

SDI Online Tutorial:

Claimant Registration, Online Access, and Claim Filing

SDI Online Tutorial: Registration

▶ State Disability Insurance

Disability Insurance and Paid Family Leave Benefits

The California State Disability Insurance (SDI) program provides short-term Disability Insurance (DI) and Paid Family Leave (PFL) wage replacement benefits to eligible workers who need time off work. You may be eligible for DI if you are unable to work due to non-work-related illness or injury, pregnancy, or childbirth. You may be eligible for PFL to care for a seriously ill family member or to bond with a new child. To file for benefits, visit [SDI Online](#).

To provide feedback about the SDI information available on the EDD website, take our [SDI Survey](#).

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To create an SDI Online account, visit www.edd.ca.gov/disability.

On the **State Disability Insurance** overview page select any **SDI Online** link.

You will be directed to the **State Disability Insurance (SDI) Online** page.



SDI Online

En español

The Employment Development Department (EDD) automated some key State Disability Insurance (SDI) services to better serve you with your Disability Insurance (DI) and Paid Family Leave (PFL) needs.

SDI Online is convenient and secure. The system reduces claim processing time, provides electronic confirmation of forms submitted online, decreases costs in paper and postage, and includes security safeguards to detect and manage fraud and abuse. A mobile-friendly version, [SDI Online Mobile](#) is available for your smartphone and tablet.

Log In or Register

If you have an existing account, select the appropriate login option. Before using SDI Online or SDI Online Mobile, you must register in SDI Online.

Log In

Log into Mobile

Register

Note: If you are experiencing trouble accessing SDI Online, visit [Troubleshooting Tips for Accessing SDI Online](#).

Disability Insurance Claimants

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Select the **Register for SDI Online** link.

You will be directed to the **SDI Registration Instructions** page.



Language: English ▾

Contact SDI

Online

By Location

By Phone

Telephone

Numbers

Automated Info

System

SDI Registration Instructions

Important: You are required to have a valid e-mail address to register in SDI Online.

Welcome to State of California Employment Development Department's (EDD) State Disability Insurance (SDI) Online Registration process.

The Disability Insurance (DI) Branch of EDD provides four registration choices. Select the registration option for the type of account that you need to access the system.

CLAIMANTS

If you already have an account with SDI Online, [log in here](#). If you already have an account with Unemployment Insurance (UI Online) [log in here](#) and use your UI Online username and password to complete SDI Online registration. If you do not have an SDI Online account or UI Online account, select the [Continue to Claimant Registration](#) link to create an SDI Online account. You can file a DI or Paid Family Leave (PFL) claim, [access your personal claim information](#), and view payment history. You will need to provide your Social Security Number and California Driver License or State ID Number to complete the registration. Please check your California Driver License (CDL) or Identification (ID) card for your full legal name, correct date of birth and CDL or ID number when completing your entries. NOTE: If you do not have a CA License or ID, please contact the EDD to have the Claim for Disability Insurance (DI) Benefits – DE 2501 form mailed to you. You may request the form through [Ask EDD](#) by selecting the category <Disability Insurance Benefits>, sub-category <Miscellaneous>, topic <Other (Questions or Comments)>, and Continue. Indicate your request for the mailing of the Claim for Disability Insurance (DI) Benefits – DE 2501 form in the body of your message and select Submit. You may also obtain the claim form by visiting <http://edd.ca.gov/Forms/> or by calling 1-800-480-3287, select option 1 for English and then option 2 for forms requests. Registration is available Monday – Saturday 6 a.m. to 6 p.m. and Sunday 6 a.m. to 5:30 p.m.

PHYSICIAN/PRACTITIONERS

Select this option if you are a Physician or Practitioner who certifies DI or PFL claims for your patients. The SDI Online allows authorized Physicians and Practitioners and their designated representatives to view their patient's initial claim for benefits, submit DI and PFL claim certifications, and view their claim certification history. You will need to provide your medical license information as filed with the California Department of Consumer Affairs in order to complete registration. Physicians and Practitioners will need to first register for an account before they can designate representatives for their account. Registration is available Monday-Saturday 4 a.m. to 12 a.m. and Sunday 4 a.m. to 9 p.m.

[Continue to Physician/Practitioner Registration](#)

If a Physician or Practitioner has designated you as a representative in the system, you will need to provide registration information as entered by the Physician or Practitioner. Registration is available 24 hours a day, 7 days a week.

On the **SDI Registration Instructions** page, select the **Continue to Claimant Registration** link.

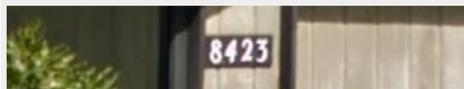
Contact SDI

- Online
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Security Check

*Indicates Required Field

Security Check



- Try Another
- Vision Impaired
- Help

This Security Check allows us to:**Ensure Restricted Access to Registration**

Automated programs known as "Bots" cannot read distorted text as well as humans. The Security Check helps prevent automated programs from blocking other users from registering for accounts with the EDD.

Provide an Audio Option for Visually Impaired Customers

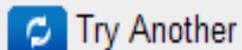
An audio option allows visually impaired customers to hear a set of eight (8) digits that can be entered instead of the word challenge.

*Please type both words separated by a space below:

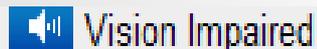
You do not have permission to access this website if you are using an automated program.

[Next](#)

On the **Security Check** page, type the text displayed then select **Next**.



Select **Try Another** to change the text shown.



Select **Vision Impaired** to listen to the words.

Contact SDI

- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

Claimant: Terms and Conditions

Terms and Conditions

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

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

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

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

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

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

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

I Do Not Agree

I Agree

Read the Terms and Conditions and select **I Agree**.

Selecting **I Do Not Agree** prevents an account from being established.

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- Online
- By Location
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Claimant: Account Verification Information

***Indicates Required Field**

If you already have an account with SDI Online, [log in here](#). If you already have an account with Unemployment Insurance (UI Online) [log in here](#) and use your UI Online username and password to complete SDI Online registration. NOTE: If you do not have a CA License or ID please contact the EDD to have the Claim for Disability Insurance (DI) Benefits – DE 2501 form mailed to you. You may request the form through [Ask EDD](#). You may also obtain the claim form by visiting <http://edd.ca.gov/Forms/> or by calling 1-800-480-3287. Registration is available Monday – Saturday 6 a.m. to 6 p.m. and Sunday 6 a.m. to 5:30 p.m.

Personal Information

Please enter your full legal name as it appears on your California Driver's License or Identification card to register.

*First Name:

Middle Name:
(If you have no middle name, leave blank.)

*Last Name:

Suffix:
(If you have no suffix, leave blank.)

*E-mail Address:

*Re-Type E-mail Address:

*Gender: ▼

*Date of Birth: (MMDDYYYY)

*Social Security Number: (Do not enter dashes)

*Re-Type Social Security Number:

*CA Driver License or CA State ID Number:

*Re-Type CA Driver License or CA State ID Number:

Next Cancel

On the **Account Verification Information** page, complete all required fields as indicated. Please use your full legal name, date of birth, and California Driver License (CDL) or Identification (ID) number as it appears on your CDL or ID when completing your entries for registration. Then select **Next**.

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

- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

Claimant: Setup Security Profile Information

***Indicates Required Field**

Account Information

Enter a Username and Password. Do not share your password with anyone.

*Username: (must be 8 to 15 characters, no special characters)

*Password: (case sensitive)
(must be 8 to 12 characters long, including an uppercase letter, a lowercase letter, a number, and one of the following: ! # \$ % ^ & * () -)

*Re-Type Password: (case sensitive)

*Password Hint: (50 characters maximum, no special characters)

Choose your Security Questions and enter your answer to each question. This will be part of your Account Recovery Options.

*Question 1:
*Answer to Question 1: (50 characters maximum, no special characters)

*Question 2:
*Answer to Question 2: (50 characters maximum, no special characters)

*Question 3:
*Answer to Question 3: (50 characters maximum, no special characters)

*Question 4:
*Answer to Question 4: (50 characters maximum, no special characters)

*Choose your Personal Image and enter a Personal Image Caption for it. The image along with your image caption helps you know that you are at a valid EDD site and that it is safe to enter information. [Refresh to get a new set of personal images.](#)



*Personal Image Caption: (50 characters maximum, no special characters)

Next | Cancel

Create a username and password. Select the security questions and provide an answer for each question.

Select a personal image and create a caption for the image. Then select **Next**.

Note: Selecting **Refresh** to get new set of personal images erases the password entered at the top of the page.



Claimant: Personal Profile Information

- Online
- By Location
- By Phone
- Telephone Numbers Automated Info System

*Indicates Required Field

Residence Address

Do not include PO BOX, PMB, General Delivery or Rural Route Number.

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:

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
(No dashes or spaces)

Cell Phone Number: Check here if the phone number is international
(No dashes or spaces)

Preferred Language

*Preferred Language:

Other Language:

Communication Preferences

Indicate below how you prefer to be notified. Some EDD forms are not available online and will be sent through the US Postal Service.

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

On the **Personal Profile Information** page, enter the required information.

Then select **Submit**.

This will complete your registration.

Contact SDI

Account Setup Confirmation

Online

By Location

By Phone

Telephone Numbers

Automated Info

System

Successful Account Creation Notification

Your account has been created and your EDD Customer Account Number is 9123456789. A notification has been sent to you via e-mail and US Postal Service. If you do not receive an email, please check your junk/spam folder. To ensure e-mails from the EDD appear in your inbox, add noreply@edd.ca.gov to your address book.

