

SDI Online Tutorial

Claimant Registration, Online Access, and Claim Filing

This tutorial will explain how to:

1. [Create a Benefit Programs Online Account \(Step 1\)](#)
2. [Register as a Claimant in SDI Online \(Step 2\)](#)
3. [Access Your SDI Online Account](#)
4. [File a Disability Insurance Claim](#)
5. [File a Paid Family Leave Bonding Claim - New Mother](#)
6. [File a Paid Family Leave Bonding Claim for New Mothers \(without a prior pregnancy-related disability claim\), New Fathers, or Foster Care or Adoptive Parents](#)
7. [Submit Paid Family Leave Bonding Claim Attachments](#)
8. [File a Paid Family Leave Care Claim](#)
9. [Submit Paid Family Leave Care Claim Attachments](#)
10. [File a Paid Family Leave Military Assist Claim](#)
11. [Submit Paid Family Leave Military Assist Claim Attachments](#)
12. [Update My Benefit Programs Online Profile - Email, Password, Security Questions, or Personal Image and Caption](#)
13. [Complete Paper Claim Forms](#)

Create a Benefit Programs Online Account (Step 1)

1 2 3 4 5 6 7 8 9 10 11 12 13

First time access to Employment Development Department (EDD) benefits services requires a one-time registration for Benefit Programs Online.

Benefit Programs Online allows you to use a single login to access the following EDD services:

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

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

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

Benefit Programs Online Registration:

1. Visit [Benefit Programs Online](http://edd.ca.gov/BPO) (edd.ca.gov/BPO) to complete a one-time registration.
2. From the Benefit Programs Online login screen, select **Register now** to create an account. To change the language of all screens to Spanish, select **En español** on the login screen.
3. Accept the **Terms and Conditions**. You must select **I Agree** in order to establish an online account.
4. Provide a personal email address that is current and is used only by you.
5. Set up a password that is between 8 and 20 characters. The password is case sensitive and must contain at least:
 - One uppercase letter
 - One lowercase letter
 - One number
 - One special character from this list: !@#\$%^&*()
6. Create the **Security Profile** with security questions and answers and a personal image and caption.
7. Once you submit your registration information, an email with a link will be sent to you. Select the unique link within 48 hours to complete your registration.
8. After you have registered for and logged in to Benefit Programs Online, select **SDI Online**. You will be directed to the SDI Online Registration Options (see [Register as a Claimant in SDI Online](#)). You will always use Benefit Programs Online to access SDI Online to file a Disability Insurance or Paid Family Leave claim.

Register as a Claimant in SDI Online (Step 2)

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Log in to Benefit Programs Online

[En español](#)

Email:

1.

2. ☐ I am not a robot

reCAPTCHA
Privacy - Terms

3.

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

Benefit Programs Online gives you access to these EDD services:

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


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


Follow these directions to log in to Benefit Programs Online:


1. Enter the email address that you used to register.
2. Complete the security check.
3. Select **Log In**.

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


1 2 3 4 5 6 7 8 9 10 11 12 13

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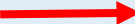
 **Password**

To log in to Benefit Programs Online, you must verify your personal image and personal caption, and enter your password.
* Use the latest version of Chrome or Firefox for the best experience.

4. 
Personal Caption: Cup

5. * Password:
[Forgot Password?](#)

6.  

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

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

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

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

6. Select **Log In**.

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Employment Development Department

Home My Profile Benefit Programs Online

Benefit Programs Online

UI OnlineSM

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

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

UI Online

UI Online Mobile

SDI Online

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

SDI Online

Benefit Overpayments

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

Benefit Overpayments

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

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[Log Out](#)

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

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

Note: If you already filed your Disability Insurance claim by paper, you will still be able to view and manager your claim through SDI Online. At this time, you can only file Paid Family Leave claims through SDI Online.

SDI Online Registration

Select your account type.

Claimant

Select **Register as a Claimant** to:

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


You will need:

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

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

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

Register as a Claimant



Employer

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

You will need:

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

Register as an Employer

Physician/Practitioner

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

You will need:

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

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

Register as a Physician/Practitioner

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

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

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

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

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

Claimant Registration

*Indicates Required Field

Personal Information

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

*First Name:

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

*Last Name:

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

E-mail Address: jdoe@gmail.com

*Gender: Select ▼

*Date of Birth: (MMDDYYYY)

*Social Security Number: (Do not enter dashes)

*Retype Social Security Number:

*California Driver License or Identification Number:

*Retype California Driver License or Identification Number:

Cancel

Next

You **must** provide the following personal information. Required fields are marked with a red asterisk (*).

- Your full legal name as it appears on your California Driver License or Identification card.
- Gender.
- Date of birth as shown on your California Driver License or Identification card.
- Social Security number.
- California Driver License or Identification number.

Select **Next**.

Claimant: Personal Profile Information

*Indicates Required Field

Residence Address

☒ US ☐ International

*Address Line 1:

Address Line 2:

*City:

*State: ▼

*ZIP Code:

Mailing Address

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

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

☒ US ☐ International

*Address Line 1:

Address Line 2:

*City:

*State: ▼

*ZIP Code:

Complete and review your:

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

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

Phone Numbers

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

*Primary Phone Number: ☒ Home Phone Number ☐ Cell Phone Number

Home Phone Number:

☐ Check here if the phone number is international

Cell Phone Number:

☐ Check here if the phone number is international

Preferred Language

*Preferred Language:

Other Language:

Communication Preferences

Indicate below how you prefer to be notified.

Note: It may be necessary to send some documents via US Postal Service. This includes Paid Family Leave (PFL) payments and PFL claim-related forms. Updates made to your communication preference may take additional time to take effect.

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

☐ I prefer to be notified by paper mail

Cancel

Submit

Next, provide your:

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

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

Select **Submit**.

Claimant: Personal Profile Information

* Indicates Required Field

Address Validation

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

Entered Address

1123 Main Street
Sacramento CA 95814

Updated Address

123 Main Street
Sacramento CA 95814

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

No

Yes

The SDI Online system may adjust your address information under the **Updated Address** field to follow USPS standards.

- Verify the address shown is correct by selecting **Yes**.
- If the address information is incorrect, select **No** to re-enter the correct address.

SDI Online Account Registration Complete

Account Registration Successful

Your SDI Online account has been created and your EDD Customer Account Number is 123456789. A notification has been sent to you via email and US Postal Service.

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

[Benefit Programs Online](#)

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

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

- Care for a seriously ill child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner;
- Bond with a new child after birth, adoption, or foster care placement; or
- Assist with matters related to a family member's military deployment to a foreign country.

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

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

Please keep and secure your assigned EDD Customer Account Number for future reference. You may be asked to provide this information when requesting assistance from a customer service representative.

You may now file your Disability Insurance or Paid Family Leave claim by:

1. Selecting the **Benefit Programs Online** link.
2. Logging in to Benefit Programs Online.
3. Selecting the **SDI Online** button.
4. Selecting **New Claim** from your SDI Online account main menu bar.

Access Your SDI Online Account

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Home

Log in to Benefit Programs Online

[En español](#)

Email:

1.

2. ☐ I am not a robot 
reCAPTCHA
Privacy - Terms

3.

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

Benefit Programs Online gives you access to these EDD services:

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

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

Follow these directions to log in to Benefit Program Online:

1. Enter the email address that you used to register.
2. Complete the security check.
3. Select **Log In**.

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

1 2 3 4 5 6 7 8 9 10 11 12 13


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Home

▶ Password

To log in to Benefit Programs Online, you must verify your personal image and personal caption, and enter your password.
* Use the latest version of Chrome or Firefox for the best experience.

4. **Personal Image:**



Personal Caption: Cup

5. *** Password:** [Forgot Password?](#)

6.

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

6. Select **Log In**.



Benefit Programs Online

UI OnlineSM

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

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

UI Online

UI Online Mobile

SDI Online

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

SDI Online

Benefit Overpayments

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

Benefit Overpayments

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

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

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

Home

Message Center

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

Inbox [New: 0, Total: 0]

Personal Information

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

Current Disability Insurance Claim(s)

No Results Found

Pending Disability Insurance Claim Application(s)

No Results Found

Submitted Paid Family Leave Claim Forms

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

No Results Found

Use your SDI Online account Home screen to:

- File a new claim.
- Update profile information.
- Continue a saved draft.
- View claim history.
- View inbox messages and take required actions.
- View a current Disability Insurance claim summary, payment history, form history, and send claim requests.
- View a pending Disability Insurance claim.
- View your submitted Paid Family Leave claim information.

File a Disability Insurance Claim

Follow these instructions to begin filing a Disability Insurance claim:

1. Access your SDI Online account by logging in to **Benefit Programs Online**.
2. Select the **SDI Online** button to be directed to your SDI Online **Home** screen.
3. Select **New Claim** from the main menu bar on your SDI Online Home screen.



SDI Home

Inbox

New Claim

Draft

Profile

History

Home

Message Center

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

Inbox [New: 0, Total: 0]

Personal Information

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

Current Disability Insurance Claim(s)

No Results Found

Pending Disability Insurance Claim Application(s)

No Results Found

Submitted Paid Family Leave Claim Forms

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

No Results Found

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

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

Apply for Disability Insurance Benefits

[Disability Insurance](#)

Apply for Paid Family Leave Benefits

[Paid Family Leave Bonding](#)

[Submit Electronic Paid Family Leave Bonding Attachment](#)

[Paid Family Leave Care](#)

[Submit Electronic Paid Family Leave Care Attachment](#)

[Paid Family Leave Military Assist](#)

[Submit Electronic Paid Family Leave Military Assist Attachment](#)

Saved Drafts

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

Select the **Disability Insurance** link located under the **Apply for Disability Insurance Benefits** header to apply for Disability Insurance benefits.

Submit your claim no earlier than the first day your disability begins, but no later than 49 days after your disability begins, or you may lose benefits.

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

Disability Insurance Claim Filing Instructions

Before You Start and After You File

Please have the following information available while completing this form:

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

Cancel

Next

The **Disability Insurance Claim Filing Instructions** screen provides important information you will need to have readily available to file a Disability Insurance claim.

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

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

Personal Information

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

You are currently on Step 1 Personal Information

Section 1 - Personal Information

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

Section 2 - Other Names and Social Security Numbers Used

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

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

Previous

Cancel

Save as Draft

Next

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

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

If your personal information has changed, select **Save as Draft** and update your SDI Online account profile.

Select **Next** to proceed to the next step.

Note:

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

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?

 (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?

 Select

*How would you describe or classify your job?

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

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

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

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

Other Type of Pay:

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

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

*Was this disability caused by your job? ☐ Yes ☐ No

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

 Previous

 Cancel

 Save as Draft

 Next

Complete Section 3 - Employment Information.

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

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

Select **Next**.

Employment Summary

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

You are currently on Step 3 Employment Information

Section 4A - List of Employers

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

No Results Found

Previous

Cancel

Add

Save as Draft

Next

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

You must add at least one employer.

Employer Search

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

You are currently on Step 3 Employment Information

* Indicates Required Field

Section 4B - Search Criteria

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

* **Employer Name:**

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

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

Select **Search** to proceed.

Section 4B - Search Criteria

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

* Employer Name:

Begins With



B Dalton

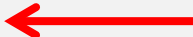
Reset

Search

Search Results

Employer Name

B Dalton Bookseller



Action

Select

Previous

Cancel

Not Found

If your employer's name populates in the **Search Results** table, click **Select** under the **Action** column.

If your employer is not listed under **Search Results**, select **Not Found** and skip to slide 32.

Section 4C - Employer Contact Information

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

Last or Current Employer Name: B Dalton Bookseller

☒ US ☐ International

Address Line 1:

Address Line 2:

City:

State: CA

ZIP Code:

Employer Phone Number: **Ext:**

☐ Check here if the phone number is international

Employment Information

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

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

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

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

If you have more than one employer, enter additional employers by selecting **Yes** to "Do you currently have another employer that you have not yet reported?"

Select **Next**.

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:

Bob Jones

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:

800 Capitol Mall

Address Line 2:

* City:

Sacramento

* State:

CA

* ZIP Code:

95814

Employer Phone Number:

9161234567

Ext:

123

☐ Check here if the phone number is international

Employment Information

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

07/31/2018

* Do you currently have another employer that you have not yet reported?

☒ Yes ☐ No

Previous

Cancel

Save as Draft

Next

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

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

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

Select **Next**.

