

SDI Online Tutorial:

Employer Registration, Access, and
Form Submission

SDI Online Overview for Employers

Employers:

You may use SDI Online to:

- Submit a *Notice to Employer of Disability Insurance Claim Filed* (DE 2503).
- Submit a *Disability Insurance Eligibility – Workers' Compensation* (DE 2578A).
- Submit an *Employer's Statement of Job Duties* (DE 2546PE).
- Update contact information.

You may have an unlimited number of representatives with your employer accounts. Each representative will use their own email address as a unique login.

Employer representatives:

You may complete and submit claim information on behalf of the employer once the you have created your own separate account using your own email address as a unique login.

Note: To enable employers to manage their employer representative accounts, the employer representatives should provide their email and password information to the employer. Employers should maintain this information in a secure environment, to be used only to inactivate representative accounts.

Requirements to Register an Employer Account:

- You, the employer, must be registered and have filed quarterly payroll taxes with the Employment Development Department (EDD).
- You must provide your:
 - EDD employer account number.
 - ZIP Code as reported to the EDD.
 - Total subject wages from the most recent *Quarterly Contribution Return and Report of Wages* (DE 9C).
- To establish an account, an employer's entries in SDI Online must match the EDD's payroll tax records.

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

You will now complete a one-time registration for Benefit Programs Online to access SDI Online, but will still file your Disability Insurance employer forms using SDI Online.

Benefit Programs Online New Registration

You must complete a one-time registration in Benefit Programs Online to access SDI Online as an employer or employer representative.

To register for Benefit Programs Online,
edd.ca.gov/BPO

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

SDI Online Employer Registration



▶ Registration Success

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

[Benefit Programs Online](#)

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

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



▶ Log in to Benefit Programs Online

En español

Email:

I'm not a robot



Log In

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

Benefit Programs Online gives you access to these EDD services:

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

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



▶ Password

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

* Indicates required field.

Personal Image:



Personal Caption: IOU TEST

* Password:

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[Previous](#)

[Log In](#)

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

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



Benefit Programs Online

UI OnlineSM

UI Online is a fast, convenient, and secure way for Unemployment Insurance (UI) customers to file a new claim or manage an existing claim.

Select UI Online to file a claim for 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

SDI Online is a fast, mobile-friendly, and secure way for claimants, physicians/practitioners, physician/practitioner representatives, employers, and voluntary plan administrators to file a new claim, manage a claim, or submit forms online.

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

SDI Online

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



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

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

SDI Online Registration

Select your account type.

Claimant

Select **Register as a Claimant** to:

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

You will need:

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

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

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

Register as a Claimant

Employer

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

You will need:

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

Register as an Employer



Physician/Practitioner

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

You will need:

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

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

Register as a Physician/Practitioner

You will be directed to the **SDI Online Registration Options** page.

Select the link for **Employer Registration**.

Employer: 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.

Read the terms and conditions and select **I Agree**.

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

Employer: Account Verification Information

*Indicates Required Field

To register for a new SDI Online account, provide the following information.

Personal Information

Please enter your full legal name to register.

*First Name:

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

*Last Name:

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

E-mail Address: WTEMPREG52@edd.ca.gov

*Employer Account Number: (Do not include dashes.)

*Employer ZIP Code:

*Total Subject Wages from most recent Wage Report: (Enter dollars and cents. Do not include dashes.)

Cancel

Next

Complete the **Personal Information** section and select **Next**. Mandatory fields are marked with a red asterisk (*).

Note: An employer account number is eight digits and should not contain any spaces or dashes. Total subject wages from the most recent wage report can be found on the *Quarterly Contribution Return and Report of Wages* (DE 9C). This should be a number with two digits after the decimal—no commas or dollar signs

Employer: Personal Profile Information

*Indicates Required Field

Mailing Address

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

Employer Name: Make Money Financial Group

US International

*Address Line 1:

Address Line 2:

*City:

*State: CA

*ZIP Code:

Phone Number

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

Check here if the phone number is international

Communication Preferences

Indicate below how you prefer to be notified.

