

SDI Online Tutorial:

Claimant Registration, Online Access, and
Claim Filing

This tutorial will cover:

- [Benefit Programs Online New Registration](#)
- [SDI Online Account Registration](#)
- [Accessing Your Account](#)
- [Filing a Disability Insurance Claim](#)
- [Filing a Paid Family Leave Bonding Claim - New Mother](#)
- [Filing a Paid Family Leave Bonding Claim for New Mothers \(without a prior pregnancy-related disability claim\), New Fathers, or Foster Care or Adoptive Parents](#)
- [Submitting Additional Paid Family Leave Bonding Attachments](#)
- [Filing a Paid Family Leave Care Claim](#)
- [Submitting Paid Family Leave Care Claim Attachments](#)
- [Updating My Benefit Programs Online Profile - Email, Password, Security Questions, or Personal Image and Caption](#)
- [Paper Claim Forms](#)

Benefit Programs Online New Registration

The way you access Employment Development Department (EDD) benefits and services has changed.

You will now complete a one-time registration for Benefit Programs Online, which allows you to use a single login to access SDI Online and UI OnlineSM.

You will still file your Disability Insurance and Paid Family Leave claims using SDI Online.

You must complete a one-time registration in Benefit Programs Online to create a new SDI Online account.

Visit [Benefit Programs Online](http://edd.ca.gov/BPO) (edd.ca.gov/BPO) to register.

Watch our [Benefit Programs Online video \(YouTube\)](#) for registration instructions on a new account.

SDI Online Account Registration



Registration Success

You have successfully registered for an account. Return to Benefit Programs Online to log in.

[Benefit Programs Online](#)

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Once you have completed your Benefit Programs Online registration, select the **Benefit Programs Online** button to complete your SDI Online registration process.



▶ Log in to Benefit Programs Online

[En español](#)

Email:

I'm not a robot



Log In

Don't have an account? [Register now.](#)

Benefit Programs Online gives you access to these EDD services:

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

Enter the email address used to register, complete the security check, and select **Log In**.

For Spanish, select the **En español** link.



▶ Password

To log in to Benefit Programs Online, you must verify your personal image and personal caption, and enter your password.

* Use the latest version of Chrome or Firefox for the best experience.

Personal Image:



Personal Caption: Cup

* Password:

[Forgot Password?](#)

Previous

Log In

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Enter the password you created during the registration process and select **Log In**.

If you do not recognize your personal image and caption, review the email address entered on the login screen to make sure it is correct. Call 1-800-480-3287 for further assistance.



Benefit Programs Online

UI OnlineSM

Select UI Online to file a claim for Unemployment Insurance (UI) benefits or to create or access your UI Online account.

To use UI Online Mobile, you must have already created a UI Online account.

UI Online

UI Online Mobile

SDI Online

Select SDI Online to file a claim for Disability Insurance (DI) or Paid Family Leave (PFL) benefits or to create or access your SDI Online account.

SDI Online

Benefit Overpayments

Select Benefit Overpayments to view your benefit overpayment balance, make a payment, and set up an installment agreement.

Benefit Overpayments

Note: You will be logged out after 30 minutes on any page.



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

After you have logged in, select the **SDI Online** link to complete your registration for SDI Online.

SDI Online Registration

Select your account type.

Claimant

Select **Register as a Claimant** to:

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

You will need:

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

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

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

[Register as a Claimant](#)



Employer

Select **Register as an Employer** if you represent an employer.

You will need:

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

[Register as an Employer](#)

Physician/Practitioner

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

You will need:

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

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

[Register as a Physician/Practitioner](#)

You will be directed to the **SDI Online Registration Option(s)** page. Select the link for **Claimant Registration**.

Claimant: Terms and Conditions

Terms and Conditions

Please read through the entire Terms and Conditions before proceeding. The information you provide may be used to verify your identity with federal and/or state agencies. If “I Do Not Agree” is selected, you will not be able to establish an online account.

These Terms and Conditions, which include the Conditions of Use and Privacy Statements, govern the use of and access to: (i) this website (www.edd.ca.gov/); and (ii) the information on or provided through this website.

If you establish an online account you are responsible for maintaining the confidentiality of your username and password, and you are responsible for all activities which you authorize under your username and password. You agree to: (i) immediately notify the Employment Development Department (EDD) of any unauthorized use of your username and password or any other breach of security; and (ii) log out from your account at the end of each session.

By registering for an online account, you agree to check your account regularly and frequently for messages from the EDD. Please note that e-mails will only be used to send notifications to log in to your account or when you request to reset your username or password. No confidential claim information will be sent via e-mail.

The information submitted by any party will be used by the Employment Development Department to carry out its responsibilities under the California Unemployment Insurance Code, which may include the sharing of the information with other entities as required by law.

These Terms and Conditions may change from time to time and it is your responsibility to check for updates. The last revision date for these Terms and Conditions is February 1, 2012.

I have read and understand all the above information and wish to continue with establishing an account in the State Disability Insurance (SDI) Online.

You must agree to the terms and conditions to continue. Select **I Agree**.

Claimant Registration

*Indicates Required Field

Personal Information

To register for a new SDI Online account, you must enter your full legal name and date of birth as it appears on your California driver license or identification card.

*First Name:	<input type="text"/>
Middle Name:	<input type="text" value="(If you have no middle name, leave blank.)"/>
*Last Name:	<input type="text"/>
Suffix:	<input type="text" value="(If you have no suffix, leave blank.)"/>
E-mail Address:	Usability_Test92@edd.ca.gov
*Gender:	<input type="text" value="Select"/>
*Date of Birth:	<input type="text" value="(MMDDYYYY)"/>
*Social Security Number:	<input type="text" value="(Do not enter dashes)"/>
*Retype Social Security Number:	<input type="text"/>
*California Driver License or Identification Number:	<input type="text"/>
*Retype California Driver License or Identification Number:	<input type="text"/>

Cancel

Next

Provide your personal information and select **Next**.

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

Claimant: Personal Profile Information

*Indicates Required Field

Residence Address

US International

*Address Line 1:

Address Line 2:

*City:

*State:

*ZIP Code:

Mailing Address

All written correspondence from EDD regarding this account will be sent to this address.

Check here to copy your Residence Address to your Mailing Address:

US International

*Address Line 1:

Address Line 2:

*City:

*State:

*ZIP Code:

Complete your residence address and mailing address.

Phone Numbers

Choose the phone number that you would like to select as your primary phone number.

*Primary Phone Number: Home Phone Number Cell Phone Number

Home Phone Number:

Check here if the phone number is international

Cell Phone Number:

Check here if the phone number is international

Preferred Language

*Preferred Language:

Other Language:

Communication Preferences

Indicate below how you prefer to be notified.

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. Updates made to your communication preference may take additional time to take effect.

*Preferred Communication: I prefer to be notified by e-mail.
 I prefer to be notified by paper mail

Next, provide your phone numbers, preferred language, and communication preference, then select **Submit**.

Claimant: Personal Profile Information

* Indicates Required Field

Address Validation

The address you have provided has been updated to meet USPS standards. Please verify the address is correct.

Entered Address

1123 Main Street
Sacramento CA 95814

Updated Address

123 Main Street
Sacramento CA 95814

Would you like to proceed with the standardized address? Select 'Yes' to proceed or 'No' to return to correct the address.

Verify the address shown is correct and select **Yes**.

If the address information is incorrect, select **No** to return and correct the address.

SDI Online Account Registration Complete

Account Registration Successful

Your SDI Online account has been created and your EDD Customer Account Number is 4608393031. A notification has been sent to you via email and US Postal Service.

Select **Benefit Programs Online** to log in to your SDI Online account.

[Benefit Programs Online](#)

Have you heard of Paid Family Leave? You or a family member may be eligible.

People who qualify for PFL can get benefits when they need time off work to:

- Care for a seriously ill child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner
- Bond with a new child after birth, adoption, or foster care placement

Visit [Paid Family Leave](#) to learn about eligibility and how to apply.

You have successfully completed your SDI Online account registration and have been given an EDD Customer Account Number to reference.

You may now access your **Home** page by selecting the **Benefit Programs Online** link above to log in and file your claim.



▶ Log in to Benefit Programs Online

[En español](#)

Email:

I'm not a robot



reCAPTCHA
[Privacy](#) - [Terms](#)

Log In

Don't have an account? [Register now.](#)

Benefit Programs Online gives you access to these EDD services:

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

Enter the email address you used to register, complete the security check, and select **Log In**. You will then be directed to the **Password** page.



▶ Password

To log in to Benefit Programs Online, you must verify your personal image and personal caption, and enter your password.

* Use the latest version of Chrome or Firefox for the best experience.

Personal Image:



Personal Caption: Cup

* Password:

[Forgot Password?](#)

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Log In

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Provide your password and select **Log In** to file your claim.

If you do not recognize your personal image and caption, review the email address entered on the login screen to make sure it is correct. Call 1-800-480-3287 for further assistance.

Accessing Your Account



▶ Log in to Benefit Programs Online

[En español](#)

Email:

I'm not a robot



reCAPTCHA

[Privacy](#) - [Terms](#)

Log In

Don't have an account? [Register now.](#)

Benefit Programs Online gives you access to these EDD services:

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

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

Enter the email address used to register, complete the security check, and select **Log In**. You will then be directed to the **Password** page.



▶ Password

To log in to Benefit Programs Online, you must verify your personal image and personal caption, and enter your password.

* Use the latest version of Chrome or Firefox for the best experience.

Personal Image:



Personal Caption: Cup

* Password:

[Forgot Password?](#)

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Enter the password you created during the registration process and select **Log In**.

If you do not recognize your personal image and caption, review the email address entered on the login screen to make sure it is correct. Call 1-800-480-3287 for further assistance.



Benefit Programs Online

UI OnlineSM

Select UI Online to file a claim for Unemployment Insurance (UI) benefits or to create or access your UI Online account.

To use UI Online Mobile, you must have already created a UI Online account.

UI Online

UI Online Mobile

SDI Online

Select SDI Online to file a claim for Disability Insurance (DI) or Paid Family Leave (PFL) benefits or to create or access your SDI Online account.

SDI Online

Benefit Overpayments

Select Benefit Overpayments to view your benefit overpayment balance, make a payment, and set up an installment agreement.

Benefit Overpayments

Note: You will be logged out after 30 minutes on any page.

Select **SDI Online**.

Home

Message Center

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

Inbox [New: 0, Total: 0]

Personal Information

Full Name:	John Doe	EDD Customer Account Number:	123456789
Mailing Address:	123 Main St Sacramento, CA 95814	Phone Number:	916-555-1212
Residence Address:	123 Main St Sacramento, CA 95814	Cell Phone Number:	916-555-1213
E-mail Address:	Jdoe@gmail.com		

Current Disability Insurance Claim(s)

No Results Found

Pending Disability Insurance Claim Application(s)

No Results Found

Submitted Paid Family Leave Claim Forms

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

No Results Found



Once you have successfully logged into your account, you will be directed to your **Home** page.

Filing a Disability Insurance Claim

Home

Message Center

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

Inbox [New: 0, Total: 0]

Personal Information

Full Name:	John Doe	EDD Customer Account Number:	123456789
Mailing Address:	123 Main St Sacramento, CA 95814	Phone Number:	916-555-1212
Residence Address:	123 Main St Sacramento, CA 95814	Cell Phone Number:	916-555-1213
E-mail Address:	Jdoe@gmail.com		

Current Disability Insurance Claim(s)

No Results Found

Pending Disability Insurance Claim Application(s)

No Results Found

Submitted Paid Family Leave Claim Forms

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

No Results Found

Log into your SDI Online account using Benefit Programs Online and select **SDI Online** to be directed to your **Home** page.

