APPLICATION FOR

Disability Benefits

Employment Development Department
State of California

California's disability program provides up to 52 weeks of benefit payments.

If you're not able to do your regular work because of a disability, you may be eligible for benefits.

A disability includes:

- An illness or injury, either physical or mental.
- Surgery, including elective surgery.
- Pregnancy and childbirth.

When to Apply

You can apply nine days after you're not able to do your regular work because of your disability. Apply within 49 days of this date to avoid losing benefits.

How to Complete Your Application

When completing your application:

- Use black ink only.
- Write clearly within the boxes provided.
- Enter your Social Security number on all pages of the application, including any attachments. If you do not have a Social Security number, you can leave the boxes blank.

How to Submit Your Application

Mail your completed application to us using the envelope provided. If your application is late, has errors, or is missing information, it could delay your claim or you could be denied benefits.

After we've received your application, including Part A and B, you'll receive information by mail in about two weeks. The time it takes to process an application can vary. For faster processing, you can apply using **SDI Online** at edd.ca.gov/SDI_Online.

If you cannot complete your application because of your disability, or if you're an authorized representative applying on behalf of an incapacitated or deceased person, call 1-800-480-3287 or send us a message using Ask EDD at askedd.edd.ca.gov.

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities.

Requests for services, aids, or alternate formats need to be made by calling 1 (866) 490-8879 (voice). TTY users, please call the California Relay Service at 711

The application has two parts.
For your application to be complete,
we must receive Part A and Part B.

Part A –
Claimant's Statement

You must complete and sign Part A.

- For question A13, if you have a private mailbox, include "PMB" at the beginning of the address.
- For help with questions A18 and A19, see "Your Benefit Amounts" on page 2. For A18, the first day you could not do your regular work is the date your disability began.
- If you have a work-related disability, complete questions A31 to A38. If your Workers' Compensation claim has been accepted, denied, or delayed, include the status letter from the insurance carrier.

Note: Do **not** complete this application if you're:

- Insured by a Voluntary Plan. Ask your employer for information on how to apply.
- A state government employee in bargaining unit 2, 5, 6, 7, 8, 9, 10, 12, 13, 16, 18, or 19. Use the *Claim for Nonindustrial Disability Insurance (NDI)* (DE 8501).

Part B –
Physician/Practitioner's Certification

Your licensed health professional must complete and sign the "Physician/Practitioner's Certificate." They can do this using SDI Online or **Part B** of this application. If they use Part B, make sure you submit it with Part A.

If you're under the care of an accredited religious practitioner, they must complete and sign the *Claim for Disability Insurance Benefits - Religious Practitioner's Certificate* (DE 2502). To get the DE 2502, call 1-800-480-3287.

We do not accept rubber stamped signatures.

Basic Eligibility

To be eligible for disability benefits, you must:

- Be unable to do your regular work for at least eight consecutive days.
- Be employed or actively looking for work when your disability began.
- Have lost wages because of your disability. If unemployed, you must have been actively looking for work.
- Have earned at least $300 from which State Disability Insurance (SDI) deductions were withheld during the past 5 to 18 months. See "Your Benefit Amounts" in the next column.
- Be under the care and treatment of a licensed health professional during the first eight days of your disability. The start date of your claim can be adjusted to meet this requirement. You must remain under care and treatment to continue receiving benefits.
- Submit your application within 49 days of the date your disability began or you may lose benefits.

Your licensed health professional must complete the medical certification of your disability. A licensed midwife or nurse-midwife can complete the medical certification for disabilities related to normal pregnancy or childbirth.

If you're under the care of a religious practitioner, they must complete and sign the *Claim for Disability Insurance Benefits – Religious Practitioner's Certificate* (DE 2502). To get the DE 2502, call 1-800-480-3287. Certification by a religious practitioner is acceptable only if the practitioner has been accredited by the EDD.

We may need an independent medical examination to determine your eligibility.

Ineligibility

Apply for benefits even if you're not sure you're eligible. If we find you ineligible for all or part of your claim, we will let you know. You may not be eligible if:

- You're claiming or receiving unemployment or Paid Family Leave benefits.
- Your disability began while committing a crime resulting in a felony conviction.
- You're receiving Workers' Compensation benefits at a weekly rate equal to or greater than the disability rate.
- You're in jail or prison because you were convicted of a crime.
- You're a resident in an alcoholic recovery home or drug-free residential facility that is not licensed and certified by the state.
- You do not submit to an independent medical examination, if requested.