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

- *Preferred Communication:
- I prefer to be notified by e-mail.
 - I prefer to be notified by paper mail
 - I do not want to receive notifications. I will be reviewing the items in my message center regularly

Cancel

Submit

Enter the required information, select your preferred method of communication, then select **Submit**.

SDI Online Account Registration Complete

Account Registration Successful

Your SDI Online account has been created and your EDD Customer Account Number is 9123456789 A notification has been sent to you via email.

To access your SDI Online Account, select the Benefit Programs Online link below to log in.

[Benefit Programs Online](#)

Be sure to make a note of your EDD Customer Account Number. If you selected electronic communication, a notification will be sent to you via email.

If you selected paper mail notification, a letter will be mailed to your address to confirm this account has been created.

You may now select the **Benefit Programs Online** link and log in to access your newly created account.



▶ Log in to Benefit Programs Online

[En español](#)

Email:

I'm not a robot



reCAPTCHA
Privacy - Terms

Log In

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

Benefit Programs Online gives you access to these EDD services:

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

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



▶ Password

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

* Indicates required field.

Personal Image:



Personal Caption: IOU TEST

* Password:

[Forgot Password?](#)

Previous

Log In

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Enter the password you created during the registration process and select **Log In**. You will be directed to your **Home** page.

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

Home

*Indicates Required Field

Message Center

Inbox [New: 450, Total: 451]

Saved Drafts [Total: 8]

Search

To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by the Receipt Number.

*Search By:

Claim ID

*Employee Last Name:

Reset

Search

Search Results

From your **Home** page you may select your next action.

Access Your Employer Account



▶ Log in to Benefit Programs Online

[En español](#)

Email:

I'm not a robot



reCAPTCHA
Privacy - Terms

Log In

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Benefit Programs Online gives you access to these EDD services:

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

To access your account, go directly to the **Benefit Programs Online** page to log in:
www.edd.ca.gov/BPO.

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



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Personal Caption: IOU TEST

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Benefit Programs Online

UI OnlineSM

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Select UI Online to file a claim for 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

SDI Online is a fast, mobile-friendly, and secure way for claimants, physicians/practitioners, physician/practitioner representatives, employers, and voluntary plan administrators to file a new claim, manage a claim, or submit forms online.

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

SDI Online

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

Select SDI Online to be directed to your SDI Online **Home** page.

CA.gov

Home Benefits Programs Online Utilities Help Log Out

EDD Employment Development Department State of California

SDI Home Inbox Draft Profile

Home

*Indicates Required Field

Message Center

Inbox [New: 450, Total: 451]

Saved Drafts [Total: 0]

Search

To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by the Receipt Number.

*Search By: Claim ID

*Employee Last Name:

Reset Search

Search Results

On the **Home** page you may:

- Update your mailing address, phone number, and preferred communication by selecting **Profile** from the **Main Menu** section.
- Complete forms by selecting **Inbox** under the **Message Center** or by using the **Search By** drop down menu and searching by **Claim ID** and entering the **Employee Last Name**. This information is printed on the *Notice to Employer of Disability Insurance Claim Filed (DE 2503)* .
- Search by **Receipt Number** and enter **Employer Last Name** to view the form you have submitted.

Message Center

Inbox

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

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

1 2 3 4 5 ... >>

Claimant Name	Date of Birth	Subject	Sent Date	Due Date	Type	Read?	Action
smith james	10-15-1999	DE 2503, Notice to Employer of SDI Claim Filed	09-08-2018	09-11-2018	Requires Attention	No	Delete
smith james	10-15-1999	DE 2503, Notice to Employer of SDI Claim Filed	09-08-2018	09-11-2018	Requires Attention	No	Delete

Selecting **Inbox** under the **Main Menu** or **Message Center** on the **Home** page will direct you to the **Inbox** on the **Message Center** page.

Select the message link under **Subject** that you wish to review, select **Delete** under **Action** column to delete items that you have already read or completed.

Note: You will receive a hard copy DE 2503 and can use the **search** option to find the claim to complete the form online. If the form was sent electronically, select the **DE 2503, Notice to Employer of SDI Claim Filed** link from the **Subject** column to begin completing the form.

Saved Drafts

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 Delete action.