Employment Details (Add Employer)

* Indicates Required Field

Address Validation

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

Entered Address

800 Capitol Mall
Sacramento CA 95814

Updated Address

800 Capitol Mall
Sacramento CA 95814 - 4807

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

No

Yes

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

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

Declaration

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

You are currently on Step 5 Certification

*Indicates Required Field

Section 9 - Payment Choice

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

*Preferred Payment Method: ☒ EDD Debit Card
☐ Check

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

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

In **Section 9 – Declaration**, you have the option to select your preferred payment method. You may select to receive benefit payments by EDD Debit Card or by check. You do not have to accept the EDD Debit Card.

If your preferred payment method is the EDD Debit Card, select the ***EDD Debit Card Fee Declaration (DE 5617PD) (PDF)*** link to view the disclosure agreement.

Select the check box below to acknowledge you have reviewed the disclosures.

Section 10 - Declaration

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

Health Insurance Portability and Accountability Act (HIPAA)

☐ I authorize the below named Physician/Practitioner to furnish and disclose all my health information and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability for which this claim is filed that are within their knowledge to the following employees of the California Employment Development Department (EDD): Disability Insurance Branch examiners, their direct supervisors/managers and any other EDD employee who may have a need to access this information in order to process my claim and/or determine eligibility for State Disability Insurance benefits. I understand that EDD is not a health plan or health care provider, so the information released to EDD may no longer be protected by federal privacy regulations. (45 CFR Section 164.508(c)(2)(iii)). EDD may disclose information as authorized by the California Unemployment Insurance Code. I agree that photocopies of this authorization shall be as valid as the original. I understand I have the right to revoke this authorization by sending written notification stopping this authorization to the EDD, DI Branch MIC 29, PO Box 826880, Sacramento, CA 94280. The authorization will stop on the date my request is received. I understand that the consequences for my revoking this authorization may result in denial of further State Disability Insurance benefits. I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by EDD or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled. I understand that I am signing this authorization voluntarily and that payment or eligibility for my benefits will be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization may result in an incomplete claim form that cannot be processed for payment of State Disability Insurance benefits. I understand I have the right to receive a copy of this authorization.

Authorized Physician/Practitioner Name:

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

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

Previous

Cancel

Save as Draft

Submit

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

Select the **View Claim: *Claim for Disability Insurance (DI) Benefits (DE 2501)*** link to view, save, or print your application for your records.

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

Note: Your claim is NOT complete. Your physician/practitioner must submit the "Physician/Practitioner's Certification" section of the *Claim for Disability Insurance (DI) Benefits (DE 2501)*.

Confirmation

Confirmation

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

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

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

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

Form Receipt Number: R100000000035351

Customer Satisfaction Survey

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

[Link to Survey](#)

On the **Confirmation** screen, you will be assigned a **Form Receipt Number**.

Save this number and provide it to your physician/practitioner so they can submit the medical certification.

Your physician/practitioner can complete the medical certificate through SDI Online or by completing Part B of the paper claim form, *Claim for Disability Insurance (DI) Benefits* (DE 2501).

Selecting the **Form Receipt Number** link will open a PDF printer-friendly view of the information that you submitted.

File a Paid Family Leave Bonding Claim – New Mother

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

- Receive a *Claim for Paid Family Leave (PFL) Benefits – New Mother* (DE 2501FP) automatically by mail in a separate envelope at the time your final Disability Insurance payment is issued.
- Or, if you have an SDI Online account, the link to the DE 2501FP will automatically be sent to your inbox at the time your final Disability Insurance payment is issued.

Note: If you are a new mother who did not have a pregnancy-related Disability Insurance claim, a new father, or a foster/adoptive parent, please refer to the [File a Paid Family Leave Bonding Claim for New Mothers \(without a prior pregnancy-related disability claim\), New Fathers, or Foster Care or Adoptive Parents](#) section of the tutorial.

Home

Message Center

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

Inbox [New: 0 , Total: 0]

Personal Information

Full Name: Jane Doe

EDD Customer Account Number: 123456789

Mailing Address: 123 Main St
Sacramento, CA 95814

Phone Number: 916-555-1212

Residence Address: 123 Main St
Sacramento, CA 95814

Cell Phone Number: 916-555-1213

E-mail Address: Jdoe@gmail.com

Current Disability Insurance Claim(s)

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

1. Access your SDI Online account by logging in to **Benefit Programs Online**.
2. Select the **SDI Online** button to be directed to your SDI Online **Home** screen (screen above).
3. Select **Inbox** from the SDI Online main menu bar or the **Message Center**.

Forms Available to Submit Online

Claim Information

Claimant Name:

Jane Doe

Claim ID:

DI-1000-XXX-XXX

Expected Return to Work Date:

03-05-2018

Claim Effective Date:

02-15-2018

Forms Available to Submit

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

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

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

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

[Paid Family Leave Bonding](#)

Saved Drafts

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

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

Delete

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

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

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

Prescreening Questions

* Indicates Required Field

Prescreening Questions

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

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

Cancel

Next

Answer the prescreening questions:

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

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

Initial Questions



You are currently on Step 1 Initial Questions

* Indicates Required Field

Section 1 - Contact Information

Claimant Name: Jane Doe

EDD Customer Account Number: 123456789

Mailing Address: 123 Main St
Sacramento, CA 95814

Phone Number: 916-555-1212

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

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

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

Previous

Cancel

Save as Draft

Next

Note:

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

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

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

Note: If you have not stopped claiming Disability Insurance benefits, you will not be able to complete this claim form. Please submit this form after the final Disability Insurance payment has been issued.

Select **Next** to proceed.

DI Claim Information

Initial Questions 2 DI Claim Information 3 Claim Information 4 Declaration

You are currently on Step 2 DI Claim Information

Section 2 - DI Claim Information

Social Security Number: XXX-XX-XXXX

* Disability Insurance Claim Effective Date:

(MMDDYYYY)

* Final Date of Disability Insurance Benefits:

(MMDDYYYY)

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

Previous

Cancel

Save as Draft

Next

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

If you have **not** stopped claiming Disability Insurance benefits, select **Save as Draft** and complete the form at a later date.

To continue, verify the populated information is correct. Next, enter the date your Disability Insurance claim started and ended to ensure your Paid Family Leave claim is processed correctly.

Select **Next** to proceed.

Paid Family Leave Claim Information

Initial Questions ☒ DI Claim Information ☒ **3 Claim Information** ☐ 4 Declaration

You are currently on Step 3 Claim Information

*Indicates Required Field

Section 3 - Baby Information

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

*Baby's First Name:
Baby's Middle Initial:
*Baby's Last Name:
Baby's Suffix:
*Baby's Date of Birth:
*Baby's Gender: ☐ Male ☐ Female

Section 4 - Paid Family Leave Claim Information

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

*Last Day Worked:

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

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

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

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

Section 5 - Employer Information

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

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

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

If "Yes," indicate type of pay

Beginning Payment Date:

Ending Payment Date:

*Do you have more than one employer? ☐ Yes ☐ No

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

Previous

Cancel

Save as Draft

Next

You must complete the following sections:

- **Section 3 - Baby Information**
- **Section 4 - Paid Family Leave Claim Information**
- **Section 5 - Employer Information**

Confirm you are entering the correct information and dates to avoid a possible delay or loss of benefits before proceeding.

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

Select **Next** to proceed.

Declaration

Initial Questions DI Claim Information Claim Information 4 Declaration

You are currently on Step 4 Declaration

* Indicates Required Field

Section 6 - Payment Choice

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

* Preferred Payment Method: ☒ EDD Debit Card
☐ Check

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

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

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

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

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

Section 7 - Declaration

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

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

Previous

Cancel

Save as Draft

Submit

Next, select the box to authorize an electronic signature and the release of your information.

Select **Submit** to send your Paid Family Leave – New Mother claim form to the EDD.

Confirmation

Print this page for your records. If a printer is unavailable at this time, record the Form Receipt Number below. The Form Receipt Number is required to retrieve a copy of the *Claim for Paid Family Leave (PFL) – New Mother* (DE 2501FP) application. You will not be able to access your confirmation page and Form Receipt Number after this window is closed.

Most claims are processed and a decision is made within two weeks of the date the claim was submitted. If you have not received anything from PFL within 10 days or if you have any questions you may call 1-877-238-4373.

Confirmation Information

Claimant Name: Jane Doe

Social Security Number: XXX-XX-XXXX

Receipt Number: R100000000035399

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

Warning

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

On the **Confirmation** screen, save and secure your **Receipt Number** for future reference. You may be asked for this number when requesting assistance from a customer service representative.

Most claims are processed and a decision is made within 14 days from the date the claim was submitted. Do not file a duplicate claim during this time, you may delay payment further.

If you need additional assistance, view your options to [Contact the EDD](http://edd.ca.gov/about_edd/contact_edd.htm) (edd.ca.gov/about_edd/contact_edd.htm).

Information for Before You Start and After You File

Before you Start: Information you need to submit a *Claim for Paid Family Leave (PFL) Benefits – New Mother* (DE 2501FP)

When your pregnancy-related

- The last date you work
- Whether you returned
- Information concerning
- Information as to whether
- and a false statement
- Whether you have claim
- Whether you were you
- The date you want you

FILING A DRAFT

Saves your entered informat

To retrieve your saved draft(s)

All available information will
reduced, you will receive a w

After You Have Filed Your Application

WHEN YOUR CLAIM IS SUCCESSFULLY SUBMITTED

The PFL office will notify you of your weekly benefit amount and request any additional information needed to determine your eligibility. If you meet all requirements, a payment will be issued to you. The majority of claims are processed and payments issued within 14 days of receipt of a correctly completed claim.

Note: It may be necessary to send some documents via US Postal Service. This includes Paid Family Leave (PFL) payments and PFL claim-related forms.

YOUR RIGHTS

Information about your claim will be kept confidential, except for the purposes allowed by law. California Civil Code, section 1798.34, gives you the right to inspect any personal records maintained about you by EDD. Section 1798.35 permits you to request that the record be corrected if you believe it is not accurate, relevant, timely, or complete. Certain types of information that would generally be considered personal are exempt from disclosure to you: medical or psychological records where knowledge of the contents might be harmful to the subject (Civil Code, section 1798.40); records of active criminal, civil or administrative investigations (Civil Code, section 1798.40).

If you are denied access to records which you believe you have a right to inspect or if you request to amend your records is refused, you may file an appeal with the PFL office. You may request a copy of your file by calling the telephone number shown on your *Notice of Computation* (DE 429D).

You also have the right to appeal any disqualification, overpayment, or penalty. Specific instructions on how to appeal will be provided on any appealable document you receive.

SPECIAL CIRCUMSTANCE RELATING TO YOUR PAID FAMILY LEAVE CLAIM

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

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

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

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

Job Benefits and Protection Programs. Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) offer job protected leave to "eligible" employees for certain family and medical reasons. Contact FMLA at 866-487-9243 or the Department of Labor Web site: <https://www.dol.gov/whd/fmla> or CFRA at 800-884-1684 or the Department of Fair Employment and Housing Web site: <https://www.dfeh.ca.gov> for additional information on these programs.

Phone Number Link
https://www.edd.ca.gov/Disability/Contact_SDI.htm#bypHONE

Frequently Asked Questions Link
<https://www.edd.ca.gov/Disability/FAQs.htm#pfl>

Cancel

Next

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

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

* Indicates Required Field

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

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

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

Previous

Cancel

Next

Select the box to authorize an electronic signature.

Select **Next**.

Paid Family Leave (PFL) Survey Questions

* Indicates Required Field

Paid Family Leave (PFL) Survey

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

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

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

Submit

Complete the survey and select **Submit**.

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

Home

Message Center

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

Inbox [New: 0, Total: 0]

Personal Information

Full Name: John Doe

EDD Customer Account Number: 123456789

Mailing Address: 123 Main St
Sacramento, CA 95814

Phone Number: 916-555-1212

Residence Address: 123 Main St
Sacramento, CA 95814

Cell Phone Number: 916-555-1213

E-mail Address: Jdoe@gmail.com

Current Disability Insurance Claim(s)

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

1. Access your SDI Online account by logging in to **Benefit Programs Online**.
2. Select the **SDI Online** button to be directed to your SDI Online **Home** screen.
3. Select **New Claim** from the main menu bar on your SDI Online Home screen.

Note: You will need to upload or mail a “Proof of Relationship” document after completing your online Paid Family Leave Bonding claim. To skip to the instructions on uploading your document(s) to your SDI Online account, please view the [Submit Additional Paid Family Leave Bonding Attachments](#) section of this tutorial.

