



SDI ONLINE TUTORIAL

File Your Disability Claim Paper Application



Complete a Paper Application

Learn how to complete and submit a paper application for disability benefits.



[Get Started](#)



Paper Claim Forms

You should file a paper application if you:

- Do not have a valid California driver's license or ID.
- Do not have a valid Social Security number (SSN).
- Have a name longer than 12 characters, which does not fit our online form.
- Recently changed your name.
- Received an error code you cannot fix when applying online.
 - For technical help applying online, call 1-800-480-3287. Select your language option and then **option 2**, **option 4**, and then **press 0** to speak with a person. Make sure you listen to the recorded directions.
- Are under 18 years old.

How to get a paper DE 2501 application

- Order [online](#) to have it mailed to you.
- Visit an [SDI Office](#).
- Call 1-800-480-3287 to have a paper application mailed to you.
- Get the application from your physician/practitioner or employer.

Important: This form can't be downloaded and printed. It must be an original form.

SAMPLE, this page for reference only

EDD Employment Development Department
STATE OF CALIFORNIA

Application for Disability Insurance Benefits

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Social Security Number 0000000000

Claimant Name (First) (M) (Last)
S a m p l e C l a i m a n t

I authorize
G o f f B o c k e r

(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 164.506(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

DE 2501 Rev. 82 (10-24) (INTERNET) Page 7 of 13

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

Complete the *Application for Disability Insurance Benefits* (DE 2501) to apply for disability benefits

Your application is complete when you submit both parts of the DE 2501:

- Part A - Claimant's Statement pages 1-4
- Part B - Physician/Practitioner's Medical Certificate pages 5-7

Important

If you already applied online, do not file a paper application. It can delay benefits.

SAMPLE, this page for reference only

EDD Employment Development Department
State of California

Application for Disability Insurance Benefits

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Social Security Number

Claimant Name (First) (M) (Last)

I authorize

(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

DE 2501 Rev. 82 (10-24) (INTERNET) Page 7 of 13

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

To avoid delays when completing your paper claim form

Do

- Use black ink only.
- Type or write clearly **within** the boxes provided.
- Mail the completed form in the pre-addressed envelope provided.

Don't

- Do not send photocopied or faxed forms.
- Do not mail the paper form if you already filed a claim online.



SAMPLE, this page for reference only

Application for Disability Insurance Benefits

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Social Security Number

Claimant Name (First) (MI) (Last)

I authorize

(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) Date signed

Application for Disability Insurance Benefits (DE 2501) – Page 1

This is your Health Insurance Portability and Accountability Act (HIPAA) Authorization.

- Enter the name of your physician/practitioner.
- Sign and date the HIPAA Authorization.

You must complete all questions.

Note

The application comes with important claim information, filing instructions, and debit card fee disclosures.

Review all information before completing your paper claim form.

Print with black ink.

Part A - Claimant's Statement

A1. Your Social Security Number

00000000

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

Sample

A9. If you have worked under an agency contract, enter the agency name (First, Middle, Last, Suffix)

(First) (Middle) (Last) (Suffix)

A10. Your home phone number and area code

999 0236789

A11. Your cell phone number and area code

111 0020047

A12. Language you prefer to use

English ☒ 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 State Zip or Postal Code Country (if not U.S.A.)

Anytown CA 12345

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. Name of your employer (State Government Employees, please provide the agency name, for example: California)

Roadrunner Pastries

Number, Street, Suite# (State Government Employees, please provide the address of your accounts office)

647 Armistice Way

City State Zip or Postal Code Country (if not U.S.A.)

Anywhere CA 66222

Employer's phone number

499 3111111

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 ☐ 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

MM/DD/YYYY

A20. Since your disability began, have you worked or are you working any full or partial days?

Yes ☐ No ☒

A21 A. If you recovered, enter the date you recovered:

MM/DD/YYYY

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

MM/DD/YYYY

Your disability claim can also be filed online at www.edd.ca.gov

PLEASE PRINT WITH BLACK INK.

PART A - CLAIMANT'S STATEMENT

A1. YOUR SOCIAL SECURITY NUMBER

0000000000

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 FEMALE

X

A5. IF YOU EVER USED OTHER SOCIAL SECURITY NUMBERS, ENTER THOSE NUMBERS BELOW

A6. STATE GOVERNMENT EMPLOYEE (IF "YES" INDICATE BARGAINING UNIT#)

YES ☒ NO ☐ UNIT#

A7. YOUR DATE OF BIRTH

01011900

Application for Disability Insurance Benefits (DE 2501) - Page 2

Part A - Claimant's Statement.

