Employment Development Department
State of California

Claim for Paid Family Leave (PFL) Benefits

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

Please read instruction and information pages (A through D) before completing the enclosed forms.

For faster processing, file your claim using SDI Online at edd.ca.gov. If you file online, do NOT mail this form to the Employment Development Department (EDD).

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

If you cannot complete this form due to a disability, or if you are an authorized representative filing for benefits on behalf of an incapacitated or deceased claimant, call 1-877-238-4373.

HOW TO COMPLETE THIS FORM

- Use black ink only.
- Type or write clearly **within** the boxes provided.
- Enter your Social Security number on all pages of the claim form including attachments.
- Do not fax the form.
- Mail the completed form to the EDD in the envelope provided. Submit your claim no earlier than the first day your family leave begins but no later than 41 days after your family leave begins. **You may lose benefits if your claim is late**.

1. Complete **ALL** items on the enclosed "PART A – STATEMENT OF CLAIMANT" and **sign box A24.** Errors or missing information **may cause your claim to be returned and delay payment.** For box A8, the United States Postal Service will not deliver mail to a private mail box unless it is preceded by the initials "PMB."
2. For bonding, also complete "PART B – BONDING CERTIFICATION" and enclose a copy of one of the documents listed in box B10. Do **not** complete Part B if you are filing to care for a family member.
3. For care:
    a. Have the care recipient read and sign the "CARE RECIPIENT'S AUTHORIZATION FOR DISCLOSURE OF PERSONAL-HEALTH INFORMATION" on page 2.
    b. Have the care recipient complete and sign "PART C – STATEMENT OF CARE RECIPIENT." If the care recipient is a minor or incapacitated, an authorized representative may complete this part.
    c. Have the treating physician/practitioner complete and sign "PART D – PHYSICIAN/ PRACTITIONER'S CERTIFICATION." 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 the care recipient is under the care of an accredited religious practitioner, obtain a *Practitioner's Certification for Paid Family Leave (PFL) Benefits*, (DE 2502F) by calling 1-877-238-4373. **Rubber stamp signatures are not accepted.**
4. **You should carefully decide the date you want your claim to begin because it may affect your benefit amount.** See "YOUR BENEFIT AMOUNTS" on page B for information.
5. Place the completed, signed form(s) in the envelope provided. Claims are generally processed within 14 days after the EDD receives a completed claim.
    - For bonding, a claim is complete when parts A and B, and supporting documents are received.
    - For care, a claim is complete when parts A, C, and D are received.
6. Keep these instructions and information pages (A through D) for future reference.

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). TTY users, please call the California Relay Service at 711.

BASIC ELIGIBILITY. PFL benefits can be paid only after you meet **all** of the following requirements:

- You must be **unable** to do your regular or customary work **due to the need to provide care or to bond with a new child**.
- You must be **employed** or actively **looking for work** at the time your family leave begins.
- If working, you must have **lost wages** because you were caring for a seriously ill family member or bonding with a new child.
- You must have **earned at least $300** from which State Disability Insurance (SDI) deductions were withheld during a previous period. (See "YOUR BENEFIT AMOUNTS" in the next column.)
- You must **complete and mail a claim form** within 41 days after the first day your family leave begins or you may lose benefits.

In addition, the following requirements must be met only if your PFL claim is to care for a seriously ill family member:

- The care recipient must be your child, parent, spouse, registered domestic partner, grandparent, grandchild, sibling, or parent-in-law.
- The care recipient must be **under the continuing treatment** or supervision of a licensed physician/practitioner or accredited religious practitioner while you are receiving benefits.
- The care recipient's **physician/practitioner must complete the certification** that he/she requires care. If the care recipient is under the care of a religious practitioner, request a *Practitioner's Certification for Paid Family Leave (PFL) Benefits*, (DE 2502F) from the PFL office. Certification by a religious practitioner is acceptable only if the practitioner has been accredited by the EDD.

The following requirements must also be met only if your PFL claim is to bond with a new child:

- Your leave must take place within 12 months of the birth, adoption, or foster care placement of the child.
- The new child must be either your or your registered domestic partner's biological child, adopted child, or foster child.

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. You may not be eligible for PFL benefits if:

- You are claiming or receiving Unemployment Insurance (UI) or Disability Insurance (DI) benefits.
- You are receiving workers' compensation benefits at a weekly rate equal to or greater than the PFL rate.
- You are in jail, prison, or any other facility.