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

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

Apply for Disability Insurance Benefits

[Disability Insurance](#)

Apply for Paid Family Leave Benefits

[Paid Family Leave Bonding](#)

[Submit Electronic Paid Family Leave Bonding Attachment](#)

[Paid Family Leave Care](#)

[Submit Electronic Paid Family Leave Care Attachment](#)

[Paid Family Leave Military Assist](#)

[Submit Electronic Paid Family Leave Military Assist Attachment](#)

Saved Drafts

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

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

- Submit your claim no earlier than the first day your family leave begins, but no later than 41 days after your family leave begins, or you may lose benefits.
- If you have already submitted a claim, do not submit a duplicate claim. It may take up to 14 days for your claim to be reviewed and processed.
- If you are unsure about the type of claim to file for, refer to the [Types of Claims](http://edd.ca.gov/Disability/Types_of_Claims.htm) (edd.ca.gov/Disability/Types_of_Claims.htm) on the EDD website.

Prescreening Questions

* Indicates Required Field

Prescreening Questions

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

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

Cancel

Next

You must answer the prescreening questions:

- If you are a new mother applying for bonding benefits and DID NOT file a Disability Insurance pregnancy claim, select **Yes** for the first question and **No** for the second question.
- If you are a new father or an adoptive/foster parent applying for bonding benefits, select **No** for both questions.

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

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

Information for Before You Start and After You File

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

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

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

PROOF OF RELATIONSHIP FOR BONDING

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

- Child's Birth Certificate
- Official letter from foster care agency
- Child's Hospital Birth Certificate
- Adoptive Placement Agreement, AD-907
- Declaration of Paternity, CE-600

After You Have Filed Your Application

WHEN YOUR CLAIM IS RECEIVED

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

SPECIAL CIRCUMSTANCES RELATING TO YOUR PAID FAMILY LEAVE CLAIM

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

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

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

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

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

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

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

Phone Number Link

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

Frequently Asked Questions Link

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

Cancel

Next

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

Review and gather the information before proceeding.

Select **Next**.

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, to bond with a new child or assist with matters related to a family member's military deployment to a foreign country.

(B) Call 1-877-238-4373 for required forms and instructions if:

1. A disability prevents you from completing the claim form and you need to designate a representative to sign for you.
2. You are an authorized representative filing for benefits on behalf of a physically or mentally incapacitated care provider/care recipient or a deceased care provider/care recipient.

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

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

INELIGIBILITY:

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

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

FRAUD:

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

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

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

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

If you deliberately report incorrect information, willfully omit or withhold information, a false statement disqualification of up to 92 days may be assessed. In addition, any resulting 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

Cancel

Next

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

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

Select **Next** to proceed.

Note:

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

Personal Information

1 Personal Information

2 Employment Information

3 Additional Questions

4 Certification

5 Qualifying Events

6 Declaration

You are currently on Step 1 Personal Information

Verify Your Personal Information

If your personal information has changed, select **Save as Draft**, then select **Profile** from the main menu to update your information before completing this form.

Social Security Number:	XXX-XX-XXXX	EDD Customer Account Number:	123456789
Full Name:	John Doe	Other Names (if any, under which you have worked):	<input type="text"/>
Date of Birth:	XX-XX-XXXX	Gender:	Male
Mailing Address:	123 Main St Sacramento, CA 95814 United States	Phone Number:	916-555-1213
Preferred Language:	English		

Previous

Cancel

Save as Draft

Next

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

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

Select **Next** to proceed.

EDD Employment Development Department
State of California

SDI Home Inbox New Claim Draft Profile History

Employment Information

1 Personal Information **2 Employment Information** 3 Additional Questions 4 Certification 5 Qualifying Events 6 Declaration

You are currently on Step 2 Employment Information

*Indicates Required Field

Your Employment Details

*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: ☐ Participating in a qualifying event ☐ Other

Other Reason:

Employer Information

Enter your current or most recent employer information.

Note: An incorrect employer name or address can delay benefit payments.

*Name of Employer:

☒ US ☐ International

*Address Line 1:

Address Line 2:

*City:

*State:

Employer Phone Number: Ext:

☐ Check here if the phone number is international

Previous Cancel Save as Draft **Next**

Website for ecd313a372e07 network1.com.edd.ca.gov

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

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

Select **Next** to proceed.

Employment Details



Personal Information

2

Employment
Information

3

Additional Questions

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Bonding Certification

5

Declaration

You are currently on Step 2 Employment Information

*Indicates Required Field

Address Validation

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

Entered Address

414 k st
sacramento CA 95834

Updated Address

414 K St
Sacramento CA 95814 - 3335

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

No

Yes

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

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

Additional Questions

✓ Personal Information ✓ Employment Information **3 Additional Questions** 4 Bonding Certification 5 Declaration

You are currently on Step 3 Additional Questions

*Indicates Required Field

Section 7 - Additional Questions

*Date you last worked:

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

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

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

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

Date you returned to work:

Or date you plan to return to work:

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

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

Specify if "Other type of pay":

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

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

Previous

Cancel

Save as Draft

Next

Complete **Section 7 - Additional Questions** and confirm the dates you entered are correct to avoid a possible delay or loss of benefits.

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

Select **Next** to proceed.

Bonding Certification

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

You are currently on Step 4 Bonding Certification

* Indicates Required Field

Section 3 - Personal Information

* Child relationship:

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

Section 4 - Child's Legal Name and Information

Child's Social Security Number (if available):

* Child's First Name:

Middle Initial:

* Last Name:

Suffix:

* Date of Birth:

* Child's Gender: ☐ Male ☐ Female

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

In the **Section 3 - Personal Information**, select your relationship to the child you are bonding with from the drop-down menu. Complete **Section 4 - Child's Legal Name and Information** with the child's information.

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

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

Section 5 - Proof of Relationship

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

Proof of Relationship document includes:

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

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

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

Previous

Cancel

Save as Draft

Next

The accepted "Proof of Relationship" document options are:

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

To be eligible for Paid Family Leave Bonding benefits, you must submit an approved "Proof of Relationship" document. Submit one of the accepted documents within 10 days from the date you submit your online bonding claim.

From the drop-down menu, select the "Proof of Relationship" document you will upload or mail after completing the online claim.

Further instructions to upload or mail your "Proof of Relationship" document(s) will be provided on the confirmation screen.

Select **Next** to proceed.

Child's Residence Address



Personal Information



Employment Information



Additional Questions

4

Bonding Certification

5

Declaration

You are currently on Step 4 Bonding Certification

*Indicates Required Field

Section 6 - Residence Address

☒ US ☐ International

*Address Line 1:

Address Line 2:

*City:

*State:

*ZIP Code:

Previous

Cancel

Save as Draft

Next

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

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

If you selected **No** to the above question, you will not see this screen. Please skip to the next slide.

Select **Next** to proceed.

Declaration



Personal Information



Employment
Information



Additional Questions



Bonding Certification



Declaration

You are currently on Step 5 Declaration

* Indicates Required Field

Section 8 - Payment Choice

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

* Preferred Payment Method:

☒ EDD Debit Card

☐ Check

Disclosures Agreement:

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



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

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

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

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

Section 9 - Declaration

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

* ☐ By my signature on this bonding certification, I authorize the medical provider, adoption agency, adoption party(ies), or foster care placement agency to disclose to the Employment Development Department all facts concerning the birth, adoption, or foster care placement of the above-named child. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements or documents, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.

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

Previous

Cancel

Save as Draft

Submit

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

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

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

Paid Family Leave (PFL) Survey Questions

*Indicates Required Field

Survey Questions

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

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

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

Submit

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

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
Date you requested to have your Paid Family Leave claim begin: 07-01-2018

Social Security Number: XXX-XX-XXXX

Receipt Number: R100000000033001

Instructions for Submitting Proof of Relationship

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

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

Electronically

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

[Attach my Proof of Relationship](#)

You may also submit your electronic "Proof of Relationship" at a later date by following these navigation instructions:

1. Select New Claim on the Main Menu.
2. Choose Submit Electronic Paid Family Leave Bonding Attachment.

Mail

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

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

On the **Confirmation** screen, you will be assigned a **Receipt Number**.

Save the Receipt Number for future reference. You will need this number to upload your supporting documentation to the correct online claim.

The **Confirmation** screen will also provide instructions to upload the additional documentation for your Paid Family Leave Bonding claim.

Instructions for Submitting Proof of Relationship

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

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

Electronically

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

[Attach my Proof of Relationship](#)

You may also submit your electronic Proof of Relationship at a later date by following these navigation instructions:

1. Select New Claim on the Main Menu.
2. Choose Submit Electronic Paid Family Leave Bonding Attachment.

Mail

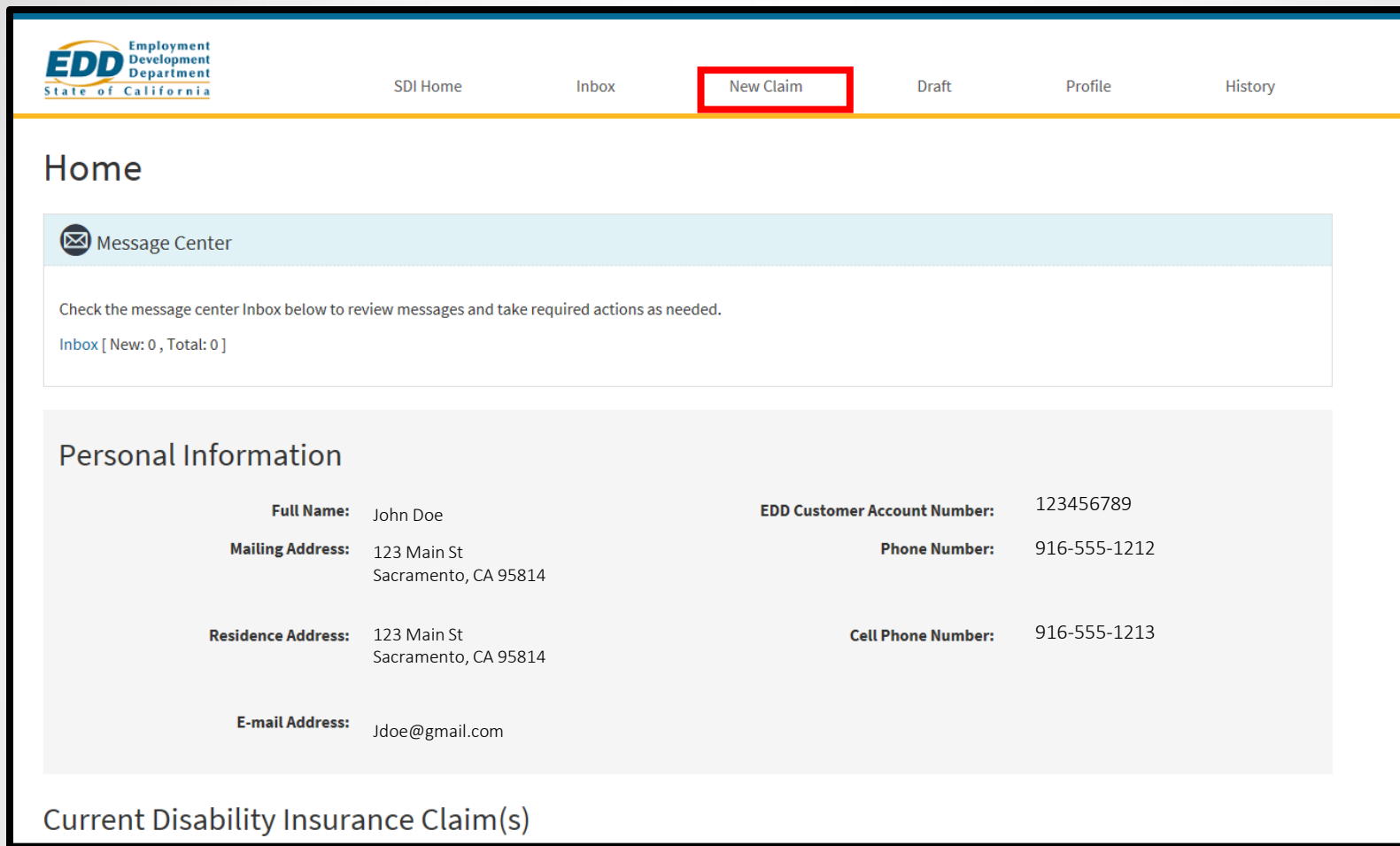
If you are mailing a "Proof of Relationship" document it must be a photocopy. Do not mail originals. On each page include your 9-digit Social Security Number, receipt number and date you requested to have your Paid Family Leave claim begin. The receipt number can be found above.

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

To complete your Paid Family Leave Bonding claim, you will need to submit your "Proof of Relationship" either electronically or by mail.

