SDI ONLINE TUTORIAL

File a Paid Family Leave Application by Mail

Last Updated: September 2026

Completing Paper Applications

Learn more about how to complete your paper application for bonding, care, or military assist benefits.

Get Started

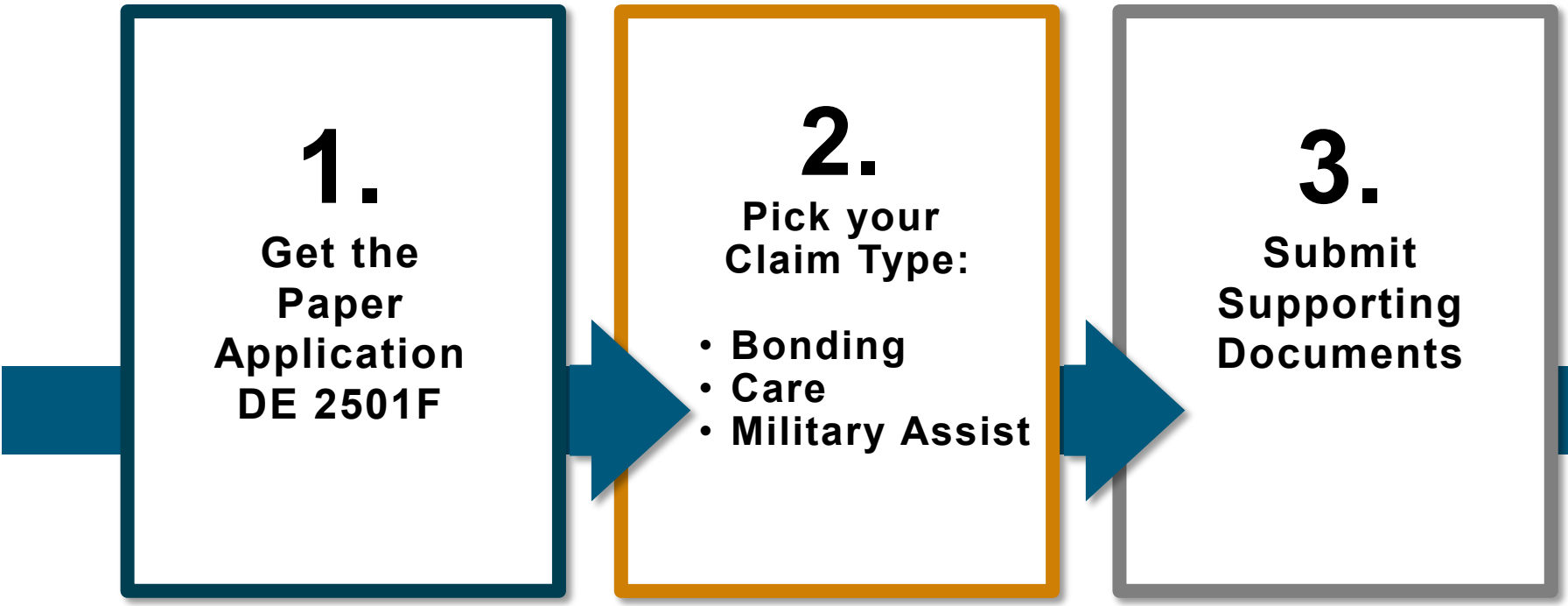
Paper Applications

If any of the following apply, you should file a paper application instead of filing online:

- You do not have a valid California driver license or ID.
- You do not have a valid SSN.
- You have a name that does not fit the space in the online form.
- You had a recent name change.
- You received an error code you cannot resolve or have any other difficulty filing an application online.
  - For technical help applying online, call 1-877-238-4373. Select your language option and then **option 2, option 4, then press 0 to speak with a person.** Make sure you listen to the recorded directions.

Get Started

How to apply for benefits by mail



Important

If you already applied online, do not send a paper claim form. It can delay claim processing.