If you have not already submitted your claim form by mail, you can now log in to your SDI Online account and file a claim electronically.

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

The State Disability Insurance program also offers California workers [Paid Family Leave](#) (PFL) benefits to qualified individuals. PFL provides up to six weeks of benefits for individuals who need to take time off work to care for a seriously ill child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner, or to bond with a new child after birth, adoption or foster care placement. To receive benefits, individuals must not be receiving Disability benefits or Unemployment benefits.

[Login](#)

When the account is successfully created, the **Account Setup Confirmation** page will appear.

Select **Login** to access your newly created account.

SDI Online Tutorial: Logging into Your Account



State Disability Insurance

Disability Insurance and Paid Family Leave Benefits

The California State Disability Insurance (SDI) program provides short-term Disability Insurance (DI) and Paid Family Leave (PFL) wage replacement benefits to eligible workers who need time off work. You may be eligible for DI if you are unable to work due to non-work-related illness or injury, pregnancy, or childbirth. You may be eligible for PFL to care for a seriously ill family member or to bond with a new child. To file for benefits, visit [SDI Online](#).

To provide feedback about the SDI information available on the EDD website, take our [SDI Survey](#).

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To file a claim for Disability Insurance (DI) or Paid Family Leave (PFL) online, you must first have an SDI Online account. If you do not have an account, please refer to the SDI Online Tutorial: Registration.

To begin, visit www.edd.ca.gov/disability and select any **SDI Online** link.



SDI Online

En español

The Employment Development Department (EDD) automated some key State Disability Insurance (SDI) services to better serve you with your Disability Insurance (DI) and Paid Family Leave (PFL) needs.

SDI Online is convenient and secure. The system reduces claim processing time, provides electronic confirmation of forms submitted online, decreases costs in paper and postage, and includes security safeguards to detect and manage fraud and abuse. A mobile-friendly version, [SDI Online Mobile](#) is available for your smartphone and tablet.

Log In or Register

If you have an existing account, select the appropriate login option. Before using SDI Online or SDI Online Mobile, you must register in SDI Online.

[Log In](#)

[Log into Mobile](#)

[Register](#)

Note: If you are experiencing trouble accessing SDI Online, visit [Troubleshooting Tips for Accessing SDI Online](#).

Disability Insurance Claimants

- [How to File a DI Claim in SDI Online](#)
- [Manage Your Claim with SDI Online](#)
- [Am I Eligible for DI?](#)
- [SDI Online Tutorials](#)
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Paid Family Leave Claimants

- [How to File a PFL Claim in SDI Online](#)
- [Manage Your PFL Claim with SDI Online](#)
- [Am I Eligible for PFL?](#)
- [SDI Online Tutorials](#)
- [SDI Online Tips for Claimants](#)
- [SDI Online FAQs](#)

To access your account, select the **Log In to SDI Online** link.



Language: English ▾

Contact SDI

- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

SDI Online Login

*Indicates Required Field

*Username:

Submit

[Forgot username?](#)

[Register for a new online account](#)

SECURITY REMINDER

Enter the username you provided during registration. We will ask you for your new password and display your personal image on the next screen.

On the **SDI Online Login** page, enter your username and select **Submit**.

Help | Login

Contact SDI

Additional Authentication

Online
By Location
By Phone
Telephone Numbers
Automated Info System

*Indicates Required Field

Security Questions

To continue, please correctly answer your security questions.

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

Next Cancel

If you do not recall your previous responses, please contact EDD at (800) 480-3287. The EDD staff is available from 8 a.m. to 5 p.m. (PT), Monday through Friday, except on [state holidays](#).

Back to Top | Contact EDD | Conditions of Use | Privacy Policy | Equal Opportunity Notice

In some instances, you may be asked to respond to one or more of the security questions that you established when creating the account.

Type the answer to the security question(s) and select **Next**.

Contact SDI
Online
By Location
By Phone
Telephone Numbers
Automated Info System

Confirm Your Personal Image and Log In

*Indicates Required Field

Verify your personal image and enter your password.

Personal Image:



Personal Image Caption: Test

Username: JDoe1

*Password: ●●●●●●

(case sensitive)

Log In

[Forgot your personal image?](#)
[Incorrect personal image showing?](#)
[Forgot password?](#)

SECURITY REMINDER

Recognizing your Personal Image and Personal Image Caption helps you know that you are at a valid EDD web site, and that it is safe to enter your password.

If you do not recognize your personal image, do not enter your password.

The personal image you selected when you registered will appear on this screen. Enter your password, then select **Log In**.

Note: The personal image helps identify that you are accessing the real EDD website.

SDI Online Tutorial: Filing a Disability Insurance (DI) Claim



MAIN MENU

- Home
- Inbox
- File a New Claim**
- Continue a Saved Draft
- Manage My Profile
- My Claim History

Home

Personal Information

Full Name:	Jane Doe	EDD Customer Account Number:	000-00-0000
Mailing Address:	123 Main St Sacramento CA 95814. United States	Phone Number:	000-000-0000
Residence Address:	123 Main St Sacramento CA 95814. United States	Cell Phone Number:	000-000-0000
E-mail Address:	Jdoe@yahoo.com		

Message Center

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

[Inbox](#) [New: 1 , Total: 1]

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. Paid Family Leave claim status is currently not available online. For assistance with a Paid Family Leave claim you may call 1-877-238-4373.

No Results Found

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

To file a Disability Insurance (DI) claim, select **File a New Claim** from the Main Menu.

MAIN MENU

- Home
- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

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.

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

Delete

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.

Next

Cancel

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

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



You are currently on Step 1 Personal Information

Section 1 - Personal Information

Social Security Number: XXX-XX-1234

EDD Customer Account Number:

Legal Name: Jane Doe

California Driver License

Date of Birth: 00-00-0000

Gender: Female

Preferred Language: English

Mailing Address: 123 Main St
Sacramento, CA 95814.

Residence Address: 123 Main St
Sacramento, CA 95814.

United States

United States

Home Phone Number:

Cell 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:

Middle Initial:

Last Name:

Suffix:

Social Security Number:

First Name:

Middle Initial:

Last Name:

Suffix:

Social Security Number:

Previous

Next

Save as Draft

Cancel

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.

*Indicates Required Field

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? (MMDDYYYY) *When did your disability begin? 07162012 (MMDDYYYY)

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

*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: (MMDDYYYY)

*Have you returned to work? Yes No
If "Yes," enter date: (MMDDYYYY)

*What is your regular or customary occupation? *Why did you stop working? Illness, Injury or Pregnancy

*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

Next

Save as Draft

Cancel

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

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

Employer Search



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**.

MAIN MENU

- Home
- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

Employer Search

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:

Search Results

Employer Name	Action
PAR ABC EMPLOYER	Select
PARK STUDIO EXERCISE STUD	Select

Under the **Action** column select your employer's name from the list provided.

If your employer's name is not listed under **Search Results**, select **Not Found** to be directed to a screen where the employer information can be added.

You are currently on Step 3 Employment Information

*Indicates Required Field

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: PAR ABC EMPLOYER

US International

Address Line 1:

Address Line 2:

City:

State:

ZIP Code:

Employer Phone Number: Ext: Check here if the phone number is international
(No dashes or spaces)

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

Next

Save as Draft

Cancel

Once you have selected your employer from the options in the search results, you will be taken to this page.

Complete the **Employer Contact Information** and **Employment Information** sections, then select **Next**.

Employment Summary



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.

Employer Name	Employer Address	Last Day Worked	Action
PAR ABC Employer	123 Main St Anytown, CA 95814	05-14-2012	Delete

Previous

Next

Add

Save as Draft

Cancel

Verify that the employer information is correct and select **Next**.

Employment Summary



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

Next

Add

Save as Draft

Cancel

If your employer is not found, selecting **Not Found** on the Search Results will direct you to this page.

Select **Add** to provide information about your last or current employer.

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: CA

*ZIP Code:

Employer Phone Number: Ext: Check here if the phone number is international
(No dashes or spaces)

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

Next

Save as Draft

Cancel

On this screen you will add information about your employer.

Complete all required fields and select **Next**.

Employment Summary



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.

Employer Name	Employer Address	Last Day Worked	Action
Employment Development Department	800 Capitol Mall Sacramento, CA 95814-4807 United States	12-31-2011	Delete

Previous

Next

Add

Save as Draft

Cancel

This page shows the employer information you added from the previous page.

Verify the employer information is correct and select **Next**, or you may select **Add** to enter additional employers.

Address Validation

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

Entered Address

123 Main St.
Sacramento

Updated Address

123 Main St.
Sacramento, CA 95814-0012

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

Yes

No

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

1 → 2 → 3 → 4 → 5
 Personal Information Initial Questions Employment Information Additional Information Certification

You are currently on Step 5 Certification

*Indicates Required Field

Section 9 - 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" portion of this form. 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 the EDD is not a health plan or health care provider, so the information released to the EDD may no longer be protected by federal privacy regulations (42 CFR Section 165.508©(2)(iii)). The 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. This 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 Disability Insurance benefits. I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by the 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 the 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 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**.

Submit Save as Draft Cancel

On the Declaration page select the first check box to authorize an electronic signature.

Select the second check box and enter the name of the 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 this receipt number to your physician or practitioner so that they may submit a Physician/Practitioner Certificate for your claim. Your claim form is not complete without the Physician/Practitioner Certificate. Your physician or practitioner will use this receipt number to file the Physician/Practitioner certificate online or by mail.