To file a Disability Insurance claim, select **New Claim** from the menu.

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 or mailed in a Claim for Disability Insurance Benefits, DE2501 or a Claim for Paid Family Leave, DE2501F, 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](#)

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.

No Results Found

Select the **Disability Insurance** link.

Disability Insurance Claim Filing Instructions

Before You Start and After You File

Please have the following information available while completing this form:

- Most current employer(s) business name, telephone number, and mailing address as stated on your W2 form and/or paycheck stub.
- Last date you worked your regular or customary duties and hours.
- Date you began working at less than full duty or modified duty.
- Wages you received or expect to receive from your employer: sick leave, paid time off (PTO), vacation pay, annual leave, and wages earned after you stopped working.
- Workers' Compensation claim information, if applicable.
- The name, address, and telephone number, if any, of the Alcoholic Recovery Home or Drug-Free Facility where you are currently receiving in-patient treatment.
- You are responsible for obtaining a Physician/Practitioner Certification for your disability. Your claim will be returned if the Physician/Practitioner Certification is not received within 30 days. Please note that your employer will be notified that you have submitted a DI claim. However, your detailed claim information is confidential and will not be shared with your employer.

Cancel

Next

The **Disability Insurance Claim Filing Instructions** page provides important information you will need to file a Disability Insurance claim.

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

Personal Information



You are currently on Step 1 Personal Information

Section 1 - Personal Information

Social Security Number:	XXX-XX-XXXX	EDD Customer Account Number:	1234567890
Legal Name:	John Doe	California Driver License or ID Number:	X1234567
Date of Birth:	01-01-XXXX	Gender:	Male
Preferred Language:	English	Residence Address:	123 Main St Sacramento, CA 95814
Mailing Address:	123 Main St Sacramento, CA 95814	Cell Phone Number:	555-123-4567
Home Phone Number:			

Section 2 - Other Names and Social Security Numbers Used

Please enter any other names or other Social Security Numbers under which you have worked. If you have never worked under another name or Social Security Number please leave this section blank.

First Name:	<input type="text"/>	Middle Initial:	<input type="text"/>
Last Name:	<input type="text"/>	Suffix:	<input type="text"/>
Social Security Number:	<input type="text"/>		
First Name:	<input type="text"/>	Middle Initial:	<input type="text"/>
Last Name:	<input type="text"/>	Suffix:	<input type="text"/>
Social Security Number:	<input type="text"/>		

Information from your SDI Online account will automatically populate in portions of the application. Verify the information and complete any open fields, as appropriate. Then select **Next**.

Note: Select **Save as Draft** at any point in the process to complete the form at a later time.

Section 3 - Employment Information

*Are you self employed? Yes No

*Are you a State Government employee? Yes No

If "Yes," indicate Bargaining Unit Number:

*At any time during your disability, were you in the custody of law enforcement authorities because you were convicted of violating law or ordinance? Yes No

*Before your disability began, what was the last day you worked?

*When did your disability begin?

Date you want your Disability Insurance claim to begin if different than the date your disability began:

*Since your disability began, have you worked or are you working any full or partial days? Yes No

*Have you recovered? Yes No

If "Yes," enter date:

*Have you returned to work?

If "Yes," enter date:

*What is your regular or customary occupation?

*Why did you stop working?

*How would you describe or classify your job?

- Mostly sitting; occasionally standing and walking; occasionally lift, carry, push, pull or otherwise move objects that weigh 10 lbs. or less
- Walking/standing most of the time; occasionally lift, carry, push, pull or otherwise move objects that weigh up to 20 lbs.
- Constantly lift, carry, push, pull or otherwise move objects that weigh up to 10 lbs.; frequently up to 20 lbs.; occasionally up to 50 lbs.
- Constantly lift, carry, push, pull or otherwise move objects that weigh up to 20 lbs.; frequently up to 50 lbs.; occasionally up to 100 lbs.
- Constantly lift, carry, push, pull or otherwise move objects that weigh up to 20 lbs.; frequently over 50 lbs.; occasionally over 100 lbs.

*Has or will your employer continue to pay you during your disability leave? Yes No

If "Yes," indicate type(s) of pay:

- Sick
- Vacation
- Paid Time Off
- Annual Leave
- Other Type of Pay

Other Type of Pay:

*May we disclose benefit payment information to your employer(s)? Yes No

*Have you filed or do you intend to file for Workers' Compensation benefits? Yes No

*Was this disability caused by your job? Yes No

*Are you a resident of an alcohol recovery home or drug-free facility? Yes No

Previous

Cancel

Save as Draft

Next

Complete the **Employment Information** section and select **Next**.

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

Employment Summary

✓ Personal Information ✓ Initial Questions **3** Employment Information 4 Additional Information 5 Certification

You are currently on Step 3 Employment Information

Section 4A - List of Employers

Please click the "Add" button to add information about your last or current employer. You must add at least one employer.

No Results Found

Previous

Cancel

Add

Save as Draft

Next

Select **Add**.

Employer Search

✓ Personal Information ✓ Initial Questions 3 Employment Information 4 Additional Information 5 Certification

You are currently on Step 3 Employment Information

* Indicates Required Field

Section 4B - Search Criteria

Please search for your current or most recent employer. After clicking the "Search" button, if your employer is not found, click the "Not Found" button to enter your employer information.

* Employer Name: 

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, then select **Search**.

Section 4B - Search Criteria

Please search for your current or most recent employer. After clicking the "Search" button, if your employer is not found, click the "Not Found" button to enter your employer information.

* Employer Name:

Begins With



B Dalton

Reset

Search

Search Results

Employer Name	Action
B Dalton Bookseller	Select

Previous

Cancel

Not Found

Select your employer from the options in the search results.

If your employer is not listed under **Search Results**, select **Not Found**.

Section 4C - Employer Contact Information

Enter your current or most recent employer's contact information as found on your W2 and/or paycheck stub. If you are a State government employee, enter the agency name (for example, Caltrans). If you are self-employed, enter "Self."

Last or Current Employer Name: B Dalton Bookseller

US International

Address Line 1:

Address Line 2:

City:

State: CA

ZIP Code:

Employer Phone Number: **Ext:**

Check here if the phone number is international

Employment Information

* Before your disability began, what was the last day you worked for this employer? (MMDDYYYY)

* Do you currently have another employer that you have not yet reported? Yes No

Previous

Cancel

Save as Draft

Next

If you selected your employer from the options in the search results, you will be asked to complete the **Employer Contact Information** and **Employment Information** sections, then select **Next**.

Select **Yes** to "Do you currently have another employer that you have not yet reported?" to enter additional employers.

Employment Details (Add Employer)

* Indicates Required Field

Section 4D - Employer Contact Information

Enter your most recent employer first. If your employer has a PO Box, please use that as their mailing address. If you have more than one employer, you must provide the information for each additional employer. If you are a State government employee, enter the agency name (for example Caltrans). If you are self employed, enter "Self."

* **Last or Current Employer Name:**

Please provide your most current employer's mailing address as found on your W2 form and/or paycheck stubs. If your employer has a PO Box please use that as their mailing address.

US International

* **Address Line 1:**

Address Line 2:

* **City:**

* **State:**

* **ZIP Code:**

Employer Phone Number: **Ext:**

Check here if the phone number is international

Employment Information

* **Before your disability began, what was the last day you worked for this employer?**

* **Do you currently have another employer that you have not yet reported?** Yes No

If you selected **Not Found** in Section 4B, you will add your employer information here. Complete all required fields and select **Next**.

Select **Yes** to "Do you currently have another employer that you have not yet reported?" to enter additional employers.

Employment Details (Add Employer)

* Indicates Required Field

Address Validation

The address you have provided has been updated to meet USPS standards. Please verify the address is correct.

Entered Address

800 Captiol Mall
Sacramento CA 95814

Updated Address

800 Capitol Mall
Sacramento CA 95814 - 4807

Would you like to proceed with the standardized address? Select 'Yes' to proceed or 'No' to return to correct the address.

No

Yes

The SDI Online system may adjust the employer address information to follow US Postal Service standards. Confirm the **Updated Address** section is correct by selecting **Yes**.

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

Declaration



You are currently on Step 5 Certification

*Indicates Required Field

Section 9 - Payment Choice

If you are eligible to receive benefits, you have two options to receive your benefit payments: by the EDD Debit CardSM, through Bank of America, or by check, which is mailed to you from the Employment Development Department (EDD). You do not have to accept the EDD Debit Card. Select your preferred payment method below.

***Preferred Payment Method:** EDD Debit Card
 Check

Disclosures Agreement: [EDD Debit Card Fee Disclosures, DE 5617PD \(PDF\)](#)

I acknowledge that I have reviewed the EDD Debit Card Fee Disclosures.

On the **Declaration** page (Section 9) 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 and select the check box below to acknowledge you have reviewed the disclosures.

Section 10 - Declaration

By my signature on this claim statement, I claim benefits and certify that for the period covered by this claim I was unemployed and disabled. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law and that such violation is punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to the best of my knowledge and belief true, correct, and complete. By my signature on this claim statement, I authorize the California Department of Industrial Relations and my employer to furnish and disclose to State Disability Insurance all facts concerning my disability, wages or earnings, and benefit payments that are within their knowledge. By my signature on this claim statement, I authorize release and use of information as stated in the "Information Collection and Access" section of the [Important Disability Insurance Program Information](#) page. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature of the effective date of the claim, whichever is later.

Health Insurance Portability and Accountability Act (HIPAA)

I authorize the below named Physician/Practitioner 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 the 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.

Authorized Physician/Practitioner Name:

To print or view your application in a new window, select [Claim for Disability Insurance \(DI\) Benefits \(DE 2501\)](#). To save and file your claim, select Submit.

[View Claim: Claim for Disability Insurance \(DI\) Benefits \(DE 2501\)](#)

Previous

Cancel

Save as Draft

Submit

On the **Declaration** page (Section 10) select the first check box to authorize an electronic signature. Select the second check box and enter the name of your physician/practitioner in the field.

Both boxes must be selected to complete your claim. Select the ***Claim for Disability Insurance (DI) Benefits (DE 2501)*** link to view or print your application for your records. Select **Submit** to finalize the process.

Confirmation

Confirmation

You are responsible for providing your claim receipt number to your physician/practitioner so they may complete and submit a medical certification for your claim. Your claim form is not complete without the Physician/Practitioner's Certificate. For faster processing, your physician/practitioner may complete and submit this form online at www.edd.ca.gov.

Alternatively, your physician/practitioner may submit the Physician/Practitioner's Certificate using the paper "Claim for Disability Insurance (DI) Benefits", DE 2501 form and mailing it to the EDD. Have your physician/practitioner complete and sign "Part B - PHYSICIAN/PRACTITIONER'S CERTIFICATE." Certification may be made by a licensed physician or practitioner authorized to certify to a patient's disability or serious health condition pursuant to California Unemployment Insurance Code, Section 2708. If you are under the care of an accredited religious practitioner, obtain a "Claim for Disability Insurance Benefits - Religious Practitioner's Certificate," DE 2502, by calling 1-800-480-3287 and ask your religious practitioner to complete and sign it. Rubber stamp signatures are not accepted.

