

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



State of California

# Employment Development Department

Contact EDD | Forms & Publications | Online Services

Search

This Site  California

Home

Unemployment

**Disability**

Jobs & Training

Payroll Taxes

Labor Market Info

## New Online Services

Services have been enhanced and automated. You can now file a claim for Disability Insurance and Paid Family Leave online, submit forms online, and view claim information online. To register, visit:



**New!** SDI Online

**New!** SDI Online En Español

**New!** Troubleshooting: Accessing SDI Online

Previously registered with SDI Online?

If you have previously registered with SDI Online and want to log in to your account, visit:

**SDI Online Login**

SDI Online Login En Español

## Disability Insurance

- ▶ How to File a DI Claim
- ▶ DI Eligibility
- ▶ DI Program Information
- ▶ DI Benefit Amounts
- ▶ **New!** SDI Online

More Disability Insurance Information

## Paid Family Leave

- ▶ How to File a PFL Claim
- ▶ PFL Eligibility
- ▶ PFL Program Information
- ▶ PFL Benefit Amounts
- ▶ **New!** SDI Online

More Paid Family Leave Information

To file a claim for Paid Family Leave (PFL) online, you must first have a State Disability Insurance (SDI) Online account.

To access your account:

- Visit [www.edd.ca.gov](http://www.edd.ca.gov).
- Select **Disability**.
- Select the **SDI Online Login** hyperlink.

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](#)

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

### 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**.

Contact SDI

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

## Additional Authentication

\*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](#).

In some instances, a claimant may be asked to respond to the security questions established when creating the account.

Type the answer to the security question 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.



Username:

\*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.

Confirm the Personal Image and enter your Password. Then select **Log In**.

**Note:** the Personal Image helps identify that the user has entered the correct username on the previous screen.

**MAIN MENU**

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

**Utilities**

- Set Application User
- Date Time
- Refresh User
- Add BOCs Claim Note

**Home**

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**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.

Select **File a New Claim** from the Main Menu.

## 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 link that best describes your claim. This example is for PFL Bonding.

Visit [www.edd.ca.gov](http://www.edd.ca.gov) for more information about which type of claim to file.

## Prescreening Questions

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\*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**.

## Information for Before You Start and After You File

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

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

- Your name (including other names under which you have worked), date of birth, gender, preferred language, and Social Security account number.
- Your mailing address (including ZIP code) and telephone number (including area code).
- The last date you worked for any employer.
- Your occupation.
- The name, mailing address and telephone number of your last employer or employers. (Be specific about the spelling of the employer's name and make sure the mailing address is correct. An incorrect address may delay benefit payments.)
- Any period you returned to work or will continue to work during your period of PFL.
- The reason why you have reduced work hours or stopped working.
- Information concerning the new minor child with whom you are bonding, including: your relationship to the child, the date of foster care or adoption placement, and the Social Security number (if available), date of birth, name, gender, and residence address of the child.
- Information if you are receiving, or expect to receive, any payments from your employer(s), including: the type of payment received, such as but not limited to sick leave, vacation, wage continuation, military, commissions, earnings from part-time or modified duty, residuals, bonuses, and holiday pay. Failure to report any payment could result in an overpayment, penalties, and a false statement disqualification.
- Whether you have claimed or plan to claim workers' compensation benefits for any portion of the period covered by this claim.
- Whether you were in custody of law enforcement authorities because you were convicted of violating law or ordinance at any time during PFL.
- The date you want your PFL bonding claim to begin. (See the PFL Benefit Amounts for more information regarding how the starting date of your claim may impact on your benefit amount.)

### PROOF OF RELATIONSHIP FOR BONDING

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

- Child's Birth Certificate
- Child's Hospital Birth Certificate
- Declaration of Paternity CS-909
- Foster Care Placement Record SOC-815 or Official Letter From Foster Care Agency
- Notice of Placement AD-907
- Independent Adoption Placement Agreement AD-924
- Or other evidence of relationship

Previous

Next

Cancel

This screen provides important information about the items you will need to file a PFL claim.

Review the information then select **Next**.

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

\*Indicates Required Field

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

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

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

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

If you need this form in an alternate format (e.g., Braille) or if you do not understand this form or any form provided by PFL, call us at 1-877-238-4373. TTY access (for individuals with disabilities requesting auxiliary aids and service only) to PFL is provided at 1-800-445-1312. You may also contact PFL on the Internet at <http://www.edd.cahwnet.gov/mcaccs.asp>.

#### BONDING CLAIMS:

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

Review the instructions, then select the box to agree to the terms. Then select **Next**.

## Personal Information



You are currently on Step 1 Personal Information

### Section 1 - Personal Information

Social Security Number: XXX-XX-1234

EDD Customer Account  
Number:

Full Name: John Doe

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

Date of Birth: 00-00-0000

Gender: Female

Mailing Address: 123 Main St.  
Anytown, CA 95814-4504  
United States

Phone Number: 000-000-0000

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

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

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

Then select Next.