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 certificate.

Certification can be made by a licensed medical or osteopathic physician and surgeon, chiropractor, dentist, podiatrist, optometrist, designated psychologist, or an authorized medical officer of a United States Government facility. Certification can be made by a nurse practitioner for disabilities other than normal pregnancy or childbirth after performance of a physical examination and collaboration with a physician and/or surgeon. Certification may also be made by a certified nurse-midwife, nurse practitioner, or licensed midwife for disabilities related to normal pregnancy and childbirth. Certification by a religious practitioner is acceptable only if the practitioner has been accredited by the Employment Development Department.

If you are receiving temporary Workers' Compensation benefits and are filing for reduced SDI benefits for the same disability period, the Physician/Practitioner certificate may not be required. Please call the Disability Insurance Customer Service Center at (800) 480-3287 for further instructions.

Print this page for your records and record the Form Receipt Number below. For future reference, you can also view your form on your Home page by selecting the same receipt number. This page is only a confirmation that your application has been received by the DIA system and is not meant to imply that you have been found eligible to receive SDI benefits.

Form Receipt Number [R10000000060977](#)

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 portion online or mail in the hard copy 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.

SDI Online Tutorial: Filing a Paid Family Leave (PFL) Bonding Claim – New Mother

MAIN MENU

- Home
- Inbox
- File a New Claim**
- Continue a Saved Draft
- Manage My Profile
- My Claim History
- SCDB Login
- Contact Us

Home

Personal Information

Full Name	Jane Doe	EDD Customer Account Number:	000-00-0000
Mailing Address:	123 Main St. Stockton, CA 95204-3512 United States	Phone Number:	000-000-0000
Residence Address:	123 Main St. Stockton, CA 95204-3512 United States	Cell Phone Number:	000-000-0000
E-mail Address:			

Message Center

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

[Inbox](#) [New: 0 , Total: 0]

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. Paid Family Leave claim status is currently not available online. For assistance with a Paid Family Leave claim you may call 1-877-238-4373.

No Results Found

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

To file a Paid Family Leave (PFL) bonding claim for new mothers, begin by selecting **Inbox** from the Main Menu or the Message Center.

MAIN MENU

Message Center

Inbox

It is important to read all messages from EDD carefully. Select the subject hyperlink below to view the message.

Claimant Name	Date of Birth	Subject	Sent Date	Due Date	Type	Read?	Action
Jane Doe	01-07-1990	Supplemental Certification	04-07-2015	04-27-2015	Requires Attention	Yes	Delete
Jane Doe	01-07-1990	FORM DE 2501 FP, Claim for Paid Family Leave (New Mother)	04-07-2015	None	Notification	Yes	Delete
Jane Doe	01-07-1990	Notice of Automatic Payment	08-08-2013	None	Notification	Yes	Delete
Jane Doe	01-07-1990	Notice of Automatic Payment	01-07-1990	None	Notification	Yes	Delete
Jane Doe	01-07-1990	DE 429D, Notice of Computation	05-09-2013	None	Notification	Yes	Delete

In your Message Center, select the **Form DE 2501 FP Claim for Paid Family Leave (New Mother)** link that will be sent to you when your pregnancy disability claim ends.

Inbox

Message

Subject: FORM DE 2501 FP, Claim for Paid Family Leave (New Mother)

Sent Date: 04-07-2015

Due Date: None

Message: Our records indicate you are a new mother receiving Disability Insurance (DI) benefits for a pregnancy-related disability. After your baby is born and you have stopped claiming disability, you may be eligible for a maximum of six weeks of Paid Family Leave (PFL) benefits to bond with your baby/babies. A Claim for PFL Benefits – New Mother (DE 2501FP) has been mailed to you. You may return the paper form or you may file for benefits online by clicking the link below.

Link to Form: [Forms Available to Submit](#)

Claim ID: DI-1000-111-123

Supporting Documentation

No Results Found

Delete

When the message opens, select the **Forms Available to Submit** link to file a claim.

If you did not have a disability pregnancy claim, please refer to **Filing a Paid Family Leave (PFL) Bonding Claim, New Father, Adoption, or Foster Care** section of the tutorial.

MAIN MENU Home Inbox File a New Claim Continue a Saved Draft Manage My Profile My Claim History	<h2>Forms Available to Submit Online</h2>	
	Claim Information	
	Claimant Name: Jane Doe	Claim ID: DI-1000-111-123
	Expected Return to Work Date: 09-17-2013	Claim Effective Date: 04-17-2013
	Forms Available to Submit	
PAGE MENU Claim Summary Available Forms Form History Payment History Benefit Details Request Claim Update	<p>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. If you have already submitted or mailed any of the forms listed below, do not submit a duplicate form. Please allow 5-7 business days for your form to be processed. Submitting duplicate forms may delay the processing of your claim.</p>	
	Paid Family Leave Bonding	
	2587 Notice-Automatic Payment	
	2587 Notice-Automatic Payment	
	Saved Drafts	
	<p>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.</p>	
	No Results Found	
	<div style="text-align: right;"> <input type="button" value="Delete"/> </div>	

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

Next

Cancel

Answer the prescreening questions:

- If you are a new mother applying for bonding benefits and are transitioning from a Disability Insurance pregnancy claim, select **Yes** for both questions.
- If you are a new mother applying for bonding benefits and **did not** file a Disability Insurance pregnancy claim, select **Yes** for the first question and **No** for the second question. Refer to the “SDI Online Tutorial: Filing a Paid Family Leave Bonding Claim – New Father, Adoption, or Foster Care” for more information.
- If you are a new father applying for bonding benefits, or a parent applying for bonding with an adopted or foster child, select **No** for both questions and refer to the “SDI Online Tutorial: Filing a Paid Family Leave Bonding Claim – New Father, Adoption, or Foster Care” for more information.

Once the two questions have been answered, select **Next**.

MAIN MENU

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- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

Initial Questions

***Indicates Required Field**

You are currently on Step 1 Initial Questions

Section 1 - Contact Information

Claimant Name	Jane Doe
EDD Customer Account Number	1234567891
Mailing Address	123 Main St. Anytown, CA 95814-4504 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 Manage My Profile. Submission of the Claim for Paid Family Leave (PFL) Benefits – New Mother (DE2501FP) is available Monday – Saturday, 6 a.m. to 7:30 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](#) [Next](#) [Save as Draft](#) [Cancel](#)

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

Information from your SDI Online account will automatically populate portions of the PFL claim form.

Verify the information and complete any open fields, as appropriate.

Then select **Next**.

MAIN MENU

- Home
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- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

DI Claim Information

*Indicates Required Field



You are currently on Step 2 DI Claim Information

Section 2 - DI Claim Information

Social Security Number: XXX-XX- 0000

Disability Insurance Claim Effective Date: 01-01-15

Final Date of Disability Insurance Benefits: 04-06-2015

Paid Through Date: 04-06-15

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](#)

[Next](#)

[Save as Draft](#)

[Cancel](#)

Verify information then select **Next**.

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

You are currently on Step 3 Claim Information

Section 3 - Baby Information

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

*First Name: Middle Initial:
*Last Name: Suffix:
*Date of Birth: (MMDDYYYY) *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: (MMDDYYYY)
*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: (MMDDYYYY)
*You can claim up to six weeks of Paid Family Leave benefits in a 365 day period from your baby's date of birth. Do you want to claim the full six weeks now? Yes No
If "No," enter the date you want to be paid through: (MMDDYYYY)

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: (MMDDYYYY)
*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: (MMDDYYYY)
Ending Payment Date: (MMDDYYYY)
*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

Next

Save as Draft

Cancel

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

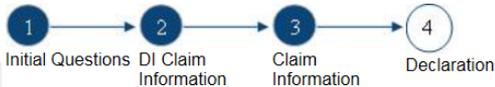
Mandatory fields are marked with a red asterisk (*).

MAIN MENU

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- Continue a Saved Draft
- Manage My Profile
- My Claim History

Declaration

*Indicates Required Field



You are currently on Step 4 Declaration

Section 6 - 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](#)[Submit](#)[Save as Draft](#)[Cancel](#)

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

Select **Submit** to finalize the process.



MAIN MENU

- Home
- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

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-1234

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:

Receipt Number: [R100000000291746](#)

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.

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

The receipt number will show on your **Home** page under the **Submitted Paid Family Leave Claim Forms** section.

Refer to the **Submitting Additional PFL Bonding Attachments** tutorial for instructions on how to attach the birth certificate.

SDI Online Tutorial: Filing a Paid Family Leave (PFL) Bonding Claim – New Father, Adoption, or Foster Care

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- Continue a PFL Claim Draft
- Manage My Profile
- My Claim History
- SCDB Login
- Contact Us

Home

Personal Information

Full Name:	John Doe	EDD Customer Account Number:	000-00-0000
Mailing Address:	123 Main St. Stockton, CA 95204-3512 United States	Phone Number:	000-000-0000
Residence Address:	123 Main St. Stockton, CA 95204-3512 United States	Cell Phone Number:	000-000-0000
E-mail Address:			

Message Center

Check the message center [Inbox](#) below to review messages and take required actions as needed.

[Inbox](#) [New: 0 , Total: 0]

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. Paid Family Leave claim status is currently not available online. For assistance with a Paid Family Leave claim you may call 1-877-238-4373.

