

**APPLICATION FOR APPROVAL OF SELF-INSURED VOLUNTARY PLAN  
OF DISABILITY BENEFITS**

1. The requested effective date of this voluntary plan is \_\_\_\_\_.

EMPLOYER INFORMATION

2. California Employer Account Number \_\_\_\_\_ (the eight-digit number that the Employment Development Department assigned to the employer when the employer registered with the Department).

3. Employer's legal name: \_\_\_\_\_

4. If this employer is doing business in the State of California under any other business name(s) besides the one identified above, list the dba(s) or commercial nickname(s) (provide a separate list if necessary): \_\_\_\_\_  
\_\_\_\_\_.

5. Employer's headquarters address: \_\_\_\_\_

City, State, ZIP Code: \_\_\_\_\_

6. Describe the employer's business, for example, type of product manufactured or service provided: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

7. Individual responsible for coordinating all activities of the voluntary plan:

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

Company name: \_\_\_\_\_

Address (if different from address above): \_\_\_\_\_  
\_\_\_\_\_

City, State, ZIP Code: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax No.: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

8. Voluntary plan claims will be processed by:

\_\_\_\_\_ Third Party Administrator

\_\_\_\_\_ Self-Administered by employer

Individual who will process voluntary plan claims:

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

Company name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP Code: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

PLAN PROVISIONS

9. Will the voluntary plan be made available to employees in all establishments of the employer in California? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, provide an alphabetical list by city of the locations that will be covered. Include the physical address. Separate the list according to different business names, if more than one. Note the number of eligible employees at each location. Also provide a similar list of all locations that will not be covered.

10. Are part-time employees (employed less than half the hours in the workweek) eligible for coverage? Yes \_\_\_\_\_ No \_\_\_\_\_
11. Are short-term employees (employed with the expectation that employment will not exceed two weeks) eligible for coverage? Yes \_\_\_\_\_ No \_\_\_\_\_
12. The contribution required of employees electing the voluntary plan will be:  
\_\_\_\_\_ % of the first \$ \_\_\_\_\_ of taxable wages paid in this calendar year, or  
(other) \_\_\_\_\_.

**NOTE:** A complete description of the voluntary plan benefits, limitations, and exclusions must be included in the plan text.

ENROLLMENT INFORMATION

13. Total number of employees eligible to be covered by the plan:  
\_\_\_\_\_ as of \_\_\_\_\_.  
Number Date
14. Total number of employees who have consented, in writing or by electronic mail, at the employee's option, if electronic means are available, to be covered by the plan:  
\_\_\_\_\_ as of \_\_\_\_\_.  
Number Date
15. The enrollment was conducted between \_\_\_\_\_ and \_\_\_\_\_.  
Date Date

SECURITY DEPOSIT

16. Check the type of security that will be filed to secure the voluntary plan:

- \_\_\_\_\_ Guarantee Bond, DE 2544V or later revision
- \_\_\_\_\_ Letter of Credit (based on Model Letter of Credit provided by the Employment Development Department)
- \_\_\_\_\_ Cash
- \_\_\_\_\_ Bearer Bond(s)

**NOTE: Do not send the security with this application.** Instructions for sending the security will be provided to the individual identified in Question 7 upon approval of the plan. If cash is being deposited, file the form, Agreement Regarding Deposit of Cash, DE 2545V, with this application. If a bearer bond(s) is being deposited, file the form, Agreement Regarding Deposit of Bearer Bond, DE 2545VB, with this application.

17. Estimated State Disability Insurance (SDI) taxable wages projected to be paid over the 12-month period following your requested voluntary plan effective date:

Estimated SDI taxable wages: \$\_\_\_\_\_.

**NOTE:** (1) The estimated SDI taxable wages are used to determine the amount of deposit required using the following formula:

Estimated Annual Taxable Wages x .5 x SDI Contribution Tax Rate =  
Amount of Security Deposit; and

(2) The minimum required deposit is \$1,000 (uneven dollar amounts will be rounded up to the next \$100).

REQUIRED DOCUMENTS

**Items 18 through 20 must be filed with this application:**

- 18. A copy of the written text which fully describes the provisions of the voluntary plan.
- 19. Security deposit form if posting cash or bearer bond (see items 16 through 17).
- 20. Copies of all enrollment literature which were distributed to the employees to secure their consent for the voluntary plan.

Did the literature include a copy of the written text? Yes \_\_\_\_\_ No \_\_\_\_\_

Did the literature include a copy of a statement of coverage? Yes \_\_\_\_\_ No \_\_\_\_\_

21. A copy of the statement of coverage which will be given to all covered employees (if this is not attached, check one of the following).

\_\_\_\_\_ The covered employees will be given a copy of the written text instead of a separate statement; therefore, a statement of coverage has not been developed.

\_\_\_\_\_ The statement of coverage is not attached but will be sent within 30 days.

CERTIFICATION

By signing below:

- A. I am submitting an application for approval of a voluntary plan under the California Unemployment Insurance Code (hereinafter identified as "Code") and Title 22 of the California Code of Regulations (hereinafter identified as "Regulations").
- B. I agree to operate the voluntary plan in conformity with the Code and Regulations and in accordance with the provisions of the voluntary plan text provided to the Employment Development Department Voluntary Plan Group.
- C. I understand and agree that approval of the plan is contingent upon the deposit of security as required under the Code and Regulations, and further agree that such security may be held or disposed of in accordance with the provisions of the Code and Regulations. I agree to send the security within 30 days upon notification by the Employment Development Department Voluntary Plan Group.
- D. I agree to pay any assessments which are levied in conformity with the Code and Regulations.
- E. I certify that all eligible employees were given the opportunity to elect or reject coverage under the plan and that a majority of the eligible employees consented, in writing, to coverage under the plan.
- F. I agree to offer the plan to all eligible new employees, and will maintain available for inspection by Department representatives the signed consent documents of all employees.
- G. I certify that the plan will be in effect for not less than one year and that no reduction in disability benefits or increase in employee contributions for disability benefits will be made while the plan is in effect without the approval of the Department.
- H. I certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true and correct.

Complete this side if plan is proposed by the employer.

By \_\_\_\_\_  
(Must be signed by Owner, Partner, or Officer if a Corporation)

\_\_\_\_\_  
Print Name and Title

Date \_\_\_\_\_

Complete this side if plan is proposed by an employee group.

By \_\_\_\_\_  
Authorized Representative

\_\_\_\_\_  
Print Name and Title

The employer consents to the proposed plan and agrees to make employee deductions, if any.

By \_\_\_\_\_  
(Must be signed by Owner, Partner, or Officer if a Corporation)

\_\_\_\_\_  
Print Name and Title

Date \_\_\_\_\_