Form Name	Claimant Name	Saved Date	Saved By	Draft will be saved until	Action
2503 Employer Notice of DI Claim	John Doe	09-05-2018	Manning Ryan	10-05-2018	Delete
2503 Employer Notice of DI Claim	Jane Doe	09-05-2018	Manning Ryan	10-05-2018	Delete

Access previously saved drafts by selecting **Drafts** from the **Main Menu** or **Message Center**. This will direct you to the **Saved Drafts** page which displays a list of forms that were started, but not completed or submitted.

Select the form under the **Form Name** column to view and complete the form.

Select **Delete** under the **Action** column to delete the form.

Note: Drafts are saved in SDI Online for 30 days.

Submit a *Notice to Employer of Disability Insurance Claim Filed* (DE 2503)

Home

*Indicates Required Field

 Message Center

Inbox [New: 450, Total: 451]

Saved Drafts [Total: 8]

Search

To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by the Receipt Number.

*Search By:

*Employee Last Name:

Search Results

Claim ID	Employee Name	Claim Effective Date	Claim Type	Last 4 Digits of SSN
DI1000020353	John Doe	02-15-2018	Disability Insurance	0899

On the **Home** page, select **Claim ID** from the drop down menu and enter **Employee Last Name**. Select **Search**.

Under **Search Results** Select the **Claim ID** link.

Claim Summary

Claim Summary

Claimant Name: John Doe

Claim ID: DI-1000-020-353

Claim Effective Date: 02-15-2018

 My Message Center Regarding John Doe ;

Inbox [New: 0 , Total: 0]

Saved Drafts [Total: 1]

My Forms Available to Submit for John Doe

Below is a list of forms available for submission. Please note that not all forms will be available at all times. If a form for the same dates has already been submitted or mailed, do not submit a duplicate form. Please allow 5-7 business days for the form to be processed.

[2503 Employer Notice of DI Claim](#)

My Forms Submitted for John Doe

No Results Found

Under the **My Forms Available to Submit** section, select the **2503 Employer Notice of DI Claim** link.

Verify Employee

- 1 Employee Verification
- 2 Employee Questionnaire
- 3 Return to Work and Wage Information
- 4 Workers' Compensation Information
- 5 Signature

You are currently on Step 1 Employee Verification

*Indicates Required Field

Section 1 - Employee Information

Name: John Doe Social Security Number: XXX-XX-XXXX
Claim ID: DI-1000-020-598 Claim Effective Date: 03-15-2018

Section 2 - Form Information

The California Unemployment Insurance Code, Section 2707.1, requires that you complete and return this form by the due date listed below.

Issue Date: 09-08-2018 Due Date: 09-11-2018

Section 3 - Verify Employment

*Was the employee shown above ever employed by you? Yes No

Cancel

Next

Verify the **Employee Information** section. Select **Yes** to confirm that the person was ever employed by you. Select **Next**.

Note: If the employee has **ever** been employed by your company, select **Yes**.

Employee Questionnaire

- 1 Employee Verification
- 2 Employee Questionnaire**
- 3 Return to Work and Wage Information
- 4 Workers' Compensation Information
- 5 Signature

You are currently on Step 2 Employee Questionnaire

*Indicates Required Field

Section 4A - Employee Status

Employee's Date of Birth:

*Employment Status Current Employee Former Employee

If "Former Employee," reason no longer working:

If "Other," please explain:

Separation Date:

*Hours worked per week (Exclude Overtime Pay):

*Hourly Rate(\$):

Reported Last Day Worked: 03-15-2018

*Do your records show a different ACTUAL last day of work than shown above in 'Reported Last Date worked'? Yes No

If "Yes," please provide the correct last day worked:

The last day worked was: Full day Partial day

If "Partial Day," number of hours worked:

Hourly Rate (\$):

Previous

Cancel

Save as Draft

Next

Complete the **Employee Status** section and select **Next**.