No Results Found

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

To file a Paid Family Leave (PFL) bonding claim, select **File a New Claim** from the Main Menu.

Note: You will need to provide proof of relationship to complete your claim. Please refer to the **Submitting Additional PFL Bonding Attachments** tutorial for instructions on uploading documents.

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits.

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

No Results Found

Delete

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

Next

Cancel

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

If you are a new father applying for bonding benefits, or a parent applying for bonding for a foster or adopted child, select **No** for both questions.

MAIN MENU

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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).

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. Benefits may be available for no more than six (6) weeks within any 12-month period. The first seven (7) days of your claim is a waiting period for which no benefits are paid.

When contacting PFL through the mail, include your name and Social Security number on all correspondence.

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 your 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 PFL office.

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 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:

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

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_for_Paid_Family_Leave.htm

[Next](#) [Cancel](#)

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

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

Visit www.edd.ca.gov for more information about which type of claim to file or follow the links provided on the page for additional information.

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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.)

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 the 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). Additionally, the EDD will not disclose or provide copies of care recipients' medical information to care providers. If you are denied access to records which you believe you have a right to inspect or if your 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 4290.

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.

HOW BENEFITS ARE PAID:

When your claim is received, 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 notification will be mailed to you. The majority of claims are processed and payments issued within 14 days of receipt of a correctly completed claim. Benefits may be available for no more than six (6) payable weeks within any 12-month period. The first seven (7) days of your claim is a waiting period for which no benefits are paid.

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 "[How Benefits are Paid or Adjusted](#)," 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 overpayment 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](#)

[Next](#) [Cancel](#)

This screen provides additional information about filing a PFL bonding claim.

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

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

MAIN MENU

- Home
- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

Personal Information



You are currently on Step 1 Personal Information

Section 1 - Personal Information

Social Security Number: XXX-XX-4626

EDD Customer Account Number: 123456781

Full Name: John Doe

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

Date of Birth: 06-14-1978

Gender: Male

Mailing Address: 123 Main St
Anytown, CA 95757

Phone Number: 916-584-7485

Preferred Language: English

If any of your personal information has changed from what is listed above, please Save this form as a Draft. Select 'Manage My Profile' to update your personal information before completing this form.

[Previous](#)

[Next](#)

[Save as Draft](#)

[Cancel](#)

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.

MAIN MENU

- Home
- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

Employment Details

***Indicates Required Field**



You are currently on Step 2 Employment Information

Section 2 - Employer Information

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

*Name of Your Employer: <input type="text"/>	*Occupation: <input type="text"/>
*Are you a state government employee? <input type="radio"/> Yes <input type="radio"/> No	If "Yes", Indicate Bargaining Unit Number: <input type="text"/>
*May we disclose benefit payment information to your employer(s)? <input type="radio"/> Yes <input type="radio"/> No	*Do you have more than one employer? <input type="radio"/> Yes <input type="radio"/> No
*Reason for reducing work hours or stopping work: <input type="radio"/> Bonding with a child <input type="radio"/> Other	Other Reason: <input type="text"/>

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
(No dashes or spaces)

[Previous](#)

[Next](#)

[Save as Draft](#)

[Cancel](#)

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

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

MAIN MENU

- Home
- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

Additional Questions

***Indicates Required Field**



You are currently on Step 3 Additional Questions

Section 7 - Additional Questions

*Date you last worked: (MMDDYYYY)

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 Paid Family Leave claim to begin: (MMDDYYYY)

*Your claim effective date begins your non-payable waiting period. Would you like to be paid six Yes No continual weeks of benefits after your non-payable waiting period has been served?

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

Date you returned to work: (MMDDYYYY)

Or date you plan to return to work: (MMDDYYYY)

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

If you will receive any type of pay from your employer (s) during your family leave, 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](#)[Next](#)[Save as Draft](#)[Cancel](#)

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

MAIN MENU

- Home
- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

Bonding Certification

***Indicates Required Field**

1 Personal Information → 2 Employment Information → 3 Additional Questions → 4 Bonding Certification → 5 Declaration

You are currently on Step 4 Bonding Certification

Section 3 - Personal Information

*Child relationship: (MMDDYYYY)

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): (Do not enter dashes)

*Child's First Name: Middle Initial:

*Last Name: Suffix:

*Date of Birth: (MMDDYYYY) *Child's Gender: Male Female

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

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.

Further instructions on how to submit your Proof of Relationship will be provided upon submission of this form.

Proof of Relationship document includes:

- Official Child's Birth Certificate
- Child's Hospital Birth Certificate
- Declaration of Paternity, CS-909
- Approval of Family Caregiver Home, SOC-815 (also known as Family Caregiver Home, SOC-815)
- Official Letter From Foster Care Agency (also known as Official Foster Care Agency Letter)
- Notice of Placement, AD-907
- Independent Adoption Placement Agreement, AD-924 (also known as Independent Adoption, AD-924)
- Official Letter from Adoption Agency (also known as Official Adoption Agency Letter)

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

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

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.

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

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

*Indicates Required Field



You are currently on Step 4 Bonding Certification

Section 6 - Residence Address

Do not include "PO Box", "PMB", "General Delivery" or "Rural Route Number".

US International

*Address Line 1:

Address Line 2:

*City:

*State: CA

*ZIP Code:

Previous

Next

Save as Draft

Cancel

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

MAIN MENU

- Home
- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

Declaration

*Indicates Required Field



You are currently on Step 5 Declaration

Section 8 - 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](#)[Submit](#)[Save as Draft](#)[Cancel](#)

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

Then select **Submit**.

MAIN MENU

- [Home](#)
- [Inbox](#)
- [File a New Claim](#)
- [Continue a Saved Draft](#)
- [Manage My Profile](#)
- [My Claim History](#)

Confirmation

IMPORTANT: 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 Bonding* (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: John Doe

Social Security Number: XXX-XX-4626

Date you requested to have your Paid Family Leave claim begin: 01-02-2014

Receipt Number: **R10000000291754**

Instruction 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.

Please follow the instructions below to submit your "Proof of Relationship" electronically or through the mail.

Electronically

You may attach your electronic **Proof of Relationship** at this time, or you may submit it at a later date by following these navigation instructions:

1. Select "File a New Claim."
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

At the **Confirmation** screen, a receipt number will appear. Save this number for future reference.

To complete your PFL bonding claim you will need to submit your proof of relationship either by mail or electronically.

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

MAIN MENU

- Home
- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

Attachment

*Indicates Required Field

Identifying Information for Previously Submitted Paid Family Leave Initial Bonding Claim

Your Social Security XXX-XX-4626
Number:

Date you requested to have 01-02-2014
your Paid Family Leave
claim begin:

Form Receipt Number: R100000000291754

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: Documents\KangRoo.jp

Browse...

*Do you want to attach more documents? Yes No

Previous

Submit

Cancel

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 XXX-XX-4626
Number:

Date you requested to have
your Paid Family Leave
claim begin: 01-02-14

Form Receipt Number: R100000000003734

Previously Submitted Attachments for Paid Family Leave Initial Bonding Claim

File Name	Receipt Number
Adoption Agency Letter.pdf	R100000000003735

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 PFL Bonding Attachments

MAIN MENU

- [Home](#)
- [File a New Claim](#)
- [Continue a Saved Draft](#)
- [Manage My Profile](#)
- [My Claim History](#)

Home**Personal Information**

Full Name: Jane Doe EDD Customer: 1234567891

Mailing Address: 123 Main St.
Anytown, CA 95758 Phone Number: 000-00-0000
United States

Residence Address: 123 Main St.
Anytown, CA 95758 Cell Phone Number: 000-000-0000
United States

E-mail Address: Jdoe@gmail.com

Message Center

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

[Inbox](#) [New: 1, Total: 1]

Current Disability Insurance Claim(s)

No Results Found

Pending Disability Insurance Claim Application(s)

Form Name	Submitted Date	Receipt Number	Status
2501 Claim for DI Benefits A	10-19-2011	R100000000000177	Pending Processing

Submitted Paid Family Leave Claim Forms

Only forms you submitted online are listed below. Paid Family Leave claim status is currently not available online. For assistance with a Paid Family Leave claim you may call 1-877-238-4373.

Form Name	Submitted Date	Receipt Number
2501F PFL Bonding Claim A&B	02-07-2013	R100000000289431
2501F PFL Bonding Claim A&B	12-19-2014	R100000000291754

In general you will only need to submit one bonding attachment on a claim. However, if you need to submit more than one (e.g. birth certificates for twins or to resubmit a previous document), select **File a New Claim** from the Main Menu of your SDI Online account.



MAIN MENU

- [Home](#)
- [Inbox](#)
- [File a New Claim](#)
- [Continue a Saved Draft](#)
- [Manage My Profile](#)
- [My Claim History](#)

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.

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

Delete

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

MAIN MENU

Form Attachment

- Home
- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

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 Proof of Relationship

Form Name	Submitted Date	Receipt Number	Action
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Bond with Child	12-19-2014	R100000000291754	Select
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Bond with Child	02-07-2013	R100000000289431	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.

MAIN MENU

- Home
- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

Attachment

*Indicates Required Field

Identifying Information for Previously Submitted Paid Family Leave Initial Bonding Claim

Your Social Security XXX-XX-0134
Number:

Date you requested to have 07-01-2013
your Paid Family Leave
claim begin:

Form Receipt Number: R100000000290171

Previously Submitted Attachments for Paid Family Leave Initial Bonding Claim

File Name	Receipt Number
[Untitled1].pdf	R100000000290172

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:

*Do you want to attach more documents? Yes No

This screen shows one document uploaded.