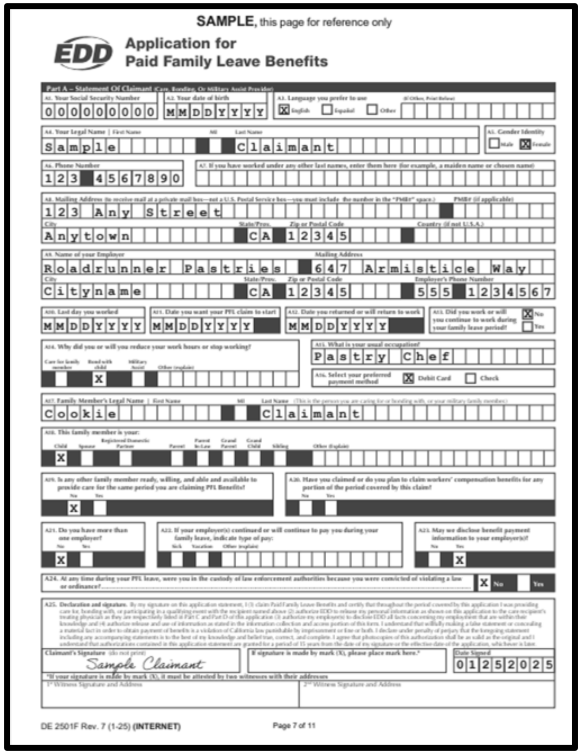
Get the *Application for Paid Family Leave Benefits* (DE 2501F)

- Order an application online to have it mailed to you.
- Visit an SDI Office.
- Call 1-877-238-4373 to request a paper application be mailed to you.
- Get the application from your employer or physician/practitioner.

It may take up to 10 days to get your application in the mail.

Note

New mothers applying for bonding after a pregnancy-related disability claim: A *Claim for Paid Family Leave (PFL) Benefits – New Mother* (DE 2501FP) form is automatically sent to you with your final disability payment.


SAMPLE, this page for reference only

EDD Application for Paid Family Leave Benefits

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SAMPLE
Application for Paid Family Leave Benefits (DE 2501F)

To avoid processing 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.

Application for Paid Family Leave Benefits (DE 2501F) - Page 1

Part A - Statement of Claimant:

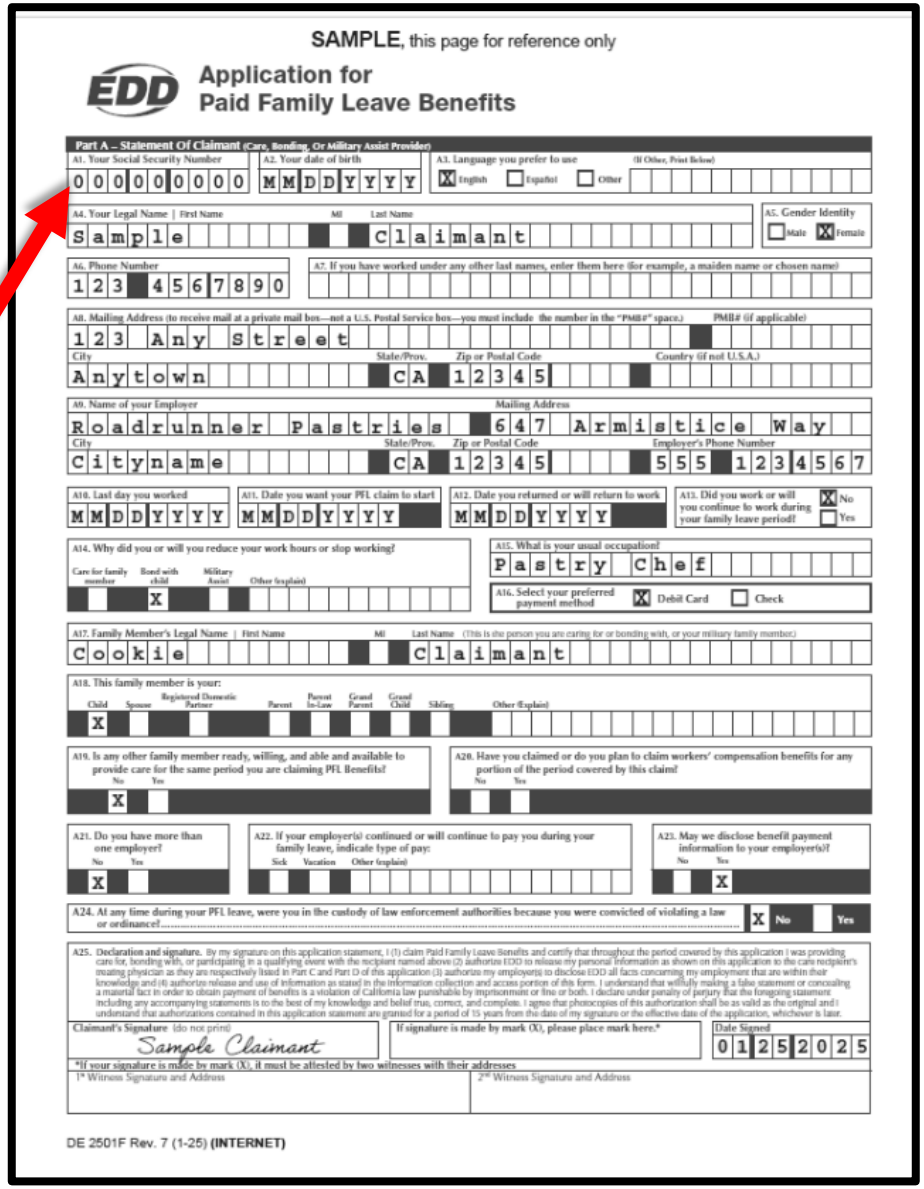
- Complete all related information, including your personal information, last day worked and employer information. Make sure to sign and date the form.