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

Return to Work and Wage Information

- Employee Verification
- Employee Questionnaire
- 3 Return to Work and Wage Information**
- 4 Workers' Compensation Information
- 5 Signature

You are currently on Step 3 Return to Work and Wage Information

*Indicates Required Field

Section 4B - Return to Work Information

*Has the employee returned to work? Yes No

If "Yes," date returned to work:

Return to work status:

If "Other/Explain," please explain:

Section 4C - Voluntary Plan Information

*At the time the employee's disability began, did your company have a state-approved voluntary plan for disability insurance benefits instead of the state plan? Yes No

If "Yes," enter the plan number:

Is this employee covered? Yes No

If "No," provide a non-coverage explanation:

Section 4D - Wage Information

*Will the employee's wages be coordinated/integrated with the State Disability Insurance benefits (Less State Disability Insurance)? Yes No

If "No," has or will the employee receive wages in the form of paid sick leave, vacation, personal time off, holiday, bonus, commission, or other type of payment while disabled? Yes No

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

Complete the **Return to Work and Wage Information** page and select **Next**.

Note: If the employee received wages that are not being coordinated with SDI benefits, you must answer additional questions regarding wages paid to the employee.

Additional Wages Paid to Employee

- Employee Verification
- Employee Questionnaire
- 3 Return to Work and Wage Information**
- 4 Workers' Compensation Information
- 5 Signature

You are currently on Step 3 Return to Work and Wage Information

*Indicates Required Field

Section 5A - Additional Wages Paid to Employee

Please report all wages paid to the employee and the actual dates for which they were paid. Report each pay type separately.

*Pay Type:

If "Other," please explain:

*From:

*To:

*Amount (\$):

*Do you want to add any other wages? Yes No

Previous

Cancel

Save as Draft

Next

If you selected **Yes** to indicate the employee received wages on the **Return to Work and Wage Information** page, the system directs you to the **Added Additional Wages Paid to Employee** page.

Note: This page will only display if you selected **Yes** to additional wages paid to employee.

Additional Wages Paid to Employee

- Employee Verification
- Employee Questionnaire
- 3 Return to Work and Wage Information**
- 4 Workers' Compensation Information
- 5 Signature

You are currently on Step 3 Return to Work and Wage Information

*Indicates Required Field

Section 5A - Additional Wages Paid to Employee

Please report all wages paid to the employee and the actual dates for which they were paid. Report each pay type separately.

*Pay Type:

If "Other," please explain:

*From:

*To:

*Amount (\$):

*Do you want to add any other wages? Yes No

Previous

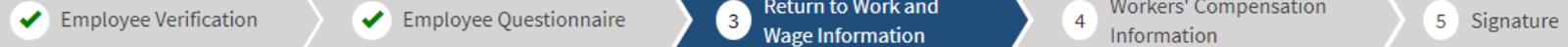
Cancel

Save as Draft

Next

Select **Pay Type** from the drop down menu. Enter the type of pay, dates, and the amount paid to the employee. Select **Yes** to add other **Additional Wages Paid to Employee** information and select **Next**.

Added Additional Wages Paid to Employee



You are currently on Step 3 Return to Work and Wage Information

Section 5B - Additional Wages Summary

Please select the "Add" button to report wages paid to the employee in the form of sick leave, vacation, personal time off, holiday, bonus, commission, or other payment while disabled. You must add at least one wage.

Pay Type	Amount	From	To	Action
Paid Time Off	\$5,555.00	05-05-2018	06-06-2018	Delete

Previous

Cancel

Add

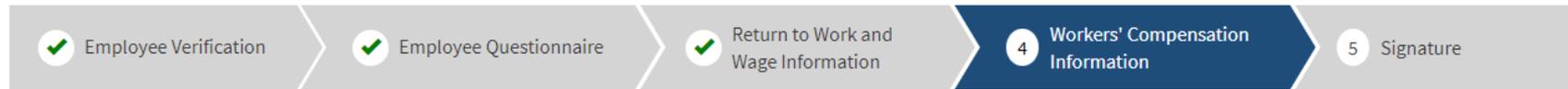
Save as Draft

Next

Verify the information you entered under **Additional Wages Summary** is correct and select **Next**.

If necessary, select **Add** to enter additional wages paid.

Workers' Compensation Information



You are currently on Step 4 Workers' Compensation Information

*Indicates Required Field

Section 6 - Work-related Injury

*Has the employee reported a work-related or occupational illness? Yes No

Previous

Cancel

Save as Draft

Next

If you are directed to this page, complete the **Work-related Injury** question and select **Next**.