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

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

SDI Online Tutorial: Filing a Paid Family Leave (PFL) Care Claim

MAIN MENU

- Home
- Jobs
- File a New Claim**
- Continue a Saved Draft
- Manage My Profile
- My Claim History
- SCDB Login
- Contact Us

Home

Personal Information

Full Name:	Jane Doe	EDD Customer Account Number:	000-00-0000
Mailing Address:	123 Main St. Stockton, CA 95204-3512 United States	Phone Number:	000-000-0000
Residence Address:	123 Main St. Stockton, CA 95204-3512 United States	Cell Phone Number:	000-000-0000
E-mail Address:			

Message Center

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

[Inbox](#) [New: 0 , Total: 0]

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. Paid Family Leave claim status is currently not available online. For assistance with a Paid Family Leave claim you may 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 (PFL) Care Claim, select **File a New Claim** from the Main Menu.

Note: You will need to provide additional care claim documents to complete your claim. Please refer to the **Submitting Additional PFL Care Attachments** tutorial for instructions on uploading documents.

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits.

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

No Results Found

Delete

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

Visit

www.edd.ca.gov/disability
for more information about
which type of claim to file.

MAIN MENU

- Home
- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

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.

Next **Cancel**

This screen provides important information you will need to know to file a PFL care claim.

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

MAIN MENU

- Home
- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

Personal Information

You are currently on Step 1 Personal Information

Section 1 - Personal Information

Social Security Number: XXX-XX 1234

EDD Customer Account Number: 123457890

Full Name: Jane Doe

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

Date of Birth: 00/00/0000

Gender: Female

Mailing Address: 555 Main Street
Sacramento, CA 95818
United States

Phone Number: 000-000-0000

Preferred Language: English

If your personal information has changed, select Save as Draft. To update your personal information before completing this form, select Manage My Profile. Submission of the Claim for Paid Family Leave (PFL) Benefits – New Mother (DE2501FP) is available Monday – Saturday, 6 a.m. to 7:30 p.m. and Sunday 6 a.m. to 5:30 p.m.

Previous

Next

Save as Draft

Cancel

Information from your SDI Online account will automatically populate portions of the PFL 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.

- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

*Indicates Required Field



You are currently on Step 2 Employment Information

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 Other Reason:

Employer Mailing Address

US International

*Address Line 1:

Address Line 2:

*City:

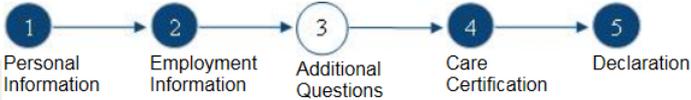
*State:

*ZIP Code:

Employer Phone Number: Ext: Check here if the phone number is international
(No dashes or spaces)

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

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



You are currently on Step 3 Additional Questions

Section 3 - Additional Questions

*Date you last worked: (MMDDYYYY)

*Date you want Paid Family Leave claim to begin: (MMDDYYYY)

*Your claim effective date begins your non-payable waiting period. Would you like to be paid six continual weeks of benefits after your non-payable waiting period has been served? Yes No

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

Date you returned to work: (MMDDYYYY)

Or date you plan to return to work: (MMDDYYYY)

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

If you will receive any type of pay from your employer (s) during your family leave, 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

Next

Save as Draft

Cancel

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

- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

*Indicates Required Field



You are currently on Step 4 Care Certification

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: (MMDDYYYY)

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

*Relationship to care recipient: 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
(No dashes or spaces)

Previous

Next

Save as Draft

Cancel

Complete the Care Recipient's Information and Residence Address sections with information about the person for whom you will be providing care.

Then select Next.

MAIN MENU

- Home
- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

Declaration

*Indicates Required Field



You are currently on Step 5 Declaration

Section 5 - 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 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 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 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 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](#)[Submit](#)[Save as Draft](#)[Cancel](#)

Select the box to authorize an electronic signature.

The box must be selected 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 and the Physician's/Practitioner's Certification sections of the Claim for Paid Family Leave (PFL) Benefits, DE 2501FC.

MAIN MENU

- Home
- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

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

Social Security Number: XXX-XX 1234

Date you requested to have 09-01-2014
your Paid Family Leave
claim begin:

Receipt Number: **R100000000291744**

Instructions for Submitting Doctor's Certification for Care Recipient

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 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 "Doctor's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information" or you may submit it at a later time by following these navigation instructions:

1. Select "File a New Claim"
2. Choose "Paid Family Leave Claim Care Attachment"

Mail

You may send the "Doctor's certification for care recipient" and "Care recipient authorization for disclosure of personal health information" documents by mailing it to:

EDD - Paid Family Leave
PO BOX 997017
SACRAMENTO CA 95799-7017

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

At the **Confirmation** screen, a receipt number will appear. Save this number for future reference.

MAIN MENU

- Home
- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

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

Social Security Number: XXX-XX 1234

Date you requested to have 09-01-2014
your Paid Family Leave
claim begin:

Receipt Number: [R100000000291744](#)

Instructions for Submitting Doctor's Certification for Care Recipient

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 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 "Doctor's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information" or you may submit it at a later time by following these navigation instructions:

1. Select "File a New Claim"
2. Choose "Paid Family Leave Claim Care Attachment"

Mail

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EDD - Paid Family Leave
 PO BOX 997017
 SACRAMENTO CA 95799-7017

[Back to Top](#) | [Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Equal Opportunity Notice](#)

On the **Confirmation** screen you will also find instructions to complete your PFL care claim.

You will need to submit the Claim for Paid Family Leave (PFL) Care Benefits, DE 2501FC, either by mail or electronically.

Select this link to open a PDF copy of the form. You will need to print this PDF, have it filled out entirely and signed by all parties, then scan it and save it to your computer to be uploaded to your account.

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.

R1

1

PART C – INSTRUCTIONS FOR PFL CARE CLAIMS

The care recipient (the person for whom you are providing care) must do the following: Complete and sign “Part C – Statement of Care Recipient.” 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 as electronically in SDI Online as attachments. If submitting by mail, send to the following address: Paid Family Leave, P.O. Box 997017, Sacramento, CA 95799-7017. 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, P.O. Box 997017, Sacramento, CA 95799-7017. If the care recipient is under the care of an accredited religious practitioner, call Paid Family Leave at 1-877-238-4373 for the proper form DE 2502F.

For instructions on how to complete the DE 2501FC in Spanish go to the following link: http://www.edd.ca.gov/Disability/PFL_Forms_and_Publications_En_Espanol.htm

PART C – STATEMENT OF CARE RECIPIENT			
<small>(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.)</small>			
C1. CARE PROVIDER SSN	C2. RECIPIENT'S DATE OF BIRTH M M D D Y Y Y Y	C3. RECIPIENT'S TELEPHONE NUMBER	C4. RECIPIENT'S GENDER MALE FEMALE
C5. LEGAL NAME OF CARE RECIPIENT (FIRST, MIDDLE INITIAL, LAST)			
C6. CARE RECIPIENT'S RESIDENCE ADDRESS			
CITY	STATE/PROV.	ZIP OR POSTAL CODE	COUNTRY (IF NOT U.S.A.)
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 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 <small>(DO NOT PRINT)</small>	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 <small>(DO NOT PRINT)</small>	Date Signed (MM DD YYYY)		

2

3

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

To avoid delays in claim processing:

1. Enter the receipt number from your Paid Family Leave Care Claim filing in the top right corner.
2. Make sure all applicable information is completed in the appropriate section.
3. Obtain all the required signatures prior to uploading or mailing the form.

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 P.O. Box 997017, Sacramento, CA 95799-7017, 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 your receipt number from your Paid Family Leave Care Claim filing in the top right corner.
2. The care recipient or his/her authorized agent must sign and date the bottom of this page.

Certification may be made by a licensed physician and surgeon, osteopathic physician, chiropractor, dentist, podiatrist, optometrist, psychologist, or a nurse practitioner, and in the case of a nurse practitioner, after performance of a physical examination by a nurse practitioner and collaboration with a physician and surgeon. If the care recipient is hospitalized in or under the authority of a county hospital in California, the certificate may be signed by the hospital registrar. If the care recipient is hospitalized in or under the authority of a medical facility of the United States government, the certificate may be signed by an authorized medical officer of the facility.

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 NO (SKIP TO D16) <input type="checkbox"/> <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	D9. SECONDARY ICD CODES	D5. 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 NO <input type="checkbox"/> <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 (SHORT ADDRESS BOX IS NOT ACCEPTABLE AS IS THE BOX IS ADDRESS)

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

D19. TYPE OF PHYSICIAN/PRACTITIONER	D20. SPECIALTY (IF ANY)
-------------------------------------	-------------------------

D21. As a Physician or Nurse Practitioner, I certify under penalty of perjury that I have treated this patient within the scope of my practice and that the patient has a serious health condition that warrants the care of a care provider and that this Physician/Practitioner Certificate truly describes the patient's condition, the need for care, and the estimated duration for which care is needed. If I am a Nurse Practitioner certifying a condition other than normal pregnancy or delivery, I additionally certify I have performed a physical examination and have collaborated with a physician and surgeon. If I am a Registrar of a County Hospital in California or a medical officer of a US government medical facility, I certify that the patient's serious health condition is shown in the patient's hospital chart.