Fraud

Making false statements or withholding information to receive benefit payments is a felony. Penalties may include fines, a loss of benefits, and criminal prosecution. To detect and discourage fraud, we monitor claims, investigate suspicious activity, and seek restitution and conviction through prosecution (CUIC, sections 2101, 2116, and 2122).

Your Responsibilities

- Submit your application within 49 days of the date your disability began. If your application is late, include a written explanation of why it's late.
- Read the instructions on all forms you receive from us. If you're not sure about what you need to do, contact a disability office (edd.ca.gov/Office_Locator).
- You must let us know in writing, through SDI Online, or by phone if you:
  - Change your address or phone number.
  - Return to part-time or full-time work.
  - Recover from your disability.
  - Receive any type of income.

Keep an appointment for an independent medical examination, if requested.

- **Include your name and Social Security number used to obtain benefits or Claim ID number on all correspondence.**

Your Rights

Information about your claim is confidential, except for the purposes allowed by law. You have the right to inspect any personal records we have about you and ask that we correct our records if you believe they are not accurate, relevant, timely, or complete (Civil Code, section 1798.34, and 1798.35).

Certain types of information are exempt from disclosure to you:

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

If you're denied access to records that you believe you have a right to inspect, or if your request to amend your records is refused, you may file an appeal with an SDI office. You may request a copy of your file by calling us at 1-800-480-3287 (Civil Code, section 1798.40).

You also have the right to appeal any disqualification, overpayment, or penalty. Instructions on how to appeal are provided on documents that can be appealed. If you file an appeal and your disability continues, you must complete and return continued claim certifications.

Your Benefit Amounts — Generally, your claim begins on the date your disability begins. The first day you cannot do your regular work is the date your disability begins.

We calculate your **weekly benefit amount** using your base period. The date your disability begins determines your base period unless we adjust the claim effective date. If you want your claim to begin later so that you will have a different base period, call 1-800-480-3287 before you submit your application.

Your base period covers 12 months and is divided into four consecutive quarters. It includes wages subject to SDI tax that you were paid about 5 to 18 months before your disability claim began. Your base period does not include wages being paid at the time the disability began.

Use the following information to determine your base period.

- If your claim begins in January, February, or March, your base period is the 12 months ending last September 30.
- If your claim begins in April, May, or June, your base period is the 12 months ending last December 31.
- If your claim begins in July, August, or September, your base period is the 12 months ending last March 31.
- If your claim begins in October, November, or December, your base period is the 12 months ending last June 30.

Your highest-earning quarter determines your weekly benefit amount. You may not change the start date of your claim or adjust your base period after you have established a valid claim.

Your **daily benefit amount** is your weekly benefit amount divided by seven. Your **maximum benefit amount** is 52 times your weekly benefit amount or the total wages subject to SDI tax paid in your base period, whichever is less. Exceptions are:

- For employers and self-employed individuals who elect SDI coverage, the maximum benefit amount is 39 times the weekly rate.
- For residents in a state licensed and certified alcoholic recovery home or drug-free residential facility, the maximum payable period is 90 days. However, disabilities related to or caused by acute or chronic alcoholism or drug abuse that are being medically treated do not have this limitation.

Contact a disability office (edd.ca.gov/Office_Locator) for more information if:

- You do not have sufficient base period wages and your disability continues. You may be able to use a later start date on your claim.
- You do not have enough base period wages and you were actively seeking work for 60 days or more in any quarter of the base period. You may be able to substitute wages paid in prior quarters.
- During your base period you were in the US military service, received Workers' Compensation benefits, or did not work because of a labor dispute. You may be entitled to substitute wages paid in prior quarters either to make your claim valid or to increase your benefit amount.

How Benefits Are Paid

When we receive your completed application, we will mail you a *Notice of Computation* (DE 429D), which lets you know what your weekly payments could be. We may ask for more information to determine your eligibility.

If you're eligible to receive benefits, you have the option to receive payments by direct deposit, debit card, or by check. **Direct deposit is the fastest and most secure way to receive your payments.** *To receive your payments by direct deposit, you must apply using* **SDI Online** (edd.ca.gov/sdi_online).

You do not have to accept payments by direct deposit or debit card. To receive your payments by check, allow 7 to 10 days for delivery by US mail. Select your preferred payment method in question A39.

Most claims are processed and payments issued within 14 days of receiving both Part A and Part B of the application. **The first seven days of your claim is a non-payable waiting period.**

If you're eligible for further benefits, we will send payments automatically or enclose a continued claim certification form for the next period. Usually, the certification periods are for two weeks; however, the period will vary under certain circumstances.