A1 Tip: If you **do not** have a Social Security number **leave question A1 blank**. Or use your ECN if you have a prior claim.

Send proof of your wages (such as copies of your W-2s and paystubs) that cover the last 18 months with your application.

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 0 0 0 0 0 0 0 0 0 0	A2. If you have previously been assigned an EDD customer account number, enter that number here N o	A3. California Driver License or ID number Z 1 2 3 4 5 6 7	A4. Gender Male ☒ Female ☐
A5. If you ever used other Social Security Numbers, enter those numbers below		A6. State government employee (If "yes" indicate bargaining unit #) Yes ☒ No ☐ unit #	
A7. Your date of birth 0 1 0 1 1 9 0 0			
A8. Your full legal name (First) (MI) (Last) Suffix S a m p l e c l a i m a n t			
A9. If you have worked under any other names, enter them here (for example, a maiden name or chosen name) (First) (MI) (Last) Suffix			
A10. Your home phone number and area code 9 9 9 0 2 3 6 7 8 9			
A11. Your cell phone number and area code 1 1 1 0 0 2 0 0 4 7			
A12. Language you prefer to use English ☒ 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) 1 2 3 A n y S t r e e t City Anytown State CA Zip or Postal Code 1 2 3 4 5 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)) R o a d r u n n e r P a s t r i e s NUMBER/STREET/SUITE# (STATE GOVERNMENT EMPLOYEES: PLEASE PROVIDE THE ADDRESS OF YOUR PERSONNEL OFFICE) 6 4 7 A r m i s t i c e W a y City Anywhere State CA Zip or Postal Code 6 6 2 2 2 Country (if not U.S.A.) EMPLOYER'S TELEPHONE NUMBER 4 9 9 3 1 1 1 1 1 1			

Application for Disability Insurance Benefits (DE 2501) - Page 2 cont.

Part A - Claimant's Statement.

A15 Tip: Enter your employer's name and address as shown on your W-2 or paystub.

If you are unsure what address to enter, ask your employer.

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))	
R o a d r u n n e r P a s t r i e s	
NUMBER/STREET/SUITE# (STATE GOVERNMENT EMPLOYEES: PLEASE PROVIDE THE ADDRESS OF YOUR PERSONNEL OFFICE)	
6 4 7 A r m i s t i c e W a y	
CITY	STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)
A n y w h e r e	C A 6 6 2 2 2
EMPLOYER'S TELEPHONE NUMBER	
4 9 9 3 1 1 1 1 1 1	

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 0 0 0 0 0 0 0 0 0 0	A2. If you have previously been assigned an EDD customer account number, enter that number here N o	A3. California Driver License or ID number Z 1 2 3 4 5 6 7	A4. Gender Male Female X	
A5. If you ever used other Social Security Numbers, enter those numbers below		A6. State government employee (If "yes" indicate bargaining unit #) Yes ☒ No ☐ unit #		A7. Your date of birth 0 1 0 1 1 9 0 0
A8. Your full legal name (First) (MI) (Last) Suffix S a m p l e C l a i m a n t				
A9. If you have worked under any other names, enter them here (for example, a maiden name or chosen name) (First) (MI) (Last) Suffix				
A10. Your home phone number and area code 9 9 9 0 2 3 6 7 8 9		A11. Your cell phone number and area code 1 1 1 0 0 2 0 0 4 7		
A12. Language you prefer to use English ☒ 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) 1 2 3 A n y S t r e e t City: A n y t o w n State: C A Zip or Postal Code: 1 2 3 4 5 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) R o a d r u n n e r P a s t r i e s Number, Street, Suite# (State Government Employees, please provide the address of your assigned office) 6 4 7 A r m i s t i c e W a y City: State: Zip or Postal Code: Country (if not U.S.A.): A n y w h e r e				

Application for Disability Insurance Benefits (DE 2501) - Page 2 cont.

Part A - Claimant's Statement.

A17 Tip: Enter the last day you worked your regular schedule before your disability started.

A18 Tip: Enter the day your disability started.