If you select **Yes**, you will be directed to the **Worker's Compensation Information** page to provide additional information .

Workers' Compensation Information

- ✓ Employee Verification
- ✓ Employee Questionnaire
- ✓ Return to Work and Wage Information
- 4 Workers' Compensation Information**
- 5 Signature

You are currently on Step 4 Workers' Compensation Information

*Indicates Required Field

Section 7 - Workers' Compensation Carrier Information

Please enter Workers' Compensation Carrier information below. If you do not have a Workers' Compensation Carrier, enter the employer's name and address.

*Workers' Compensation Insurance Company Name:

US International

*Address Line 1:

Address Line 2:

*City:

*State:

*ZIP Code:

Section 8 - Workers' Compensation Claim Information

Enter the date(s) of injury as shown on the Workers' Compensation claim. If it was a cumulative trauma injury, enter the date the injury began.

Date of Injury:

Date of Injury:

Date of Injury:

Date of Injury:

Claim Number:

Adjuster's Name:

Adjuster's Phone Number: Ext:

WC Status:

Additional Comments:

Previous

Cancel

Save as Draft

Next

Enter applicable **Workers' Compensation Information** and select **Next**.

Submit Form



Employee Verification



Employee Questionnaire



Return to Work and
Wage Information



Workers' Compensation
Information

5

Signature

You are currently on Step 5 Signature

*Indicates Required Field

Section 9 - Signature

Submitted by: North Jason

*By checking this box, I am indicating my signature for submission.

Previous

Cancel

Save as Draft

Submit

To submit the form, select the box to authorize an electronic signature and select **Submit**.

Confirmation

Form Successfully Submitted

Please print this page for your records. If a printer is unavailable at this time, please record the Form Receipt Number below. You will not be able to access your confirmation page and Form Receipt Number after this window is closed. To retrieve this form in the future, you will need the Form Receipt Number. You may retrieve forms submitted using the claimant search on your home page.

Form Receipt Number: [R10000000123456](#)

You will receive a **Form Receipt Number** on the **Confirmation** page. Save the number for future reference. Select the **Form Receipt Number** link to view the form submitted.

Submit a *Disability Insurance
Eligibility-Workers' Compensation*
(DE 2578A)

Home

*Indicates Required Field

 Message Center

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

[Saved Drafts](#) [Total: 0]

Search

To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by the Receipt Number.

*Search By:

*Employee Last Name:

Search Results

Claim ID	Employee Name	Claim Effective Date	Claim Type	Last 4 Digits of SSN
D11000020460	Jane Doe	10-04-2018	Disability Insurance	1496

On the **Home** page, select **Claim ID** from the drop down menu and enter **Employee Last Name**. Select **Search**.

Under **Search Results** Select the **Claim ID** link.

Claim Summary

Claim Summary

Claimant Name: Jane Doe

Claim ID: DI-1000-020-460

Claim Effective Date: 10-04-2018

 My Message Center Regarding Jane Doe

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

[Saved Drafts](#) [Total: 0]

My Forms Available to Submit for Jane Doe

Below is a list of forms available for submission. Please note that not all forms will be available at all times. If a form for the same dates has already been submitted or mailed, do not submit a duplicate form. Please allow 5-7 business days for the form to be processed.

[2503 Employer Notice of DI Claim](#)

[2578A Employer Work Comp Form](#)

Under **My Forms Available to Submit** select the **2578A Employer Work Comp Form** link.

Notice of Potential Industrial Injury

1 Industrial Injury

2 WC Information

3 Attorney Information

4 Certification

You are currently on Step 1 Industrial Injury

*Indicates Required Field

Employee Information

Name: Jane Doe

Social Security Number: 444-44-4444

Claim ID: DI-1000-020-357

Claim Effective Date: 02-15-2018

Form Due Date

Please complete and submit this form by the due date listed below.

Form Due Date: 09-06-2018

Establish Potential Industrial Injury

*Has a workers' compensation claim been filed? Yes No

Cancel

Save as Draft

Next

Verify the information on this screen. Answer **Yes** or **No** to the question and select **Next**.