You will be paid 1/7 of your weekly benefit amount for each calendar day you're eligible unless benefits are reduced. See "Benefit Reductions" below. If you receive disability benefits in place of unemployment or Paid Family Leave benefits, the amounts paid will be reported to the IRS. Contact the IRS **(irs.gov)** for specific tax information.

Benefit Reductions

Under certain circumstances, you may not be eligible for benefits for a period of your claim or you may be entitled only to partial benefits. We will determine if benefits must be reduced. The following types of income should be reported to us even though they may not always affect your benefits:

- Sick leave pay
- Self-employment income
- Military pay
- Commissions
- Wages, including modified duty wages
- Residuals
- Part-time work income
- Bonuses
- Workers' Compensation benefits
- Insurance settlements
- Holiday pay

Failure to report your income could result in an overpayment, penalties, and a false statement disqualification. In addition, your benefits may be reduced because of a prior unemployment, Paid Family Leave, or disability overpayment, or for delinquent court-ordered support payments.

Benefit Interruption and Termination

We will send a *Notice of Final Payment* when records show you have:

- Been paid up to the date your licensed health professional estimated as your date of recovery. If your disability continues, ask your licensed health professional to complete and return the *Physician/Practitioner's Supplementary Certificate* (DE 2525XX) enclosed with the *Notice of Final Payment*.
- Recovered or returned to work. If you return to work but are again unable to do your regular work because of a disability, immediately submit an application and report the dates you worked.

Overpayment

An overpayment results when you receive disability benefit payments you were not eligible to receive. Once we determine that you were overpaid, we will contact you to explain the reason. It's important that you complete and return all information requests, as there are instances when an overpayment can be waived.

If we determine that you were overpaid and the overpayment cannot be waived, you must repay the money. Payments issued after an overpayment is established may be reduced by 25 to 100 percent to collect your overpayment. We will send you a *Notice of Overpayment Offset* (DE 826) if your weekly benefit amount is reduced due to a disability, Paid Family Leave, or unemployment overpayment.

Disqualification

We will consider all available information before paying or disqualifying your claim. Benefits will be paid only for the days you're eligible. If payment is denied or reduced, we will send you a *Notice of Determination* (DE 2517) explaining the reason and the time period.

If you knowingly report incorrect information or willfully withhold information, we may issue false statement disqualifications of up to 92 days. This can apply if you accept

disability benefit payments you know include days you should not be paid, such as days after you returned to work. In addition, any overpayment will be increased by a 30 percent penalty.

Special Circumstances

- When you suffer a work-related injury or illness, report it to your employer and have your licensed health professional send a report to your employer's Workers' Compensation insurance carrier. If the Workers' Compensation insurance carrier delays or refuses payments, we may pay you benefits while your case is pending. However, we will pay benefits only for the period of your disability and will file a lien to recover benefits paid.

  Note: SDI and Workers' Compensation are two separate programs. You cannot legally be paid full benefits from both programs for the same period. However, if your Workers' Compensation benefit rate is less than your disability rate, we can pay you the difference.

  For information about Workers' Compensation, contact your local **Workers' Compensation Appeals Board office** (dir.ca.gov).

- For pregnancy, your disability begins the first day you're not able to do your regular work. Disability benefits will be paid for the period of time reported on your "Physician/Practitioner's Certificate." Pregnancy disability claims should **not** be submitted until after the eighth day following the date your licensed health professional certifies your disability. We will send an *Application for Paid Family Leave Benefits – Bonding for New Mother* (DE 2501FP) with your final disability payment to transition to a bonding claim.
- For child support questions, contact the Department of Child Support Services at 1-866-249-0773.
- For spousal or parental support questions, contact the District Attorney's office administering the court order.
- If a family member must stop work to care for you, or if you stop work to care for a seriously ill family member, visit edd.ca.gov/PaidFamilyLeave or contact the program at 1-877-238-4373 for more information.
- If you expect your disability to be long-term or permanent, contact the Social Security Administration before you finish collecting your disability benefits. For information, call the Social Security Administration toll-free at 1-800-772-1213.
- If you have a disability that prevents you from getting or keeping a job, the Department of Rehabilitation may be
- able to help you with vocational training, education, career opportunities, independent living, and use of assistive technology.
- If a person receiving disability benefits dies, an heir or legal representative should report the death to us. Benefits are payable through date of death.