Your completed claim form must be received no earlier than 9 days, but no later than 49 days, after the first day you became disabled. If your completed claim form is late, you may lose benefits. Most claims are processed within 14 days of receipt of a properly completed claim form, which includes your portion of the DE 2501 and the Physician/Practitioner's Certificate.

If you are receiving temporary workers' compensation benefits and are filing for reduced Disability Insurance benefits for the same days, "PART B - PHYSICIAN/PRACTITIONER'S CERTIFICATE" of this form is not required, however after filing, contact SDI by calling 1-800-480-3287.

Form Receipt Number: R100000000035351

Customer Satisfaction Survey

Your opinion is important to us. Select the link below to complete a survey about your online experience.

[Link to Survey](#)

The **Confirmation** page will provide a **Form Receipt Number**, which you need to give to your physician/practitioner.

Note: Your physician/practitioner can complete the medical certificate through SDI Online or by completing 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 was submitted.

Filing 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 [Filing 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.

Home

Message Center

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

Inbox [New: 0 , Total: 0]

Personal Information

Full Name:	Jane Doe	EDD Customer Account Number:	123456789
Mailing Address:	123 Main St Sacramento, CA 95814	Phone Number:	916-555-1212
Residence Address:	123 Main St Sacramento, CA 95814	Cell Phone Number:	916-555-1213
E-mail Address:	Jdoe@gmail.com		

Current Disability Insurance Claim(s)

Log into your SDI Online account using Benefit Programs Online and select **SDI Online** to be directed to your **SDI Home** page.

To file a Paid Family Leave bonding claim for new mothers, begin by selecting **Inbox** from the menu or the **Message Center**.

Forms Available to Submit Online

Claim Information

Claimant Name: Jane Doe

Claim ID: DI-1000-XXX-XXX

Expected Return to Work Date: 03-05-2018

Claim Effective Date: 02-15-2018

Forms Available to Submit

Below is a list of forms available to submit electronically. If you have received a form in the mail, return it by the due date listed on the form. Please allow 5-7 business days for your form to be processed.

If you have already submitted or mailed any of the forms listed below, do not submit a duplicate form. Submitting duplicate forms may delay the processing of your claim.

Note: "The DE 2587 Notice-Automatic Payment" will only apply to your Disability Insurance claim and should not be used if you are currently receiving Paid Family Leave benefits.

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

[Paid Family Leave Bonding](#)

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.

Form Name	Saved Date	Drafts will be saved until	Select
2500A Cert for Continued Benefits	06-29-2018	07-29-2018	<input type="checkbox"/>

Delete

Select the **Paid Family Leave Bonding** link.

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 or mailed in a Claim for Disability Insurance Benefits, DE2501 or a Claim for Paid Family Leave, DE2501F, 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](#)

Prescreening Questions

* Indicates Required Field

Prescreening Questions

* Are you a mother bonding with your newborn? Yes No

* Did you receive California State Disability Insurance benefits for your pregnancy with this newborn? Yes No

Cancel

Next

Answer the prescreening questions:

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

Initial Questions



You are currently on Step 1 Initial Questions

* Indicates Required Field

Section 1 - Contact Information

Claimant Name: Jane Doe

EDD Customer Account Number: 123456789

Mailing Address: 123 Main St
Sacramento, CA 95814
United States

Phone Number: 916-555-1212

If your personal information has changed, select Save as Draft. To update your personal information before completing this form, select Profile. Submission of the Claim for Paid Family Leave (PFL) Benefits – New Mother, DE2501FP, is available Monday – Saturday, 6 a.m. to 6 p.m. and Sunday, 6 a.m. to 5:30 p.m.

Is this address different from the address where you received your last payment for your Disability Insurance claim? Yes No

*** Have you stopped claiming Disability Insurance benefits?** Yes No

Previous

Cancel

Save as Draft

Next

Information from your SDI Online account will automatically populate portions of the Paid Family Leave claim form.

Verify the information and complete any open fields, as appropriate. Then select **Next**.

DI Claim Information

✓ Initial Questions

2 DI Claim Information

3 Claim Information

4 Declaration

You are currently on Step 2 DI Claim Information

Section 2 - DI Claim Information

Social Security Number: xxx-xx-xxxx

* Disability Insurance Claim Effective Date:

(MMDDYYYY)

* Final Date of Disability Insurance Benefits:

(MMDDYYYY)

Do not submit this form unless you have stopped claiming Disability Insurance benefits and you are ready to claim PFL benefits to bond with your baby/babies.

Previous

Cancel

Save as Draft

Next

Verify information then select **Next**.

Note: Select **Save as Draft** at any point in the process to complete the form at a later time.

Paid Family Leave Claim Information

- Initial Questions
- DI Claim Information
- 3 Claim Information**
- 4 Declaration

You are currently on Step 3 Claim Information

*Indicates Required Field

Section 3 - Baby Information

If you had a multiple birth, provide information for only one baby.

*Baby's First Name:

Baby's Middle Initial:

*Baby's Last Name:

Baby's Suffix:

*Baby's Date of Birth:

*Baby's Gender: Male Female

Section 4 - Paid Family Leave Claim Information

Any overlapping period between Disability Insurance and Paid Family Leave will result in a disqualification of benefits from one of the programs.

*Last Day Worked:

*Do you want your Paid Family Leave claim to begin on the day after you stop claiming disability insurance benefits? Yes No

If "No," enter the date you want your Paid Family Leave claim to begin:

*Do you want to claim the maximum amount of benefit weeks now? Yes No

If "No," enter the date you want to be paid through:

Section 5 - Employer Information

*Will you work at any time during your family leave? Yes No

If "Yes," enter the date you returned to work:

*Will you continue to receive wages from your employer(s) during the period you are claiming Paid Family Leave benefits? Yes No

If "Yes," indicate type of pay:

Beginning Payment Date:

Ending Payment Date:

*Do you have more than one employer? Yes No

*Have you filed or do you intend to file for workers' compensation benefits? Yes No

- Previous
- Cancel
- Save as Draft
- Next**

Complete the **Baby Information, Paid Family Leave Claim Information, and Employer Information** sections and select **Next**.

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

Declaration

Initial Questions ✓ DI Claim Information ✓ Claim Information ✓ 4 Declaration

You are currently on Step 4 Declaration

* Indicates Required Field

Section 6 - Payment Choice

If you are eligible to receive benefits, you have two options to receive your benefit payments: by the EDD Debit CardSM, through Bank of America, or by check, which is mailed to you from the Employment Development Department (EDD). You do not have to accept the EDD Debit Card. Select your preferred payment method below.

* Preferred Payment Method: EDD Debit Card
 Check

Disclosures Agreement: [EDD Debit Card Fee Disclosures, DE 5617PD \(PDF\)](#)

* acknowledge that I have reviewed the EDD Debit Card Fee Disclosures.

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

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

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

Section 7 - Declaration

Read the information below and check the box if you agree. A check in the box indicates an electronic signature executed by you, and is a legally binding equivalent of traditional hand-written signatures.

By my electronic signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was bonding with the bonding recipient named above; (2) authorize EDD to release my personal information as shown on this claim to the bonding recipient; (3) authorize my employer(s) to disclose to EDD all facts concerning my employment that are within their knowledge; and (4) authorize release and use of information as stated in the Information Collection and Access section of the [Important Paid Family Leave Program Information](#) page. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my electronic signature or the effective date of the claim, whichever is later.

Previous

Cancel

Save as Draft

Submit

Select the box to authorize an electronic signature and the release and use of your information.

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 *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, a **Receipt Number** will appear.

Save this number for future reference.

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**.

Applying for Claim for Paid Family Leave (PFL) Benefits - New Mother

* Indicates Required Field

Applying for Claim for Paid Family Leave (PFL) Benefits - New Mother

Read the information below and check the box if you agree. A check in the box indicates an electronic signature executed by you, and is a legally binding equivalent of traditional hand-written signatures.

* I have read and understand the instructions above. I understand that failure to supply any or all information may cause delay in issuing benefit checks or may cause a denial of benefits. If I make any false statement or misrepresentation or knowingly withhold of a material fact to obtain or increase any benefit or payment, EDD will disqualify me from receiving benefits and/or services and may initiate criminal prosecution against me.

Previous

Cancel

Next

Select the box to authorize an electronic signature.

Select **Next**.

Paid Family Leave (PFL) Survey Questions

* Indicates Required Field

Paid Family Leave (PFL) Survey

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

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

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

Submit

Select a response to the question that best applies to you.

Select **Submit**.

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

Home

Message Center

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

Inbox [New: 0, Total: 0]

Personal Information

Full Name: John Doe

EDD Customer Account Number: 123456789

Mailing Address: 123 Main St
Sacramento, CA 95814

Phone Number: 916-555-1212

Residence Address: 123 Main St
Sacramento, CA 95814

Cell Phone Number: 916-555-1213

E-mail Address: Jdoe@gmail.com

Current Disability Insurance Claim(s)

Log into your SDI Online account using Benefit Programs Online and select **SDI Online** to be directed to your **Home** page. To file a Paid Family Leave bonding claim, select **New Claim** from the menu.

Note: You will need to provide proof of relationship to complete your claim. Please refer to the [Submitting Additional Paid Family Leave Bonding Attachments](#) section of this tutorial for instructions on uploading documents.

Personal Information

Full Name:	John Doe	EDD Customer Account Number:	123456789
Mailing Address:	123 Main St Sacramento, CA 95814	Phone Number:	916-555-1212
Residence Address:	123 Main St Sacramento, CA 95814	Cell Phone Number:	916-555-1213
E-mail Address:	Jdoe@gmail.com		

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 or mailed in a Claim for Disability Insurance Benefits, DE2501 or a Claim for Paid Family Leave, DE2501F, 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](#)

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.

No Results Found

Select the **Paid Family Leave Bonding** link.

Prescreening Questions

* Indicates Required Field

Prescreening Questions

* Are you a mother bonding with your newborn? Yes No

* Did you receive California State Disability Insurance benefits for your pregnancy with this newborn? Yes No

Cancel

Next

Answer the prescreening questions, then select **Next**.

- 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.

Information for Before You Start and After You File

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

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

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

PROOF OF RELATIONSHIP FOR BONDING

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

- Child's Birth Certificate
- Official letter from foster care agency
- Child's Hospital Birth Certificate
- Adoptive Placement Agreement, AD-907
- Declaration of Paternity, CS-609

After You Have Filed Your Application

WHEN YOUR CLAIM IS RECEIVED

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

SPECIAL CIRCUMSTANCES RELATING TO YOUR PAID FAMILY LEAVE CLAIM

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

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

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

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

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

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

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

Phone Number Link

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

Frequently Asked Questions Link

<http://www.edd.ca.gov/Disability/FAQs.htm#pfl>

Cancel

Next

The **Information for Before You Start and After You File** page provides important information you will need to file a Paid Family Leave bonding claim.

Review the information provided. At the bottom of the page, select **Next**.

View [Types of Claims](http://edd.ca.gov/Disability/Types_of_Claims.htm) (edd.ca.gov/Disability/Types_of_Claims.htm) on the EDD website for more information about which type of claim to file or follow the links provided on the page for additional information.