- To submit electronically, select the **Attach my Proof of Relationship** link and follow the instructions. View the [Submit Paid Family Leave Bonding Claim Attachments](#) section of this tutorial for additional instructions.
- To submit by mail, send your proof of relationship to the address on the screen. Send photocopies of your documents, do not mail originals. On each page include your 9-digit Social Security number, **Receipt Number**, and your requested claim start date.


Submit Paid Family Leave Bonding Claim Attachments



EDD Employment Development Department
State of California

SDI Home Inbox **New Claim** Draft Profile History

Home

 Message Center

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

Inbox [New: 0 , Total: 0]

Personal Information

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

Current Disability Insurance Claim(s)

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

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

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

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

Apply for Disability Insurance Benefits

[Disability Insurance](#)

Apply for Paid Family Leave Benefits

[Paid Family Leave Bonding](#)

[Submit Electronic Paid Family Leave Bonding Attachment](#)

[Paid Family Leave Care](#)

[Submit Electronic Paid Family Leave Care Attachment](#)

[Paid Family Leave Military Assist](#)

[Submit Electronic Paid Family Leave Military Assist Attachment](#)

Saved Drafts

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

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

Form Attachment

To attach a file to your successfully submitted Paid Family Leave claim form, choose the 'Select' link under the Action field. Most claims are processed and a decision is made within two weeks of the date the claim was submitted.

If you have not received anything from PFL within 10 days or if you have any questions you may call 1-877-238-4373.

Select Claim to Attach Document

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

Cancel

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

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

Attachment

* Indicates Required Field

Identifying Information for Previously Submitted Paid Family Leave Initial Bonding Claim

Your Social Security Number: XXX-XX-XXXX

Date you requested to have your Paid Family Leave claim begin: 05-06-2018

Form Receipt Number: R100000000035357

Previously Submitted Attachments for Paid Family Leave Initial Bonding Claim

No Results Found

Attachment

To attach a document, select the Browse button below.

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

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

No file chosen

Browse

* Do you want to attach more documents? ☐ Yes ☒ No

Previous

Cancel

Submit

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

To upload more than one document, select **Yes** and then select the **Browse** button. This will navigate you back to the **Attachment** screen to continue uploading documents.

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

Attachment Confirmation

Identifying Information for Previously Submitted Paid Family Leave Initial Bonding Claim

Your Social Security Number: XXX-XX-XXXX

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

Form Receipt Number: R100000000035351

Previously Submitted Attachments for Paid Family Leave Initial Bonding Claim

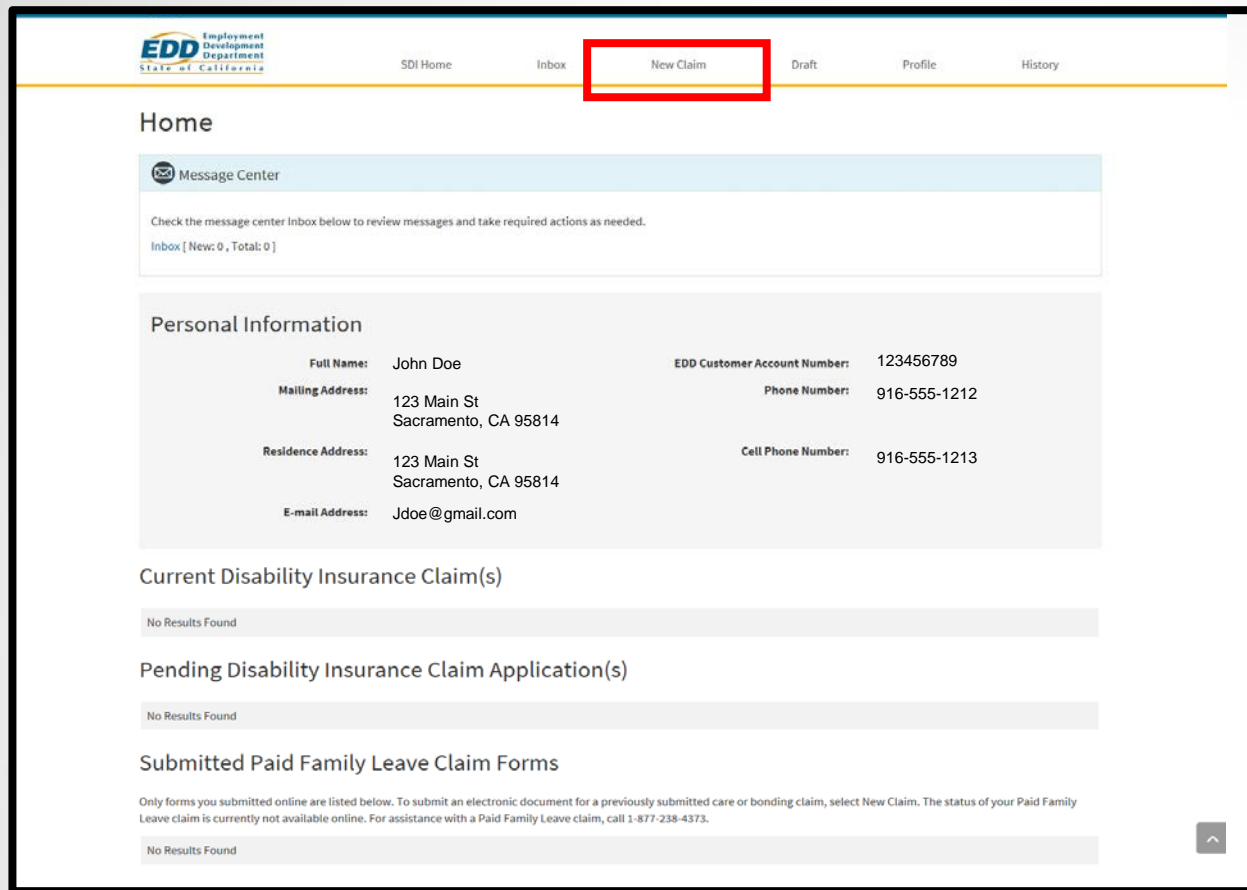
File Name	Receipt Number
Birth Certificate.jpg	R100000000035359

This screen confirms that the attachment(s) were submitted to the EDD.

Save the **Receipt Number(s)** for future reference.

You have now completed your Paid Family Leave Bonding claim. Please allow up to 14 days for the EDD to process your claim.

File a Paid Family Leave Care Claim



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

1. Access your SDI Online account by logging in to **Benefit Programs Online**.
2. Select the **SDI Online** button to be directed to your SDI Online **Home** screen.
3. Select **New Claim** from the main menu bar on your SDI Online Home screen.

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

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

Apply for Disability Insurance Benefits

[Disability Insurance](#)

Apply for Paid Family Leave Benefits

[Paid Family Leave Bonding](#)

[Submit Electronic Paid Family Leave Bonding Attachment](#)

[Paid Family Leave Care](#)

[Submit Electronic Paid Family Leave Care Attachment](#)

[Paid Family Leave Military Assist](#)

[Submit Electronic Paid Family Leave Military Assist Attachment](#)

Saved Drafts

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

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

- Submit your claim no earlier than the first day your family leave begins, but no later than 41 days after your family leave begins, or you may lose benefits.
- If you have already submitted a claim, do not submit a duplicate claim. It may take up to 14 days for your claim to be reviewed and processed.
- If you are unsure about the type of claim to file for, refer to the [Types of Claims](http://edd.ca.gov/Disability/Types_of_Claims.htm) (edd.ca.gov/Disability/Types_of_Claims.htm) on the EDD website.

Information for Before You Start and After You File

Before You Start and After You File

Please have the following information available while completing this form:

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

Cancel

Next

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

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

1

Personal Information

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Employment Information

3

Additional Questions

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Care Certification

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Declaration

You are currently on Step 1 Personal Information

Section 1 - Personal Information

Social Security Number:

XXX-XX-XXXX

Full Name:

John Doe

Date of Birth:

XX-XX-XXXX

Mailing Address:

123 Main St
Sacramento, CA 95814

Preferred Language:

EDD Customer Account Number:

123456789

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

Gender:

Male

Phone Number:

916-555-1212

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

Previous

Cancel

Save as Draft

Next

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

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

Employment Details

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

You are currently on Step 2 Employment Information

* Indicates Required Field

Section 2 - Employer Information

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

* Name of Your Employer:

* Occupation:

* Are you a state government employee? ☐ Yes ☐ No

If "Yes", Indicate Bargaining Unit Number:

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

* Do you have more than one employer? ☐ Yes ☐ No

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

Employer Mailing Address

☒ US ☐ International

* Address Line 1:

Address Line 2:

* City:

* State: CA

* ZIP Code:

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

☐ Check here if the phone number is international

Previous

Cancel

Save as Draft

Next

Complete **Section 2 - Employer Information** by entering your most current employer's business name, phone number, and mailing address as stated on your W-2 or paystub.

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

Select **Next** to proceed.

Additional Questions



Personal Information



Employment
Information

3

Additional Questions

4

Care Certification

5

Declaration

You are currently on Step 3 Additional Questions

*Indicates Required Field

Section 3 - Additional Questions

*Date you last worked:

(MMDDYYYY)

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

(MMDDYYYY)

*Do you want to claim the maximum amount of benefit weeks now?

☐ Yes ☐ No

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

(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":

Select

*At any time during your Paid Family Leave, were you in the custody of law
enforcement authorities because you were convicted of violating a law or ordinance?

☐ Yes ☐ No

*Have you claimed or do you plan to claim Workers' Compensation Benefits for any
portion of the period covered by this claim?

☐ Yes ☐ No

Previous

Cancel

Save as Draft

Next

Complete **Section 3 - Additional Questions** and confirm all dates are correct to avoid a possible delay or loss of benefits.

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

Select **Next**.

Care Recipient's Information

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

You are currently on Step 4 Care Certification

* Indicates Required Field

Section 4 - Care Recipient's Information

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

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

* First Name:

Middle Initial:

* Last Name:

Suffix:

* Gender: ☐ Male ☐ Female

* Date of Birth:

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

* Person you are caring for is your:

Other Relationship:

Residence Address

☒ US ☐ International

* Address Line 1:

Address Line 2:

* City:

* State:

* ZIP Code:

Phone Number: Ext:

☐ Check here if the phone number is international

Previous

Cancel

Save as Draft

Next

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

Details on how to submit a signed "Statement of Care Recipient" form will be provided on the confirmation screen.

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

Select **Next**.

Declaration



Personal Information



Employment
Information



Additional Questions



Care Certification

5

Declaration

You are currently on Step 5 Declaration

* Indicates Required Field

Section 5 - Payment Choice

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

* Preferred Payment Method:

☒ EDD Debit Card

☐ Check

Disclosures Agreement:

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

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

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

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

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

Section 6 - Declaration

Read the information below and check each box if you agree. A check in the box indicates an electronic signature executed by you, and is a legally binding equivalent of traditional 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/practitioner as they are listed on this claim; (3) authorize my employer(s) to disclose to EDD all facts concerning my employment that are within their knowledge; and (4) authorize release and use of information as stated in the EDD "Information Collection and Access" section of the [Important Paid Family Leave Program Information](#) page. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my electronic signature or the effective date of the claim, whichever is later.

Previous

Cancel

Save as Draft

Submit

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

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

Note: Your claim is NOT complete. You must submit the "Statement of Care Recipient" and the "Physician's/Practitioner's Certification" sections of the *Claim for Paid Family Leave (PFL) Care Benefits* (DE 2501FC).

The **Confirmation** screen will provide instructions to complete and upload or mail the additional documentation for your Paid Family Leave Care claim.

Paid Family Leave (PFL) Survey Questions

* Indicates Required Field

Paid Family Leave (PFL) Survey

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

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

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

Submit

Complete the survey and select **Submit**.

Confirmation

Print this page for your records. If a printer is unavailable at this time, record the Form Receipt Number below. The Form Receipt Number is required to retrieve a copy of the *Paid Family Leave Claim Care* (DE 2501F) application. You will not be able to access your confirmation page and Form Receipt Number after this window is closed.

Most claims are processed and a decision is made within two weeks of the date the claim was submitted. If you have not received anything from PFL within 10 days or if you have any questions you may call 1-877-238-4373.

Confirmation Information

XXX-XX-XXXX

Claimant Name: Jane Doe

Social Security Number: XXX-XX-1014

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

08-01-2018

Receipt Number: R100000000033448

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

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

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

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

Electronically

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

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

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

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

Mail

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

Mail your document to:

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

On the **Confirmation** screen, you will be assigned a **Receipt Number**.

Save the **Receipt Number** for future reference. You will need this number to complete the additional documentation and to upload to the correct online claim.