FRAUD. Under sections 1143, 2101, 2116, 2122, and 3305 of the California Unemployment Insurance Code, it is a violation to willfully make a false statement or knowingly conceal a material fact in order to obtain the payment of any benefits. Such violation is punishable by imprisonment, and/or by a fine not exceeding $20,000, or both. To detect and discourage fraud, the EDD continually monitors claims, vigorously investigates suspicious activity, and will seek restitution and conviction through prosecution.

YOUR RESPONSIBILITIES

- File your claim and other forms completely, accurately, and in a timely manner. If a form is late, include with the form a written explanation of the reason(s).
- Carefully read the instructions on this and all other forms you receive from PFL. If you are not sure what is required, contact the PFL office.
- Call or report in writing to the PFL office any:
  - Change of address or telephone number.
  - Return to part-time or full-time work.
  - Need for care or bonding to stop.
  - Income you receive.
- **Include your name and Social Security number on all correspondence.**

YOUR RIGHTS. Information about your claim will be kept confidential, except for the purposes allowed by law. California Civil Code, section 1798.34, gives you the right to inspect any personal records maintained about you by the EDD. Section 1798.35 permits you to request that the record be corrected if you believe it is not accurate, relevant, timely, or complete. Certain types of information that would generally be considered personal are exempt from disclosure to you: medical or psychological records where knowledge of the contents might be harmful to the subject (Civil Code, section 1798.40); records of active criminal, civil, or administrative investigations (Civil Code, section 1798.40). Additionally, the EDD will not disclose or provide copies of care recipients' medical information to care providers. If you are denied access to records which you believe you have a right to inspect or if your request to amend your records is refused, you may file an appeal with the PFL office. You may request a copy of your file by calling the telephone number shown on your *Notice of Computation*, (DE 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.

YOUR BENEFIT AMOUNTS. Your claim begins on the date your family leave began. The EDD calculates your weekly benefit amount using your base period. The date your family leave began determines your base period. You may not change the beginning date of your claim or adjust your base period after you have established a valid claim.

This base period covers 12 months and is divided into four consecutive quarters. Your base period includes wages subject to SDI tax that you were paid approximately 5 to 18 months before your PFL claim begins. Your base period does not include wages being paid at the time family leave begins. For a PFL claim to be valid, you must have earned at least $300 in wages in the base period. Using the following, you may determine the 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.

The quarter of your base period in which you were paid the highest wages determines your **weekly benefit amount**.

- For more information about your benefit amount visit **edd.ca.gov/Disability/Calculating_PFL_Benefit_Payment_Amounts.htm**.

Contact the PFL office to inquire about benefits and to provide additional information if your situation fits any of these circumstances:

- If you do not have sufficient base period wages, you may be able to establish a valid claim by using a later beginning date.
- If 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.
- If during your base period you served in the military, received workers' compensation benefits, or did not work because of a labor dispute.

HOW BENEFITS ARE PAID. When your claim is received, the PFL office will notify you of your weekly benefit amount and request any additional information needed to determine your eligibility. If you meet all requirements, a payment will be issued to you using the EDD Debit Card℠, which will be mailed to you. The majority of claims are processed and payments issued within 14 days of receipt of a correctly completed claim.

If you are eligible for further benefits, additional payments will be issued automatically. 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 "BENEFIT REDUCTIONS" below.)

BENEFIT REDUCTIONS. Under certain circumstances, you may not be eligible for a period of your claim or you may be entitled only to partial benefits. The EDD will determine whether or not benefits must be reduced. The types of income shown in the following list should be reported to the EDD even though they may not always affect your benefits. Failure to report your income could result in an overpayment, penalties, and/or a false statement disqualification.

- Sick leave pay
- Vacation pay
- Self-employment income
- Military pay
- Commissions
- Wages, including modified duty wages
- Residuals
- Bonuses
- Workers' compensation benefits
- Holiday pay
- Paid time off
- Part-time work income

In addition, your benefits may be reduced because of a prior UI, DI, or PFL overpayment or for delinquent court-ordered **child** or **spousal support** payments.

BENEFIT INTERRUPTION and TERMINATION. You will see "Notice of Exhaustion of Paid Family Leave Benefits" on the *Electronic Benefit Payment (EBP) Notification*, (DE 2500E) when:

- You have been paid to the date the care recipient no longer requires care, as estimated by the care recipient's physician/practitioner. If the care recipient still requires care, complete and sign the PFL Claimant's Certification portion and ask the care recipient's physician/practitioner to complete and mail the *Physician/Practitioner's Supplementary Certificate*, (DE 2525XFA).
- The care recipient has recovered. If you return to work and the care recipient again requires care, immediately submit a new claim form and report the dates you worked.

A *Notice of Exhaustion of Paid Family Leave Benefits*, (DE 2525AF) will be issued when records show you have been paid the maximum amount of PFL benefits.