Applying for Paid Family Leave (PFL) Initial Claim Form for Bonding

* Indicates Required Field

Applying for Paid Family Leave (PFL) Initial Claim Form for Bonding (DE 2501F)

Please read these instructions and information before completing the electronic Claim for Paid Family Leave (PFL) Benefits (DE 2501F). Do not complete this claim form if you are insured by a Voluntary Plan maintained by your employer. (Ask your employer for the proper forms.)

The Paid Family Leave (PFL) program provides affordable, worker-funded benefits to eligible workers suffering a full or partial loss of wages due to the need to care for a seriously ill family member or to bond with a new child.

The California State Paid Family Leave Program is a recipient of state funds obtained from SDI deductions on wages received by employees of employers in the State of California. The PFL Program is an equal opportunity employer/program, and is in compliance with section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA).

(B) Call 1-877-238-4373 for required forms and instructions if:
1. A disability prevents you from completing the claim form and you need to designate a representative to sign for you.
2. You are an authorized representative filing for benefits on behalf of a physically or mentally incapacitated care provider/care recipient or a deceased care provider/care recipient.

BONDING: Do NOT submit an electronic PFL Claim for bonding if the purpose of your family leave is to care for a seriously ill family member. Follow these instructions to file for a Paid Family Leave Care application.

1. Select New Claim.
2. Choose Paid Family Leave Care.

INELIGIBILITY:

You may apply for benefits even if you are not sure you are eligible. If you are found to be ineligible for all or part of a period claimed, you will be notified of the ineligible period and the reason(s) why you were not eligible. Below are some reasons why you may not be eligible for benefits:

- If you are claiming or receiving Unemployment Insurance or Disability Insurance (DI) benefits.
- If you are receiving workers' compensation benefits at a weekly rate equal to or greater than the PFL rate.
- If you are in custody of law enforcement authorities because you were convicted of violating law or ordinance.

FRAUD:

If you are eligible for further benefits, additional payments will either be sent automatically or in response to your submitted certification, whichever is appropriate to your claim. You will be paid 1/7 of your weekly benefit amount for each calendar day you are eligible unless benefits are reduced for some reason. (See [Calculating Paid Family Leave Benefit Payment Amounts](#) for more information.)

TAXABILITY OF BENEFITS: Paid Family Leave benefits are subject to federal income taxes and will be reported to the Internal Revenue Service. Each person receiving PFL benefits will receive a 1099G form to include with his/her federal income tax return. PFL benefits are not subject to California income taxes.

OVERPAYMENT: An overpayment results when you receive PFL benefits you were not eligible to receive. Once PFL determines that you were overpaid, the PFL office will contact you to explain the reason for your overpayment. It is important that you complete and return all information requests, as there are some instances when an overpayment can be waived. If it is determined that you were overpaid and the overpayment cannot be waived, you must repay this money. Benefit payments issued after an overpayment is established may be reduced by 25 to 100 percent to collect your payment. You will receive a "Notice of Overpayment Offset" if a reduction is taken for a DI, PFL, or Unemployment Insurance (UI) overpayment.

DISQUALIFICATION: All available information will be considered before paying or disqualifying your claim. Benefits will be paid only for the days for which you are eligible. If payment of benefits is denied or reduced for any period, you will receive a written notice stating the reason for the disqualification or reduction.

If you deliberately report incorrect information, willfully omit or withhold information, a false statement disqualification of up to 92 days may be assessed. In addition, any resulting payment may be increased by a 30 percent penalty. This penalty can apply to benefits you received but were not entitled to, even if the payment has not been cashed.

I have read and understand the instructions above. I understand that failure to supply any or all information may cause delay in issuing benefit payments or may cause a denial of benefits. If I make any false statement or misrepresentation or knowingly withhold of a material fact to obtain or increase any benefit or payment, EDD will disqualify me from receiving benefits and/or services and may initiate criminal prosecution against me.

Previous

Cancel

Next

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

Review the information or select links for more information, and select the box to agree to the terms.

Then select **Next** at the bottom of the page.

Personal Information

1 Personal Information

2 Employment Information

3 Additional Questions

4 Bonding Certification

5 Declaration

You are currently on Step 1 Personal Information

Section 1 - Personal Information

Social Security Number: xxx-xx-xxxx

EDD Customer Account Number: 123456789

Full Name: John Doe

Other Names (if any, under which you have worked):

Date of Birth: XX-XX-XXXX

Gender: Male

Mailing Address: 123 Main St
Sacramento, CA 95814
United States

Phone Number: 916-555-1213

Preferred Language: English

If any of your personal information has changed from what is listed above, please save this form as a draft. Select Profile to update your personal information before completing this form.

Previous

Cancel

Save as Draft

Next

Verify your information in the **Personal Information** section. This information is automatically populated from your SDI Online account. Then select **Next**.

Note: Select **Save as Draft** at any point in the process to complete the form at a later time.

Employment Details



You are currently on Step 2 Employment Information

* Indicates Required Field

Section 2 - Employer Information

Enter your current employer. If unemployed, enter your most recent employer.

* Name of Your Employer:

* Occupation:

* Are you a state government employee? Yes No

If "Yes", Indicate Bargaining Unit Number:

* May we disclose benefit payment information to your employer(s)? Yes No

* Do you have more than one employer? Yes No

* Reason for reducing work hours or stopping work: Bonding with a child Other

Other Reason:

Employer Mailing Address

US International

* Address Line 1:

Address Line 2:

* City:

* State:

* ZIP Code:

Employer Phone Number: Ext:

Check here if the phone number is international

Previous

Cancel

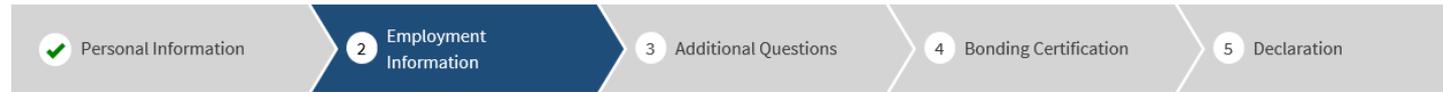
Save as Draft

Next

Complete the **Employer Information** section and select **Next**.

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

Employment Details



You are currently on Step 2 Employment Information

*Indicates Required Field

Address Validation

The address you have provided has been updated to meet USPS standards. Please verify the address is correct.

Entered Address

414 k st
sacramento CA 95834

Updated Address

414 K St
Sacramento CA 95814 - 3335

Would you like to proceed with the standardized address? Select 'Yes' to proceed or 'No' to return to correct the address.

No

Yes

The SDI Online system may adjust the employer address information to follow US Postal Service standards. Confirm the **Updated Address** section is correct by selecting **Yes**.

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

Additional Questions



You are currently on Step 3 Additional Questions

*Indicates Required Field

Section 7 - Additional Questions

*Date you last worked:

The date you want your Paid Family Leave claim to begin should not be before the child's date of birth (or the Date of foster care or adoption placement).

*Date you want your Paid Family Leave claim to begin:

*Do you want to claim the maximum amount of benefit weeks now? Yes No

If "No," enter the date you want to be paid through:

Date you returned to work:

Or date you plan to return to work:

*Will you work at any time during your family leave? Yes No

If you will receive any type of pay from your employer(s) during your family leave, indicate type of pay:
 Sick
 Employer Required Vacation
 Other Type of Pay

Specify if "Other type of pay":

*At any time during your Paid Family Leave, were you in the custody of law enforcement authorities because you were convicted of violating a law or ordinance? Yes No

*Have you claimed or do you plan to claim Workers' Compensation Benefits for any portion of the period covered by this claim? Yes No

Previous

Cancel

Save as Draft

Next

Complete the **Additional Questions** section and select **Next**.

Bonding Certification

✓ Personal Information ✓ Employment Information ✓ Additional Questions **4 Bonding Certification** 5 Declaration

You are currently on Step 4 Bonding Certification

* Indicates Required Field

Section 3 - Personal Information

* Child relationship:

If you select foster care, adoption or guardianship, please provide the date of placement:

Section 4 - Child's Legal Name and Information

Child's Social Security Number (if available):

* Child's First Name:

Middle Initial:

* Last Name:

Suffix:

* Date of Birth:

* Child's Gender: Male Female

* Is child's residence address different from your residence address? Yes No

Select your relationship to the child with whom you are bonding from the drop-down menu in the **Personal Information** section. Complete the **Child's Legal Name and Information** section.

Note: If child's legal residence is different than yours, another screen will appear to give the child's legal address.

Section 5 - 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.

Proof of Relationship document includes:

- 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

*** Please indicate the type of "Proof of Relationship" you plan on providing from the list of approved "Proof of Relationship" documents:**

Failure to submit the "Proof of Relationship" will result in claim disqualification and no payment will be issued. Further instructions for submitting "Proof of Relationship" will be provided on the confirmation page.

Previous

Cancel

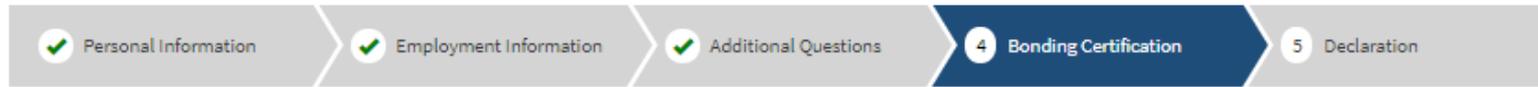
Save as Draft

Next

Your options for accepted Proof of Relationship documents are listed on the page.

From the drop-down menu, select the document you will be providing to prove your relationship to the child. Then select **Next**.

Child's Residence Address



You are currently on Step 4 Bonding Certification

*Indicates Required Field

Section 6 - Residence Address

US International

*Address Line 1:

Address Line 2:

*City:

*State:

*ZIP Code:

Previous

Cancel

Save as Draft

Next

If the child's residence is different than yours, enter the child's residential address information and select **Next**.

Declaration



Personal Information



Employment Information



Additional Questions



Bonding Certification

5

Declaration

You are currently on Step 5 Declaration

* Indicates Required Field

Section 8 - Payment Choice

If you are eligible to receive benefits, you have two options to receive your benefit payments: by the EDD Debit CardSM, through Bank of America, or by check, which is mailed to you from the Employment Development Department (EDD). You do not have to accept the EDD Debit Card. Select your preferred payment method below.

* Preferred Payment Method: EDD Debit Card
 Check

Disclosures Agreement: [EDD Debit Card Fee Disclosures, DE 5617PD \(PDF\)](#)

* I acknowledge that I have reviewed the EDD Debit Card Fee Disclosures.

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

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

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

Section 9 - Declaration

Read the information below and check the box if you agree. A check in the box indicates an electronic signature executed by you, and is a legally binding equivalent of traditional hand-written signatures.

By my signature on this bonding certification, I authorize the medical provider, adoption agency, adoption party(ies), or foster care placement agency to disclose to the Employment Development Department all facts concerning the birth, adoption, or foster care placement of the above-named child. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, 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 authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.

By my electronic signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was bonding with the bonding recipient named above; (2) authorize EDD to release my personal information as shown on this claim to the bonding recipient; (3) authorize my employer(s) to disclose to EDD all facts concerning my employment that are within their knowledge; and (4) authorize release and use of information as stated in the Information Collection and Access section of the [Important Paid Family Leave Program Information](#) page. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my electronic signature or the effective date of the claim, whichever is later.

Previous

Cancel

Save as Draft

Submit

Select both boxes to authorize an electronic signature, and the release and use of your information. Then select **Submit**.