Prepaid Debit Card Disclosures

Money Network® State Government Disbursement Program Short Form

You do not have to accept this benefits card. Ask about other ways to receive your benefits.			
Monthly fee **$0**	**Per purchase** **$0**	**ATM withdrawal** **$0** in-network **$1.00** out-of-network	**Cash reload** **N/A**
ATM balance inquiry (in-network or out-of-network)			**$0**
Customer service			**$0** per call
Inactivity			**$0**
We charge 5 other types of fees. Here are two of them:			
ATM Withdrawal Int. — $1.00 | **Priority Shipping — $8.00**			
No overdraft/credit feature: Your funds are eligible for FDIC insurance. For general information about prepaid accounts, visit cfpb.gov/prepaid. Find details and conditions for all fees and services in the Cardholder Agreement.			

Money Network State Government Disbursement Program. The Mastercard Card is issued by My Banking Direct, a service of Flagstar N.A., Member FDIC, pursuant to a license from Mastercard U.S.A. Inc. Incorporated. Card is serviced by Money Network Financial, LLC.

List of all fees (Long Form) for the Money Network® State Government Disbursement Program

All Fees	Program Fees	Details
Monthly Usage		
Account Opening and Card Receipt	**$0.00**	No fee for Account Opening and initial Card.
Monthly Maintenance Fee	**$0.00**	We do not assess a monthly maintenance fee.
Add Money		
Payer Deposit	**$0.00**	Funds are loaded only by your Payer.
Spend Money		
Signature Debit Transactions	**$0.00**	Select "Credit" or sign at point-of-sale (POS). International Service Assessment or Cross Border Assessment may also apply to International Transactions.
PIN Debit Transactions	**$0.00**	Select "Debit" and enter PIN at POS; cash back option at participating merchants. International Service Assessment or Cross Border Assessment may also apply to International Transactions.
Get Cash or Send Cash		
ATM Withdrawal Fee or ATM Decline Fee | In-Network	**$0.00**	Withdrawal or Decline from ATM that is a part of our network. To find in-network ATMs, use the locator on our Mobile App (data rates may apply) or on our Website, or call Customer Service.
ATM Withdrawal Fee | Out-of-Network	**$1.00**	This is our fee. You will receive two (2) free withdrawals after each deposit made to your account. You may also be charged a fee by the ATM operator, even if you do not complete a transaction. "Out-of-Network" means ATMs that are not in-network ATMs. To find in-network ATMs, use the locator on our Mobile App (data rates may apply) or on our Website, or call Customer Service.
ATM Decline Fee | Out-of-Network	**$0.00**	We do not charge a fee for this service. You may be charged a fee by the ATM operator.
Bank Teller Over the Counter Cash Withdrawal	**$1.00**	At banks displaying the card association logo on your Card's front side. This is our fee. You will receive one (1) free per deposit made to your account. International Service Assessment or Cross Border Assessment may also apply to International Transactions.
Transfer to Customer Bank Fee	**$0.00**	Domestic ACH transactions are subject to additional terms that are disclosed when transaction is initiated.
International ACH Withdrawal Fee	**$0.00** plus 0% of the exchange rate	This transaction allows you to transfer funds via ACH to an international bank account. We charge transfer fees consisting of a flat fee of up to $7.00 plus a mark-up on the exchange rate of up to 3.5%. The transfer fees may be less depending on the amount transferred and market conditions. Applicable transfer taxes will also be charged. The exact amount of transfer fees and transfer taxes charged by us will be disclosed to you before you complete the transaction. Your transaction is subject to an exchange rate conversion, and may be subject to additional fees and taxes from 3rd parties. Recipient's financial institution may also charge fees and taxes. We do not monitor exchange rates or fees established by 3rd parties, and these amounts are subject to change. These transactions are subject to additional terms that are disclosed when a transaction is initiated. See Website for more information. You may call Customer Service for assistance.