Part A is needed for all Paid Family Leave claim types:

- Bonding
- Care
- Military assist

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.



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EDD Application for Paid Family Leave Benefits

Part A – Statement Of Claimant (Care, Bonding, Or Military Assist Provider)

A1. Your Social Security Number: 000000000 | A2. Your date of birth: MM DD YYYY | A3. Language you prefer to use: [X] English [ ] Español [ ] Other

A4. Your Legal Name | First Name: Sample | MI | Last Name: Claimant | A5. Gender Identity: [ ] Male [X] Female

A6. Phone Number: 123 4567890 | A7. If you have worked under any other last names, enter them here (for example, a maiden name or chosen name)

A8. Mailing Address (to receive mail at a private mail box—not a U.S. Postal Service box—you must include the number in the "PMB#" space.) | PMB# (if applicable)
123 Any Street
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: Cityname | State/Prov.: CA | Zip or Postal Code: 12345 | Employer's Phone Number: 5555 1234567

A10. Last day you worked: MM DD YYYY | A11. Date you want your PFL claim to start: MM DD YYYY | A12. Date you returned or will return to work: MM DD YYYY | A13. Did you work or will you continue to work during your family leave period? [X] No [ ] Yes

A14. Why did you or will you reduce your work hours or stop working? Care for family member: X | Bond with child | Military Assist | Other (explain)

A15. What is your usual occupation? Pastry Chef

A16. Select your preferred payment method: [X] Debit Card [ ] Check

A17. Family Member's Legal Name | First Name: Cookie | MI | Last Name: Claimant (This is the person you are caring for or bonding with, or your military family member.)

A18. This family member is your: Child: X | Spouse | Registered Domestic Partner | Parent | Parent In-Law | Grand Parent | Grand Child | Sibling | Other (Explain)

A19. 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

A20. Have you claimed or do you plan to claim workers' compensation benefits for any portion of the period covered by this claim? No | Yes

A21. Do you have more than one employer? No: X | Yes

A22. If your employer(s) continued or will continue to pay you during your family leave, indicate type of pay: Sick | Vacation | Other (explain)

A23. May we disclose benefit payment information to your employer(s)? No | Yes: X

A24. 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? [X] No [ ] Yes

A25. Declaration and signature. By my signature on this application statement, I (1) claim Paid Family Leave Benefits and certify that throughout the period covered by this application I was providing care for, bonding with, or participating in a qualifying event with the recipient named above (2) authorize EDD to release my personal information as shown on this application to the care recipient's treating physician as they are respectively listed in Part C and Part D of this application (3) authorize my employer(s) to disclose 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 application statement are granted for a period of 15 years from the date of my signature or the effective date of the application, whichever is later.

Claimant's Signature (do not print): Sample Claimant | If signature is made by mark (X), please place mark here.* | Date Signed: 01 25 2025

*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

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Application for Paid Family Leave Benefits (DE 2501F) - Page 2