Original Signature of Physician/Practitioner - NUMBER STRAP IS NOT ACCEPTABLE	PHYSICIAN/PRACTITIONER'S TELEPHONE NO.	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.

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 filing in the top right corner.
2. Make sure all applicable information is completed in the appropriate section.
3. Obtain a signature from the care recipient's physician/practitioner prior to uploading or mailing the form.

Submitting Additional PFL Care Attachments

MAIN MENU

- Home
- Inbox
- File a New Claim**
- Continue a Saved Draft
- Manage My Profile
- My Claim History

Home

Customer Satisfaction Survey

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

[Link to Survey](#)

Personal Information

Full Name	Jane Doe	EDD Customer Account Number:	
Mailing Address:	123 Main St. Sacramento, CA 95814	Phone Number:	200-000-0000
Residence Address:		Cell Phone Number:	300-000-0000
E-mail Address:			

Message Center

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

[Inbox](#) [New: 0 , Total: 0]

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

MAIN MENU

- Home
- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits.

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

Delete

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 Proof of Relationship

Form Name	Submitted Date	Receipt Number	Action
DE 2501F, Claim for Paid Family Leave (PFL) Benefits	08-24-2012	R100000000060954	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 your form to your claim.

MAIN MENU

- [Home](#)
- [Inbox](#)
- [File a New Claim](#)
- [Continue a Saved Draft](#)
- [Manage My Profile](#)
- [My Claim History](#)

Attachment

*Indicates Required Field

Identifying Information for Previously Submitted Paid Family Leave Initial Care Claim

Your Social Security XXX-XX-0134
Number:

Date you requested to have 07-01-2013
your Paid Family Leave
claim begin:

Form Receipt Number: R100000000290168

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: C:\Documents and Settings

*Do you want to attach more documents? Yes No

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.

MAIN MENU

- Home
- Inbox
- File a New Claim
- Continue a Saved Draft
- Manage My Profile
- My Claim History

Attachment

*Indicates Required Field

Identifying Information for Previously Submitted Paid Family Leave Initial Care Claim

Your Social Security XXX-XX-0134
Number:

Date you requested to have 07-01-2013
your Paid Family Leave
claim begin:

Form Receipt Number: R100000000290168

Previously Submitted Attachments for Paid Family Leave Initial Care Claim

File Name	Receipt Number
[Untitled].pdf	R100000000290169

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: C:\Documents and Settings [Browse...]

*Do you want to attach more documents? Yes No

[Previous](#)[Submit](#)[Cancel](#)

This screen shows one document already uploaded.

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

Your Social Security XXX-XX-1234 Date you requested to have 04-12-2012
your Paid Family Leave
claim begin:

Form Receipt Number: R1000000000037

Previously Submitted Attachments for Paid Family Leave

File Name	Receipt Number
Physician Certificate	R1000000000037

This page confirms that the attachments 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.

SDI Online Tutorial: Paper Forms

EDD Employment Development Department
Claim for Disability Insurance (DI) Benefits 250104121

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Claimant Social Security Number: [REDACTED]

Claimant Name (First) (M) (Last): [REDACTED]

I authorize (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) [REDACTED] Date Signed [REDACTED]

DE 2501 Rev 7/9 (4-14) Page 1 of 7 DU

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

The DE 2501 for DI benefits and the DE 2501F for PFL 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, you do not need to file a paper claim form. Duplicate claim requests will delay claim processing.

EDD Employment Development Department
Claim for Paid Family Leave (PFL) Benefits 2501P0141

PART A - STATEMENT OF CURRENT EMPLOYER (EMPLOYING BUSINESS)

41. YOUR SOCIAL SECURITY NO. 123456789 42. YOUR DATE OF BIRTH 05211959 43. LANGUAGE YOU PREFER TO USE ENGLISH SPANISH OTHER BIRTH DATE [REDACTED]

44. YOUR LEGAL NAME FIRST NAME JANE LAST NAME D JONES 45. YOUR GENDER MALE FEMALE X

46. YOUR TELEPHONE NUMBER 916 5551212 47. OTHER LAST NAMES, IF ANY, ENTER WHICH YOU HAVE WORKED SMITH

48. YOUR HOME ADDRESS (PLEASE PRINT FULL ADDRESS INCLUDING POST OFFICE BOX)
 321 SPRING STREET ANYTOWN CA 999999999

49. NAME OF YOUR EMPLOYER ABC CORPORATION MAILING ADDRESS 987 BUSINESS BLVD ANYTOWN CA 999997777 916 5559999

50. DATE YOU LAST WORKED FOR EMPLOYER 09102014 51. DATE YOU WANT YOUR PFL CLAIM TO BEGIN 09202014 52. DATE YOU WERE HIRED BY EMPLOYER 11082014 53. DOES YOUR WORK OR WILL YOU CONTINUE TO WORK DURING YOUR FAMILY LEAVE PERIOD? YES NO X

54. HAVE YOU CHANGED YOUR WORK HOURS OR EMPLOYMENT? YES NO X 55. WHAT TYPE OF OCCUPATION DO YOU HOLD? CAREER CONTRACT OTHER EX RESEARCH ANALYST

56. LEGAL NAME OF PERSON FOR WHOM YOU ARE PROVIDING CARE (PLEASE PRINT FULL NAME) MARY 57. WITH WHOM YOU ARE PROVIDING CARE (PLEASE PRINT FULL NAME) J SMITH

58. THE ABOVE-NAMED CARE OR BONDING SECRET IS YOUR: WIFE/DOMESTIC PARTNER CHILD OTHER EX

59. IS ANY OTHER FAMILY MEMBER BEING WELL AND ARE OTHERS AVAILABLE TO PROVIDE CARE FOR THE SAME PERIOD YOU ARE CLAIMING PFL BENEFITS? YES NO X

60. HAVE YOU CLAIMED OR DO YOU PLAN TO CLAIM WORKERS' COMPENSATION BENEFITS FOR ANY PORTION OF THE PERIOD COVERED BY THIS CLAIM? YES NO X

61. DO YOU HAVE INSURANCE FROM AN EMPLOYER? YES NO X 62. ARE YOU EMPLOYER? CONTINUED OR WILL CONTINUE TO PAY YOU? YES NO X 63. MAY WE DISCLOSE BENEFIT PAYMENT INFORMATION TO YOUR EMPLOYER? YES NO X

64. AT ANY TIME DURING YOUR LEAVE, WERE YOU IN THE CUSTODY OF LAW ENFORCEMENT AUTHORITIES BECAUSE YOU WERE CONSIDERED TO BE A SUSPECT OR SUSPICIOUS?

65. Declaration and Signature: I, the undersigned, do hereby certify that the information provided on this claim is true and correct to the best of my knowledge and belief, and I understand that the consequences for my providing false information may result in denial of my claim and/or prosecution. I understand that the consequences for my providing false information may result in denial of my claim and/or prosecution. I understand that the consequences for my providing false information may result in denial of my claim and/or prosecution. I understand that the consequences for my providing false information may result in denial of my claim and/or prosecution.

Claimant's Signature: Jane D. Jones Date Signed: 09222014

EDD 2501F Rev 1/14 (INTERNET) Page 1 of 4 DU

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

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Claimant Social Security Number

Claimant Name (First) (MI) (Last)

I authorize

(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.

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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

Claim for Disability Insurance (DI) Benefits, DE 2501, Part A - Claimant's Statement, pages 1-4.

Page 1 – The Health Insurance Portability and Accountability (HIPAA) Authorization needs to be signed by the claimant.

Pages 2, 3, and 4 – Complete the claimant information. Page 4 needs to be signed by the claimant.

Claim for Paid Family Leave (PFL) Benefits

2501P07141

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

A1. YOUR SOCIAL SECURITY NO. 1 2 3 4 5 6 7 8 9
 A2. YOUR DATE OF BIRTH 0 5 2 1 1 9 5 9
 A3. LANGUAGE YOU PREFER TO USE ENGLISH ESPAÑOL OTHER (PRINT BELOW)

A4. YOUR LEGAL NAME FIRST NAME MI LAST NAME J A N E D J O N E S
 A5. YOUR GENDER MALE FEMALE

A6. YOUR TELEPHONE NUMBER 9 1 6 5 5 5 1 2 1 2
 A7. OTHER LAST NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED S M I T H

A8. YOUR MAILING ADDRESS (DO NOT RECEIVE MAIL AT A PRIVATE MAIL BOX—NOT A U.S. POSTAL SERVICE BOX—YOU MUST SHOW THE NUMBER IN THE "PMB#2" SPACE) PMB#2 (IF APPLICABLE)
 3 2 1 S P R I N G S T R E E T
 CITY STATE/PROV. ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)
 A N Y T O W N C A 9 9 9 9 9 9 9 9 9 9

A9. NAME OF YOUR EMPLOYER MAILING ADDRESS
 A B C C O R P O R A T I O N 9 8 7 B U S I N E S S B L V D
 CITY STATE/PROV. ZIP OR POSTAL CODE EMPLOYER'S TELEPHONE NUMBER
 A N Y T O W N C A 9 9 9 9 9 7 7 7 9 1 6 5 5 5 9 9 9 9

A10. DATE YOU LAST WORKED 0 9 1 0 2 0 1 4
 A11. DATE YOU WANT YOUR PFL CLAIM TO BEGIN 0 9 2 0 2 0 1 4
 A12. DATE YOU RETURNED OR WILL RETURN TO WORK 1 1 0 8 2 0 1 4
 A13. DID YOU WORK OR WILL YOU CONTINUE TO WORK DURING YOUR FAMILY LEAVE PERIOD? NO YES

A14. WHY DID YOU OR WILL YOU REDUCE YOUR WORK HOURS OR STOP WORKING?
 CARE FOR BOND WITH
 FAMILY MEMBER CHILD OTHER (EXPLAIN)

A15. WHAT IS YOUR OCCUPATION? R E S E A R C H A N A L Y S T

A16. LEGAL NAME OF PERSON FOR WHOM YOU ARE CARING (FIRST NAME, MIDDLE INITIAL, LAST) OR WITH WHOM YOU ARE BONDING (CARE OR BONDING RECIPIENT)
 M A R Y J S M I T H

A17. THE ABOVE-NAMED CARE OR BONDING RECIPIENT IS YOUR:
 CHILD SPOUSE REGISTERED DOMESTIC PARTNER PARENT GRAND PARENT GRAND CHILD SIBLING OTHER (EXPLAIN)

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

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

A20. DO YOU HAVE MORE THAN ONE EMPLOYER? NO YES

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

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? 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 (8)ten years from the date of my signature or the effective date of the claim, whichever is later.