A19 Tip: Leave blank if you want your claim to start the same date entered in A18. Only enter a date if you want your claim to begin on a different day. For example, your disability is work related and worker's compensation payments ended, but you are still disabled.

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 ☒ NO	A17. BEFORE YOUR DISABILITY BEGAN, WHAT WAS THE LAST DAY YOU WORKED? 1 2 0 1 2 0 1 5
A18. WHEN DID YOUR DISABILITY BEGIN? 1 2 1 6 2 0 1 5	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 ☒ NO	A21 A. IF YOU RECOVERED, ENTER DATE: M M D D Y Y Y Y
	A21 B. IF YOU RETURNED TO WORK, ENTER DATE: M M D D Y Y Y Y

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 0 0 0 0 0 0 0 0 0 0	A2. If you have previously been assigned an EDD customer account number, enter that number here N o	A3. California Driver License or ID number Z 1 2 3 4 5 6 7	A4. Gender Male Female X	
A5. If you ever used other Social Security Numbers, enter those numbers below		A6. State government employee (If "yes" indicate bargaining unit #) Yes ☒ No ☐ unit #		A7. Your date of birth 0 1 0 1 1 9 0 0
A8. Your full legal name (First) (MI) (Last) Suffix S a m p l e C l a i m a n t				
A9. If you have worked under any other names, enter them here (for example, a maiden name or chosen name) (First) (MI) (Last) Suffix				
A10. Your home phone number and area code 9 9 9 0 2 3 6 7 8 9		A11. Your cell phone number and area code 1 1 1 0 0 2 0 0 4 7		
A12. Language you prefer to use English ☒ 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) 1 2 3 A n y S t r e e t City: A n y t o w n State: C A Zip or Postal Code: 1 2 3 4 5 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. Name of your employer (State Government Employees provide the agency name, for example, CalTrans) ☐ Self R o a d r u n n e r P a s t r i e s Number, Street, Suite# (State Government Employees, please provide the address of your assigned office) 6 4 7 A r m i s t i c e W a y City: A n y w h e r e State: Zip or Postal Code: Country (if not U.S.A.) Employer's phone number				

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 ☐ NO ☒

A18. WHEN DID YOUR DISABILITY BEGIN?

1 2 1 6 2 0 1 5

A20. SINCE YOUR DISABILITY BEGAN, HAVE YOU WORKED OR ARE YOU WORKING ANY FULL OR PARTIAL DAYS?

YES ☐ NO ☒

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

M M D D Y Y Y Y

A21 A. IF YOU RECOVERED, ENTER DATE:

M M D D Y Y Y Y

A17. BEFORE YOUR DISABILITY BEGAN, WHAT WAS THE LAST DAY YOU WORKED?

1 2 0 1 2 0 1 5

A21 B. IF YOU RETURNED TO WORK, ENTER DATE:

M M D D Y Y Y Y

Application for Disability Insurance Benefits (DE 2501) Page 2 cont.

Part A - Claimant's Statement.

A20 Tip: If you are working a reduced work schedule while disabled select **Yes**.

A21 A - A21 B Tip: Only enter a recover or return to work date if you have recovered or returned to work. **Do not** enter future dates.

SAMPLE, this page for reference only

Application for Disability Insurance Benefits (DE 2501) Page 3

Part A - Claimant's Statement (continued).

A24 Tip: Tell us why you stopped working. If it was because of your disability, select **illness, injury, or pregnancy**. If you left work for reasons other than your disability, select the appropriate box.

A26 Tip: If your employer continues to pay you while getting disability benefits, select the type of pay. If your employer will supplement benefits with your paid leave, select **other** and write in "integrate." If not, select the appropriate box.

Part A - Claimant's statement - continued

A22. Enter your Social Security Number

A23. What is your regular or customary occupation?

A24. Why did you stop working? (Select only one box)

☐ Layoff ☐ Unpaid Leave Of Absence ☐ Voluntarily Quit Or Retired ☒ Illness, Injury, Or Pregnancy ☐ Terminated ☐ Other Reason

A24. WHY DID YOU STOP WORKING? (SELECT ONLY ONE BOX) ☒ ILLNESS, INJURY, OR PREGNANCY

☐ LAYOFF ☐ UNPAID LEAVE OF ABSENCE ☐ VOLUNTARILY QUIT OR RETIRED ☐ TERMINATED ☐ OTHER REASON

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/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.