TAXABILITY of BENEFITS. PFL 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. For 1099G inquiries, please call 1-800-795-0193.

OVERPAYMENT. An overpayment results when you receive PFL benefit payments you were not eligible to receive. Once the EDD 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. Payments issued after an overpayment is established may be reduced by 25 to 100 percent to collect your overpayment. You will receive a *Notice of Overpayment Offset*, (DE 826), if your weekly benefit amount is reduced due to a DI, PFL, or UI overpayment.

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

If you deliberately report incorrect information or if you willfully omit or withhold information, false statement disqualifications of up to 92 days will be assessed. This may apply if you receive a payment that you know includes days for which you should not be paid, such as days after you returned to work. In addition, any resulting overpayment will be increased by a 30 percent penalty assessment.

SPECIAL CIRCUMSTANCES

Pregnancy. Mothers who are receiving DI benefits for a pregnancy-related disability and have delivered their child may be eligible for PFL benefits to bond with their new child. A *Claim for Paid Family Leave (PFL) Benefits - New Mother*, (DE 2501FP) will automatically be sent to these new mothers at the end of their pregnancy-related DI claims.

Child Support Obligations. Contact the District Attorney's office administering the court order.

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

Job Training. Contact an America's Job Center of California℠ (1-877-872-5627 or **servicelocator.org**) for services available in your area.

Seeking Work. Contact the EDD for information and assistance concerning employment opportunities and UI benefits.

- To register for employment, visit **caljobs.ca.gov**.
- To apply for UI benefits, visit **edd.ca.gov/unemployment**.

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 the date of death, if otherwise eligible.

Death of Care or Bonding Recipient. If the person for whom you are caring for or the child with whom you are bonding with dies, report the death to PFL at 1-877-238-4373. Benefits are payable through the date of death, if otherwise eligible.

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. For more information about FMLA, call 1-866-487-9293 or visit **dol.gov/whd/fmla**. For more information on CFRA, call 1-800-884-1684 or visit **dfeh.ca.gov**.

FEDERAL PRIVACY ACT. The EDD requires 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 provided when collecting information from individuals:

Agency Name:	**Title of Official Responsible for Information Maintenance:**
Employment Development Department (EDD)	Manager, EDD Paid Family Leave Office

Local Contact Person:	**Contact Information:**
Manager, EDD Paid Family Leave Office	You may contact Paid Family Leave by calling 1-877-238-4373. A list of Paid Family Leave local office locations can be found on the Internet at **edd.ca.gov/disability/Contact_DI.htm**. The address and phone number of Paid Family Leave 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 3306.

California Code of Regulations, Title 22, sections 2706-2, 2706-3, and 2708-1.

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 and/or services and may initiate criminal prosecution against you.

Principal purpose(s) for which the information is to be used:

- To determine eligibility for Paid Family Leave benefits.
- To be summarized and published in statistical form for the use and information of government agencies and the public. (Neither your name and identification nor the name and identification of the care or bonding recipient will appear in publications.)
- To be used to locate persons who are being sought for failure to provide child or spousal 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, information may be revealed to the extent necessary for the administration of public social services or to the Director of Social Services or his/her representatives.
- Information shall be disclosed to authorized agencies in accordance with California Unemployment Insurance Code, sections 1095 and 2714.

SAMPLE, this page for reference only

Employment Development Department
State of California

Claim for Paid Family Leave (PFL) Benefits

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

A1. YOUR SOCIAL SECURITY NO.: 000-00-0000

A2. YOUR DATE OF BIRTH (MM DD YYYY): 01/01/1900

A3. LANGUAGE YOU PREFER TO USE: ENGLISH [X] ESPAÑOL [ ] OTHER (PRINT BELOW)

A4. YOUR LEGAL NAME: FIRST NAME: SAMPLE; MI: ; LAST NAME: CLAIMANT

A5. YOUR GENDER: MALE [X] FEMALE [ ]

A6. YOUR TELEPHONE NUMBER: 999-023-6789

A7. OTHER LAST NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED:

A8. YOUR MAILING ADDRESS (TO RECEIVE MAIL AT A PRIVATE MAIL BOX—NOT A US POSTAL SERVICE BOX—YOU MUST SHOW THE NUMBER IN THE "PMB#" SPACE.): 123 ANY STREET; PMB# (IF APPLICABLE):
CITY: ANYTOWN; STATE/PROV.: CA; ZIP OR POSTAL CODE: 12345; COUNTRY (IF NOT U.S.A.):

