SDI ONLINE TUTORIAL

File Your Disability Claim Paper Application

Last Updated: September 2026

Complete a Paper Application

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

Get Started

Paper Claim Forms

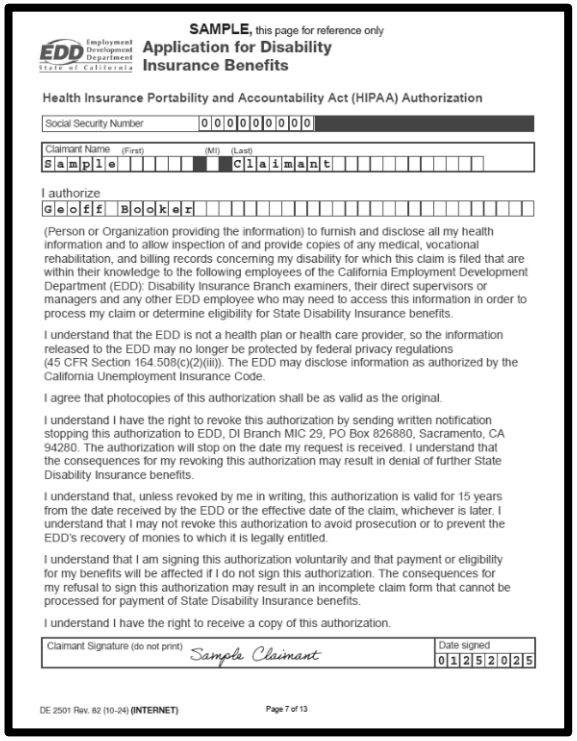
You should file a paper application if you:

- 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: 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: 01252025

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

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

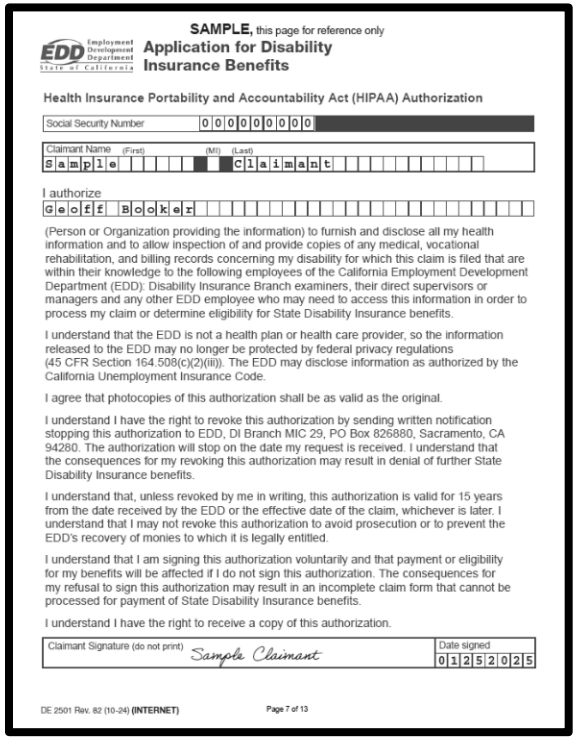
Complete the *Application for Disability Insurance Benefits* (DE 2501) to apply for disability benefits

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: 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: 01252025

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

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

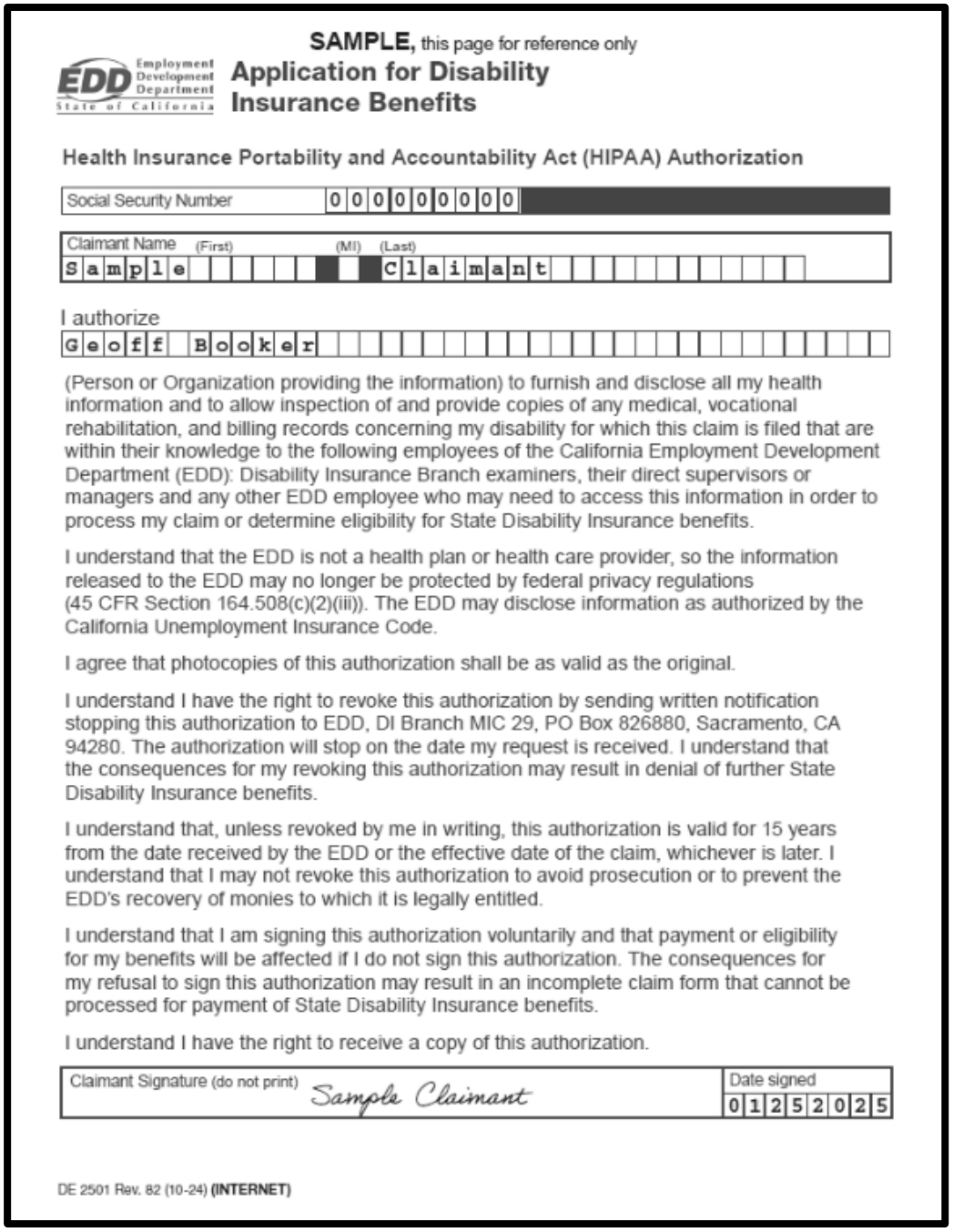
To avoid delays when completing your paper claim form