List of all fees (Long Form) for the Money Network® State Government Disbursement Program
(continued)

All Fees	Program Fees	Details
Information		
Monthly Paper Statement	**$0.00**	You may also obtain Account activity without a fee via Mobile App (data rates may apply), our Website, or by contacting Customer Service.
Customer Service	**$0.00**	24/7 toll free Account access, including account balance inquiries.
ATM Balance Inquiry Fee | In-Network	**$0.00**	To find in-network ATMs, use the locator on our Mobile App (data rates may apply) or at our Website, or call Customer Service.
ATM Balance Inquiry Fee | Out-of-Network	**$0.00**	This is our fee. You may also be charged a fee by the ATM operator, even if you do not complete a transaction.
Using Your Card Outside the U.S. (International Transactions)		
ATM Withdrawal INT Fee (Non-U.S.)	**$1.00**	This is our fee. You may also be charged a fee by the ATM operator, even if you do not complete a transaction. Currency Conversion Assessment Fee, International Service Assessment, and/or Cross Border Assessment may also apply to these transactions.
ATM Decline INT Fee (Non-U.S.)	**$0.00**	
ATM Balance Inquiry INT Fee (Non-U.S.)	**$0.00**	
Mastercard International Service Assessment	**2.0%**	This fee applies if a transaction is initiated in a currency other than U.S. dollars and a currency conversion rate applies. Fee is assessed as a percentage of the U.S. dollar amount of each International Transaction made with your Card. See the section labeled "International Transactions" in your Cardholder Agreement for additional information. If this fee applies to your transaction, it will be included in the transaction amount on your statement.
Mastercard Cross Border Assessment	**0.0%**	This fee applies if a transaction is initiated in U.S. dollars by a merchant with a non-U.S. country code. Fee is assessed as a percentage of the U.S. dollar amount of each International Transaction made with your Card. See the section labeled "International Transactions" in your Cardholder Agreement for additional information. If this fee applies to your transaction, it will be included in the transaction amount on your statement.
Other		
Reissuance of Lost/ Stolen Card	**$0.00**	Reissued Card shipped via U.S. mail 7-10 business days after order placed. One replacement Card provided at no charge each calendar year.
Priority Shipping Fee	**$8.00**	Additional fee to ship replacement Card 4-7 business days after order placed. Reissuance of Card Fee also applies.
Emergency Cash Transfer	**$15.00**	This is our fee for you to obtain an Emergency Cash Transfer, which must be initiated through customer service and is subject to the Emergency Cash Transfer guidelines.

Additional Disclosures

Your funds are eligible for deposit insurance up to the applicable limits by the Federal Deposit Insurance Corporation ("FDIC"). Your funds will be held at My Banking Direct, a service of New York Community Bank, an FDIC-insured institution. Once there, your funds are insured up to $250,000 by the FDIC in the event New York Community Bank fails, if specific deposit insurance requirements are met and your card is registered. See fdic.gov/deposit/deposits/prepaid.html for details.

No overdraft/credit feature.

Contact Customer Service by calling 1-800-684-7051, by mail at 2900 Westside Parkway, Alpharetta, GA 30004, or visit our Website at moneynetwork.com/EDD.

For general information about prepaid accounts, visit cfpb.gov/prepaid.

If you have a complaint about a prepaid account, call the Consumer Financial Protection Bureau at 1-855-411-2372 or visit cfpb.gov/complaint.

Federal Privacy Act

We require disclosure of Social Security numbers to comply with California Unemployment Insurance Code, sections 1253 and 2627; with California Code of Regulations, Title 22, sections 1085, 1088, and 1326; with Code of Federal Regulations, Title 20, Part 604; and with U.S. Code, Title 8, sections 1621, 1641, and 1642.

Information Collection and Access

State law requires the following information to be given when collecting information from individuals:

Agency name: Employment Development Department (EDD)	**Title of official responsible for information maintenance:** Manager, EDD State Disability Insurance Office
Local contact person: Manager, EDD State Disability Insurance Office	**Contact information:** You may contact State Disability Insurance by calling 1-800-480-3287. A list of State Disability Insurance local office locations can be found on the internet at edd.ca.gov/disability/Contact_DI.htm. The address and phone number of State Disability Insurance will also appear on the *Notice of Computation* (DE 429D) issued at the time your benefit determination is made.

Maintenance of the information is authorized by:

California Unemployment Insurance Code, sections 2601 through 3272.
California Code of Regulations, Title 22, sections 2706-1, 2706-3, 2708-1, and 2710-1.

Consequences of not providing all or any part of the requested information:

- Failure to supply any or all information may cause delay in issuing benefit payments or may cause you to be denied benefits to which you are entitled.
- If you willfully make a false statement or representation or knowingly withhold a material fact to obtain or increase any benefit or payment, the EDD will disqualify you from receiving benefits or services and may initiate criminal prosecution against you.