Workers' Compensation Information

- 1 Industrial Injury
- 2 WC Information**
- 3 Attorney Information
- 4 Certification

You are currently on Step 2 WC Information

*Indicates Required Field

Workers' Compensation Insurance Information

What was the date of injury?

Workers' Compensation Claim Number:

Workers' Compensation Carrier Information

*Name:

Policy Number:

*Address Line 1:

Address Line 2:

*City:

*State:

*ZIP Code:

*Phone Number: Ext:

Any additional information that you can give us regarding the denial or granting of workers' compensation benefits or information as to why a claim was not filed will be greatly appreciated:

Previous

Cancel

Save as Draft

Next

Complete the **Workers' Compensation Insurance Information** and the **Workers' Compensation Carrier Information** then select **Next**.

Attorney Information



You are currently on Step 3 Attorney Information

*Indicates Required Field

Attorney Contact Information

*If an application for adjudication is or has been filed with the workers' compensation appeals board, will you be represented by legal counsel? Yes No

Name of Attorney:

Address Line 1:

Address Line 2:

City:

State:

ZIP Code:

Phone Number: Ext:

Previous

Cancel

Save as Draft

Next

Complete the **Attorney Contact Information** (if applicable) and select **Next**.

Certify Form for Submittal

✓ Industrial Injury ✓ WC Information ✓ Attorney Information 4 Certification

You are currently on Step 4 Certification

*Indicates Required Field

Certification

By checking this box, I declare under penalty of perjury that the foregoing responses are, to the best of my knowledge and belief, true, correct, and complete.

Previous

Cancel

Save as Draft

Submit

To submit the form, select the box to authorize an electronic signature and select **Submit**.

Confirmation

Form Successfully Submitted

Please print this page for your records. If a printer is unavailable at this time, please record the Form Receipt Number below. You will not be able to access your confirmation page and Form Receipt Number after this window is closed.

To retrieve this form in the future, you will need the Form Receipt Number. You may retrieve forms submitted using the claimant search on your home page.

Form Receipt Number: R10000000040979

You will receive a form receipt number on the **Confirmation** page. Save this number for future reference. Select the **Form Receipt Number** link to view the form.

Submit an *Employer's Statement of Job Duties* (DE 2546PE)

Home

*Indicates Required Field

 Message Center

Inbox [New: 132, Total: 132]

Saved Drafts [Total: 0]

Search

To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by the Receipt Number.

*Search By:

*Employee Last Name: Doe

Search Results

Claim ID	Employee Name	Claim Effective Date	Claim Type	Last 4 Digits of SSN
D11000020355	Jane Doe	02-15-2018	Disability Insurance	2346

On the **Home** page, select **Claim ID** from the drop down menu and enter the claim ID number and the employee last name. Select **Search**.

Under **Search Results** Select the **Claim ID** link.

Claim Summary

Claim Summary

Claimant Name: Jane Doe
Claim Effective Date: 02-15-2018

Claim ID: DI-1000-020-355

 My Message Center Regarding Jane Doe

Inbox [New: 0 , Total: 0]

Saved Drafts [Total: 0]

My Forms Available to Submit for Jane Doe

Below is a list of forms available for submission. Please note that not all forms will be available at all times. If a form for the same dates has already been submitted or mailed, do not submit a duplicate form. Please allow 5-7 business days for the form to be processed.

[2503 Employer Notice of DI Claim](#)

[2546PE Employee's Job Duties](#)

My Forms Submitted for Jane Doe

No Results Found

Select the **2546PE Employee's Job Duties** link.

Employer's Statement of Job Duties

*Indicates Required Field

Section 1 - Employee Information

Name: Jane Doe **Social Security Number:** XXX-XX-XXXX
Claim ID: DI-1000-020-355 **Claim Effective Date:** 02-15-2018

Section 2 - Form Information

Please complete and submit this form by the due date listed below.

Issue Date: 09-04-2018 **Due Date:** 09-11-2018

Section 3 - Job Information

The information you submit will provide the EDD with a description of the employee's regular and customary work duties.

***Job Title:**

***Number of hours worked per day:**

***Number of days worked per week:**

***Has the above-named employee returned to work?** Yes No

If "Yes," return to work date

Return to Work Status Full Time Part Time

Verify the employee information and enter the job information. Select **Next**.