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

## Employment Details

\*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:  Bonding with a child  Other Other Reason:

### Employer 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)

Previous

Next

Save as Draft

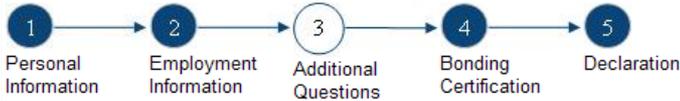
Cancel

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

Mandatory fields are marked with a red asterisk.

## 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 information and select **Next**.

## Bonding Certification

\*Indicates Required Field



You are currently on Step 4 Bonding Certification

### Section 3 - Personal Information

\*Child relationship:

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

### Section 4 - Child's Legal Name and Information

Child's Social Security Number (if available):  (Do not enter dashes)

\*Child's First Name:

Middle Initial:

\*Last Name:

Suffix:

\*Date of Birth:  (MMDDYYYY)

\*Child's Gender:  Male  Female

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

Select the child relationship from the drop down menu (Adopted Child, Biological Child, Foster Child, Legal Ward, Other, Step Child) and complete the child's information section. 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

Enter the child's address information and select **Next**.

## Declaration

\*Indicates Required Field



You are currently on Step 5 Declaration

### Section 8 - 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 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 signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was providing care for or bonding with the care recipient named above; (2) authorize EDD to release my personal information as shown on this claim to the care recipient and to the care recipient's treating physician as they are respectively listed in Part C and Part D of this claim; (3) authorize my employer(s) to disclose to EDD all facts concerning my employment that are within their knowledge; and (4) authorize release and use of information as stated in the "Information Collection and Access" portion of this form. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.

Previous

Submit

Save as Draft

Cancel

Select the first box to authorize a medical provider, an adoption agency or party, or a foster care placement agency to share your information with the Employment Development Department.

Select the second box to authorize an electronic signature.

Both boxes must be selected to complete your claim.

Select **Submit** to finalize the process.

## 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 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-1234

Date you requested to have your Paid Family Leave claim begin: 03-12-2012

Receipt Number: [R100000000022953](#)

### 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:

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

For PFL Bonding you will need to select the **Proof of Relationship** link to submit the proof of relationship electronically.

MAIN MENU	Apply for Benefits or Continue a Draft Application
<a href="#">Home</a>	
<a href="#">Inbox</a>	
<a href="#">File a New Claim</a>	
<a href="#">Continue a Saved Draft</a>	Select a link below to apply for Disability Insurance or Paid Family Leave benefits.
<a href="#">Manage My Profile</a>	<b>Apply for Disability Insurance Benefits</b>
<a href="#">My Claim History</a>	<a href="#">Disability Insurance</a>
<a href="#">SCDB Login</a>	<b>Apply for Paid Family Leave Benefits</b>
<a href="#">Contact Us</a>	<a href="#">Paid Family Leave Bonding</a>
<b>Utilities</b>	<a href="#">Submit Electronic Paid Family Leave Bonding Attachment</a>
<a href="#">Set Application User</a>	<a href="#">Paid Family Leave Care</a>
<a href="#">Date Time</a>	<a href="#">Submit Electronic Paid Family Leave Care Attachment</a>
<a href="#">Refresh User</a>	<b>Saved Drafts</b>
<a href="#">Add BOCS Claim Note</a>	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
	<a href="#">Delete</a>

Select the appropriate **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	<a href="#">Select</a>

Cancel

Verify the receipt number against the number received when you filed the claim. **Select** the link from the Action column.

## Attachment

\*Indicates Required Field

### Identifying Information for Previously Submitted Paid Family Leave Initial Care Claim

Your Social Security XXX-XX-1234  
Number:

Date you requested to have 03-12-2012  
your Paid Family Leave  
claim begin:

Form Receipt Number: R100000000022946

### 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/Disability/PFL\\_Forms\\_and\\_Publications.htm](http://www.edd.ca.gov/Disability/PFL_Forms_and_Publications.htm). 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:

\*Do you want to attach more documents?  Yes  No

Previous

Submit

Cancel

Select the **Browse** button to upload your proof of relationship.

## Attachment

\*Indicates Required Field

### Identifying Information for Previously Submitted Paid Family Leave Initial Bonding Claim

Your Social Security XXX-XX-1234  
Number:

Date you requested to have 04-12-2012  
your Paid Family Leave  
claim begin:

Form Receipt Number: R100000000003734

### 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: C:\Documents and Sett

\*Do you want to attach more documents?  Yes  No

Once successfully uploaded, select Yes or No to the question "Do you want to attach more documents?"

Then select **Submit**.

## Attachment Confirmation

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### Identifying Information for Previously Submitted Paid Family Leave Initial Bonding Claim

Your Social Security XXX-XX-1234  
Number:

Date you requested to have 04-12-2012  
your Paid Family Leave  
claim begin:

Form Receipt Number: R100000000003734

### Previously Submitted Attachments for Paid Family Leave Initial Bonding Claim

File Name

Adoption Agency Letter.pdf

Receipt Number

R100000000003735

This page confirms that the attachment has been submitted.

Save the Receipt Number for future reference.

Visit [www.edd.ca.gov](http://www.edd.ca.gov) 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 1-800-480-3287 (voice), or TTY 1-800-563-2441.