☒ 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)

NUMBER/STREET/SUITE#

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

BEFORE YOUR DISABILITY BEGAN, WHAT WAS THE LAST DAY YOU WORKED FOR THIS EMPLOYER? EMPLOYER'S TELEPHONE 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 TELEPHONE 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

SAMPLE, this page for reference only

Application for Disability Insurance Benefits (DE 2501) Page 3 cont.

Part A - Claimant's Statement (continued).

A27 Tip: If your employer supplements benefits with your paid leave, they can only get payment information from us if you select **Yes**. We will not release confidential claim information.

A31 – A 32 Tip: Do not forget to answer both questions. If the disability is not work related, select **No** to both.

Part A - Claimant's statement - continued
A22. Enter your Social Security Number 0000000000

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 ☒ Illness, Injury, or Pregnancy ☐ Terminated ☐ Other Reason

A24. WHY DID YOU STOP WORKING? (SELECT ONLY ONE BOX)
☐ LAYOFF ☐ UNPAID LEAVE OF ABSENCE ☐ VOLUNTARILY QUIT OR RETIRED ☒ ILLNESS, INJURY, OR PREGNANCY ☐ TERMINATED ☐ OTHER REASON

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/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.
☒ 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 STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)
Bluebell CA 84369
BEFORE YOUR DISABILITY BEGAN, WHAT WAS THE LAST DAY YOU WORKED FOR THIS EMPLOYER? EMPLOYER'S TELEPHONE NUMBER
12162015

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 TELEPHONE 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

SAMPLE, this page for reference only

Application for Disability Insurance Benefits (DE 2501) Page 4

Part A - Claimant's Statement
(continued).

A39 – A40 Tip: Make sure to select how you want to get payment and sign the form. We cannot process your claim without a signature.

Part A - Claimant's Statement - continued

A35. Enter your Social Security Number

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)) Samela Claimant Date signed

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.

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

I, , 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

SAMPLE, this page for reference only

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 0 0 0 0 0 0 0 0 0 0	B2. Patient's file number 6 9 - 6 4 2 - 3 8
B3. If you know the patient's electronic receipt number, enter it here: R	B4. Patient's date of birth 0 1 0 1 1 9 0 0
B5. Patient's name (First) (MI) (Last) S a m p l e C l a i m a n t	
B6. Physician or Practitioner's license number 6 3 4 - 0 2 7 9 3 0	B7. State or country (Not U.S.A.) that issued license number entered in B6 State C A Country
B8. Physician or Practitioner's license type M D	B9. Specialty (if any)
B10. Physician or Practitioner's name as shown on license (First) (MI) (Last) Suffix G e o f f B o o k e r	
B11. Physician or Practitioner's address Mailing Address, PO Box or Number, Street, Suite 2 6 9 C o m m e r c e City State Zip or Postal Code Country (if Not U.S.A.) A n y w h e r e C A 7 2 6 9 4 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 0 1 2 5 2 0 2 5 To M M M M M M M M M M ☒ Check here to indicate you are still treating the patient At intervals of: ☐ Daily ☐ Weekly ☒ Monthly ☐ As Needed ☐ Other	
B13. At any time during your attendance for this medical problem, has the patient been incapable of performing their regular or customary work? ☒ Yes - enter date disability began 0 1 2 5 2 0 2 5 ☐ No - skip to B33 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) M M M M M M M M M M ☐ 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: M M M M M M M M M M Date pregnancy ended: M M M M M M M M M M Type of delivery, if patient has delivered: ☐ Vaginal ☐ Cesarean	

Application for Disability Insurance Benefits (DE 2501) Pages 5-7

Part B - Physician/Practitioner's Certificate.

Your physician/practitioner must complete all information including:

- Treatment dates
- Diagnosis.
- ICD medical codes.
- Signing the certification.

If you completed your application online:

Enter the Receipt Number provided on your Confirmation screen in question B3 and give the form to your doctor.

If your doctor will complete their part online:

Send your claim form to us first and allow 5 business days for mailing. Then, contact your doctor and they can complete their medical certificate through SDI Online.

Mail in your completed application

Use the pre-addressed envelope to mail to:

State of California
Employment Development Department
PO Box 989777
West Sacramento, CA 95798-9777

Do not submit the same claim more than once. This can delay your benefits.