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

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: 01252025

DE 2501 Rev. 82 (10-24) **(INTERNET)**

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

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

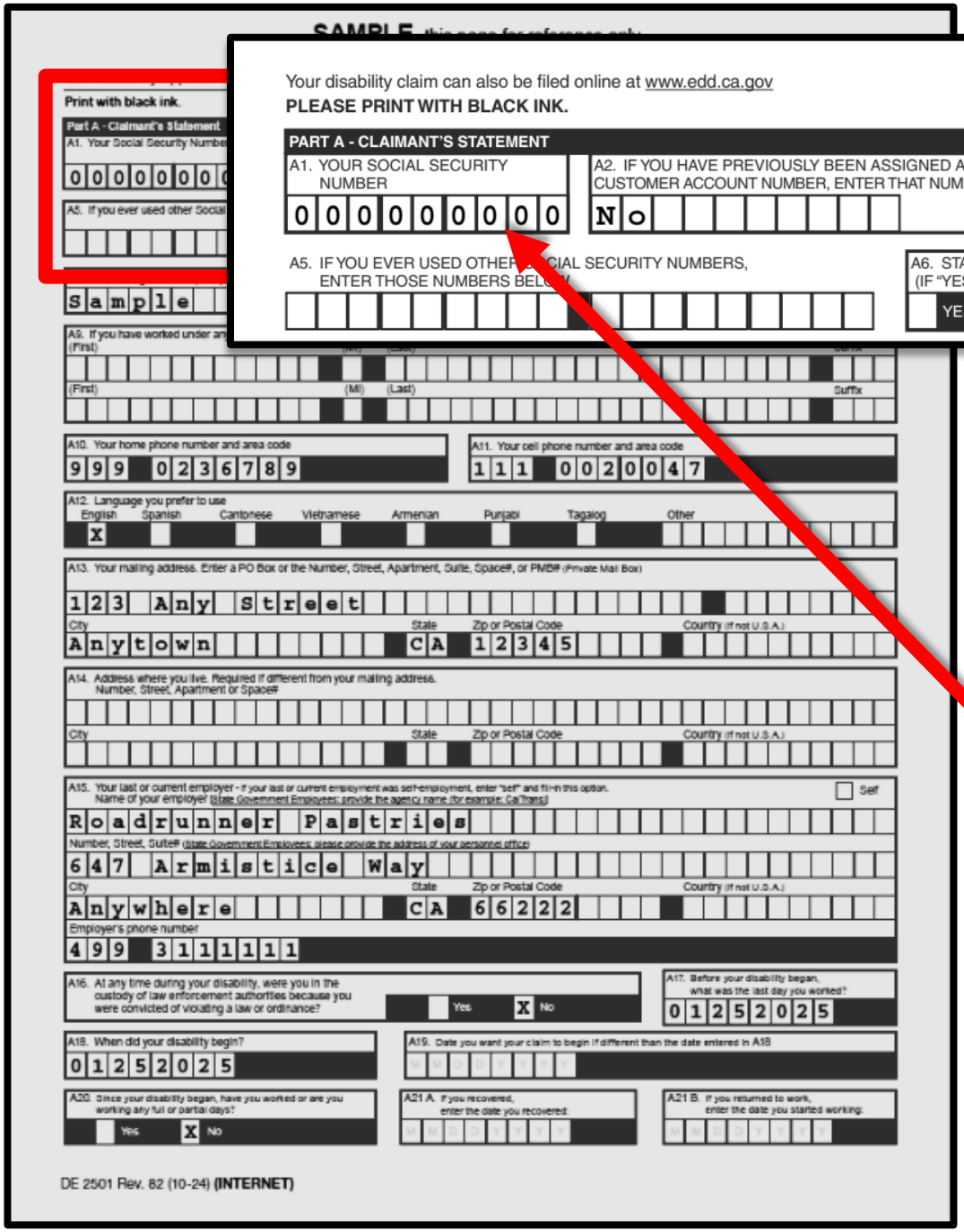
- Enter the name of your physician/practitioner.
- Sign and date the HIPAA Authorization.