Paid Family Leave (PFL) Survey Questions

* Indicates Required Field

Paid Family Leave (PFL) Survey

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

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

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

Submit

Complete the survey and select **Submit**.

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: John Doe

Social Security Number: XXX-XX-XXXX

Date you requested to have your Paid 07-01-2018

Receipt Number: R100000000033001

Family Leave claim begin:

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

On the **Confirmation** screen, a **Receipt Number** will appear.

Save this number for future reference.

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 by mail or electronically.

Select the **Proof of Relationship** link and follow the instructions to submit this information electronically or mail your proof of relationship to the address on the screen.

Home

Message Center

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

Inbox [New: 0 , Total: 0]

Personal Information

Full Name: John Doe

EDD Customer Account Number: 123456789

Mailing Address: 123 Main St
Sacramento, CA 95814

Phone Number: 916-555-1212

Residence Address: 123 Main St
Sacramento, CA 95814

Cell Phone Number: 916-555-1213

E-mail Address: Jdoe@gmail.com

Current Disability Insurance Claim(s)

No Results Found

Pending Disability Insurance Claim Application(s)

To submit your proof of relationship document electronically, select **New Claim** from the menu in your SDI Online account.

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted or mailed in a Claim for Disability Insurance Benefits, DE2501 or a Claim for Paid Family Leave, DE2501F, 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](#)

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.

No Results Found

Select the **Submit Electronic Paid Family Leave Bonding Attachment** link.

Attachment

* Indicates Required Field

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: 05-06-2018

Form Receipt Number: R100000000035357

Previously Submitted Attachments for Paid Family Leave Initial Bonding Claim

No Results Found

Attachment

To attach a document, select the Browse button below.

- File size: less than 5MB
- File type: PDF, JPG, JPEG, TIF or TIFF

* Please click the "Browse" button to browse for the document:

No file chosen

Browse

* Do you want to attach more documents? Yes No

Previous

Cancel

Submit

To begin submitting your proof of relationship electronically, select the **Browse** button.

Note: To browse and attach a document, you will need to have previously scanned and saved the document on your computer as a PDF, JPG, JPEG, TIF, or TIFF file.

Once you have attached your document, select **Submit** to finalize the process.

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 02-02-2017
Family Leave claim begin:

Form Receipt Number: R100000000035351

Previously Submitted Attachments for Paid Family Leave Initial Bonding Claim

File Name	Receipt Number
Birth Certificate.jpg	R100000000035359

This page confirms that the attachment has been submitted. Save the **Receipt Number** for future reference.

You have now completed your bonding claim which should be processed by the EDD within 14 business days.

Submitting Additional Paid Family Leave Bonding Attachments

Home

Message Center

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

Inbox [New: 0 , Total: 0]

Personal Information

Full Name:	John Doe	EDD Customer Account Number:	123456789
Mailing Address:	123 Main St Sacramento, CA 95814	Phone Number:	916-555-1212
Residence Address:	123 Main St Sacramento, CA 95814	Cell Phone Number:	916-555-1213
E-mail Address:	Jdoe@gmail.com		

Current Disability Insurance Claim(s)

If you need to submit more than one (e.g. birth certificates for twins or to resubmit a previous document), select **New Claim** from the menu in your SDI Online account.

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted or mailed in a Claim for Disability Insurance Benefits, DE2501 or a Claim for Paid Family Leave, DE2501F, 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](#)

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.

No Results Found

Select the **Submit Electronic Paid Family Leave Bonding Attachment** link.

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

Attachment

* Indicates Required Field

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: 05-06-2018

Form Receipt Number: R100000000035357

Previously Submitted Attachments for Paid Family Leave Initial Bonding Claim

No Results Found

Attachment

To attach a document, select the Browse button below.

- File size: less than 5MB
- File type: PDF, JPG, JPEG, TIF or TIFF

* Please click the "Browse" button to browse for the document:

No file chosen

Browse

* Do you want to attach more documents?

Yes No

Previous

Cancel

Submit

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

To upload another document, select **Yes** and then select the **Browse** button.

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 page confirms that the attachment has been submitted. Save the **Receipt Number** for future reference.

You have now completed your bonding claim which should be processed by the EDD within 14 business days.

Filing a Paid Family Leave Care Claim

Home

Message Center

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

Inbox [New: 0 , Total: 0]

Personal Information

Full Name:	John Doe	EDD Customer Account Number:	123456789
Mailing Address:	123 Main St Sacramento, CA 95814	Phone Number:	916-555-1212
Residence Address:	123 Main St Sacramento, CA 95814	Cell Phone Number:	916-555-1213
E-mail Address:	Jdoe@gmail.com		

Current Disability Insurance Claim(s)

No Results Found

Pending Disability Insurance Claim Application(s)

No Results Found

Submitted Paid Family Leave Claim Forms

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

No Results Found

Once you have successfully logged into your SDI Online account, you will be directed to the **Home** page. To file a Paid Family Leave care claim, select **New Claim** from the menu.

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 or mailed in a Claim for Disability Insurance Benefits, DE2501 or a Claim for Paid Family Leave, DE2501F, 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](#)

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.

No Results Found

Select the **Paid Family Leave Care** link.

Refer to [Types of Claims](http://edd.ca.gov/Disability/Types_of_Claims.htm) (edd.ca.gov/Disability/Types_of_Claims.htm) on the EDD website for more information about which type of claim to file.

Information for Before You Start and After You File

Before You Start and After You File

Please have the following information available while completing this form:

- Most current employer(s) business name, telephone number, and mailing address as stated on your W2 form and/or paycheck stub.
- Last date you worked your regular or customary duties and hours.
- Wages you received or expect to receive from your employer: sick leave, paid time off (PTO), vacation pay, annual leave, and wages earned after you stopped working.
- You are responsible for obtaining a Physician/Practitioner Certification to verify care is needed. A disqualification will be sent to you if the Physician/Practitioner Certification is not received within 10 days.
- Please note that your employer will be notified that you have submitted a PFL claim. However, your detailed claim information is confidential and will not be shared with your employer.

Cancel

Next

This screen provides important information you will need to know to file a Paid Family Leave care claim.

Review the information provided and select **Next**.

1 Personal Information

2 Employment Information

3 Additional Questions

4 Care Certification

5 Declaration

You are currently on Step 1 Personal Information

Section 1 - Personal Information

Social Security Number: XXX-XX-XXXX

EDD Customer Account Number: 123456789

Full Name: John Doe

Other Names (if any, under which you have worked):

Date of Birth: XX-XX-XXXX

Gender: Male

Mailing Address: 123 Main St
Sacramento, CA 95814

Phone Number: 916-555-1212

Preferred Language:

If your personal information has changed, select Save as Draft. To update your personal information before completing this form, select Profile.

Previous

Cancel

Save as Draft

Next

Information from your SDI Online account will automatically populate portions of the Paid Family Leave claim form.

Verify the information and complete any open fields, as appropriate. Then select **Next**.

Note: Select **Save as Draft** at any point in the process to complete the form at a later time.

Employment Details

- 1 Personal Information
- 2 Employment Information**
- 3 Additional Questions
- 4 Care Certification
- 5 Declaration

You are currently on Step 2 Employment Information

* Indicates Required Field

Section 2 - Employer Information

Enter your current employer. If unemployed, enter your most recent employer.

* Name of Your Employer:

* Occupation:

* Are you a state government employee? Yes No

If "Yes", Indicate Bargaining Unit Number:

* May we disclose benefit payment information to your employer(s)? Yes No

* Do you have more than one employer? Yes No

* Reason for reducing work hours or stopping work: Care for Family Member Other

Employer Mailing Address

US International

* Address Line 1:

Address Line 2:

* City:

* State: CA

* ZIP Code:

Employer Phone Number: (No dashes or spaces) Ext:

Check here if the phone number is international

Previous

Cancel

Save as Draft

Next

Complete the **Employer Information** section with information about your employer and select **Next**.

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

Additional Questions



You are currently on Step 3 Additional Questions

*Indicates Required Field

Section 3 - Additional Questions

*Date you last worked:

*Date you want your Paid Family Leave claim to begin:

*Do you want to claim the maximum amount of benefit weeks now? Yes No

If "No," enter the date you want to be paid through:

Date you returned to work:

Or date you plan to return to work:

*Will you work at any time during your family leave? Yes No

If you will receive any type of pay from your employer(s) during your family leave, indicate type of pay:
 Sick
 Employer Required Vacation
 Other Type of Pay

Specify if "Other type of pay":

*At any time during your Paid Family Leave, were you in the custody of law enforcement authorities because you were convicted of violating a law or ordinance? Yes No

*Have you claimed or do you plan to claim Workers' Compensation Benefits for any portion of the period covered by this claim? Yes No

Previous

Cancel

Save as Draft

Next

Complete the **Additional Questions** section and select **Next**.

Care Recipient's Information

Personal Information Employment Information Additional Questions **4 Care Certification** 5 Declaration

You are currently on Step 4 Care Certification

* Indicates Required Field

Section 4 - Care Recipient's Information

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

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

* First Name:

Middle Initial:

* Last Name:

Suffix:

* Gender: Male Female

* Date of Birth:

* Is any other family member ready, willing, and able and available to provide care for the same period you are claiming Paid Family Leave benefits? Yes No

* Person you are caring for is your:

Other Relationship:

Residence Address

US International

* Address Line 1:

Address Line 2:

* City:

* State:

* ZIP Code:

Phone Number: Ext:

Check here if the phone number is international

Previous

Cancel

Save as Draft

Next

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

Then select **Next**.

Declaration



You are currently on Step 5 Declaration

* Indicates Required Field

Section 5 - Payment Choice

If you are eligible to receive benefits, you have two options to receive your benefit payments: by the EDD Debit CardSM, through Bank of America, or by check, which is mailed to you from the Employment Development Department (EDD). You do not have to accept the EDD Debit Card. Select your preferred payment method below.

* Preferred Payment Method: EDD Debit Card
 Check

Disclosures Agreement: [EDD Debit Card Fee Disclosures, DE 5617PD \(PDF\)](#)

* I acknowledge that I have reviewed the EDD Debit Card Fee Disclosures.

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

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

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

Section 6 - Declaration

Read the information below and check each box if you agree. A check in the box indicates an electronic signature executed by you, and is a legally binding equivalent of traditional handwritten signatures.

* By my electronic signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was providing care for the care recipient named above; (2) authorize EDD to release my personal information as shown on this claim to the care recipient and to the care recipient's treating physician/practitioner as they are listed on this claim; (3) authorize my employer(s) to disclose to EDD all facts concerning my employment that are within their knowledge; and (4) authorize release and use of information as stated in the EDD "Information Collection and Access" section of the [Important Paid Family Leave Program Information](#) page. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my electronic signature or the effective date of the claim, whichever is later.

Previous

Cancel

Save as Draft

Submit

Select the box to authorize an electronic signature. You must select this box to complete your claim. Select **Submit**.

Note: Your claim is not complete. You still need to submit the Statement of Care Recipient, Care Recipient's Authorization for Disclosure of Personal-Health Information and the Physician's/Practitioner's Certification sections of the *Claim for Paid Family Leave (PFL) Care Benefits* (DE 2501FC).