A9. NAME OF YOUR EMPLOYER: ROADRUNNER PASTRIES; MAILING ADDRESS: 647 ARMISTICE WAY
CITY: ANYWHERE; STATE/PROV.: CA; ZIP OR POSTAL CODE: 66222; EMPLOYER'S TELEPHONE NUMBER: 499-311-1111

A10. DATE YOU LAST WORKED (MM DD YYYY): 12/01/2015

A11. DATE YOU WANT YOUR PFL CLAIM TO BEGIN (MM DD YYYY): 12/16/2015

A12. DATE YOU RETURNED OR WILL RETURN TO WORK (MM DD YYYY): 01/27/2016

A13. DID YOU WORK OR WILL YOU CONTINUE TO WORK DURING YOUR FAMILY LEAVE PERIOD? NO [X] YES [ ]

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

A15. WHAT IS YOUR OCCUPATION? PASTRY CHEF

A16. LEGAL NAME OF PERSON FOR WHOM YOU ARE CARING (FIRST MIDDLE INITIAL LAST) OR WITH WHOM YOU ARE BONDING (CARE OR BONDING RECIPIENT): COOKIE A CLAIMANT

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

A18. IS ANY OTHER FAMILY MEMBER READY, WILLING, AND ABLE AND AVAILABLE TO PROVIDE CARE FOR THE SAME PERIOD YOU ARE CLAIMING PFL BENEFITS? NO [X] YES [ ]

A19. HAVE YOU CLAIMED OR DO YOU PLAN TO CLAIM WORKERS' COMPENSATION BENEFITS FOR ANY PORTION OF THE PERIOD COVERED BY THIS CLAIM? NO [X] YES [ ]

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

A21. IF YOUR EMPLOYER(S) CONTINUED OR WILL CONTINUE TO PAY YOU DURING YOUR FAMILY LEAVE, INDICATE TYPE OF PAY: SICK [ ] VACATION [ ] OTHER (EXPLAIN) [ ]

A22. MAY WE DISCLOSE BENEFIT PAYMENT INFORMATION TO YOUR EMPLOYER(S)? NO [ ] YES [X]

A23. AT ANY TIME DURING YOUR PFL LEAVE, WERE YOU IN THE CUSTODY OF LAW ENFORCEMENT AUTHORITIES BECAUSE YOU WERE CONVICTED OF VIOLATING A LAW OR ORDINANCE? NO [X] YES [ ]

A24. Declaration and Signature. By my signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was providing care for or bonding with the care recipient named above; (2) authorize EDD to release my personal information as shown on this claim to the care recipient and to the care recipient's treating physician as they are respectively listed in Part C and Part D of this claim; (3) authorize my employer(s) to disclose to EDD all facts concerning my employment that are within their knowledge; and (4) authorize release and use of information as stated in the "Information Collection and Access" portion of this form. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.

Claimant's Signature (DO NOT PRINT): Sample Claimant

If signature is made by mark (X), please place mark here.*

Date Signed (MM | DD | YYYY): 12/16/2015

*If your signature is made by mark (X), it must be attested by two witnesses with their addresses

1st Witness Signature and Address

2nd Witness Signature and Address

CARE RECIPIENT'S AUTHORIZATION FOR DISCLOSURE OF PERSONAL-HEALTH INFORMATION

I authorize my physician or practitioner, as identified on Part D of this claim, to disclose my current personal-health information to my care provider, as identified on Part A of this claim, and to the California Employment Development Department (EDD).

I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and an estimation of the amount of care that I require from my care provider as a result of my current condition. I further understand that disclosure of my personal-health information may include my AIDS/HIV status, drug or alcohol addiction, or any other physical or mental condition.

I understand that EDD may disclose this information as authorized by the California Unemployment Insurance Code and that such re-disclosed information may no longer be protected. I agree that photocopies of the authorization form in conjunction with my signature on Page 3 in Item 6 of Part C shall be as valid as the original.

I understand that unless I inform EDD in writing at PO Box 989315, West Sacramento, CA 95798-9315, that I wish to revoke this authorization, it will be valid for 10 years from the date EDD receives it or the effective date of this claim, whichever is later. I understand that I have the right to receive a copy of an authorization form from EDD if I request one in writing.

I make this authorization to support my care provider's claim for Paid Family Leave benefits. I understand that I may not revoke my authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

WE CANNOT PROCESS THIS CLAIM UNLESS YOU SIGN BOTH THIS PAGE AND PAGE 3 IN ITEM C6 OF PART C.

