Employment Development Department
State of California

REPORT OF VOLUNTARY PLAN DISABILITY CLAIM

PLEASE READ INSTRUCTIONS BEFORE COMPLETING THIS FORM. TO REPORT A VOLUNTARY PLAN FAMILY LEAVE (VPFL) CLAIM, YOU MUST SUBMIT A COMPLETED REPORT OF VOLUNTARY PLAN FAMILY LEAVE CLAIM (DE 2523F).

A. CLAIMANT INFORMATION

WITHIN 15 DAYS AFTER RECEIPT OF A FIRST CLAIM FOR DISABILITY BENEFITS, COMPLETE ITEMS 1 14 AND SUBMIT. (RETAIN A COPY OF COMPLETED SECTION A*)

1. CLAIMANT'S NAME (FIRST, MIDDLE, LAST)	2. SOCIAL SECURITY NUMBER ___ – __ – ____	3. DATE DISABILITY BEGAN

4. CLAIMANT'S MAILING ADDRESS

STREET/PO BOX		TELEPHONE NUMBER – –
CITY	STATE	ZIP CODE

5. DATE OF BIRTH	6. SEX	7. VOLUNTARY PLAN EMPLOYER NAME	8. VOLUNTARY PLAN NUMBER
__/__/____ MM DD YYYY	☐ MALE ☐ FEMALE		

9. INTERNATIONAL CLASSIFICATION OF DISEASES (ICD) CODE	10. DIAGNOSIS

11. DO YOU WANT STATE AWARD INFORMATION? ☐ NO ☐ YES

IF **YES**, ENTER THE NAME AND ADDRESS (INCLUDING ZIP CODE) OF EMPLOYER OR PLAN ADMINISTRATOR

NAME:

ADDRESS:

12. (REQUIRED) TYPE OR PRINT NAME OF PERSON COMPLETING SECTION A	13. TELEPHONE NUMBER – –	14. DATE

FOR DEPARTMENT USE ONLY

CLAIM EFFECTIVE DATE	WEEKLY BENEFIT AMOUNT	MAXIMUM BENEFIT AMOUNT
	$	$

B. WITHIN 35 DAYS AFTER FINAL PAYMENT FOR EACH PERIOD OF DISABILITY (*ON RETAINED COPY), COMPLETE ITEMS 15 22 AND SUBMIT.

15. NUMBER OF DAYS BENEFITS PAID	16. BENEFITS PAID THROUGH	17. TOTAL AMOUNT OF BENEFITS PAID	18. TOTAL AMOUNT DIVERTED TO SATISFY SUPPORT OBLIGATION
		$	$

19. CLAIM STATUS (CHECK ALL APPROPRIATE BOXES)

☐ BENEFITS EXHAUSTED ☐ BENEFITS NOT EXHAUSTED ☐ BENEFITS DENIED (ATTACH A COPY OF DENIAL LETTER)

☐ RECOVERED/RETURNED TO WORK ☐ ADJUSTMENT

20. (REQUIRED) TYPE OR PRINT NAME OF PERSON COMPLETING SECTION B	21. TELEPHONE NUMBER – –	22. DATE

INSTRUCTIONS FOR COMPLETING THE REPORT OF VOLUNTARY PLAN DISABILITY CLAIM, DE 2523

Section A: Complete items 1-14 and return within 15 days after the receipt of a first claim for disability benefits. Submit to address below. (Retain a copy of completed Section A.) California Code of Regulations, Title 22, Section 3267-1.

1. Enter the claimant's full name.
2. Enter all digits of the claimant's social security number.
   (A claim cannot be processed without an accurate number. The use of an incorrect number can result in erroneous notices to the claimant and employer.)
3. Enter the date the disability began.
4. Enter the claimant's current mailing address and telephone number.
5. Enter the month, day, and year of claimant's date of birth. (mm/dd/yyyy)
6. Enter a check mark in the appropriate box.
7. Enter the employer's name.
8. Enter the six digit voluntary plan number.
9. Enter International Classification of Diseases (ICD) Code. [Published by the World Health Organization (WHO)].
10. Enter the physician's diagnosis.
11. Enter an "X" in the appropriate box. If yes is checked, the EDD will mail the award information to the address provided.
12. Enter the printed name of the person completing Section A.
13. Enter the telephone number of the person completing Section A.
14. Enter the current date.

Section B: On the retained copy of Section A, complete items 15-22 and return within 35 days after final payment for each period of disability, California Code of Regulations, Title 22, Section 3267-1. Submit to address below.

15. Enter the number of days disability benefits were paid.
    (Includes days paid under a supplemental accident and sickness plan or salary continuance only if they are part of the Voluntary Plan.)
16. Enter the last date for which disability benefits were paid.
17. Enter the amount of disability benefits paid.
    (Enter the amount paid for the days entered in item 15. Include any amount withheld for support obligation.)
18. Enter the amount of disability benefits that were diverted to satisfy a support obligation.
    (Enter the amount of benefits withheld under the Support Intercept Program. This amount must be included in the total of item 17.)
19. Enter an "X" in the boxes that apply to the current claim status.
    Benefits Exhausted: The total maximum benefit amount paid.
    Benefits Not Exhausted: A balance of the maximum benefit amount remains.
    Benefits Denied: No benefits have been paid. A copy of the denial letter to the claimant must be electronically attached or submitted under separate cover.
    Recovered/Return to Work: The claimant has recovered from the disability and/or returned to work.
    Adjustment: Use if submitting an amended report.
20. Enter the printed name of the person completing Section B.
21. Enter the telephone number of the person completing Section B.
22. Enter the current date.

INTERNET or HARDCOPY VERSION/SUBMIT COMPLETED FORM AS FOLLOWS:

MAIL TO:	**FAX TO:**
Employment Development Department Voluntary Plan Unit PO Box 120831 San Diego, CA 92112-0831	916-449-1922