Principal purposes for which the information is to be used:

- To determine eligibility for Disability Insurance benefits.
- To be summarized and published in statistical form for the use and information of government agencies and the public (your name and identification will not appear in publications).
- To be used to locate persons who are being sought for failure to provide child, spousal, or other court-ordered support.
- To be used by other governmental agencies to determine eligibility for public social services under the provisions of California Welfare and Institutions Code, Division 9.
- To be used by the EDD to carry out its responsibilities under the California Unemployment Insurance Code.
- To be exchanged pursuant to California Unemployment Insurance Code, section 322, and California Civil Code, section 1798.24, with other governmental departments and agencies, both federal and state, which are concerned with any of the following:
  (1) Administration of an Unemployment Insurance program.
  (2) Collection of taxes which may be used to finance Unemployment Insurance or State Disability Insurance.
  (3) Relief of unemployed or destitute individuals.
  (4) Investigation of labor law violations or allegations of unlawful employment discrimination.
  (5) The hearing of workers' compensation appeals.
  (6) Whenever necessary to permit a state agency to carry out its mandated responsibilities where the use to which the information will be put is compatible with the purpose for which it was gathered.
  (7) When mandated by state or federal law. Disclosures under California Unemployment Insurance Code, section 322, will be made only in those instances in which it furthers the administration of the programs mandated by that Code.
- Pursuant to California Unemployment Insurance Code, sections 1095 and 2714: (1) Information may be revealed to the extent necessary for the administration of public social services, to the Director of Social Services or their representatives, or to the Director of Child Support Services or their representatives; (2) Claimant identity may be released to the Department of Rehabilitation.
- Information shall be disclosed to authorized agencies in accordance with California Unemployment Insurance Code, sections 1095 and 2714.

EDD Employment Development Department State of California

Application for Disability Insurance Benefits

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Social Security Number: 000000000

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

I authorize

Geoff Booker

(Person or 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 or managers and any other EDD employee who may need to access this information in order to process my claim or determine eligibility for State Disability Insurance benefits.

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

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

I understand I have the right to revoke this authorization by sending written notification stopping this authorization to 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 15 years from the date received by the EDD or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent the EDD's recovery of monies to which it is legally entitled.

I understand that I am signing this authorization voluntarily and that payment or eligibility for my benefits will be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization may result in an incomplete claim form that cannot be processed for payment of 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: 01/25/2025

SAMPLE, this page for reference only

Your disability application can also be filed online at **edd.ca.gov**

Print with black ink.

Part A - Claimant's Statement

A1. Your Social Security Number: 000000000

A2. If you have previously been assigned an EDD customer account number, enter that number here: No

A3. California Driver License or ID number: Z1234567

A4. Gender: Male X Female

A5. If you ever used other Social Security Numbers, enter those numbers below:

A6. State government employee (if "yes" indicate bargaining unit #): Yes X No unit #

A7. Your date of birth: 01011900

A8. Your full legal name (First) (MI) (Last) Suffix: Sample Claimant

A9. If you have worked under any other names, enter them here (for example, a maiden name or chosen name)
(First) (MI) (Last) Suffix:
(First) (MI) (Last) Suffix:

A10. Your home phone number and area code: 999 0236789

A11. Your cell phone number and area code: 111 00200047

A12. Language you prefer to use
English X Spanish Cantonese Vietnamese Armenian Punjabi Tagalog Other

A13. Your mailing address. Enter a PO Box or the Number, Street, Apartment, Suite, Space#, or PMB# (Private Mail Box): 123 Any Street
City: Anytown State: CA Zip or Postal Code: 12345 Country (if not U.S.A.):

A14. Address where you live. Required if different from your mailing address.
Number, Street, Apartment or Space#:
City State Zip or Postal Code Country (if not U.S.A.):

A15. Your last or current employer - if your last or current employment was self-employment, enter "self" and fill-in this option. 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: Anywhere State: CA Zip or Postal Code: 66222 Country (if not U.S.A.):
Employer's phone number: 4993111111

A16. At any time during your disability, were you in the custody of law enforcement authorities because you were convicted of violating a law or ordinance? Yes X No

A17. Before your disability began, what was the last day you worked? 01252025

A18. When did your disability begin? 01252025

A19. Date you want your claim to begin if different than the date entered in A18: M M D D Y Y Y Y

A20. Since your disability began, have you worked or are you working any full or partial days? Yes X No

A21 A. If you recovered, enter the date you recovered: M M D D Y Y Y Y

A21 B. If you returned to work, enter the date you started working: M M D D Y Y Y Y