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.

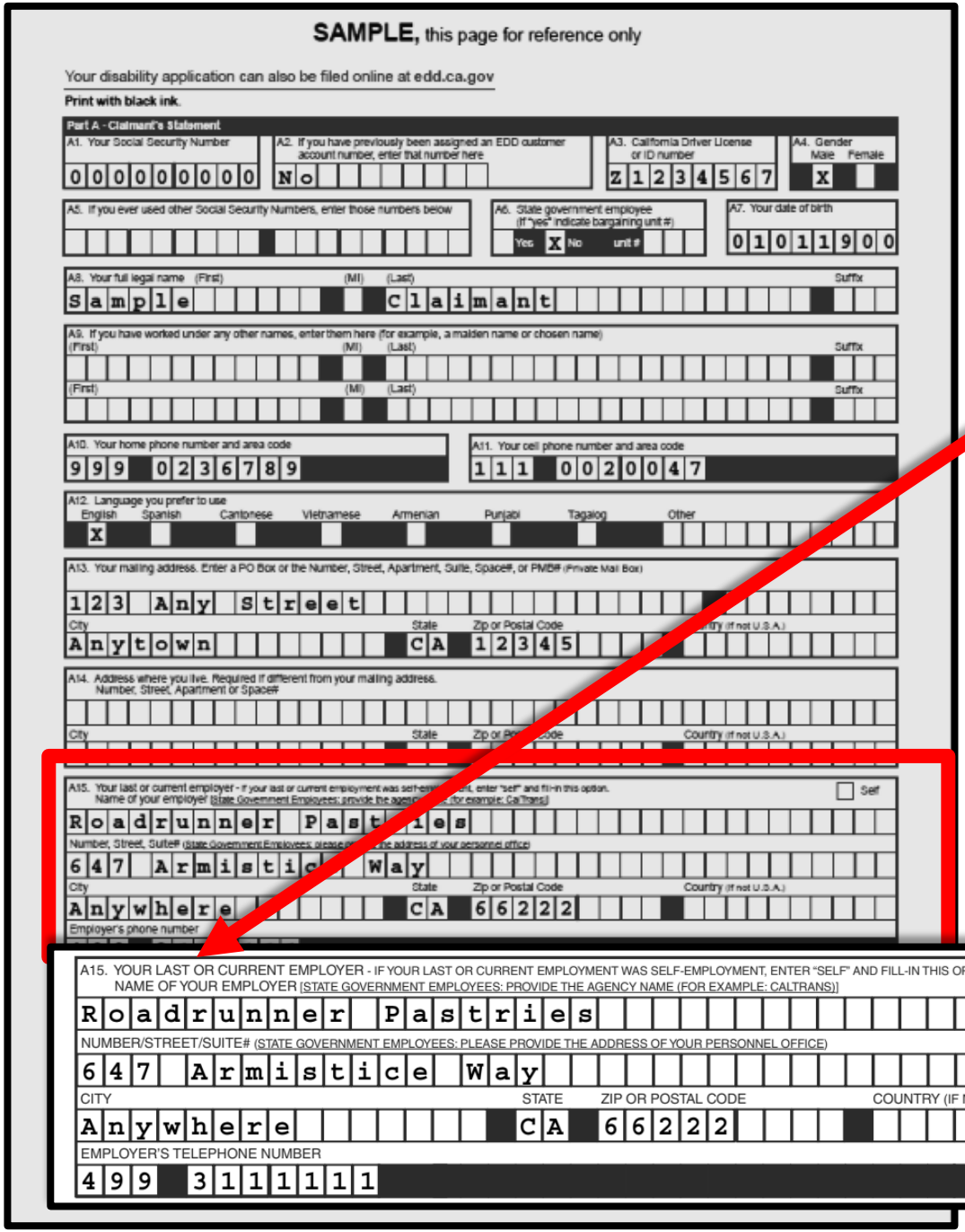


***Application for Disability Insurance Benefits* (DE 2501) - Page 2**

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.