Claimant's Signature (DO NOT PRINT) *Jane D. Jones* If signature is made by mark (X), please place mark here. Date Signed (M | D | Y | Y | Y | Y)
 0 9 2 2 2 0 1 4

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

Claim for Paid Family Leave (PFL) Benefits, DE 2501F, Part A - Statement of Claimant, page 1.

Complete the information, including whether this is for a bonding or care claim. Make sure to sign and date the form.

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 P.O. 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.

MARY J. SMITH

Care recipient's name (Print your name)

Mary J. Smith

Care recipient's signature (Sign your name)

Sept. 23, 2014
Date signed

DE 2501F, Care Recipient Authorization for Disclosure of Personal-Health Information, page 2.

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

PART B - BONDING CERTIFICATION (TO BE COMPLETED BY PERSON CLAIMING PFL BENEFITS TO BOND WITH A CHILD)

B1. YOUR SOCIAL SECURITY NUMBER 1 2 3 4 5 6 7 8 9		B2. DATE OF FOSTER CARE OR ADOPTION PLACEMENT M M D D Y Y Y Y		B3. CHILD NAMED IN B3 IS MY BIOLOGICAL CHILD STEPCHILD FOSTER CHILD ADOPTED CHILD OTHER	
B4. YOUR LEGAL LAST NAME (NEEDED IN CASE PAGES OF THIS CLAIM BECOME SEPARATED) J O N E S		B5. CHILD'S SOCIAL SECURITY NUMBER (IF AVAILABLE)		B6. CHILD'S DATE OF BIRTH M M D D Y Y Y Y	
B7. CHILD'S GENDER MALE FEMALE		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 type="checkbox"/> CHILD'S BIRTH CERTIFICATE		<input type="checkbox"/> CERTIFICATE OF PLACEMENT, AD-907		<input type="checkbox"/> CHILD'S PASSPORT SHOWING IMMIGRATION AND NATURALIZATION SERVICE STAMP I-551	
<input type="checkbox"/> CHILD'S HOSPITAL DISCHARGE RECORD		<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 parryless, 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 three 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				Date Signed (M M D D Y Y Y Y)	

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 FEMALE	
0 2 0 9 1 9 2 8		5 3 0 5 5 5 7 7 7 7		X	
C4. LEGAL NAME OF CARE RECIPIENT (FIRST MIDDLE INITIAL LAST) M A R Y J S M I T H					
C5. CARE RECIPIENT'S RESIDENCE ADDRESS CITY STATE/PROV. ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.) S O M E C I T Y C A 9 7 7 7 7 0 0 0 0					
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) Mary J. Smith				Date Signed (M M D D Y Y Y Y) 0 9 2 3 2 0 1 4	
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)	

DE 2501F, Part B - Bonding Certification (bonding claims only) and Part C - Statement of Care Recipient (care claims only), page 3.

Part B – For bonding claims the claimant must complete all bonding information and sign the form.

Part C – For care claims the care recipient or claimant must fill out the appropriate care information. The care recipient or their authorized representative must sign the form.

Doctor's Certification may be made by a licensed medical or osteopathic physician and surgeon, chiropractor, dentist, podiatrist, optometrist, designated psychologist, or an authorized medical officer of a United States Government facility

2501F07143

If using typewriter/printer, type across boxes in UPPER CASE as shown

If hand printing, place each letter/number in a separate box as shown

PATIENT'S DATE OF BIRTH M M D D Y Y Y Y 07 26 1930				TYPE OF DOCTOR PODIATRIST				PATIENT'S DATE OF BIRTH M M D D Y Y Y Y 07 26 1930				TYPE OF DOCTOR P O D I A T R I S T			
--	--	--	--	------------------------------	--	--	--	--	--	--	--	---------------------------------------	--	--	--

PART D - DOCTOR'S CERTIFICATION (DO NOT COMPLETE THIS PART IF REASON FOR PFL LEAVE IS BONDING WITH CHILD)

D1. PFL CLAIMANT'S (CARE PROVIDER'S) SOCIAL SECURITY NUMBER 1 2 3 4 5 6 7 8 9									D2. PFL CLAIMANT'S NAME (FIRST MIDDLE INITIAL LAST) J A N E D J O N E S								
--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

D3. PATIENT'S DATE OF BIRTH M M D D Y Y Y Y 02 09 1958				D4. DOES YOUR PATIENT REQUIRE CARE BY THE CARE PROVIDER? NO (SKIP TO D15) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES			
--	--	--	--	---	--	--	--

D5. PATIENT'S NAME (FIRST MIDDLE INITIAL LAST) M A R Y J S M I T H											
---	--	--	--	--	--	--	--	--	--	--	--

D6. DIAGNOSIS OR, IF NOT YET DETERMINED, A DETAILED STATEMENT OF SYMPTOMS F R A C T U R E D F E M U R											
--	--	--	--	--	--	--	--	--	--	--	--

D7. PRIMARY ICD CODE 820 • 09			D8. SECONDARY ICD CODES S72 • 0			D9. DATE PATIENT'S CONDITION COMMENCED M M D D Y Y Y Y 09 13 2014		
----------------------------------	--	--	------------------------------------	--	--	---	--	--

D10. FIRST DATE CARE NEEDED M M D D Y Y Y Y 09 20 2014			D11. DATE YOU EXPECT RECOVERY M M D D Y Y Y Y TERMINAL 02 15 2015			D12. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CARE PROVIDER M M D D Y Y Y Y 12 31 2014		
--	--	--	---	--	--	--	--	--

D13. APPROXIMATELY HOW MANY TOTAL HOURS PER DAY WILL PATIENT REQUIRE CARE BY A CARE PROVIDER? HOURS COMMENTS 24											
---	--	--	--	--	--	--	--	--	--	--	--

D14. WOULD DISCLOSURE OF THIS CERTIFICATE TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES											
--	--	--	--	--	--	--	--	--	--	--	--

D15. DOCTOR'S LICENSE NUMBER A987654						D16. STATE OR COUNTRY (IF NOT U.S.A.) IN WHICH DOCTOR IS LICENSED TO PRACTICE CALIFORNIA					
---	--	--	--	--	--	---	--	--	--	--	--

D17. DOCTOR'S NAME (FIRST MIDDLE INITIAL LAST) D O N A L D R B R O W N											
---	--	--	--	--	--	--	--	--	--	--	--

D18. DOCTOR'S ADDRESS (POST OFFICE BOX IS NOT ACCEPTABLE AS THE SOLE ADDRESS) 678 CENTRAL BLVD CITY STATE/PROV. ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.) S O M E C I T Y C A 97777 9999											
--	--	--	--	--	--	--	--	--	--	--	--

D19. TYPE OF DOCTOR M E D I C A L D O C T O R						D20. SPECIALTY (IF ANY) O R T H O P E D I C S					
--	--	--	--	--	--	--	--	--	--	--	--

D21. Doctor's Certification and Signature (REQUIRED): I certify under penalty of perjury that, based on my examination, this Doctor's Certificate truly describes the patient's condition and need for care and the estimated duration thereof. Original Signature of Attending Doctor - RUBBER STAMP IS NOT ACCEPTABLE Donald R. Brown, M.D.											
DOCTOR'S TELEPHONE NO. 530 5554444						Date Signed (MM DD YYYY) 09 27 2014					

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

DE 2501F, Part D - Doctor's Certification, page 4.

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

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

SDI Online Tutorial: Username Recovery



State Disability Insurance

Disability Insurance and Paid Family Leave Benefits

The California State Disability Insurance (SDI) program provides short-term Disability Insurance (DI) and Paid Family Leave (PFL) wage replacement benefits to eligible workers who need time off work. You may be eligible for DI if you are unable to work due to non-work-related illness or injury, pregnancy, or childbirth. You may be eligible for PFL to care for a seriously ill family member or to bond with a new child. To file for benefits, visit [SDI Online](#).

To provide feedback about the SDI information available on the EDD website, take our [SDI Survey](#).