Part A - Claimant's Statement - continued

A22. Enter your Social Security Number: 000000000

A23. What is your regular or customary occupation? Pastry Chef

A24. Why did you stop working? (Select only one box)
- [ ] Layoff
- [ ] Unpaid Leave Of Absence
- [ ] Voluntarily Quit Or Retired
- [ ] Terminated
- [ ] Other Reason
- [X] Illness, Injury, or Pregnancy

A25. How would you describe or classify your job?
- [ ] Mostly sit; occasionally stand or walk; occasionally lift, carry, push, pull, or otherwise move objects that weigh 10 lbs. or less.
- [ ] Mostly walk or stand; 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.
- [X] 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 over 20 lbs.; frequently over 50 lbs.; occasionally over 100 lbs.

A26. If your employer(s) continued or will continue to pay you during your disability, indicate type of pay:
Sick [ ] Vacation [ ] Paid Time Off (PTO) [ ] Annual [ ] Other (explain)

A27. May we disclose benefit payment information to your employer(s)?
Yes [ ] No [ ]

A28. Second employer name (if you have more than one employer)
Cosmic Cookies

Number, Street, Suite#
469 Thrifty Way

City: Bluebell | State: CA | Zip or Postal Code: 84369 | Country (If Not U.S.A.):

Before your disability began, what was the last day you worked for this employer? 01252025 | Employer's phone number:

A29. If you have more than 2 employers check here. [ ]

A30. If you are a resident of an alcoholic recovery home or a drug-free residential facility, provide the following:
Name of facility

Number, Street, Suite#

City | State | Zip or Postal Code | Area Code and Phone Number

A31. Have you filed or do you intend to file for workers' compensation benefits?
- [ ] Yes - complete items A32 through A38
- [ ] No - skip items A33 through A38

A32. Was this disability caused by your job?
- [ ] Yes
- [ ] No

A33. Date(s) of injury shown on your workers' compensation claim
MM DD YYYY | MM DD YYYY | MM DD YYYY | MM DD YYYY

A34. Workers' compensation insurance company name | Area Code and Phone Number | Extension (if any)

Number, Street, Suite#

City | State | Zip or Postal Code | Workers' Compensation Claim Number

Part A - Claimant's Statement - continued

A35. Enter your Social Security Number: 0 0 0 0 0 0 0 0 0

A36. Workers' Compensation Adjuster's Name | Area Code and Phone Number | Extension (If Any)

A37. Employer's name shown on your workers' compensation claim | Area Code and Phone Number | Extension (if any)

A38. Your attorney's name (if any) for your workers' compensation case | Area Code and Phone Number | Extension (if any)

Number, Street, Suite#

City | State | Zip or Postal Code | Workers' Compensation Appeals Board or ADJ Case Number

A39. Select your preferred payment method: ☐ Debit Card ☐ Check

A40. Declaration and Signature. By my signature on this application statement, I claim benefits and certify that for the period covered by this application 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 application 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 application statement, I authorize release and use of information as stated in the "Information Collection and Access" portion of this form (see Informational Instructions, page F). 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 15 years from the date of my signature or the effective date of the claim, whichever is later.

Claimant's signature (do not print) or signature made by mark (x): Sample Claimant | Date signed: 01312025

A41. If your signature is made by mark (x), check the box and it must be attested by two witnesses with their addresses. ☐

1st witness signature (print and sign) | Date signed: M M D D Y Y Y Y

Number, Street, Apartment or Space#, PO Box (Private Mail Box Addresses Not Acceptable).

City | State | Zip or Postal Code

2nd witness signature (print and sign) | Date signed: M M D D Y Y Y Y

Number, Street, Apartment or Space#, PO Box (Private Mail Box Addresses Not Acceptable).

City | State | Zip or Postal Code

A42. ☐ If you are the personal representative signing on behalf of the applicant, check this box and complete the section below:

I, (First) (MI) (Last), represent the claimant

in this matter as authorized by ☐ Declaration of Individual Claiming Disability Insurance Benefits Due an Incapacitated or Deceased Claimant, DE 2522

☐ Power of Attorney (attach copy)

Personal representative's signature (do not print) | Date signed: M M D D Y Y Y Y

Application for Disability Insurance (DI) Benefits – Physician or Practitioner's Certificate

Print with black ink.