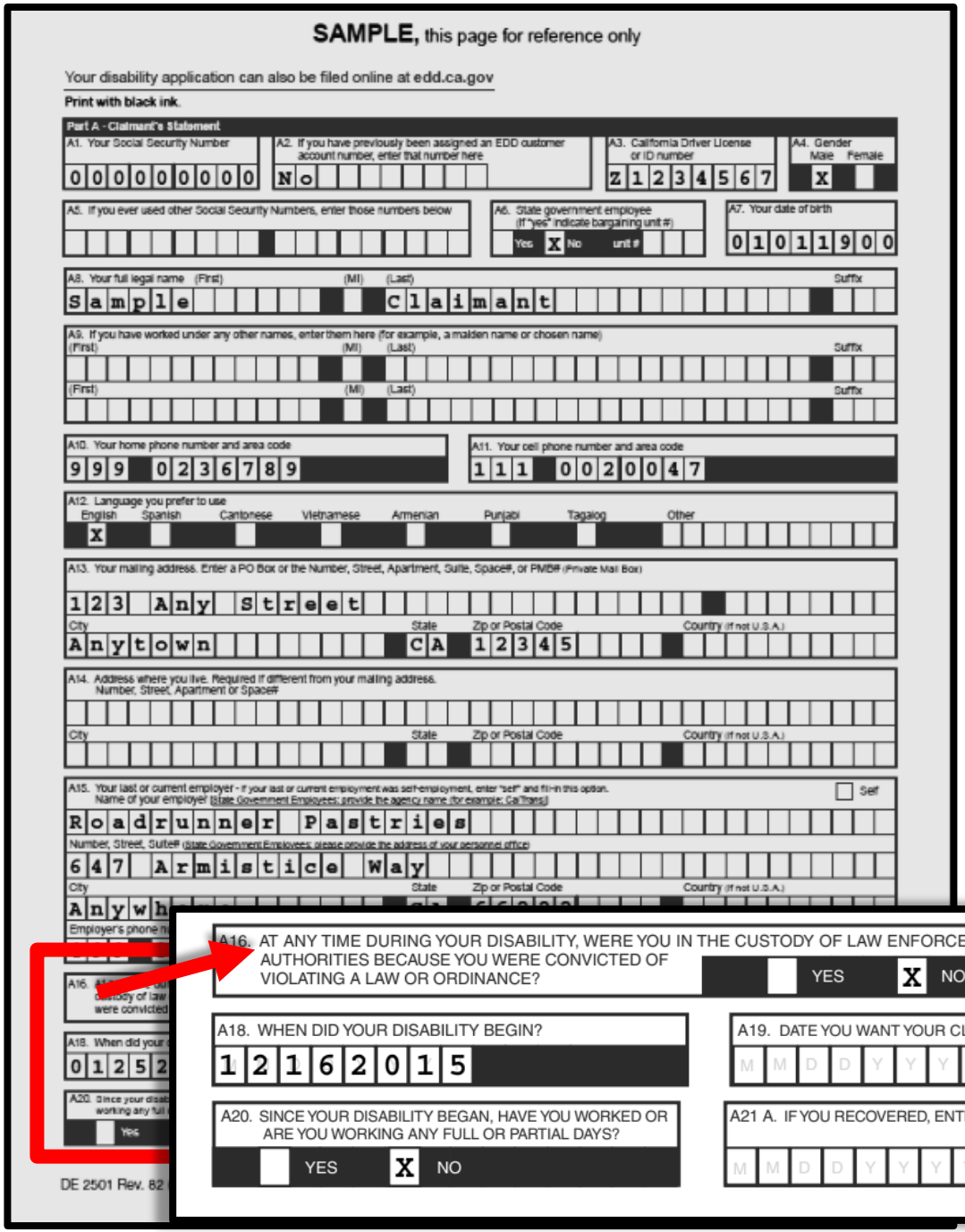


***Application for Disability Insurance Benefits* (DE 2501) - Page 2 cont.**

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.



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

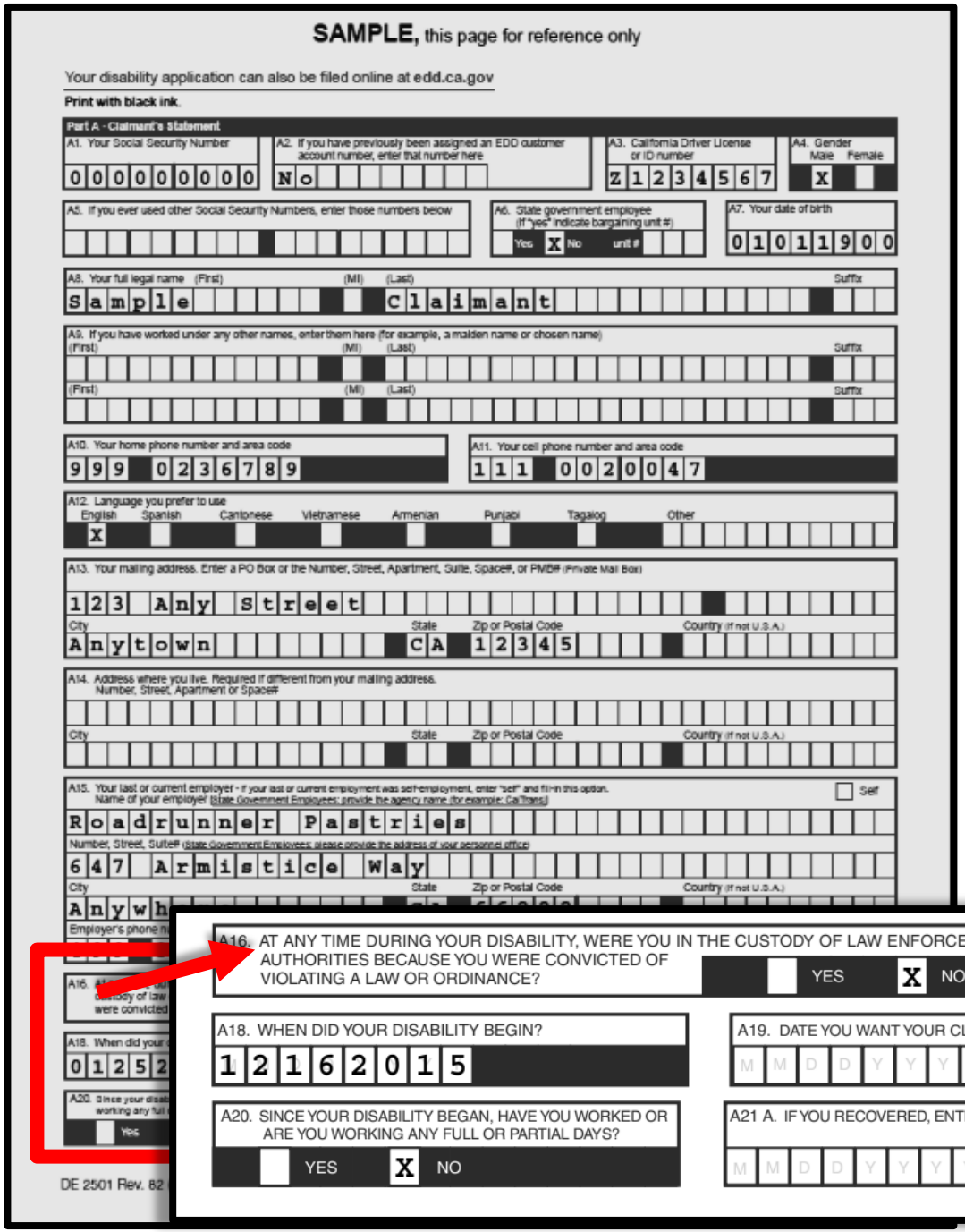
Part A - Claimant's Statement.