Paid Family Leave (PFL) Survey Questions

* Indicates Required Field

Paid Family Leave (PFL) Survey

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

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

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

Submit

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

Claimant Name: Jane Doe
Date you requested to have your Paid Family Leave claim begin: 08-01-2018

Social Security Number: XXX-XX-XXXX

Receipt Number: R10000000033448

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

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

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

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

Electronically

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

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

You may also submit it at a later time by following these navigation instructions:

1. Select New Claim
2. Choose Submit Electronic Paid Family Leave Care Attachment.

Mail

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, a **Receipt Number** will appear.

Save this number for future reference.

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

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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 also find instructions to complete your Paid Family Leave care claim.

Select the link to open a PDF copy of the *Claim for Paid Family Leave (PFL) Care Benefits (DE 2501FC)* form. Print this PDF and have it filled out entirely and signed by all parties.

You can also print the DE 2501FC form and the *Solicitud de Beneficios del Permiso Familiar Pagado (PFL) para Proveer Cuidado (DE 2501FC/S)* from [Paid Family Leave Forms and Publications](http://edd.ca.gov/pfl_forms_and_publications.htm) (edd.ca.gov/pfl_forms_and_publications.htm).

Once the DE 2501FC is completed and signed, scan and save it (as a PDF, JPG, JPEG, TIF, or TIFF file) to your computer if you will submit it electronically.

You may also mail the completed form to the address on this page.



Claim for Paid Family Leave (PFL) Care Benefits

Enter your receipt number here.

RI

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.” Read and sign the “Care Recipient’s Authorization for Disclosure of Personal-Health information” on page 2. If the care recipient is physically or mentally unable to sign, call PFL at 1-877-238-4373 for instructions.

Both pages may be mailed or sent electronically in SDI Online as attachments. If submitting by mail, send to the following address: Paid Family Leave, PO Box 997017, Sacramento, CA 95899-7017. If submitting electronically in SDI Online, under Main Menu on your Home page click on: “File a New Claim,” then click “Submit Electronic Paid Family Leave Care Attachments.”

If the care recipient’s physician/practitioner has completed “Part D – Physician/Practitioner’s Certification” ONLINE (electronically), Stop Here! Do not go to the next step.

Have the care recipient’s physician/practitioner complete and sign “Part D – Physician/Practitioner’s Certification” and mail it to the following address: Paid Family Leave, PO Box 997017, Sacramento, CA 95899-7017. If the care recipient is under the care of an accredited religious practitioner, call PFL at 1-877-238-4373 for the proper form DE 2502F.

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 M M D D Y Y Y Y	
		c3. RECIPIENT'S PHONE NUMBER	
		c4. RECIPIENT'S GENDER MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
c6. LEGAL NAME OF CARE RECIPIENT (FIRST, MIDDLE INITIAL, LAST)			
c8. CARE RECIPIENT'S RESIDENCE ADDRESS			
CITY		STATE/PROV. ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)	
c7. CONFIRMATION OF MEDICAL DISCLOSURE AUTHORIZATION. I have read and signed the Care Recipient's Authorization for Disclosure of Personal-Health Information on page 2 of this claim. I understand that by signing it I have agreed to all its provisions and terms. I further understand that copies of my signature below are as valid as the original.			
Care Recipient's Signature (DO NOT PRINT)		Date Signed (MM DD YYYY)	
c8. Authorized Representative signing on behalf of care recipient must complete the following: I, _____, represent the care or bonding recipient in this matter as authorized by <input type="checkbox"/> parental right <input type="checkbox"/> power of attorney (attach copy) <input type="checkbox"/> court order (attach copy) (For spouse or domestic partner, contact EDD).			
Authorized Representative's Signature (DO NOT PRINT)		Date Signed (MM DD YYYY)	

2

3

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 electronic 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 agent must sign and date the bottom of this page.

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

Enter your receipt number here.

R1

1

**CARE RECIPIENT'S AUTHORIZATION FOR DISCLOSURE OF
PERSONAL-HEALTH INFORMATION**

I authorize my physician or practitioner, as identified on Part D of this claim, to disclose my current personal-health information to my care provider, as identified on Part A of this claim, and to the California Employment Development Department (EDD).

I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and an estimation of the amount of care that I require from my care provider as a result of my current condition. I further understand that disclosure of my personal-health information may include my AIDS/HIV status, drug or alcohol addiction, or any other physical or mental condition.

I understand that EDD may disclose this information as authorized by the California Unemployment Insurance Code and that such re-disclosed information may no longer be protected. I agree that photocopies of the authorization form in conjunction with my signature on Page 1 in Item C7 of Part C shall be as valid as the original.

I understand that unless I inform EDD in writing at PO Box 997017, Sacramento, CA 95899-7017, that I wish to revoke this authorization, it will be valid for 10 years from the date EDD receives it or the effective date of this claim, whichever is later. I understand that I have the right to receive a copy of an authorization form from EDD if I request one in writing.

I make this authorization to support my care provider's claim for Paid Family Leave benefits. I understand that I may not revoke my authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

**WE CANNOT PROCESS THIS CLAIM UNLESS YOU SIGN BOTH THIS PAGE AND
PAGE 1 IN ITEM C7 OF PART C.**

Care recipient's name (Print your name)

2

Date signed

Care recipient's signature (Sign your name)

Page 2 is the Care Recipient's
Authorization for Disclosure of
Personal-Health Information.

1. Be sure to enter the receipt number you were given when you completed the electronic portion of your Paid Family Leave care claim in the top right corner.
2. The care recipient or his/her authorized agent must sign and date the bottom of this page.

Medical certifications must be completed by a licensed physician or practitioner authorized to certify to 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)
---	---

2

D3. PATIENT'S DATE OF BIRTH M M D D Y Y Y Y	D4. DOES YOUR PATIENT REQUIRE CARE BY THE CARE PROVIDER? YES <input type="checkbox"/> NO (SKIP TO D16) <input type="checkbox"/>
--	--

D6. PATIENT'S NAME (FIRST, MIDDLE INITIAL, LAST)

D8. 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 M M D D Y Y Y Y
----------------------	-------------------------	---

D10. FIRST DATE CARE NEEDED M M D D Y Y Y Y	D11. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CARE PROVIDER M M D D Y Y Y Y PERMANENT CARE REQUIRED <input type="checkbox"/>	D12. DATE YOU EXPECT RECOVERY M M D D Y Y Y Y NEVER <input type="checkbox"/>
--	---	---

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 <input type="checkbox"/> NO <input type="checkbox"/>	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	PHYSICIAN/PRACTITIONER'S PHONE NUMBER	Date Signed (MM DD YYYY)
---	---------------------------------------	--------------------------

3

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.

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.

Submitting Paid Family Leave Care Claim Attachments

Home

Message Center

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

Inbox [New: 0 , Total: 0]

Personal Information

Full Name: John Doe

EDD Customer Account Number: 123456789

Mailing Address:
123 Main St
Sacramento, CA 95814

Phone Number: 916-555-1212

Residence Address:
123 Main St
Sacramento, CA 95814

Cell Phone Number: 916-555-1213

E-mail Address:
Jdoe@gmail.com

Current Disability Insurance Claim(s)

To attach your completed and signed *Claim for Paid Family Leave (PFL) Care Benefits* (DE 2501FC) to your claim, return to your SDI Online account **Home** page. Select **New Claim** from the menu.

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 or mailed in a Claim for Disability Insurance Benefits, DE2501 or a Claim for Paid Family Leave, DE2501F, 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](#)

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.

No Results Found

Select the **Submit Electronic Paid Family Leave Care Attachment** link.

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

Attachment

* Indicates Required Field

Identifying Information for Previously Submitted Paid Family Leave Initial Care Claim

Your Social Security Number: XXX-XX-XXXX

Date you requested to have your Paid Family Leave claim begin: 08-01-2018

Form Receipt Number: R100000000033448

Previously Submitted Attachments for Paid Family Leave Initial Care Claim

No Results Found

Attachment

To be eligible for Paid Family Leave benefits to care for a family member, you must submit a "Doctor's certification for care recipient" and "Care recipient authorization for disclosure of personal health information". These documents must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online care claim.

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

To attach a document, select the Browse button below.

- File size: less than 5MB
- File type: PDF, JPG, JPEG, TIF or TIFF

* Please click the "Browse" button to browse for the document:

No file chosen

Browse

* Do you want to attach more documents? Yes No

Previous

Cancel

Submit

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

Note: To browse and attach a document, you will need to have previously scanned and saved the document on your computer as a PDF, JPG, JPEG, TIF, or TIFF file.

Attachment

* Indicates Required Field

Identifying Information for Previously Submitted Paid Family Leave Initial Care Claim

Your Social Security Number: XXX-XX-XXXX

Date you requested to have your Paid Family Leave claim begin: 08-01-2018

Form Receipt Number: R10000000033448

Previously Submitted Attachments for Paid Family Leave Initial Care Claim

No Results Found

Attachment

To be eligible for Paid Family Leave benefits to care for a family member, you must submit a "Doctor's certification for care recipient" and "Care recipient authorization for disclosure of personal health information". These documents must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online care claim.

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

To attach a document, select the Browse button below.

- File size: less than 5MB
- File type: PDF, JPG, JPEG, TIF or TIFF

* Please click the "Browse" button to browse for the document:

No file chosen

Browse

* Do you want to attach more documents? Yes No

Previous

Cancel

Submit



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

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

Attachment Confirmation

Identifying Information for Previously Submitted Paid Family Leave Initial Care Claim

Your Social Security Number: XXX-XX-XXXX

Date you requested to have your Paid 08-01-2018

Family Leave claim begin:

Form Receipt Number: R100000000033448

Previously Submitted Attachments for Paid Family Leave Initial Care Claim

File Name	Receipt Number
Care Recipient Authorization.JPG	R100000000033449

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

Save the **Receipt Number** for future reference.

You have now completed your care claim which should be processed by the EDD within 14 business days.

Updating My Benefit Programs Online Profile -

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



Log in to Benefit Programs Online

[En español](#)

Email:

I'm not a robot



reCAPTCHA
Privacy - Terms

Log In

Don't have an account? [Register now.](#)

Benefit Programs Online gives you access to these EDD services:

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

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

Enter the email address used to register, complete the security check, and select **Log In**. You will then be directed to the **Password** page.



▶ Password

To log in to Benefit Programs Online, you must verify your personal image and personal caption, and enter your password.

* Use the latest version of Chrome or Firefox for the best experience.

Personal Image:



Personal Caption: Cup

* Password:

[Forgot Password?](#)

Previous

Log In

[Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Accessibility](#)

Copyright © 2019 State of California

Enter your password and select **Login**.

If you do not recognize your personal image and caption, review the email address entered on the login screen to make sure it is correct. Call 1-800-480-3287 for further assistance.



My Profile

Benefit Programs Online

Benefit Programs Online

UI OnlineSM

Select UI Online to file a claim for Unemployment Insurance (UI) benefits or to create or access your UI Online account.

To use UI Online Mobile, you must have already created a UI Online account.

UI Online

UI Online Mobile

SDI Online

Select SDI Online to file a claim for Disability Insurance (DI) or Paid Family Leave (PFL) benefits or to create or access your SDI Online account.

SDI Online

Benefit Overpayments

Select Benefit Overpayments to view your benefit overpayment balance, make a payment, and set up an installment agreement.

Benefit Overpayments

Note: You will be logged out after 30 minutes on any page.

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



My Profile

Select the links to the right of each section to update your profile.

Note: You will be logged out after 30 minutes on any page. Any information entered will not be saved.