Allow at least 14 days for processing once we get Part A and Part B of the DE 2501 form.

EDD Employment Development Department
STATE OF CALIFORNIA

SAMPLE, this page for reference only
Application for Disability Insurance Benefits

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Social Security Number: 0000000000

Claimant Name (First) (Last)
SAMPLE CLAIMANT

I authorize
GOLF BLOCK

(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 926680, 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

DE 2501 Rev. 82 (10-24) (INTERNET) Page 7 of 13

SAMPLE
Application for Disability Insurance Benefits (DE 2501)

CONTACT US

1-800-480-3287

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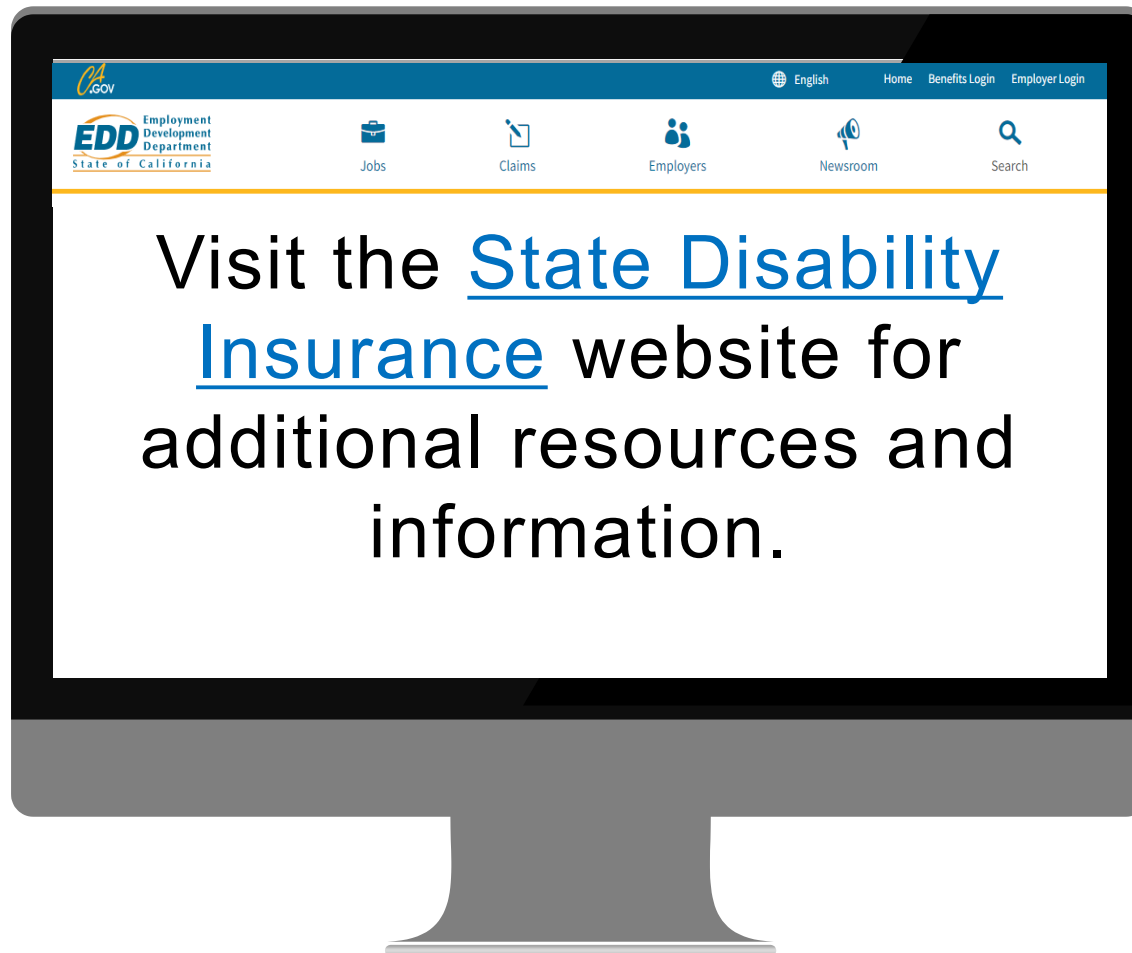
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The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and alternate formats need to be made by calling 1-866-490-8879 (voice), or through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