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.

.

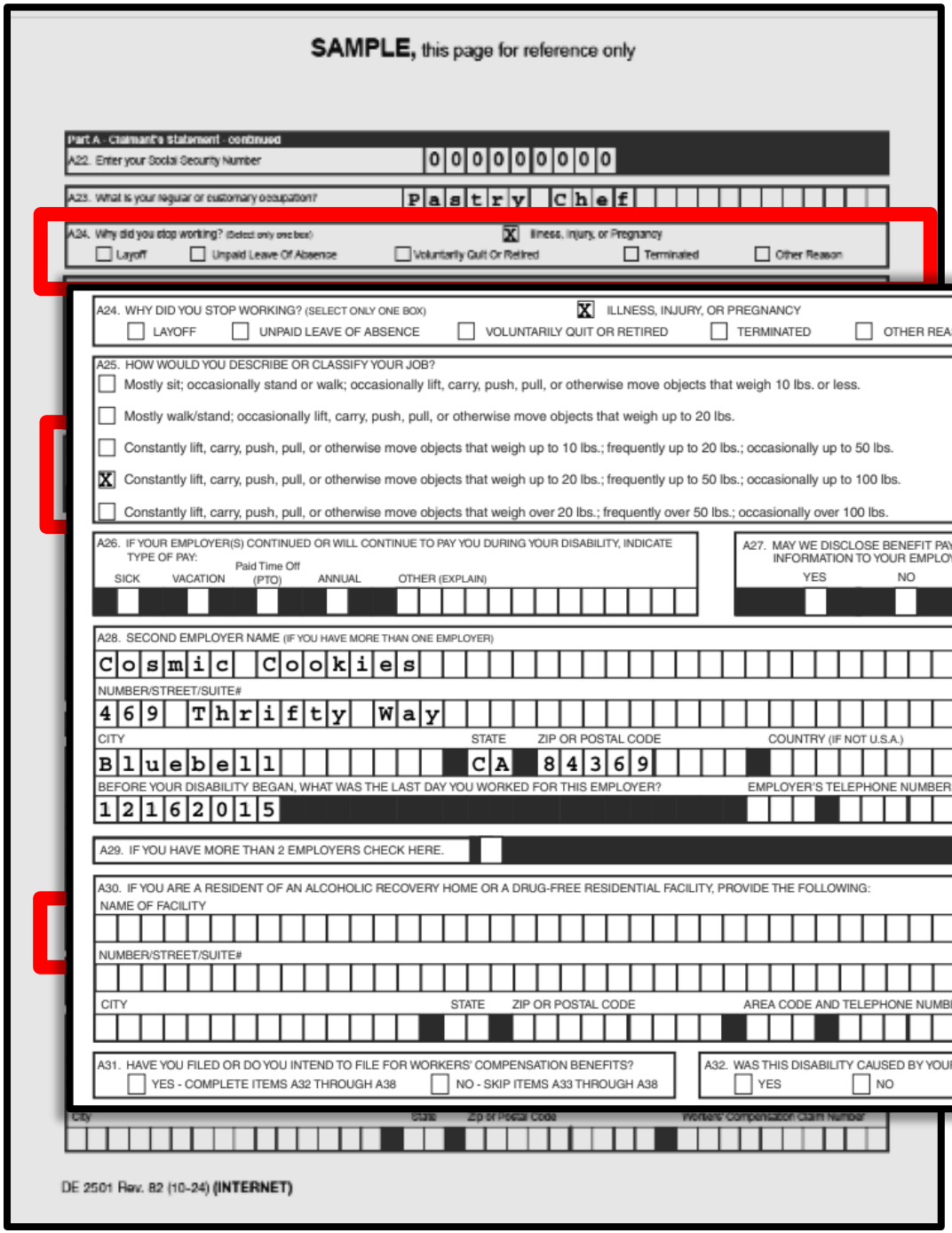


Application for Disability Insurance Benefits (DE 2501) Page 2 cont.

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.