Email and Password

Email: rreleigh@lou.com

[Update Email](#)

Password: *****

[Update Password](#)

Security Questions

[Update Security Questions](#)

Question 1: What was the first movie you saw in a movie theater?

Answer: *****

Question 2: Where is the coldest location you visited as a child?

Answer: *****

Question 3: What is the name of your favorite cartoon character?

Answer: *****

Question 4: What was your father's occupation?

Answer: *****

Personal Image and Caption

[Update Personal Image and Caption](#)

Personal Image:



Personal Caption: UAT

On the **My Profile** page select the link to the section you wish to update.

Follow the instructions given to update your profile information.



▶ My Profile

You have successfully updated your profile. A notification will be sent to your email confirming this update.

Email and Password

Update Email

Email: Savanna.spence1@lou.com

Update Password

Password: *****

Security Questions

Update Security Questions

Question 1: Where did you celebrate your 21st birthday?

Answer: *****

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

Note: Use your SDI Online account profile to update your mailing and residence address, phone number, and preferences for language and communication.

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: 0000000000

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

I authorize G e o f f r e B l o o k e r
(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) Date Signed
Sample Claimant 12252015

DE 2501 Rev. 01 (3-20) (INTRANET) Page 7 of 13

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

The DE 2501 for Disability Insurance benefits and the DE 2501F for Paid Family Leave benefits are scanned to interface with SDI Online. 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.

SAMPLE, this page for reference only

EDD Employment Development Department
State of California
Claim for Paid Family Leave (PFL) Benefits

PART A - STATEMENT OF CLAIMANT (CARE OR BONDING PROVIDER)

ALL YOUR SOCIAL SECURITY NOS. 0000000000 010119000 X

ALL YOUR LEGAL NAME FIRST NAME LAST NAME MI CLAMANT CLAIMANT X

ALL YOUR TELEPHONE NUMBERS 999 0236789

ALL YOUR MAILING ADDRESS (INCLUDE MAIL IF APPLICABLE) 123 ANY STREET ANYTOWN CA 12345

ALL NAME OF YOUR EMPLOYER ROADRUNNER PASTRIES MAILING ADDRESS 647 ARMISTICE WAY CITY STATE/ZIP OR PHYSICAL CARE EMPLOYER'S TELEPHONE NUMBER ANYWHERE CA 6222 499 311111

ALL DATE YOU LAST WORKED 12012015 ALL DATE YOU WANT YOUR PFL CLAIM TO BEGIN 12162015 ALL DATE YOU RETURNED OR WILL RETURN TO WORK 01272016 ALL DID YOU WORK OR WILL YOU CONTINUE TO WORK DURING YOUR FAMILY LEAVE PERIOD? X

ALL WHY DID YOU OR WILL YOU REDUCE YOUR WORK HOURS OR STOP WORKING? CARE NUMBER 0000000000 OTHER EXPLAN: ALL WHAT IS YOUR OCCUPATION? PAstry CHRF

ALL LEGAL NAME OF PERSON FOR WHOM YOU ARE CAREING FOR: ALL HOME PHONE: ALL DID YOU OR WITH WHOM YOU ARE BONDING (CARE OR BONDING RECIPIENT)? COOKIE CLAIMANT

ALL THE ABOVE-NAMED CARE OR BONDING RECIPIENT IS YOUR: ALL IS ANY OTHER FAMILY MEMBER HELP, WILLING, AND ABLE AND AVAILABLE TO PROVIDE CARE FOR THE SAME PERSON YOU ARE CLAIMING PFL BENEFITS? X

ALL DO YOU HAVE MORE THAN ONE EMPLOYER? X ALL IF YOUR EMPLOYER CONTINUED OR WILL CONTINUE TO PAY YOU DURING YOUR FAMILY LEAVE, INDICATE TYPE OF PAY: ALL HAS MY EMPLOYER PROVIDED BENEFIT INFORMATION TO YOUR EMPLOYER? X

ALL IF ANY TIME DURING YOUR PFL LEAVE, WERE YOU IN THE CUSTODY OF LAW ENFORCEMENT AUTHORITIES BECAUSE YOU WERE CONVICTED OF VIOLATING A LAW OR ORDINANCE? X

ALL Declaration and Signature: By my signature on this claim statement, I (I) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I am providing care for a family unit for one or more specified dates; (2) authorize the EDD to release my personal information as shown on this claim to the state employer and the state employer's physician as they are permitted under the PFL and the DI of this claim; (3) authorize my employer as defined in (EDD) all laws concerning my employment that are within their knowledge; and (4) authorize release and use of information as stated in the "Information Collection and Use" section. I understand that I will continue to be responsible for providing care for the family unit throughout the period of the claim, and that the amount and duration of the benefits will be determined by the state employer. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature on the electronic claim or the date of this printed claim.

Claimant Signature (DO NOT PRINT) Date Signed
Sample Claimant 12162015

*If care recipient is made by mark 'X', it must be attested by two witnesses with their addresses.
**Witness Signature and Address

DE 2501F Rev. 4.7.20) (INTRANET) Page 5 of 8

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

SAMPLE, this page for reference only



Claim for Disability Insurance (DI) Benefits

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Claimant Social Security Number 0000000000

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

I authorize Geoffrey 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 12252015

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.

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 0 0 0 0 0 0 0 0 0 0	A2. IF YOU HAVE PREVIOUSLY BEEN ASSIGNED AN EDD CUSTOMER ACCOUNT NUMBER, ENTER THAT NUMBER HERE N o	A3. CALIFORNIA DRIVER LICENSE OR ID NUMBER Z 1 2 3 4 5 6 7	A4. GENDER MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>
A5. IF YOU EVER USED OTHER SOCIAL SECURITY NUMBERS, ENTER THOSE NUMBERS BELOW		A6. STATE GOVERNMENT EMPLOYEE (IF "YES" INDICATE BARGAINING UNIT#) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNIT#	A7. YOUR DATE OF BIRTH 0 1 0 1 1 9 0 0
A8. YOUR LEGAL NAME (FIRST) (M) (LAST) SUFFIX S a m p l e C l a i m a n t			
A9. OTHER NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED (FIRST) (M) (LAST) SUFFIX			
A10. YOUR HOME AREA CODE AND TELEPHONE NUMBER 9 9 9 0 2 3 6 7 8 9			
A11. YOUR CELL AREA CODE AND TELEPHONE NUMBER 1 1 1 0 0 2 0 0 4 7			
A12. LANGUAGE YOU PREFER TO USE ENGLISH <input checked="" type="checkbox"/> SPANISH <input type="checkbox"/> CANTONESE <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> ARMENIAN <input type="checkbox"/> PUNJABI <input type="checkbox"/> TAGALOG <input type="checkbox"/> OTHER <input type="checkbox"/>			
A13. YOUR MAILING ADDRESS, PO BOX OR NUMBER/STREET/APARTMENT, SUITE, SPACE#, OR PMB# (PRIVATE MAIL BOX) 1 2 3 A n y S t r e e t CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.) A n y t o w n C A 1 2 3 4 5			
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. <input type="checkbox"/> SELF NAME OF YOUR EMPLOYER (STATE GOVERNMENT EMPLOYEES: PROVIDE THE AGENCY NAME (FOR EXAMPLE: CALTRANS)) R o a d r u n n e r P a s t r i e s NUMBER/STREET/SUITE# (STATE GOVERNMENT EMPLOYEES: PLEASE PROVIDE THE ADDRESS OF YOUR PERSONNEL OFFICE) 6 4 7 A r m i s t i c e W a y CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.) A n y w h e r e C A 6 6 2 2 2 EMPLOYER'S TELEPHONE NUMBER 4 9 9 3 1 1 1 1 1 1			
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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		A17. BEFORE YOUR DISABILITY BEGAN, WHAT WAS THE LAST DAY YOU WORKED? 1 2 0 1 2 0 1 5	
A18. WHEN DID YOUR DISABILITY BEGIN? 1 2 1 6 2 0 1 5	A19. DATE YOU WANT YOUR CLAIM TO BEGIN IF DIFFERENT THAN THE DATE ENTERED IN A18 M M O O Y Y Y Y		
A20. SINCE YOUR DISABILITY BEGAN, HAVE YOU WORKED OR ARE YOU WORKING ANY FULL OR PARTIAL DAYS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	A21 A. IF YOU RECOVERED, ENTER DATE: M M O O Y Y Y Y	A21 B. IF YOU RETURNED TO WORK, ENTER DATE: M M O O Y Y Y Y	

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, if eligible.

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 0000000000 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 COUNTRY

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 STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)
Anywhere CA 72694
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 MMDDYY CHECK HERE TO INDICATE YOU ARE STILL TREATING THE PATIENT
AT INTERVALS OF: DAILY WEEKLY 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?
 YES - ENTER DATE DISABILITY BEGAN 12162015 NO - SKIP TO B23
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.) MMDDYY
 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: MMDDYY DATE PREGNANCY ENDED: MMDDYY
TYPE OF DELIVERY, IF PATIENT HAS DELIVERED: VAGINAL CESAREAN

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

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

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

SAMPLE, this page for reference only



Claim for Paid Family Leave (PFL) Benefits

PART A - STATEMENT OF CLAIMANT (CARE OR BONDING PROVIDER)

A1. YOUR SOCIAL SECURITY NO. 0000000000 A2. YOUR DATE OF BIRTH M D Y Y Y 01011900 A3. LANGUAGE YOU PREFER TO USE ENGLISH SPANISH OTHER (PRINT BELOW) X

A4. YOUR LEGAL NAME FIRST NAME MI LAST NAME SAMPLE CLAIMANT A5. YOUR GENDER MALE FEMALE X

A6. YOUR TELEPHONE NUMBER 9990236789 A7. OTHER LAST NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED

A8. YOUR MAILING ADDRESS (TO RECEIVE MAIL AT A PRIVATE MAIL BOX - NOT A U.S. POSTAL SERVICE BOX - YOU MUST SHOW THE NUMBER IN THE "PMBS" SPACE) PMBS (IF APPLICABLE) 123 ANY STREET CITY STATE/PROV. ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.) ANYTOWN CA 12345

A9. NAME OF YOUR EMPLOYER MAILING ADDRESS ROADRUNNER PASTRIES 647 ARMISTICE WAY CITY STATE/PROV. ZIP OR POSTAL CODE EMPLOYER'S TELEPHONE NUMBER ANYWHERE CA 66222 4993111111

A10. DATE YOU LAST WORKED M M D D Y Y Y Y 12012015 A11. DATE YOU WANT YOUR PFL CLAIM TO BEGIN M M D D Y Y Y Y 12162015 A12. DATE YOU RETURNED OR WILL RETURN TO WORK M M D D Y Y Y Y 01272016 A13. DID YOU WORK OR WILL YOU CONTINUE TO WORK DURING YOUR FAMILY LEAVE PERIOD? NO YES X

A14. WHY DID YOU OR WILL YOU REDUCE YOUR WORK HOURS OR STOP WORKING? CARE FOR BOND WITH FAMILY MEMBER CHILD OTHER (EXPLAIN) X A15. WHAT IS YOUR OCCUPATION? PASTRY CHEF

A16. LEGAL NAME OF PERSON FOR WHOM YOU ARE CARING (FIRST MIDDLE INITIAL LAST) OR WITH WHOM YOU ARE BONDING (CARE OR BONDING RECIPIENT) COOKIE A CLAIMANT