Part B - Physician or Practitioner's Certificate

B1. Patient's Social Security Number: 000000000

B2. Patient's file number: 69-642-38

B3. If you know the patient's electronic receipt number, enter it here: R

B4. Patient's date of birth: 01011900

B5. Patient's name (First) (MI) (Last): Sample Claimant

B6. Physician or 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 or Practitioner license type: MD

B9. Specialty (if any):

B10. Physician or Practitioner's name as shown on license
(First) (MI) (Last) Suffix: Geoff Booker

B11. Physician or 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 or Government Facility address
Facility Name (if applicable):
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: 01252025 To: MMDDYYYY [X] Check here to indicate you are still treating the patient
At Intervals Of: [ ] Daily [ ] Weekly [X] Monthly [ ] As Needed [ ] Other

B13. At any time during your attendance for this medical problem, has the patient been incapable of performing their regular or customary work?
[X] Yes - enter date disability began: 01252025 [ ] No - skip to B33
MMDDYYYY
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 their regular or customary work
("unknown", "indefinite", etc., not acceptable.) MMDDYYYY
[ ] Check here to indicate patient's disability is permanent and you never anticipate releasing patient to return to their 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: MMDDYYYY Date pregnancy ended: MMDDYYYY
Type of delivery, if patient has delivered: [ ] Vaginal [ ] Cesarean

Part B - Physician or Practitioner's Certificate - continued

B16. Enter patient's Social Security Number: 0 0 0 0 0 0 0 0 0

B17. If the patient has not delivered and you do not anticipate releasing the patient to return to regular or customary work prior to the estimated delivery date, enter the **number of days** that the patient will be disabled postpartum, for each delivery type:

Vaginal Delivery: ☐☐ Cesarean Delivery: ☐☐

B18. In case of an abnormal pregnancy or delivery, state the complication(s) causing maternal disability

B19. ICD diagnosis code(s) for disabling condition that prevent the patient from performing their regular or customary work (required)

Example of how to complete ICD codes

ICD-9: 3 2 0 . 1

ICD-10: G 0 0 . 1

(Check only one box)

☐ ICD-9

☒ ICD-10

Primary: 5 5 2 . 9 2 X A

Secondary:

Secondary:

Secondary:

B20. Diagnosis (required) - if no diagnosis has been determined, enter a detailed statement of symptoms

Broken left forearm closed fracture

B21. Findings - state nature, severity, and extent of the incapacitating disease or injury, include any other disabling conditions

Unable to use left arm and hand

B22. Type of treatment or medication rendered to patient

Cast immobilize arm

B23. If patient was hospitalized, provide dates of entry and discharge: M M D D Y Y Y Y To M M D D Y Y Y Y

☐ Check here to indicate the patient is still hospitalized

B24. ☐ Check here if patient is deceased, provide date of death: M M D D Y Y Y Y

City | County | State

Part B - Physician or Practitioner's Certificate - continued

B25. Enter patient's Social Security Number: 0 0 0 0 0 0 0 0 0

B26. Was the patient seen previously by another Physician or Practitioner or medical facility for the current disability, illness or injury?

☐ Yes ☒ No ☐ Unknown — If Yes, What Was The Date Of First Treatment? M M D D Y Y Y Y

B27. Date and type of surgery or procedure most recently performed or to be performed

M M D D Y Y Y Y

Was the patient unable to work immediately prior to the surgery or procedure? ☐ Yes ☐ No

If yes, provide the first date the patient was unable to work before the surgery or procedure: M M D D Y Y Y Y

B28. ICD Procedure Code(S) ☐ ICD-9 ☐ ICD-10

CPT code(s) (do not include modifiers)

B29. Was this disabling condition caused or aggravated by the patient's regular or customary work? ☐ Yes ☒ No

B30. Are you completing this form for the sole purpose of referral or recommendation to an alcoholic recovery home or drug-free residential facility as indicated by the patient in question A30? ☐ Yes ☒ No

B31. Date your patient became a resident of a drug or alcohol facility (if known) M M D D Y Y Y Y

B32. Would disclosure of the information on this form be medically or psychologically detrimental to your patient? ☐ Yes ☐ No

B33. **Physician or Practitioner's:** I certify under penalty of perjury that the patient is unable to perform their regular or customary work because of the listed disabling condition(s). I have performed a physical examination or treated the patient. I am authorized to certify a patient disability or serious health condition pursuant to California Unemployment Insurance Code section 2708.

Physician or Practitioner's original signature - **rubber stamp is not acceptable**	Date Signed	Area Code and Phone Number
Geoff Booker	0 1 2 5 2 0 2 5	4 2 3 0 0 2 4 6 9 3

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