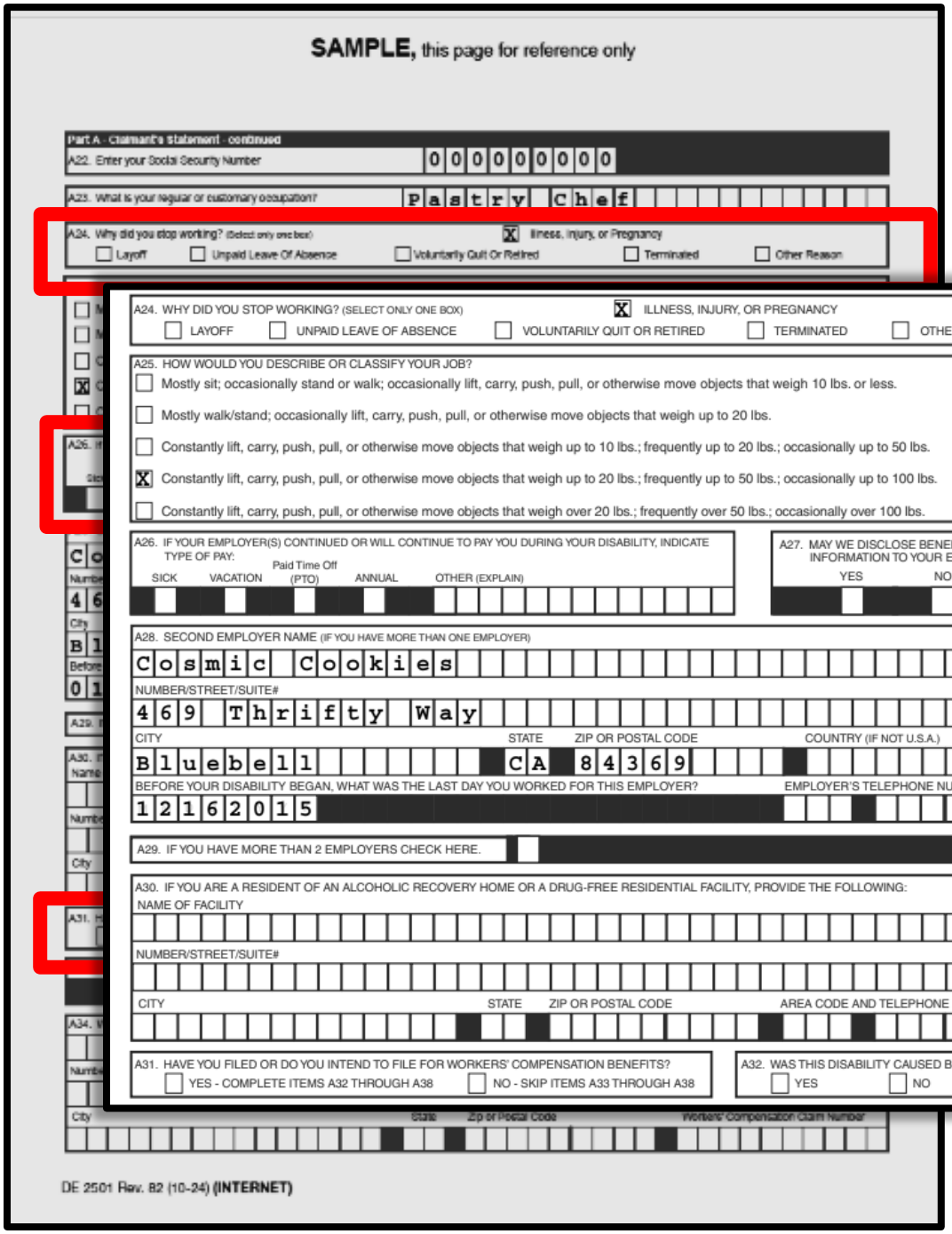
Application for Disability Insurance Benefits (DE 2501) Page 3

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.

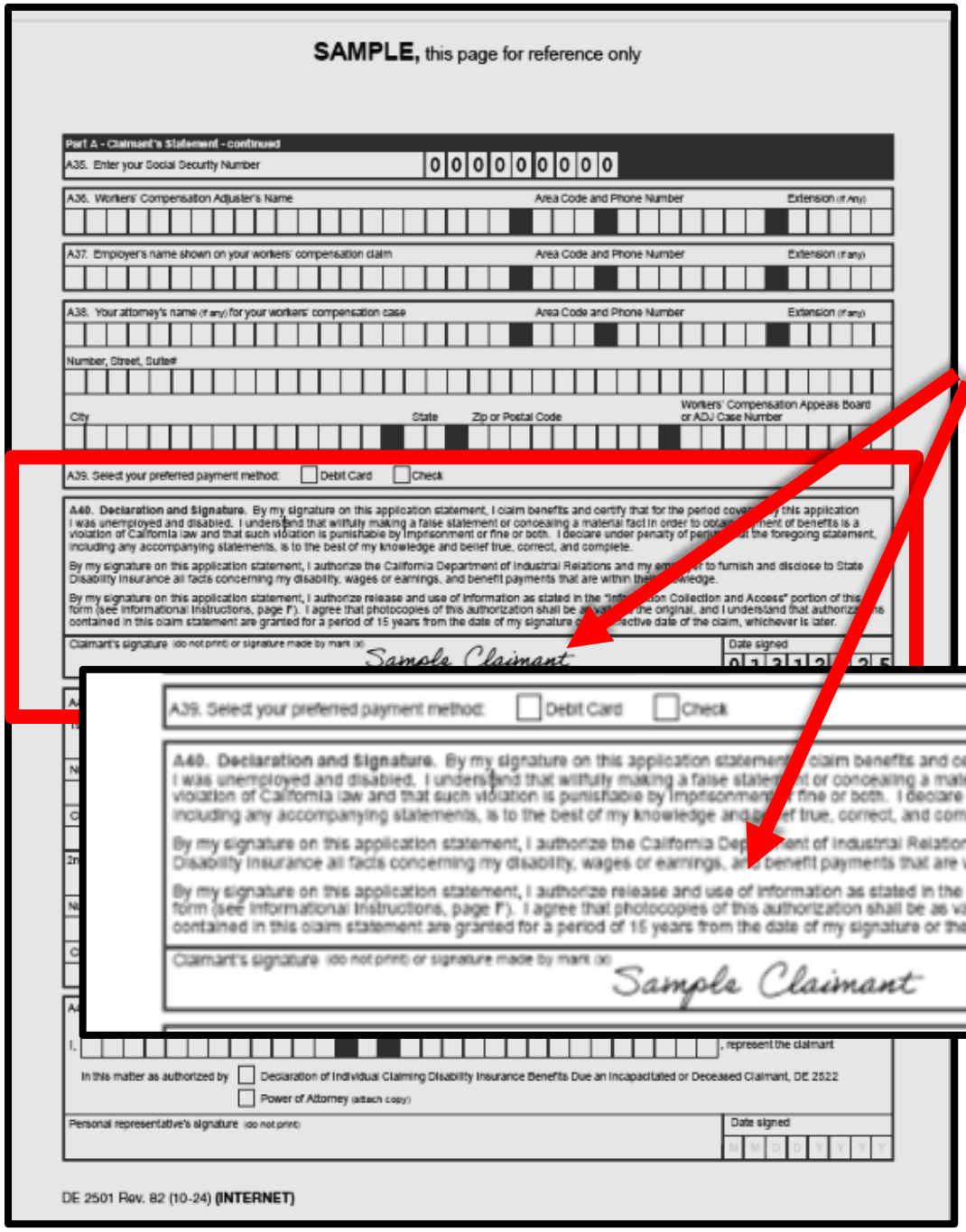
Application for Disability Insurance Benefits (DE 2501) Page 3 cont.