The **Confirmation** screen also provides instructions to complete the additional documentation for your Paid Family Leave Care claim.

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

Electronically

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

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

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

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

Mail

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

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

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

- Once the DE 2501FC is completed and signed, upload and save it (as a PDF, JPG, JPEG, TIF, or TIFF file) to your computer to submit electronically.
- You may also mail the completed form to the address on this screen if you do not submit it electronically.

Note: You can also print the DE 2501FC in English and Spanish from [Paid Family Leave Forms and Publications](http://edd.ca.gov/pfl_forms_and_publications.htm) (edd.ca.gov/pfl_forms_and_publications.htm).



Claim for Paid Family Leave (PFL) Care Benefits

Enter your receipt number here.

R1

1

PART C – INSTRUCTIONS FOR PFL CARE CLAIMS

The care recipient (the person for whom you are providing care) must do the following: Complete and sign “Part C – Statement of Care Recipient.” If the care recipient is physically or mentally unable to sign, call PFL at 1-877-238-4373 for instructions.

The care recipient’s physician/practitioner must complete “Part D – Physician/Practitioner’s Certification” either electronically in SDI Online, or by completing and signing page 3 of *Claim for Paid Family Leave (PFL) Care Benefits* (DE 2501FC). If the care recipient is under the care of an accredited religious practitioner, call PFL at 1-877-238-4373 for the proper form *Practitioner’s Certification for Paid Family Leave Benefits* (DE 2502F).

The easiest way to have your claim processed is to submit the completed forms electronically in SDI Online as an attachment. If submitting by mail, send to the following address: Paid Family Leave, PO Box 997017, Sacramento, CA 95899-7017. If submitting electronically, return to the Homepage of your SDI Online account. Select **New Claim** from the Menu, and select **Submit Electronic Paid Family Leave Care Attachment**.

PART C – STATEMENT OF CARE RECIPIENT		(MAY BE COMPLETED BY CLAIMANT IF CARE RECIPIENT IS MENTALLY OR PHYSICALLY UNABLE TO DO SO. MUST BE SIGNED BY CARE RECIPIENT OR CARE RECIPIENT’S AUTHORIZED REPRESENTATIVE.)	
C1. CARE PROVIDER SSN	C2. RECIPIENT’S DATE OF BIRTH	C3. RECIPIENT’S PHONE NUMBER	C4. RECIPIENT’S GENDER <input type="checkbox"/> MALE <input type="checkbox"/> 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 authorize my physician/practitioner to disclose my current personal-health information to my care provider and to the California Employment Development Department (EDD). I further understand that copies of my signature below are as valid as the original. Care Recipient’s Signature (DO NOT PRINT) _____ Date Signed _____			
C8. Authorized Representative signing on behalf of care recipient must complete the following: I, _____, represent the care recipient in this manner 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, consult EDD). Authorized Representative’s Signature (DO NOT PRINT) _____ Date Signed _____			

2

3

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

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

To avoid delays in claim processing:

1. Enter the **Receipt Number** you were given when you completed the online portion of your Paid Family Leave Care claim in the top right corner.
2. Make sure all applicable information is completed in the appropriate section.
3. The care recipient or his/her authorized representative must sign and date the bottom of this page.

Note: Page 2 is left blank intentionally and not shown in this tutorial.

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

Enter your receipt number here. R1

PART D – PHYSICIAN/PRACTITIONER'S CERTIFICATION

D1. PFL CLAIMANT'S (CARE PROVIDER'S) SOCIAL SECURITY NUMBER	D2. PFL CLAIMANT'S NAME (FIRST, MIDDLE INITIAL, LAST)		
D3. PATIENT'S DATE OF BIRTH	D4. DOES YOUR PATIENT REQUIRE CARE BY THE CARE PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> NO (SKIP TO D15)		
D5. PATIENT'S NAME (FIRST, MIDDLE INITIAL, LAST)			
D6. DIAGNOSIS OR, IF NOT YET DETERMINED, A DETAILED STATEMENT OF SYMPTOMS			
D7. PRIMARY ICD CODE	D8. SECONDARY ICD CODES	D9. DATE PATIENT'S CONDITION COMMENCED	
D10. FIRST DATE CARE NEEDED	D11. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CARE PROVIDER <input type="checkbox"/> PERMANENT CARE REQUIRED	D12. DATE YOU EXPECT RECOVERY <input type="checkbox"/> NEVER	
D13. APPROXIMATELY HOW MANY TOTAL HOURS PER DAY WILL PATIENT REQUIRE CARE BY A CARE PROVIDER? HOURS _____ COMMENTS _____			
D14. WOULD DISCLOSURE OF THE MEDICAL INFORMATION ON THIS CERTIFICATE BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL TO YOUR PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	D15. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER	D16. STATE OR COUNTRY (IF NOT U.S.A.) IN WHICH PHYSICIAN/PRACTITIONER IS LICENSED TO PRACTICE	
D17. PHYSICIAN/PRACTITIONER'S NAME (FIRST, MIDDLE INITIAL, LAST)			
D18. PHYSICIAN/PRACTITIONER'S ADDRESS (POST OFFICE BOX IS NOT ACCEPTABLE AS THE SOLE ADDRESS)			
CITY _____ STATE/PROV. _____ ZIP OR POSTAL CODE _____ COUNTRY (IF NOT U.S.A.) _____			
D19. TYPE OF PHYSICIAN/PRACTITIONER		D20. SPECIALTY (IF ANY)	
D21. Physician/Practitioner's Certification: I certify under penalty of perjury that this patient has a serious health condition and requires a care provider. I have performed a physical examination and/or treated the patient. I am authorized to certify a patient disability or serious health condition pursuant to California Unemployment Insurance Code section 2708. Original Signature of physician/practitioner – RUBBER STAMP IS NOT ACCEPTABLE			
PHYSICIAN/PRACTITIONER'S PHONE NUMBER _____		DATE SIGNED _____	

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

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

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

To avoid delays in claim processing:

1. Enter the **Receipt Number** from your Paid Family Leave Care claim in the top right corner.
2. Have the care recipient's physician/practitioner complete all applicable information.
3. Obtain a signature from the care recipient's physician/practitioner prior to uploading or mailing the form.

Note: You may also provide your **Receipt Number** to your care recipient's physician/practitioner so they can submit the medical certificate through SDI Online. Talk to the physician/practitioner about their process for submitting a PFL claim. They do not all follow the same process.

Submit Paid Family Leave Care Claim Attachments

Home



Message Center

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

Inbox [New: 0 , Total: 0]

Personal Information

Full Name: John Doe

EDD Customer Account Number: 123456789

Mailing Address: 123 Main St
Sacramento, CA 95814

Phone Number: 916-555-1212

Residence Address: 123 Main St
Sacramento, CA 95814

Cell Phone Number: 916-555-1213

E-mail Address: Jdoe@gmail.com

Current Disability Insurance Claim(s)

To submit your completed and signed *Claim for Paid Family Leave (PFL) Care Benefits* (DE 2501FC) form, return to your SDI Online account **Home** screen.

Select **New Claim** from the main menu bar.

Note: This form must be received within 10 days from the date you submitted your online claim.

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

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

Apply for Disability Insurance Benefits

[Disability Insurance](#)

Apply for Paid Family Leave Benefits

[Paid Family Leave Bonding](#)

[Submit Electronic Paid Family Leave Bonding Attachment](#)

[Paid Family Leave Care](#)

[Submit Electronic Paid Family Leave Care Attachment](#)

[Paid Family Leave Military Assist](#)

[Submit Electronic Paid Family Leave Military Assist Attachment](#)

Saved Drafts

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

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

Form Attachment

To attach a file to your successfully submitted Paid Family Leave claim form, choose the 'Select' link under the Action field. Most claims are processed and a decision is made within two weeks of the date the claim was submitted.

If you have not received anything from PFL within 10 days or if you have any questions you may call 1-877-238-4373.

Select Claim to Attach Document

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

Cancel

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

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

Attachment

* Indicates Required Field

Identifying Information for Previously Submitted Paid Family Leave Initial Care Claim

Your Social Security Number: XXX-XX-XXXX

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

Form Receipt Number: R100000000033448

Previously Submitted Attachments for Paid Family Leave Initial Care Claim

No Results Found

Attachment

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

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

To attach a document, select the Browse button below.

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

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

No file chosen

Browse

* Do you want to attach more documents?

☐ Yes ☒ No

Previous

Cancel

Submit

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

Note: To upload a document, you must have previously uploaded and saved the document on your computer as a PDF, JPG, JPEG, TIF, or TIFF file. All file sizes must be 5MB or less.

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

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

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Attachment Confirmation

Identifying Information for Previously Submitted Paid Family Leave Initial Care Claim

Your Social Security Number: XXX-XX-XXXX

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

Form Receipt Number: R100000000033448

Previously Submitted Attachments for Paid Family Leave Initial Care Claim

File Name	Receipt Number
Care Recipient Authorization.JPG	R100000000033449

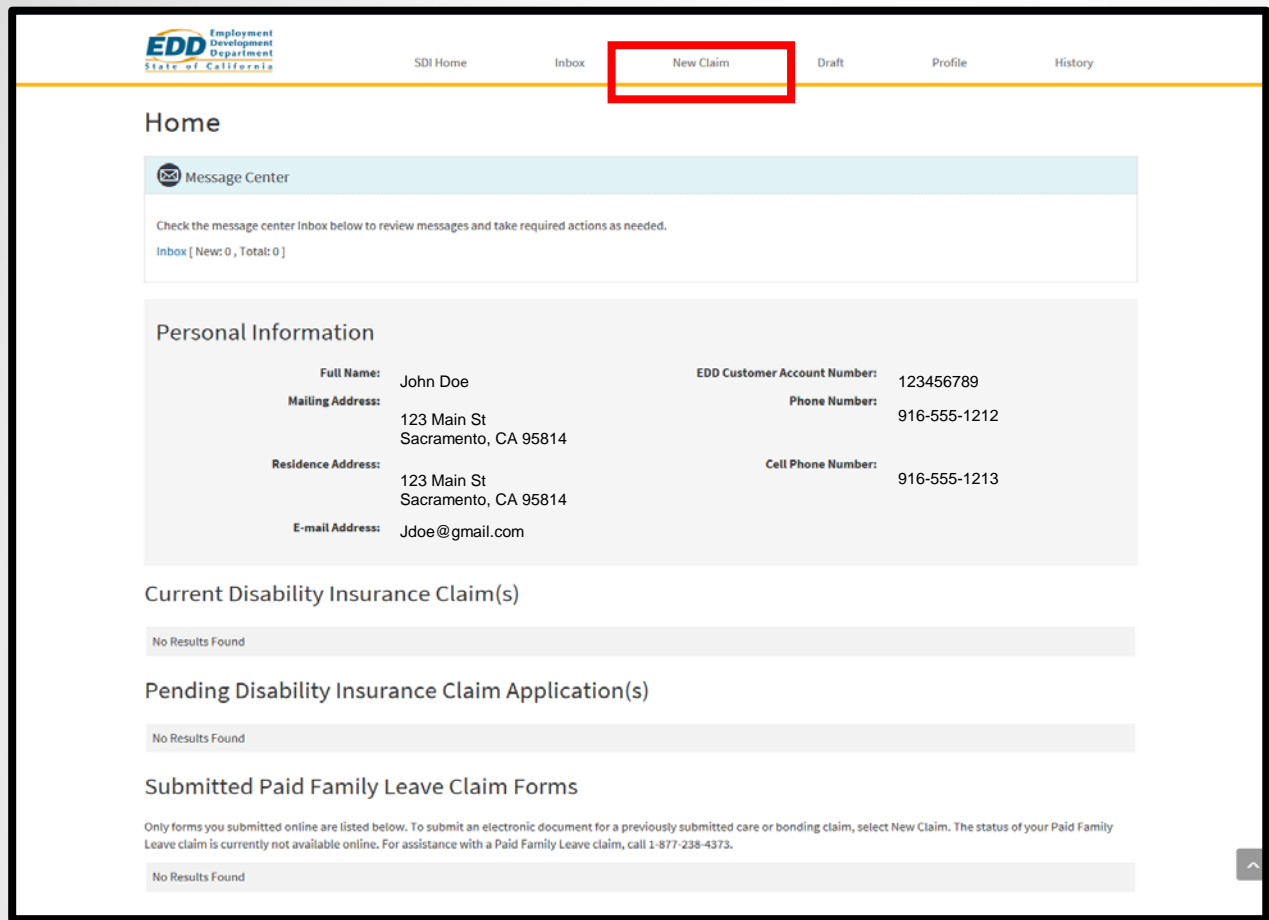
This screen confirms the attachment(s) were submitted.