A17. THE ABOVE-NAMED CARE OR BONDING RECIPIENT IS YOUR: CHILD SPOUSE PARTNER PARENT IN-LAW PARENT CHILD SIBLING OTHER (EXPLAIN) X

A18. IS ANY OTHER FAMILY MEMBER READY, WILLING, AND ABLE AND AVAILABLE TO PROVIDE CARE FOR THE SAME PERIOD YOU ARE CLAIMING PFL BENEFITS? NO YES X A19. HAVE YOU CLAIMED OR DO YOU PLAN TO CLAIM WORKERS' COMPENSATION BENEFITS FOR ANY PORTION OF THE PERIOD COVERED BY THIS CLAIM? NO YES X

A20. DO YOU HAVE MORE THAN ONE EMPLOYER? NO YES X A21. IF YOUR EMPLOYER(S) CONTINUED OR WILL CONTINUE TO PAY YOU DURING YOUR FAMILY LEAVE, INDICATE TYPE OF PAY: SICK VACATION OTHER (EXPLAIN) A22. MAY WE DISCLOSE BENEFIT PAYMENT INFORMATION TO YOUR EMPLOYER(S)? NO YES X

A23. AT ANY TIME DURING YOUR PFL LEAVE, WERE YOU IN THE CUSTODY OF LAW ENFORCEMENT AUTHORITIES BECAUSE YOU WERE CONVICTED OF VIOLATING A LAW OR ORDINANCE? X NO YES

A24. Declaration and Signature. By my signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was providing care for or bonding with the care recipient named above; (2) authorize EDD to release my personal information as shown on this claim to the care recipient and to the care recipient's treating physician as they are respectively listed in Part C and Part D of this claim; (3) authorize my employer(s) to disclose to EDD all facts concerning my employment that are within their knowledge; and (4) authorize release and use of information as stated in the "Information Collection and Access" portion of this form. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.

Claimant's Signature (DO NOT PRINT) Sample Claimant If signature is made by mark (X), please place mark here.* Date Signed (M M D D Y Y Y Y) 12162015

*If your signature is made by mark (X), it must be attested by two witnesses with their addresses.
1st Witness Signature and Address 2nd Witness Signature and Address

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

Part A -Statement of Claimant, page 1.

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

SAMPLE, this page for reference only

CARE RECIPIENT'S AUTHORIZATION FOR DISCLOSURE OF PERSONAL-HEALTH INFORMATION

I authorize my physician or practitioner, as identified on Part D of this claim, to disclose my current personal-health information to my care provider, as identified on Part A of this claim, and to the California Employment Development Department (EDD).

I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and an estimation of the amount of care that I require from my care provider as a result of my current condition. I further understand that disclosure of my personal-health information may include my AIDS/HIV status, drug or alcohol addiction, or any other physical or mental condition.

I understand that EDD may disclose this information as authorized by the California Unemployment Insurance Code and that such re-disclosed information may no longer be protected. I agree that photocopies of the authorization form in conjunction with my signature on Page 3 in Item 6 of Part C shall be as valid as the original.

I understand that unless I inform EDD in writing at PO Box 989315, West Sacramento, CA 95798-9315, that I wish to revoke this authorization, it will be valid for 10 years from the date EDD receives it or the effective date of this claim, whichever is later. I understand that I have the right to receive a copy of an authorization form from EDD if I request one in writing.

I make this authorization to support my care provider's claim for Paid Family Leave benefits. I understand that I may not revoke my authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

WE CANNOT PROCESS THIS CLAIM UNLESS YOU SIGN BOTH THIS PAGE AND PAGE 3 IN ITEM C6 OF PART C.

Care recipient's name (Print your name)

Date signed

Care recipient's signature (Sign your name)

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

Care Recipient's Authorization for Disclosure of Personal-Health Information, page 2.

Only complete this page if you are filing for a Paid Family Leave care claim.

The person receiving care, or his/her authorized agent, must sign the bottom of this page.

SAMPLE, this page for reference only

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

Part B - Bonding Certification (bonding claims only) and Part C - Statement of Care Recipient (care claims only), page 3.

Part B – If you are filing a bonding claim, you must complete all bonding information and sign the form.

Part C – If you are filing a care claim, you or the care recipient must fill out the appropriate care information. The care recipient or their authorized representative must sign the form.

You will complete either Part B or Part C – but never both for one claim.

PART B – BONDING CERTIFICATION (TO BE COMPLETED BY PERSON CLAIMING PFL BENEFITS TO BOND WITH A CHILD)				
B1. YOUR SOCIAL SECURITY NUMBER 0 0 0 0 0 0 0 0 0 0	B2. DATE OF FOSTER CARE OR ADOPTION PLACEMENT M M D D Y Y Y Y	B3. CHILD NAMED IN B1 IS MY BIOLOGICAL CHILD <input checked="" type="checkbox"/> FOSTER CHILD <input type="checkbox"/> ADOPTED CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		
B4. YOUR LEGAL LAST NAME (NEEDED IN CASE PAGES OF THIS CLAIM BECOME SEPARATED) C L A I M A N T	B5. CHILD'S SOCIAL SECURITY NUMBER (IF AVAILABLE)	B6. CHILD'S DATE OF BIRTH M M D D Y Y Y Y 1 2 0 1 2 0 1 5	B7. CHILD'S GENDER MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	
B8. LEGAL NAME OF CHILD (FIRST MIDDLE INITIAL LAST) C O O K I E A C C L A I M A N T				
B9. CHILD'S RESIDENCE ADDRESS (IF DIFFERENT FROM CLAIMANT'S) CITY STATE/PROV. ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)				
B10. AS EVIDENCE OF THE RELATIONSHIP IN B3, CHECK ONE OF THE FOLLOWING AND ATTACH A COPY OF THE DOCUMENT CHECKED. (DO NOT SEND ORIGINAL DOCUMENT. IT WILL NOT BE RETURNED.)				
<input checked="" type="checkbox"/> CHILD'S BIRTH CERTIFICATE <input type="checkbox"/> ADOPTIVE PLACEMENT AGREEMENT, AD-507 <input type="checkbox"/> DECLARATION OF PATERNITY, CS-909 <input type="checkbox"/> INDEPENDENT ADOPTION PLACEMENT AGREEMENT, AD-924 <input type="checkbox"/> FOSTER CARE PLACEMENT RECORD, SOC-815 <input type="checkbox"/> OTHER				
B11. Declaration and Signature. By my signature on this bonding certification, I authorize the medical provider, adoption agency, adoption parties), or foster care placement agency to disclose to the Employment Development Department all facts concerning the birth, adoption, or foster care placement of the above-named child. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law 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 authorizations contained in this claim statement are granted 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 Bonding Claimant – RUBBER STAMP IS NOT ACCEPTABLE Sample Claimant			Date Signed (M M D D Y Y Y Y) 1 2 1 6 2 0 1 5	
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. RECIPIENT'S DATE OF BIRTH M M D D Y Y Y Y	C2. RECIPIENT'S TELEPHONE NUMBER		C3. RECIPIENT'S GENDER MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
C4. LEGAL NAME OF CARE RECIPIENT (FIRST MIDDLE INITIAL LAST)				
C5. CARE RECIPIENT'S RESIDENCE ADDRESS CITY STATE/PROV. ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)				
C6. CONFIRMATION OF MEDICAL DISCLOSURE AUTHORIZATION. I have read and signed the Care Recipient's Authorization for Disclosure of Personal-Health Information on page 2 of this claim. I understand that by signing it I have agreed to all its provisions and terms. I further understand that copies of my signature below are as valid as the original.				
Care Recipient's Signature (DO NOT PRINT)			Date Signed (M M D D Y Y Y Y)	
C7. Authorized Representative signing on behalf of care recipient must complete the following: I, _____, represent the care or bonding recipient in this matter as authorized by <input type="checkbox"/> parental right <input type="checkbox"/> power of attorney (attach copy) <input type="checkbox"/> court order (attach copy) (For spouse or domestic partner, contact EDD.)				
Authorized Representative's Signature (DO NOT PRINT)			Date Signed (M M D D Y Y Y Y)	

SAMPLE, this page for reference only

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

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 WITH A CHILD.)

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 (M M D D Y Y Y Y)	D4. DOES YOUR PATIENT REQUIRE CARE BY THE CLAIMANT? (NO NEP YES)	
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 (M M D D Y Y Y Y)
D10. FIRST DATE CARE NEEDED (M M D D Y Y Y Y)	D11. DATE YOU EXPECT RECOVERY (M M D D Y Y Y Y) NEVER	D12. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CLAIMANT (M M D D Y Y Y Y) PERMANENT
D13. APPROXIMATELY HOW MANY TOTAL HOURS PER DAY WILL PATIENT REQUIRE CLAIMANT? (HOURS COMMENTS)		
D14. WOULD DISCLOSURE OF THIS CERTIFICATE TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL? (NO YES)		
D15. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER	D16. STATE OR COUNTRY PHYSICIAN/PRACTITIONER IS LICENSED.	
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 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 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.

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

Part D - Physician/Practitioner's Certification, page 4.

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

You should make sure all pages are completed and all signatures are obtained before the claim form is mailed to the EDD for processing.

If you are filing a bonding claim, Part D is not required.



**California Employment Development Department Debit Card
Fee Disclosure and other Important Disclosures***

You have an option in how you receive your benefit payments. The Employment Development Department (EDD) issues benefit payments by the EDD Debit CardSM or by check. The EDD Debit Card is the fastest and most secure way to receive your benefits. However, you do not have to accept the EDD Debit Card.

No action is required to receive your benefits through the EDD Debit Card. Authorized benefit payments are issued on the EDD Debit Card within 24 hours and are immediately available to you.

To receive your benefits by check, complete and return this form with your claim:

If eligible, I want to receive benefit payments by check.
Allow 7-10 days for delivery of checks in the mail.

Name (Print) _____ DOB _____

Signature _____ Date _____

EDD Debit Card Fee Disclosures

Monthly Fee	Per purchase	ATM withdrawal	Cash reload
\$0	\$0	\$0 in-network \$1.00* out-of-network	N/A
ATM balance inquiry			\$0
Customer service			\$0 per call
Inactivity			\$0

We charge 5 other types of fees. Here are some of them:			
Replacement card, express delivery			\$10.00
Each international transaction			2%

*This document entitled 'Fee Disclosure and Other Important Disclosures' is included with, and incorporated in, the California Employment Development Department Debit Card Account Agreement.
 **Fees can be lower depending on how and where this card is used.
 See the materials you received with your card for free ways to access your funds and balance information.
No overdraft/credit features.
 Your funds are eligible for FDIC insurance.
 For more information about prepaid cards, visit cfpb.gov/prepaid.
 Find details and conditions for all fees and services in the cardholder agreement.

California Employment Development Department Debit Card Fee Disclosure and other Important Disclosures (DE 5617IF)

The new DE 2501F form, Rev. 3 (4-19), claim packets include the DE 5617IF insert.

ONLY complete and return this form with your claim if you prefer to receive benefit payments by check.

To request to receive benefit payments by check, mark the checkbox and print and sign your name.

If you are completing an older version of the DE 2501F, the *California Employment Development Department Debit Card Fee Disclosure and Alternate Payment Option (DE 5617)* form will be mailed to you after the EDD receives your claim.

Visit [State Disability Insurance](https://edd.ca.gov/disability)
(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 (voice) or through the California Relay Service at 711.