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.

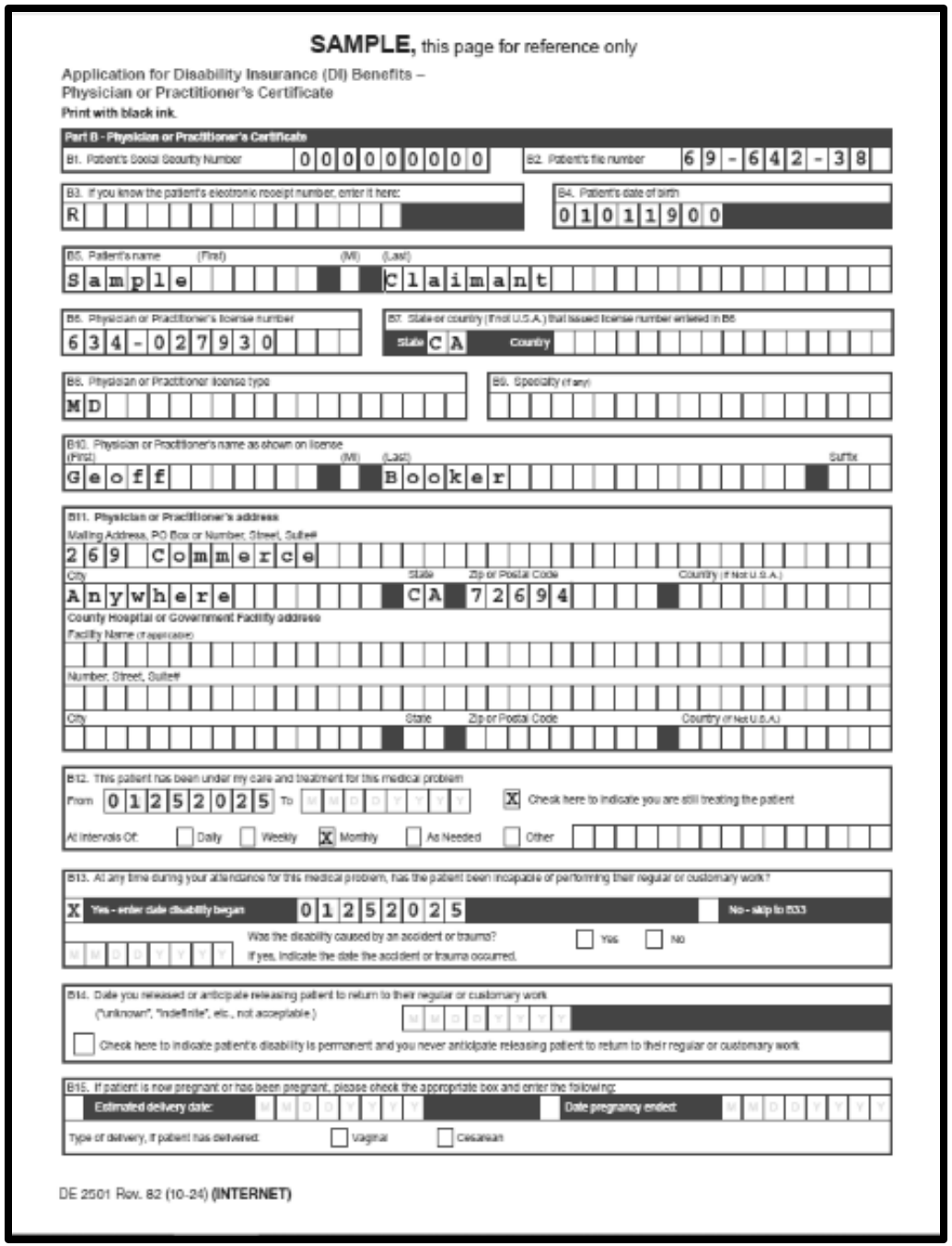
A31 – A 32 Tip: Do not forget to answer both questions. If the disability is not work related, select **No** to both.