Care recipient's name (Print your name)

Date signed

Care recipient's signature (Sign your name)

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

B1. YOUR SOCIAL SECURITY NUMBER
000000000

B2. DATE OF FOSTER CARE OR ADOPTION PLACEMENT (M M D D Y Y Y Y)

B3. CHILD NAMED IN B8 IS MY
BIOLOGICAL CHILD: X | STEPCHILD | FOSTER CHILD | ADOPTED CHILD | OTHER

B4. YOUR LEGAL LAST NAME (NEEDED IN CASE PAGES OF THIS CLAIM BECOME SEPARATED)
CLAIMANT

B5. CHILD'S SOCIAL SECURITY NUMBER (IF AVAILABLE)

B6. CHILD'S DATE OF BIRTH (M M D D Y Y Y Y)
12012015

B7. CHILD'S GENDER
MALE | FEMALE: X

B8. LEGAL NAME OF CHILD (FIRST | MIDDLE INITIAL | LAST)
COOKIE | A | CLAIMANT

B9. CHILD'S RESIDENCE ADDRESS (IF DIFFERENT FROM CLAIMANT'S)

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

B10. AS EVIDENCE OF THE RELATIONSHIP IN B3, CHECK ONE OF THE FOLLOWING AND ATTACH A COPY OF THE DOCUMENT CHECKED.
(DO NOT SEND ORIGINAL DOCUMENT. IT WILL NOT BE RETURNED.)

- [X] CHILD'S BIRTH CERTIFICATE
- [ ] ADOPTIVE PLACEMENT AGREEMENT, AD-907
- [ ] DECLARATION OF PATERNITY, CS-909
- [ ] INDEPENDENT ADOPTION PLACEMENT AGREEMENT, AD-924
- [ ] FOSTER CARE PLACEMENT RECORD, SOC-815
- [ ] OTHER

B11. Declaration and Signature. 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.

Original Signature of Bonding Claimant – RUBBER STAMP IS NOT ACCEPTABLE
Sample Claimant

Date Signed (M M | D D | Y Y Y Y)
12162015

PART C – STATEMENT OF CARE RECIPIENT

(MAY BE COMPLETED BY CLAIMANT IF CARE RECIPIENT IS MENTALLY OR PHYSICALLY UNABLE TO DO SO. MUST BE SIGNED BY CARE RECIPIENT OR CARE RECIPIENT'S AUTHORIZED REPRESENTATIVE.)

C1. RECIPIENT'S DATE OF BIRTH (M M D D Y Y Y Y)

C2. RECIPIENT'S TELEPHONE NUMBER

C3. RECIPIENT'S GENDER
MALE | FEMALE

C4. LEGAL NAME OF CARE RECIPIENT (FIRST | MIDDLE INITIAL | LAST)

C5. CARE RECIPIENT'S RESIDENCE ADDRESS

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

C6. CONFIRMATION OF MEDICAL DISCLOSURE AUTHORIZATION. I have read and signed the Care Recipient's Authorization for Disclosure of Personal-Health Information on page 2 of this claim. I understand that by signing it I have agreed to all its provisions and terms. I further understand that copies of my signature below are as valid as the original.

Care Recipient's Signature (DO NOT PRINT)

Date Signed (M M | D D | Y Y Y Y)

C7. Authorized Representative signing on behalf of care recipient must complete the following: I,_____, represent the care or bonding recipient in this matter as authorized by ☐ parental right ☐ power of attorney (attach copy) ☐ court order (attach copy) (For spouse or domestic partner, contact EDD.)

Authorized Representative's Signature (DO NOT PRINT)

Date Signed (M M | D D | Y Y Y Y)

SAMPLE, this page for reference only

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

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 WITH A CHILD.)

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
M M D D Y Y Y Y

D4. DOES YOUR PATIENT REQUIRE CARE BY THE CLAIMANT?
NO (SKIP TO D15) YES

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
M M D D Y Y Y Y

D10. FIRST DATE CARE NEEDED
M M D D Y Y Y Y

D11. DATE YOU EXPECT RECOVERY
M M D D Y Y Y Y NEVER

D12. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CLAIMANT
M M D D Y Y Y Y PERMANANT

D13. APPROXIMATELY HOW MANY TOTAL HOURS PER DAY WILL PATIENT REQUIRE CLAIMANT?
HOURS COMMENTS

D14. WOULD DISCLOSURE OF THIS CERTIFICATE TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL? NO YES

D15. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER

D16. STATE OR COUNTRY PHYSICIAN/PRACTITIONER IS LICENSED.

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 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 disability or serious health condition pursuant to California Unemployment Insurance Code Section 2708.

Original Signature of Attending Physician/Practitioner – RUBBER STAMP IS NOT ACCEPTABLE | PHYSICIAN/PRACTITIONER'S PHONE NO. | Date Signed (MM | DD | YYYY)

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.