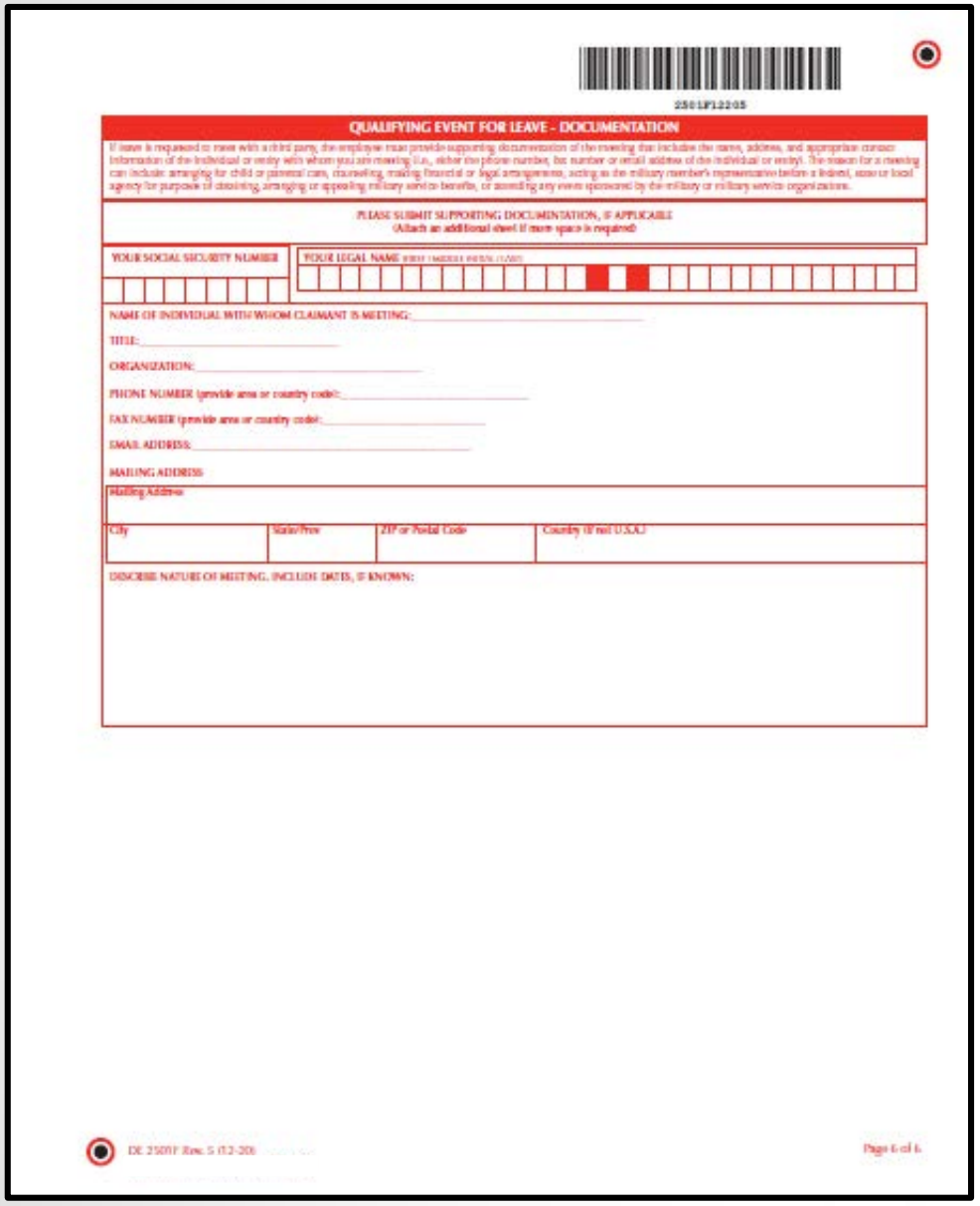
Part E – Military Assist Certification:

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.



QUALIFYING EVENT FOR LEAVE - DOCUMENTATION

If leave is requested to meet with a third party, the employee must provide supporting documentation of the meeting that includes the names, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the phone number, fax number or email address of the individual or entity). The reason for a meeting can include: arranging for child or parental care, counseling, making financial or legal arrangements, acting as the military member's representative before a federal, state or local agency for purposes of obtaining, arranging or appealing military service benefits, or attending any event sponsored by the military or military service organizations.

PLEASE SUBMIT SUPPORTING DOCUMENTATION, IF APPLICABLE
(Attach an additional sheet if more space is required)

YOUR SOCIAL SECURITY NUMBER

YOUR LEGAL NAME

NAME OF INDIVIDUAL WITH WHOM CLAIMANT IS MEETING:

TITLE:

ORGANIZATION:

PHONE NUMBER (provide area or country code):

FAX NUMBER (provide area or country code):

EMAIL ADDRESS:

MAILING ADDRESS

Mailing Address

City | State/Prov | ZIP or Postal Code | Country (If not U.S.A.)

DESCRIBE NATURE OF MEETING, INCLUDE DATES, IF KNOWN:

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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 State Disability Insurance (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.