Employee's Job Duties: Part 1 of 3

*Indicates Required Field

Section 4 - Motion

Indicate frequency and number of hours a day the employee is required to do the following specific types of activities.

Activity	Frequency	Number of Hours Per Day
Sitting	None ▼	<input type="text"/>
Walking	None ▼	<input type="text"/>
Standing	None ▼	<input type="text"/>
Bending	None ▼	<input type="text"/>
Squatting	None ▼	<input type="text"/>
Climbing	None ▼	<input type="text"/>
Kneeling	None ▼	<input type="text"/>
Twisting	None ▼	<input type="text"/>

Section 5 - Reaching

Activity	Frequency
Reaching or working above shoulder level?	None ▼
Reaching or working below shoulder level?	None ▼

Section 6 - Hands

Activity	Right Hand	Left Hand	Not Required
Simple grasping required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Power grasping required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing and/or pulling required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine manipulation required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 7 - Feet

*Does the job require the employee to use his/her feet to operate foot controls or for repetitive movement? Yes No

Previous

Cancel

Save as Draft

Next

Complete Part 1 of the
Employee's Job Duties.

Select **Next.**

Employee's Job Duties: Part 2 of 3

*Indicates Required Field

Section 8 - Vision

*Is the employee required to have good vision? Yes No

If "yes", state the reason:

Section 9 - Hearing

*Is the employee required to have good hearing? Yes No

If "yes", state the reason:

Section 10 - Lifting and Carrying

Please check all the boxes that apply and indicate the frequency per day the employee is required to lift and/or carry any of the following weights.

Weight	Lift	Frequency	Carry	Frequency
10 lbs. or less	<input type="checkbox"/>	None ▼	<input type="checkbox"/>	None ▼
11 to 25 lbs.	<input type="checkbox"/>	None ▼	<input type="checkbox"/>	None ▼
26 to 50 lbs.	<input type="checkbox"/>	None ▼	<input type="checkbox"/>	None ▼
51 to 75 lbs.	<input type="checkbox"/>	None ▼	<input type="checkbox"/>	None ▼
76 to 100 lbs.	<input type="checkbox"/>	None ▼	<input type="checkbox"/>	None ▼
More than 100 lbs.	<input type="checkbox"/>	None ▼	<input type="checkbox"/>	None ▼

Longest distance employee must carry weight: feet

Heaviest weight employee must carry: lbs for feet

Section 11 - Equipment Operation

*Is the employee required to drive cars, trucks, forklifts, or other moving equipment? Yes No

If "Yes", describe or explain:

Previous

Cancel

Save as Draft

Next

Complete Part 2 of the Employee's Job Duties.

Select Next.

Employee's Job Duties: Part 3 of 3

*Indicates Required Field

Section 12 - Working Conditions

Check the box next to the working condition(s) that apply to this employee and provide a description.

Working near hazardous equipment and/or machinery

Walking on uneven ground

Exposure to dust, gas, or fumes

Exposure to extremes in temperature or humidity

Working at heights

*Is this job still available to the employee when he/she is able to return to work? Yes No

*Can the requirements of this job be modified if necessary to accommodate the employee's disability? Yes No

If "No," please explain:

Additional Comments:

Previous

Cancel

Save as Draft

Next

Complete Part 3 of the **Employee's Job Duties**.

Select **Next**.

Submit Form

*Indicates Required Field

Section 13 - Signature

Submitted by: John Doe

*Title:

By checking this box, I declare under penalty of perjury that the foregoing are, to the best of my knowledge and belief, true, correct, and complete.

Previous

Cancel

Save as Draft

Submit

To submit the form, fill in your job position within the company in the **Title** field and select the box to authorize an electronic signature. Select **Submit**.

Confirmation

Form Successfully Submitted

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Form Receipt Number: [R100000000040955](#)

You will receive a form receipt number on the **Confirmation** page. Save the number for future reference. Select the **Form Receipt Number** link to view the form submitted.

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

For help with SDI Online for employers, call
1-855-342-3645.

(Please do not give this number out to your employees. This number is for employers only. All other callers will be redirected.)

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 1-866-490-8879 (voice), or through the California Relay Service at 711.