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.



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: 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
Was the disability caused by an accident or trauma? [ ] Yes [ ] No
If yes, indicate the date the accident or trauma occurred. MMDDYYYY

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

DE 2501 Rev. 82 (10-24) **(INTERNET)**

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.

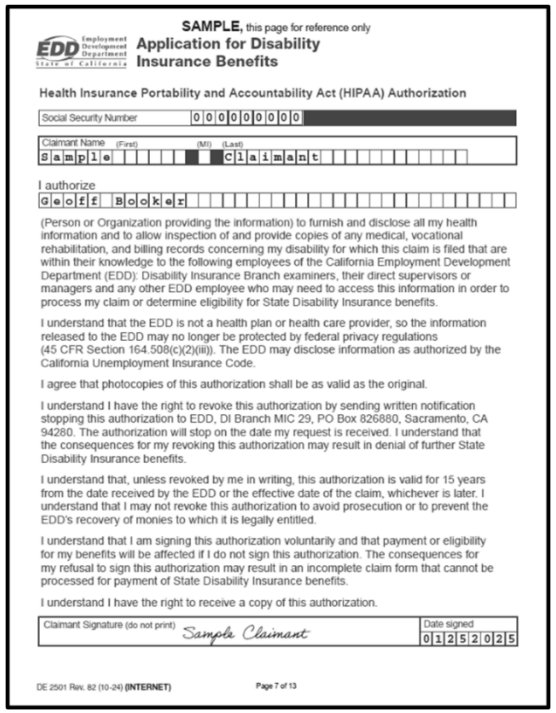
Mail in your completed application

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.



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: 000000000

Claimant Name (First) (MI) (Last): Sample C 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: 01252025

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

– Helpful Links –

Order Forms

Schedule a Webinar

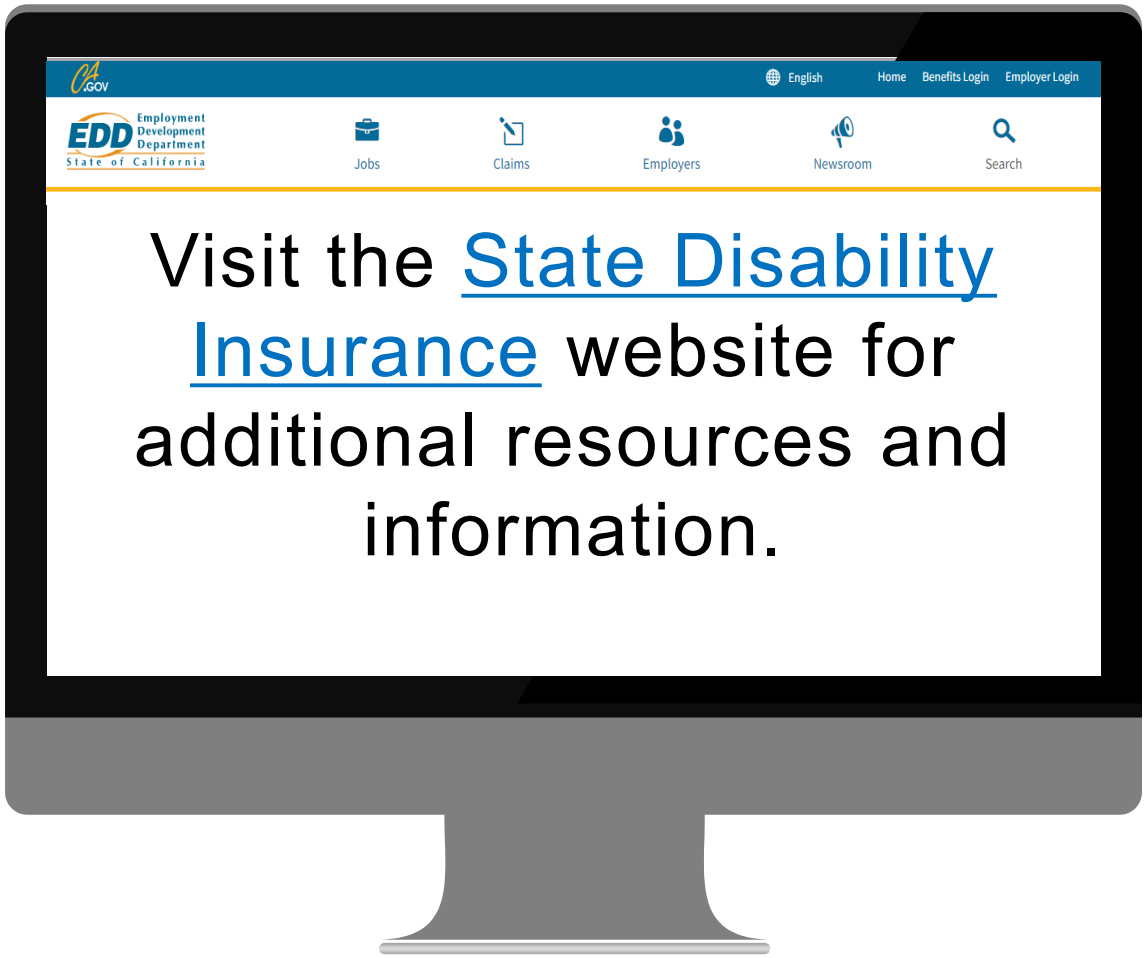
Help Fight Fraud

Contact Us

Accessibility

Language Resources

– Follow us –



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.