Save the **Receipt Number(s)** for future reference.

Your Paid Family Leave Care claim is complete once you upload the “Statement of Care Recipient” and “Physician/Practitioner’s Certification” portions of the DE 2501FC.

Please allow up to 14 days for the EDD to process your claim.

File a Paid Family Leave Military Assist Claim



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

1. Access your SDI Online account by logging in to **Benefit Programs Online**.
2. Select the **SDI Online** button to be directed to your SDI Online **Home** screen.
3. Select **New Claim** from the main menu bar on your SDI Online **Home** screen.

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

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

Apply for Disability Insurance Benefits

[Disability Insurance](#)

Apply for Paid Family Leave Benefits

[Paid Family Leave Bonding](#)

[Submit Electronic Paid Family Leave Bonding Attachment](#)

[Paid Family Leave Care](#)

[Submit Electronic Paid Family Leave Care Attachment](#)

[Paid Family Leave Military Assist](#)

[Submit Electronic Paid Family Leave Military Assist Attachment](#)

Saved Drafts

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

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

If you are unsure about the type of claim to file for, refer to [Types of Claims](http://edd.ca.gov/Disability/Types_of_Claims.htm) (edd.ca.gov/Disability/Types_of_Claims.htm) on the EDD website.

Paid Family Leave – Military Assist Claim Information

Complete this form if you had or will have a loss of wages while assisting with matters related to a family member's military deployment to a foreign country.

Note: Do not complete this form if you are insured by a Voluntary Plan maintained by your employer. Ask your employer for the proper forms.

Gather Your Information

Have the following available while completing this form:

Personal Information

- Full name (and other
- Date of birth
- Gender
- Preferred language
- Social Security numb
- Mailing address
- Phone number
- Your relation to the m

Employment Info

- Occupation
- Date you last worked
- Date you returned to
- Reason(s) why you ha
- Bargaining unit numb

Most Recent Empl

- Name of employer
- Mailing address
- Phone number

Wage Information

- If you are receiving, or expect to receive, any payments from your employer(s)
 - Type of payment received, such as (but not limited to):
 - Sick leave
 - Employer-required vacation
 - Wage continuation
 - Military pay
 - Commissions
 - Earnings from part-time or modified duty
 - Residuals
 - Bonuses
 - Holiday pay

Note: Failure to report any payment can result in an overpayment, penalties, and disqualification.

Additional Information

- If you claimed or plan to claim Workers' Compensation during your family leave period
- If you were convicted of a crime and held in custody during your family leave period
- If you want to use all your benefit weeks at once or split them over a specified period of time
- When you want your military assist claim to begin

Note: The date you want your milita

Military Member's Infor

- Full name
- Date of birth
- Gender
- Last four digits of their Social
- Date they were notified of cou
- Covered active duty start date
- Mailing address

Supporting Military Do

After you file your PFL claim, you m

- Covered active duty orders
- Letter of impending call or or
- Documentation approving res

Qualifying Events

You can request PFL benefits for multiple qualifying events. You must provide the following for each event:

- Type of qualifying event, such as (but not limited to):
 - Provide/arrange childcare for the m
 - Provide/arrange care for the military
 - Attend counseling
 - Make financial/legal arrangements
 - Assist the military member during re
 - Attend a military event
 - Represent the military member at fe
 - Address issues due to the military m
- Event start and end dates
- Contact information for the person or orga
- Description of the event

Reasonable Accommoda

Call 1-877-238-4373 for required forms and instr

- Need this form in an alternate format (e.g.,
- Do not understand this form or any form p
- Are prevented from completing the form d
- Need to choose a representative to sign for
- Are an authorized representative filling on t

For individuals with disabilities requesting auxil

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

Review and gather the information on this screen.

Select **Next**.

Resources for Special Circumstances

Child Support Obligations

Direct your questions to the Department of Child Support Services at 1-866-249-0773.

Spousal or Parental Support Obligations

Direct your questions 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 the PFL office. Benefits are payable through date of death, if otherwise eligible.

Death of Military Member

If the military member dies, report the death to the PFL office. You are eligible to receive benefits to take care of any business related to their death.

Job Benefits and Protection Programs

The 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.

- To contact FMLA, call 1-866-487-9243 or visit the [Department of Labor](#).
- To contact CFRA, call 1-800-884-1684 or visit the [Department of Fair Employment and Housing](#).

For more information about Paid Family Leave, visit the [EDD website](#).

Cancel

Next

Military Assist Claim Instructions

*Indicates Required Field

Read and understand the following information before completing this form.

Requirements

Your Responsibilities

You must:

- Read these instructions
- Include your military service information
- File your claim on time
- Report income changes
- You must be a California resident
- You must be a U.S. citizen or permanent resident
- The claim must be filed within 12 months of the date you became eligible for benefits

If you are not sure if you are eligible, you can call 1-877-238-4373 for more information.

Basic Eligibility

You must:

- Have a federal or state government contract
- Have had your military service information reviewed by the Department of Defense
- Be employed by a federal or state government agency
- Have earned at least \$1,000 in wages during the 12 months before you became eligible for benefits
- Have submitted your claim on time
- Be the spouse or dependent of a person who is eligible for benefits
- Certify that you are not receiving other benefits for the same period of time

Ineligibility

You must not be:

- Claiming or receiving Unemployment Insurance (UI) or Disability Insurance (DI) benefits.
- Receiving Workers' Compensation benefits at a weekly rate equal to or greater than the PFL benefit rate.
- In custody of law enforcement authorities because you were convicted of a crime.

You can apply for benefits even if you are not sure you are eligible. If you are ineligible for all or part of a period claimed, the EDD will notify you of the ineligible period and the reason(s) why.

Disqualification

The PFL office will consider all available information before disqualifying your claim. If the PFL office denies your claim, you will receive a written notice stating the reason(s) why.

Do not deliberately report incorrect information to collect or increase your benefits. Reporting incorrect or incomplete information to collect or increase your benefits violates the California Unemployment Insurance Code and is punishable by imprisonment, a fine up to \$20,000, or both. The EDD actively prosecutes fraud, and claimants who are caught will face criminal prosecution to the fullest extent of the law.

Benefits

Benefit Amount

Carefully decide the date you start date of your claim can't be later than the date you were discharged from active military service.

How Benefits Are Paid

After your claim is processed and you meet all requirements, a payment will be made to you. If you are not eligible for benefits, you will not receive a payment.

Note: The majority of claims are processed within 10 business days.

Taxability of Benefits

PFL benefits are subject to federal income tax. PFL benefits are not subject to state income tax.

Overpayment

If you receive PFL benefits you are not eligible for, you must repay them. If you do not repay them, you may be disqualified from receiving benefits for up to 12 months.

Fraud

Reporting incorrect or incomplete information to collect or increase your benefits violates the California Unemployment Insurance Code and is punishable by imprisonment, a fine up to \$20,000, or both. The EDD actively prosecutes fraud, and claimants who are caught will face criminal prosecution to the fullest extent of the law.

Your Rights

Confidentiality

Information about your claim will be kept confidential, except for the purposes allowed by law. The EDD will not disclose or provide copies of medical information to medical providers.

Inspection

You have the right to inspect any of your personal records maintained by the EDD, except for:

- Medical or psychological records where knowledge of the contents might be harmful to the subject.
- Records of active criminal, civil, or administrative investigations.

Call 1-877-238-4373 to request a copy of your records. If the EDD denies you access, you can mail a request to review the denial to:

Employment Development Department
Information Security Office, MIC 33
PO Box 826880
Sacramento, CA 94280-0001

Correction

Call 1-877-238-4373 to correct your records if you believe they are not accurate, relevant, timely, or complete. If the EDD refuses your request, you can mail a request to review the denial to:

Employment Development Department
Information Security Office, MIC 33
PO Box 826880
Sacramento, CA 94280-0001

Appeal

You have the right to appeal any overpayment, penalty, or disqualification. Instructions on how to appeal will be provided on any appealable document you receive.

Agree Before Continuing

☒ I understand these instructions for submitting a military assist claim. If I don't provide complete and accurate information, my benefits can be delayed or denied. If I deliberately report incorrect or incomplete information to collect or increase my benefits, the EDD will disqualify my claim and I can face criminal prosecution.

Previous

Cancel

Next

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

Review and select **Next**.

1

Personal Information

2

Employment Information

3

Additional Questions

4

Certification

5

Qualifying Events

6

Declaration

You are currently on Step 1 Personal Information

Section 1 - Personal Information

Social Security Number:

XXX-XX-XXXX

Full Name:

John Doe

Date of Birth:

XX-XX-XXXX

Mailing Address:

123 Main St
Sacramento, CA 95814

Preferred Language:

EDD Customer Account Number:

123456789

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

Gender:

Male

Phone Number:

916-555-1212

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

Previous

Cancel

Save as Draft

Next

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

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

Select **Next** to proceed.

Employment Details

1 Personal Information 2 **Employment Information** 3 Additional Questions 4 Certification 5 Qualifying Events 6 Declaration

You are currently on Step 2 Employment Information

* Indicates Required Field

Section 2 - Employer Information

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

* Name of Your Employer:

* Occupation:

* Are you a state government employee? ☐ Yes ☐ No

If "Yes", Indicate Bargaining Unit Number:

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

* Do you have more than one employer? ☐ Yes ☐ No

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

Employer Mailing Address

☒ US ☐ International

* Address Line 1:

Address Line 2:

* City:

* State: CA

* ZIP Code:

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

☐ Check here if the phone number is international

Previous

Cancel

Save as Draft

Next

Complete **Section 2 - Employer Information** by entering your most current employer's business name, phone number, and mailing address as stated on your W-2 or paystub.

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

Select **Next**.

Additional Questions

☒ Personal Information
 ☒ Employment Information
 3 Additional Questions
☐ 4 Certification
 ☐ 5 Qualifying Events
 ☐ 6 Declaration

You are currently on Step 3 Additional Questions

*Indicates Required Field

Paid Family Leave Information

*Date you last worked:

The date you want your Paid Family Leave (PFL) benefits to begin cannot be before the date the military member was notified of covered active duty status.

*Date you want your PFL claim to begin:

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

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

Date you returned to work:

Or date you plan to return to work:

*Did you or will you work at any time during your family leave period? ☐ Yes ☐ No

If you have or will receive any type of pay from your employer(s) during your family leave period, select the type of pay:

- ☐ Sick
- ☐ Employer Required Vacation
- ☐ Other Type of Pay

If "Other Type of Pay," specify the type:

*Have you claimed or do you plan to claim Workers' Compensation during your family leave period? ☐ Yes ☐ No

*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

Previous

Cancel

Save as Draft

Next

Complete the **Paid Family Leave Information** section and confirm all dates are correct to avoid a possible delay or loss of benefits.

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

Select **Next**.

Military Assist Certification

Personal Information Employment Information Additional Questions **4 Certification** 5 Qualifying Events 6 Declaration

You are currently on Step 4 Certification

*Indicates Required Field

Your Information

*The Military Member is your:

If "Other," please specify:

Military Member's Information

*Military Member's First Name:

Military Member's Middle Initial:

*Military Member's Last Name:

Military Member's Suffix:

*Military Member's Date of Birth:

*Military Member's Gender: ☒ Male ☐ Female

*Last four digits of Military Member's Social Security Number:

*Date Military Member was notified of covered active duty status:

*Covered active duty start date:

Covered active duty end date (if known):

Military Member's Mailing Address

☒ US ☐ International

*Address Line 1:

Address Line 2:

*City:

*State:

*ZIP Code:

Supporting Military Documentation

After you file this claim, you must submit an approved supporting military document to receive PFL benefits.

*Select the type of military document you will submit: ☐ Covered active duty orders
☐ Letter of impending call or order to covered active duty
☐ Documentation approving rest and recuperation leave

Instructions for submitting a supporting military document will be provided on the Confirmation page.

Previous

Cancel

Save as Draft

Next

Complete the following sections:

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

Make sure the information you are entering is about the military member you are assisting.

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

Instructions on how to submit supporting military documentation after submitting your online claim will be provided on the confirmation screen.

Select **Next**.

Qualifying Events

Personal Information Employment Information Additional Questions Certification **5 Qualifying Events** 6 Declaration

You are currently on Step 5 Qualifying Events

*Indicates Required Field

Add Event

Enter a qualifying event. If you are requesting PFL benefits for multiple events, enter each event separately. You can add up to eight events.