Disability Insurance

- About Disability Insurance
- DI Claim Process
- [SDI Online](#)
- Am I Eligible for DI Benefits?
- [More...](#)

Paid Family Leave

- About Paid Family Leave
- PFL Claim Process
- [SDI Online](#)
- Am I Eligible for PFL Benefits?
- [More...](#)

Employers and Self-Employed

- Eligibility
- Requirements
- Elective Coverage
- Workers' Compensation
- [More...](#)

Physicians/Practitioners

- Basics for Physicians/Practitioners
- Independent Medical Examiners
- Medical Certification
- Online Tutorials
- [More...](#)

Voluntary Plans

- Voluntary Plans
- Pre-Requisites for Becoming a Voluntary Plan Employer
- Legal Requirements
- Contributions Rates and Benefit Amounts
- [More...](#)

General Information

- FAQs
- Forms and Publications
- Paid Family Leave Market Research Report 2015
- PFL Community Partners
- Self-Service Options
- Contact SDI
- [More...](#)

To recover your SDI Online username, visit www.edd.ca.gov/disability.

On the **State Disability Insurance** overview page select any **SDI Online** link.



SDI Online

En español

The Employment Development Department (EDD) automated some key State Disability Insurance (SDI) services to better serve you with your Disability Insurance (DI) and Paid Family Leave (PFL) needs.

SDI Online is convenient and secure. The system reduces claim processing time, provides electronic confirmation of forms submitted online, decreases costs in paper and postage, and includes security safeguards to detect and manage fraud and abuse. A mobile-friendly version, *SDI Online Mobile* is available for your smartphone and tablet.

Log In or Register

If you have an existing account, select the appropriate login option. Before using SDI Online or SDI Online Mobile, you must register in SDI Online.

[Log In](#)

[Log into Mobile](#)

[Register](#)

Note: If you are experiencing trouble accessing SDI Online, visit [Troubleshooting Tips for Accessing SDI Online](#).

Disability Insurance Claimants

- [How to File a DI Claim in SDI Online](#)
- [Manage Your Claim with SDI Online](#)
- [Am I Eligible for DI?](#)
- [SDI Online Tutorials](#)
- [SDI Online Tips for Claimants](#)
- [SDI Online FAQs](#)

Paid Family Leave Claimants

- [How to File a PFL Claim in SDI Online](#)
- [Manage Your PFL Claim with SDI Online](#)
- [Am I Eligible for PFL?](#)
- [SDI Online Tutorials](#)
- [SDI Online Tips for Claimants](#)
- [SDI Online FAQs](#)

On the **State Disability Insurance (SDI) Online** page, select the **Log In to SDI Online** link.

You will be directed to the **SDI Online Login** page.

Language: English

- Contact SDI
- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

SDI Online Login

*Indicates Required Field

*Username:

[Forgot username?](#)

[Register for a new online account](#)

SECURITY REMINDER

Enter the username you provided during registration. We will ask you for your new password and display your personal image on the next screen.

On the **SDI Online Login** page, select **Forgot username?**

Contact SDI

- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

Forgot Username

*Indicates Required Field

Account Information

Provide your last name, e-mail address, and user account type associated with your account to retrieve your SDI Online username.

*Last Name:

*E-mail Address:

*User Account Type:

Provide your last name, email address, and select your user account type from the drop down menu. Your account type is either a claimant, a physician/practitioner, or an employer. Then select **Next**.

Contact SDI

- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

Forgot Username

*Indicates Required Field

Answer Security Questions

Before you can retrieve your SDI Online username, you must correctly answer your security questions.

Question 1: What was the model of your first car?

*Answer to Question 1:

Next

Cancel

If you do not recall your previous responses, please contact EDD at (800) 480-3287. The EDD staff is available from 8 a.m. to 5 p.m. (PT), Monday through Friday, except on [state holidays](#).

[Forgot security questions and answers?](#)

Answer the security questions and select **Next**.



Contact SDI

- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

Forgot Username

Username Sent Confirmation

Your SDI Online username has been sent to you via e-mail. If you do not receive an email, please check your junk/spam folder. To ensure e-mails from the EDD appear in your inbox, add noreply@edd.ca.gov to your address book.

[Login](#)

Once you have successfully answered your security questions, your SDI Online username will be sent to your email address.

Select **Login** to access your account with the username that was sent to your email.

SDI Online Tutorial: Password Recovery



State Disability Insurance

Disability Insurance and Paid Family Leave Benefits

The California State Disability Insurance (SDI) program provides short-term Disability Insurance (DI) and Paid Family Leave (PFL) wage replacement benefits to eligible workers who need time off work. You may be eligible for DI if you are unable to work due to non-work-related illness or injury, pregnancy, or childbirth. You may be eligible for PFL to care for a seriously ill family member or to bond with a new child. To file for benefits, visit [SDI Online](#).

To provide feedback about the SDI information available on the EDD website, take our [SDI Survey](#).

Disability Insurance



- [About Disability Insurance](#)
- [DI Claim Process](#)
- [SDI Online](#)
- [Am I Eligible for DI Benefits?](#)
- [More...](#)

Paid Family Leave



- [About Paid Family Leave](#)
- [PFL Claim Process](#)
- [SDI Online](#)
- [Am I Eligible for PFL Benefits?](#)
- [More...](#)

Employers and Self-Employed

- [Eligibility](#)
- [Requirements](#)
- [Elective Coverage](#)
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- [Paid Family Leave Market Research Report 2015](#)
- [PFL Community Partners](#)
- [Self-Service Options](#)
- [Contact SDI](#)
- [More...](#)

To recover your SDI Online password, visit www.edd.ca.gov/disability.

On the **State Disability Insurance** overview page select any **SDI Online** link



SDI Online

En español

The Employment Development Department (EDD) automated some key State Disability Insurance (SDI) services to better serve you with your Disability Insurance (DI) and Paid Family Leave (PFL) needs.

SDI Online is convenient and secure. The system reduces claim processing time, provides electronic confirmation of forms submitted online, decreases costs in paper and postage, and includes security safeguards to detect and manage fraud and abuse. A mobile-friendly version, SDI Online Mobile is available for your smartphone and tablet.

Log In or Register

If you have an existing account, select the appropriate login option. Before using SDI Online or SDI Online Mobile, you must register in SDI Online.

[Log In](#)

[Log into Mobile](#)

[Register](#)

Note: If you are experiencing trouble accessing SDI Online, visit [Troubleshooting Tips for Accessing SDI Online](#).

Disability Insurance Claimants

- [How to File a DI Claim in SDI Online](#)
- [Manage Your Claim with SDI Online](#)
- [Am I Eligible for DI?](#)
- [SDI Online Tutorials](#)
- [SDI Online Tips for Claimants](#)
- [SDI Online FAQs](#)

Paid Family Leave Claimants

- [How to File a PFL Claim in SDI Online](#)
- [Manage Your PFL Claim with SDI Online](#)
- [Am I Eligible for PFL?](#)
- [SDI Online Tutorials](#)
- [SDI Online Tips for Claimants](#)
- [SDI Online FAQs](#)

On the **State Disability Insurance (SDI) Online** page, select the **Log In to SDI Online** link.

You will be directed to the **SDI Online Login** page.



Language: English

Contact SDI

- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

SDI Online Login

*Indicates Required Field

*Username:

[Forgot username?](#)
[Register for a new online account](#)

SECURITY REMINDER

Enter the username you provided during registration. We will ask you for your new password and display your personal image on the next screen.

On the **SDI Online Login** screen, enter your username and select **Submit**.

Contact SDI

- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

Confirm Your Personal Image and Log In

*Indicates Required Field

Verify your personal image and enter your password.

Personal Image:



Personal Image Caption: phone home

Username: JDoe1

*Password: (case sensitive)

[Log In](#)

[Forgot your personal image?](#)

[Incorrect personal image showing?](#)

[Forgot password?](#)

SECURITY REMINDER

Recognizing your Personal Image and Personal Image Caption helps you know that you are at a valid EDD web site, and that it is safe to enter your password.

If you do not recognize your personal image, do not enter your password.

On the **Confirm Your Personal Image and Log In** page, select **Forgot password?**

Contact SDI

- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

Forgot Password

*Indicates Required Field

Account Information

Provide your SDI Online username and e-mail address to retrieve your password.

*Username:

*E-mail Address:

Provide your SDI Online username and email address, and select **Next**.

Contact SDI

Forgot Password

- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

*Indicates Required Field

Answer Security Questions

Before you can retrieve your SDI Online password, you must correctly answer your security questions.

Question 1: What is the title of your favorite song?

*Answer to Question 1:

Next

Cancel

If you do not recall your previous responses, please contact EDD at (800) 480-3287. The EDD staff is available from 8 a.m. to 5 p.m. (PT), Monday through Friday, except on [state holidays](#).

[Forgot security questions and answers?](#)

Answer the security questions and select **Next**.

- Contact SDI
- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

Forgot Password

Password Hint Options

Your password hint is: test

I remember my password and would like to login

Password:

Send me my temporary password

Next

Cancel

If you need further assistance, please contact EDD at (800) 480-3287. The EDD staff is available from 8 a.m. to 5 p.m. (PT), Monday through Friday, except on [state holidays](#).

On the **Forgot Password** page, select **Send me my temporary password** and then select **Next**.



- Contact SDI
- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

Forgot Password

Temporary Password Sent Confirmation

A temporary password has been sent via e-mail. This password will expire in 15 days. If you do not receive an email, please check your junk/spam folder. To ensure e-mails from the EDD appear in your inbox, add noreply@edd.ca.gov to your address book.

[Login](#)

A temporary password will be sent to your email address.

This password will expire in 15 days.

If you do not receive an email, please check your junk spam folder.

After you receive the email, select **Login** to access your account.

Visit www.edd.ca.gov/disability for more information about State Disability Insurance.

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.