- *What is your qualifying event?
- ☐ Provide/arrange childcare for the military member's child
 - ☐ Provide/arrange care for the military member's parent
 - ☐ Attend counseling
 - ☐ Make financial/legal arrangements
 - ☐ Assist the military member during rest and recuperation leave
 - ☐ Attend a military event
 - ☐ Represent the military member at federal, state, or local agencies
 - ☐ Address issues due to the military member's death
 - ☐ Other

If "Other," please specify:

*Event Start Date: (MMDDYYYY)

*Event End Date: (MMDDYYYY)

Event Details

Provide the following information related to the qualifying event.

*Name or Organization:

☒ US ☐ International

Address Line 1:

Address Line 2:

City:

State: CA

ZIP Code:

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

☐ Check here if the phone number is international

Email Address:

*Describe your qualifying event: (Max characters is 255)

You can add more events on the next page.

Previous

Cancel

Save as Draft

Next

Complete the following sections:

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

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

If you are requesting PFL Military Assist benefits for multiple events:

- Enter each event separately.
- You can add up to eight events.
- Instructions to add additional events are located on the next slide.

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

Select **Next** to proceed.

List of Qualifying Events



Personal
Information



Employment
Information



Additional
Questions



Certification



Qualifying
Events



Declaration

You are currently on Step 5 Qualifying Events

*Indicates Required Field

Your Events

Select **Add** to enter another qualifying event. If you are finished adding events, select **Next** to continue.

Qualifying Event	Name or Organization	Event Start Date	Event End Date	Action
Provide/arrange care for the military member's parent	Mother Jones	MM-DD-YYYY	MM-DD-YYYY	Delete

Previous

Cancel

Add

Save as Draft

Next

To submit more than one event:

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

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

Declaration



You are currently on Step 6 Declaration

*Indicates Required Field

Payment Choice

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

*Preferred Payment Method: ☒ EDD Debit Card
☐ Check

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

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

Digital Signature

Read the following information and check the box if you agree.

Note: A check in the box is a digital signature executed by you and is the legally binding equivalent to a traditional handwritten signature.

- ☐ By my signature on this Military Assist Certification and claim statement, I:
- Claim Paid Family Leave benefits and certify that, throughout the period covered by this claim, I was assisting a military member during a qualifying event.
 - Authorize the EDD to release my personal information as shown on this claim to the military member I am assisting.
 - Authorize my employer(s) to disclose all facts concerning my employment that are within their knowledge to the EDD.
 - Authorize the release and use of information as stated in the Information Collection and Access section on the *Claim for Paid Family Leave (PFL) Benefits (DE 2501F)*.
 - 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.
 - 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.
 - Agree that photocopies of this authorization shall be as valid as the original.
 - Understand that authorizations contained in this claim statement are granted for a period of 15 years from the date of my signature or the effective date of the claim, whichever is later.

Previous

Cancel

Save as Draft

Submit

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

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

You do not have to accept the EDD Debit Card.

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

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

Select **Submit** to proceed.

Paid Family Leave (PFL) Survey Questions

* Indicates Required Field

Paid Family Leave (PFL) Survey

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

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

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

Submit

Complete the survey and select **Submit**.

Confirmation

You have successfully submitted your PFL claim. Allow two weeks for it to be processed. If you have any questions, call 1-877-238-4373.

Claim Information

Claimant Name: John Doe

Social Security Number: XXX-XX-XXXX

Requested Claim Start Date: 11-07-2021

Receipt Number: R100001000032163

Important Next Steps

Failure to submit your supporting document will result in disqualification, and you will not receive payment. You must send it within 10 business days electronically or by mail.

Send Electronically

You can [attach your supporting document now](#) or at a later date by following these instructions:

1. Select New Claim from the main menu.
2. Select the corresponding attachment link.

Send by Mail

Mail a photocopy of your supporting document to:

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

Do not mail the original document. Include your 9-digit Social Security number, receipt number, and requested claim start date on each page.

On the **Confirmation** screen, you will be assigned a **Receipt Number**.

Save the **Receipt Number** for future reference. You will need this number to upload your additional documentation to the correct online claim.

The **Confirmation** screen will also provide instructions to upload your additional documentation to your Paid Family Leave Military Assist claim.

Important Next Steps

Failure to submit your supporting document will result in disqualification, and you will not receive payment. You must send it within 10 business days electronically or by mail.

Send Electronically

You can **attach your supporting document now** or at a later date by following these instructions:

1. Select New Claim from the main menu.
2. Select the corresponding attachment link.

Send by Mail

Mail a photocopy of your supporting document to:

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

Do not mail the original document. Include your 9-digit Social Security number, receipt number, and requested claim start date on each page.

To complete your Paid Family Leave Military Assist claim, you will need to submit your supporting military documentation and documentation of the qualifying event within 10 days.

To submit your documentation electronically:

- Select the **attach your supporting document now** link.
- View the [Submit Paid Family Leave Military Assist Claim Attachments](#) section of this tutorial for instruction on uploading your documents to your online claim.

To submit your documentation by mail:

- Send copies of your supporting military documentation and documentation of the qualifying event to the address on the screen.
- Do not mail the original documents. Include your 9-digit Social Security number, **Receipt Number**, and requested claim start date on each page.

Submit Paid Family Leave Military Assist Claim Attachments

Home



Message Center

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

Inbox [New: 0 , Total: 0]

Personal Information

Full Name: John Doe

EDD Customer Account Number: 123456789

Mailing Address: 123 Main St
Sacramento, CA 95814

Phone Number: 916-555-1212

Residence Address: 123 Main St
Sacramento, CA 95814

Cell Phone Number: 916-555-1213

E-mail Address: Jdoe@gmail.com

Current Disability Insurance Claim(s)

To upload the required military documentation and documentation of the qualifying event to your online claim:

- Return to your SDI Online account **Home** screen.
- Select **New Claim** from the main menu bar.

Note: Your documentation must be received within 10 days from the date you submitted your online claim.

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

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

Apply for Disability Insurance Benefits

[Disability Insurance](#)

Apply for Paid Family Leave Benefits

[Paid Family Leave Bonding](#)

[Submit Electronic Paid Family Leave Bonding Attachment](#)

[Paid Family Leave Care](#)

[Submit Electronic Paid Family Leave Care Attachment](#)

[Paid Family Leave Military Assist](#)

[Submit Electronic Paid Family Leave Military Assist Attachment](#)

Saved Drafts

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

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

Form Attachment

Allow two weeks for attachments to be processed. If you have any questions, call 1-877-238-4373.

Select a Claim

Only claims you have successfully submitted will be listed.

Form Name	Date Submitted	Receipt Number	Action
Claim for Paid Family Leave (PFL) Benefits - Military Assist (DE 2501F)	MM-DD-YYYY	R100001000032163	Select

Cancel

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

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

Attach File

*Indicates Required Field

Claim Information

Social Security Number: XXX-XX-XXXX

Requested Claim Start Date: MM-DD-YYYY

Receipt Number: R100001000032163

Current Attachments

No Results Found

Select a File

Select **Browse** to attach a file to your claim.

- Files must be less than 5MB
- Allowed file types: PDF, JPG, JPEG, TIF or TIFF

*Choose a file:

No file chosen

Browse

*Attach another document?

☐ Yes

☒ No

Previous

Cancel

Submit

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

Note: To upload a document, you must have previously uploaded and saved the document on your computer as a PDF, JPG, JPEG, TIF, or TIFF file. All file sizes must be 5MB or less.

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

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

Attachment Confirmation

Your file has been uploaded and attached to your claim.

Claim Information

Social Security Number: XXX-XX-XXXX

Requested Claim Start Date: MM-DD-YYYY

Receipt Number: R100001000032163

Attachments

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

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

Save the **Receipt Number(s)** for future reference.

Once the supporting military documentation and documentation of the qualifying event are submitted, your military assist claim is complete and should be processed by the EDD within 14 days.

Update My Benefit Programs Online Profile -

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

CA.Gov State of California
Employment Development Department

Home

Log in to Benefit Programs Online

En español

Email:

1.

2. ☐ I am not a robot

3.

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

Benefit Programs Online gives you access to these EDD services:

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

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

Follow these directions to login to Benefit Programs Online:


1. Enter the email address that you used to register.
2. Complete the security check.
3. Select **Log In**.

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

CA.gov State of California
Employment Development Department

Password

To log in to Benefit Programs Online, you must verify your personal image and personal caption, and enter your password.
* Use the latest version of Chrome or Firefox for the best experience.

4. **Personal Image:**

 Personal Caption: Cup

5. *** Password:**
[Forgot Password?](#)

6. [Previous](#) [Log In](#)

[Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Accessibility](#)
 Copyright © 2019 State of California

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

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

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

6. Select **Log In**.



State of California Employment Development Department

| Log Out



My Profile

Benefit Programs Online

Benefit Programs Online

UI OnlineSM

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

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

UI Online

UI Online Mobile

SDI Online

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

SDI Online


Benefit Overpayments


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

Benefit Overpayments

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

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

My ProfileBenefit Programs Online

My Profile

Select the links to the right of each section to update your profile.
Note: You will be logged out after 30 minutes on any page. Any information entered will not be saved.

Email and Password

Email:

Update Email

Password:

Update Password

Security Questions

Update Security Questions

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

Answer:

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

Answer:

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

Answer:


Question 4: What was your father's occupation?

Answer:

Personal Image and Caption

Update Personal Image and Caption

Personal Image:



Personal Caption:

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

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

Follow the instructions to update your profile information.

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CA.gov State of California
Employment Development Department

Log Out

Home My Profile Benefit Programs Online

My Profile

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

Email and Password

Email: jdoe@gmail.com Update Email

Password: ***** Update Password

Security Questions

Update Security Questions

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

Answer: *****

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

Note: Update your mailing and residence address, phone number, and preferences for language and communication through SDI Online:

- Select Benefit Programs Online
- Select the SDI Online link
- Select Profile from your SDI Online main menu bar

Complete Paper Claim Forms

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

- Use black ink only.
- Type or write clearly **within** the boxes provided.
- Complete and review your portion of the form:
 - **Disability Insurance:** Part A of the *Claim for Disability Insurance (DI) Benefits* (DE 2501) and have your physician/practitioner complete Part B.
 - **Paid Family Leave Bonding:** Part A and Part B of the *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F), and include a “Poof of Relationship” document.
 - **Paid Family Leave Care:** Part A and Part C of the *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F), and have the care recipient’s physician/practitioner complete Part D.
 - **Paid Family Leave Military Assist:** Part A and Part E of the *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F), and include the required supporting military documentation.
- The EDD does not accept photocopied or faxed forms.
- Mail the completed form to the EDD in the pre-addressed envelope provided.
- Do not mail this form to the EDD if you have already submitted this claim online.



Claim for Disability Insurance (DI) Benefits

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Claimant Social Security Number 000000000

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

I authorize

Geoff Bookert

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

I understand that EDD is not a health plan or health care provider, so the information released to EDD may no longer be protected by federal privacy regulations. (45 CFR Section 164.508(c)(2)(iii)). EDD may disclose information as authorized by the California Unemployment Insurance Code.

I agree that photocopies of this authorization shall be as valid as the original.

I understand I have the right to revoke this authorization by sending written notification stopping this authorization to EDD, DI Branch MIC 29, PO Box 826880, Sacramento, CA 94280. The authorization will stop on the date my request is received. I understand that the consequences for my revoking this authorization may result in denial of further State Disability Insurance benefits.

I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by EDD or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

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

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

Claimant Signature (Do Not Print) Sample Claimant	Date Signed 12252015
--	-------------------------

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

Health Insurance Portability and Accountability Act (HIPAA) Authorization, page 7.

You must sign and date the Health Insurance Portability and Accountability Act (HIPAA) Authorization and provide the name of your physician/practitioner.

Note: Pages 1-6 includes information and instructions for filing your Disability Insurance claim and EDD Debit Card Fee Disclosures. Please review all information before completing your paper claim form.

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

PART A - CLAIMANT'S STATEMENT

A1. YOUR SOCIAL SECURITY NUMBER										A2. IF YOU HAVE PREVIOUSLY BEEN ASSIGNED AN EDD CUSTOMER ACCOUNT NUMBER, ENTER THAT NUMBER HERE										A3. CALIFORNIA DRIVER LICENSE OR ID NUMBER								A4. GENDER			
0 0 0 0 0 0 0 0 0 0										N 0										Z 1 2 3 4 5 6 7								X			

A5. IF YOU EVER USED OTHER SOCIAL SECURITY NUMBERS, ENTER THOSE NUMBERS BELOW <div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>										A6. STATE GOVERNMENT EMPLOYEE (IF "YES" INDICATE BARGAINING UNIT#) <div> <div>YES</div> <div>X</div> <div>NO</div> <div>UNIT#</div> </div>										A7. YOUR DATE OF BIRTH <div> <div>0</div> <div>1</div> <div>0</div> <div>1</div> <div>1</div> <div>9</div> <div>0</div> <div>0</div> </div>									
--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	---	--	--	--	--	--	--	--	--	--

AB. YOUR LEGAL NAME		(FIRST)	(MI)	(LAST)	SUFFIX
S	a	m	p	l	e
C	l	a	i	m	a
n	t				

[illegible]

A10. YOUR HOME AREA CODE AND TELEPHONE NUMBER												
9	9	9	0	2	3	6	7	8	9			

A11. YOUR CELL AREA CODE AND TELEPHONE NUMBER												
1	1	1	0	0	2	0	0	4	7			

[illegible]

A13. YOUR MAILING ADDRESS, PO BOX OR NUMBER/STREET/APARTMENT, SUITE, SPACE#, OR PMB# (PRIVATE MAIL BOX)

1 2 3 Any Street

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

Anytown CA 12345

[illegible]

A15. YOUR LAST OR CURRENT EMPLOYER - IF YOUR LAST OR CURRENT EMPLOYMENT WAS SELF-EMPLOYMENT, ENTER "SELF" AND FILL-IN THIS OPTION. ☐ SELF

NAME OF YOUR EMPLOYER (STATE GOVERNMENT EMPLOYEES: PROVIDE THE AGENCY NAME (FOR EXAMPLE: CALTRANS))

Roadrunner Pastries

NUMBER/STREET/SUITE# (STATE GOVERNMENT EMPLOYEES: PLEASE PROVIDE THE ADDRESS OF YOUR PERSONNEL OFFICE)

647 Armistice Way

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

Anywhere CA 66222

EMPLOYER'S TELEPHONE NUMBER

499 3111111

<p>A16. AT ANY TIME DURING YOUR DISABILITY, WERE YOU IN THE CUSTODY OF LAW ENFORCEMENT AUTHORITIES BECAUSE YOU WERE CONVICTED OF VIOLATING A LAW OR ORDINANCE?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p>	<p>A17. BEFORE YOUR DISABILITY BEGAN, WHAT WAS THE LAST DAY YOU WORKED?</p> <p>1 2 0 1 2 0 1 5</p>
--	--

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

A20. SINCE YOUR DISABILITY BEGAN, HAVE YOU WORKED OR ARE YOU WORKING ANY FULL OR PARTIAL DAYS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												A21 A. IF YOU RECOVERED, ENTER DATE: M M M D D Y Y Y Y Y Y Y Y												A21 B. IF YOU RETURNED TO WORK, ENTER DATE: M M M D D Y Y Y Y Y Y Y Y											
--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	---	--	--	--	--	--	--	--	--	--	--	--

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

Part A - Claimant's Statement, pages 8-10.

Pages 8, 9, and 10 – You must complete all applicable information. Do not forget to sign page 10.

Page 10 also includes checkboxes to request to receive benefit payments by check or debit card.

SAMPLE, this page for reference only

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

PART B - PHYSICIAN/PRACTITIONER'S CERTIFICATE

B1. PATIENT'S SOCIAL SECURITY NUMBER 0000000000 B2. PATIENT'S FILE NUMBER 69-642-38

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

R

B4. PATIENT'S DATE OF BIRTH

01011900

B5. PATIENT'S NAME (FIRST) (MI) (LAST)

S a m p l e C l a i m a n t

B6. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER

634-027930

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

STATE CA

COUNTRY

B8. PHYSICIAN/PRACTITIONER LICENSE TYPE

MD

B9. SPECIALTY (IF ANY)

B10. PHYSICIAN/PRACTITIONER'S NAME AS SHOWN ON LICENSE

(FIRST) (MI) (LAST)

G e o f f B o o k e r

SUFFIX

B11. PHYSICIAN/PRACTITIONER'S ADDRESS

MAILING ADDRESS, PO BOX OR NUMBER/STREET/SUITE#

269 Commerce

CITY

Anywhere

STATE

CA

ZIP OR POSTAL CODE

72694

COUNTRY (IF NOT U.S.A.)

COUNTY HOSPITAL/GOVERNMENT FACILITY ADDRESS

FACILITY NAME (IF APPLICABLE)

FACILITY ADDRESS, NUMBER/STREET/SUITE#

CITY

STATE

ZIP OR POSTAL CODE

COUNTRY (IF NOT U.S.A.)

B12. THIS PATIENT HAS BEEN UNDER MY CARE AND TREATMENT FOR THIS MEDICAL PROBLEM

FROM 12162015 TO

☒ CHECK HERE TO INDICATE YOU ARE STILL TREATING THE PATIENT

AT INTERVALS OF:

☐ DAILY

☐ WEEKLY

☒ MONTHLY

☐ AS NEEDED

☐ OTHER

B13. AT ANY TIME DURING YOUR ATTENDANCE FOR THIS MEDICAL PROBLEM, HAS THE PATIENT BEEN INCAPABLE OF PERFORMING HIS/HER REGULAR OR CUSTOMARY WORK?

☒ YES - ENTER DATE DISABILITY BEGAN 12162015

☐ NO - SKIP TO B23

WAS THE DISABILITY CAUSED BY AN ACCIDENT OR TRAUMA? ☐ YES ☐ NO

IF YES, INDICATE THE DATE THE ACCIDENT OR TRAUMA OCCURRED.

B14. DATE YOU RELEASED OR ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR OR CUSTOMARY WORK

("UNKNOWN", "INDEFINITE", ETC., NOT ACCEPTABLE.)

MMDDYY

☐ CHECK HERE TO INDICATE PATIENT'S DISABILITY IS PERMANENT AND YOU NEVER ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR OR CUSTOMARY WORK

B15. IF PATIENT IS NOW PREGNANT OR HAS BEEN PREGNANT, PLEASE CHECK THE APPROPRIATE BOX AND ENTER THE FOLLOWING:

ESTIMATED DELIVERY DATE: MMDDYY

DATE PREGNANCY ENDED: MMDDYY

TYPE OF DELIVERY, IF PATIENT HAS DELIVERED:

☐ VAGINAL

☐ CESAREAN

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

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

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

2501F12202

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

01. YOUR SOCIAL SECURITY NUMBER:

02. DATE OF FOSTER CARE OR ADOPTION PLACEMENT:

03. CHILD NAMED IN 01 IS MY: ☐ BIOLOGICAL ☐ FOSTER ☐ ADOPTED ☐ OTHER

04. YOUR LEGAL LAST NAME (ENTERED IN CARE PLACES OF THIS CLAIMER'S HOME):

05. CHILD'S SOCIAL SECURITY NUMBER (IF AVAILABLE):

06. CHILD'S DATE OF BIRTH:

07. CHILD'S GENDER: ☐ MALE ☐ FEMALE

08. LEGAL NAME OF CHILD (FIRST, MIDDLE INITIAL, LAST):

09. CHILD'S RESIDENCE ADDRESS (IF DIFFERENT FROM CLAIMANT'S):

CITY: STATE/PROV: ZIP OR POSTAL CODE: COUNTRY (IF NOT USA):

10. AS EVIDENCE OF THE RELATIONSHIP IN 03, CHECK ONE OF THE FOLLOWING AND ATTACH A COPY OF THE DOCUMENT CHECKED. (DO NOT SEND ORIGINAL DOCUMENTS. IT WILL NOT BE RETURNED.)

☐ CHILD'S BIRTH CERTIFICATE ☐ ADOPTIVE PLACEMENT AGREEMENT, AD-907

☐ DECLARATION OF PATERNITY, CS-900 ☐ INDEPENDENT ADOPTION PLACEMENT AGREEMENT, AD-626

☐ FOSTER CARE PLACEMENT RECORD, SOC-815 ☐ OTHER:

11. Declaration and Signature: By my signature on this bonding certification, I authorize the medical provider, adoption agency, adoption parent(s), 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, to the best of my knowledge and belief are 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 good 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 - (BONDING CLAIMANT IS NOT ACCEPTABLE) Date Signed (mm | dd | yyyy):

PART C -- STATEMENT OF CARE RECIPIENT (ONLY TO BE COMPLETED BY CLAIMANT IF CARE RECIPIENT IS ADULTALLY OR PHYSICALLY INCAPABLE TO ENTER; OTHERWISE, SIGNATURE OF CARE RECIPIENT OR CARE RECIPIENT'S AUTHORIZED REPRESENTATIVE)

12. RECIPIENT'S DATE OF BIRTH:

13. RECIPIENT'S TELEPHONE NUMBER:

14. RECIPIENT'S GENDER: ☐ MALE ☐ FEMALE

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

16. CARE RECIPIENT'S RESIDENCE ADDRESS:

CITY: STATE/PROV: ZIP OR POSTAL CODE: COUNTRY (IF NOT USA):

C6. CONFIRMATION OF MEDICAL DISCLOSURE AUTHORIZATION. I authorize my physician/practitioner to disclose my current personal health information to my care provider and to the California Employment Development Department (EDD). I further understand that copies of my signature below are as valid as the original.

Care Recipient's Signature: I DO NOT PRINT: Date Signed (mm | dd | yyyy):

17. 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 ☐ parental rights ☐ power of attorney (attach copy) ☐ court order (attach copy) (for release or domestic partner, contact EDD).

Authorized Representative's Signature: I DO NOT PRINT: Date Signed (mm | dd | yyyy):

DE 2501F Rev. 5 (12-200) Page 3 of 6

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

PAGE 3

Part B - Bonding Certification:

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

Part C - Statement of Care Recipient:

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

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

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

Medical certification must be completed by a licensed physician or practitioner authorized to certify as a patient's disability/injury health condition pursuant to California Unemployment Insurance Code Section 2700.



2501F12203

INSTRUCTIONS FOR COMPLETING THIS FORM:

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

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

001. PFL CLAIMANT'S CARE PROVIDER'S SOCIAL SECURITY NUMBER	002. PFL CLAIMANT'S NAME (PRINT) (MIDDLE INITIAL) (LAST)
--	--

003. PATIENT'S DATE OF BIRTH	004. DOES YOUR PATIENT REQUIRE CARE BY THE CLAIMANT?
------------------------------	--

005. PATIENT'S NAME (PRINT) (MIDDLE INITIAL) (LAST)

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

007. PRIMARY ICD CODE	008. SECONDARY ICD CODES	009. DATE PATIENT'S CONDITION COMMENCED
-----------------------	--------------------------	---

010. FIRST DATE CARE NEEDED	011. DATE YOU EXPECT RECEIVERSHIP	012. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CLAIMANT
-----------------------------	-----------------------------------	--

013. APPROXIMATELY HOW MANY TOTAL HOURS PER DAY WILL PATIENT REQUIRE CLAIMANT?
--

014. WOULD DISCLOSURE OF THIS CERTIFICATE TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL?
--

015. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER	016. STATE OR COUNTRY PHYSICIAN/PRACTITIONER IS LICENSED
--	--

017. PHYSICIAN/PRACTITIONER'S NAME (PRINT) (MIDDLE INITIAL) (LAST)
--

018. PHYSICIAN/PRACTITIONER'S ADDRESS (PRINT) (MIDDLE INITIAL) (LAST) (ADDRESS) (CITY) (STATE) (ZIP) (COUNTRY) (IF NOT USA)

CITY	STATE/PROV.	ZIP OR POSTAL CODE	COUNTRY (IF NOT USA)
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019. TYPE OF PHYSICIAN/PRACTITIONER	020. SPECIALTY (IF ANY)
-------------------------------------	-------------------------

021. PHYSICIAN/PRACTITIONER'S Certification and Signature: I certify under penalty of perjury that this patient has a serious health condition and requires a care provider. I have performed a physical examination and/or treated the patient. I am authorized to certify a patient's disability or serious health condition pursuant to California Unemployment Insurance Code Section 2700.

Original Signature of Attending Physician/Practitioner - in blue ink or not acceptable	PHYSICIAN/PRACTITIONER'S PRINTING NAME	Date Signed (MM / DD / YYYY)
--	--	------------------------------

Under sections 2714 and 2722 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 under a fine not exceeding \$25,000. Sections 1143 and 1335 regard to additional administrative penalties.



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

PAGE 4

Part D - Physician/Practitioner's Certification:

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

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

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

Visit [State Disability Insurance](https://edd.ca.gov/disability)
(edd.ca.gov/disability) for more information.
For additional help call
Disability Insurance at 1-800-480-3287 or
Paid Family Leave at 1-877-238-4373.

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 1-866-490-8879. TTY users, please call the California Relay Service at 711.