Bonding Claims

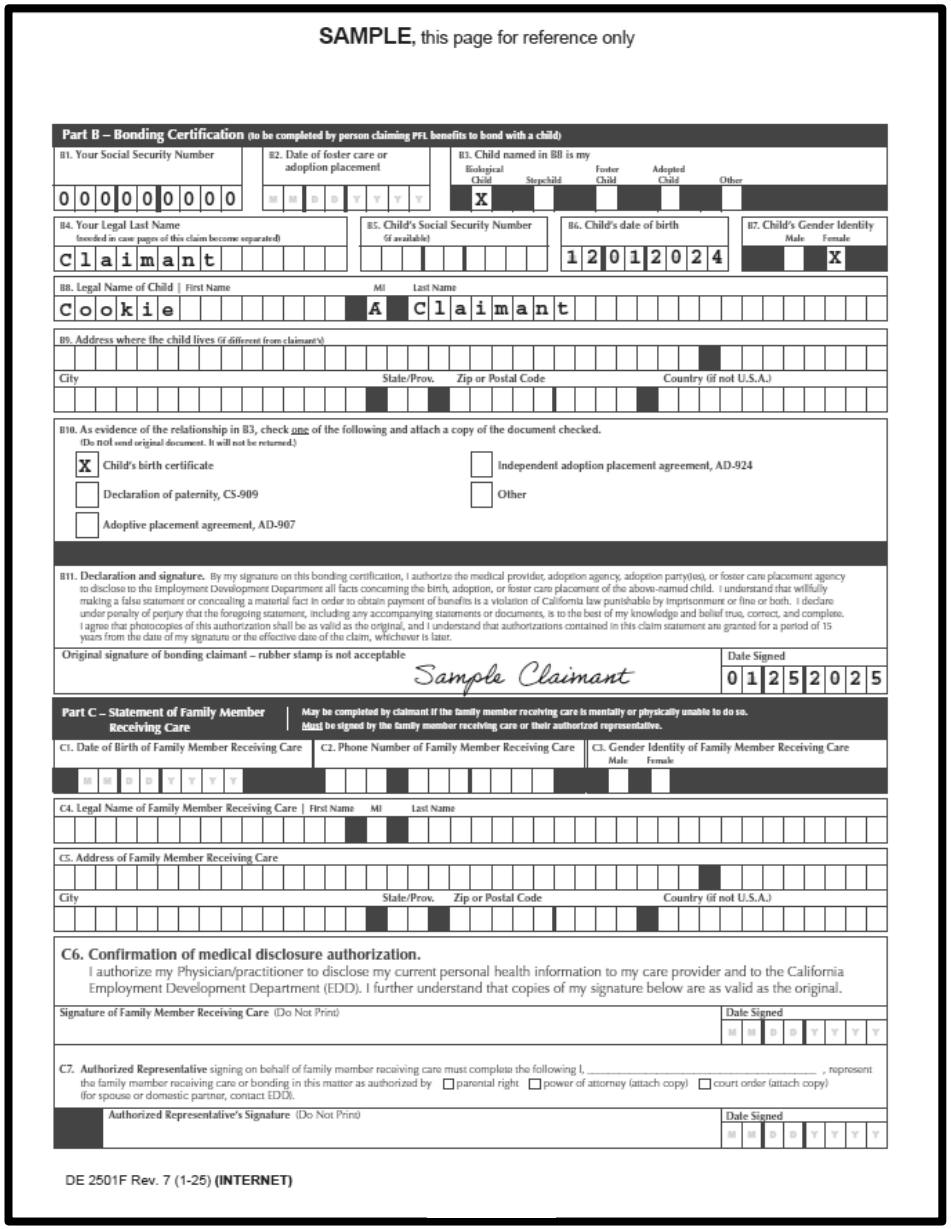
Part B - Bonding Certification:

- If you are filing a bonding claim, you must complete this section and sign the form.
- Attach your Proof of Relationship supporting documents. (B10)

Complete either Part B or Part C – **but never both** sections for one claim.

Note

Part B and Part C are not needed for military assist claims.



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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, Stepchild, Foster Child, Adopted Child, Other — X

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: 12012024

B7. Child's Gender Identity: Male, Female — X

B8. Legal Name of Child | First Name: Cookie | MI: A | Last Name: Claimant

B9. Address where the child lives (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
- [ ] Declaration of paternity, CS-909
- [ ] Adoptive placement agreement, AD-907
- [ ] Independent adoption placement agreement, AD-924
- [ ] 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 15 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: 01252025

Part C – Statement of Family Member Receiving Care | May be completed by claimant if the family member receiving care is mentally or physically unable to do so. Must be signed by the family member receiving care or their authorized representative.

C1. Date of Birth of Family Member Receiving Care | C2. Phone Number of Family Member Receiving Care | C3. Gender Identity of Family Member Receiving Care: Male, Female

C4. Legal Name of Family Member Receiving Care | First Name | MI | Last Name

C5. Address of Family Member Receiving Care

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

C6. Confirmation of medical disclosure authorization.
I authorize my Physician/practitioner to disclose my current personal health information to my care provider and to the California Employment Development Department (EDD). I further understand that copies of my signature below are as valid as the original.

Signature of Family Member Receiving Care (Do Not Print) | Date Signed

C7. Authorized Representative signing on behalf of family member receiving care must complete the following I, _____, represent the family member receiving care or bonding 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

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Application for Paid Family Leave Benefits (DE 2501F) - Page 2 cont.

Care Claims

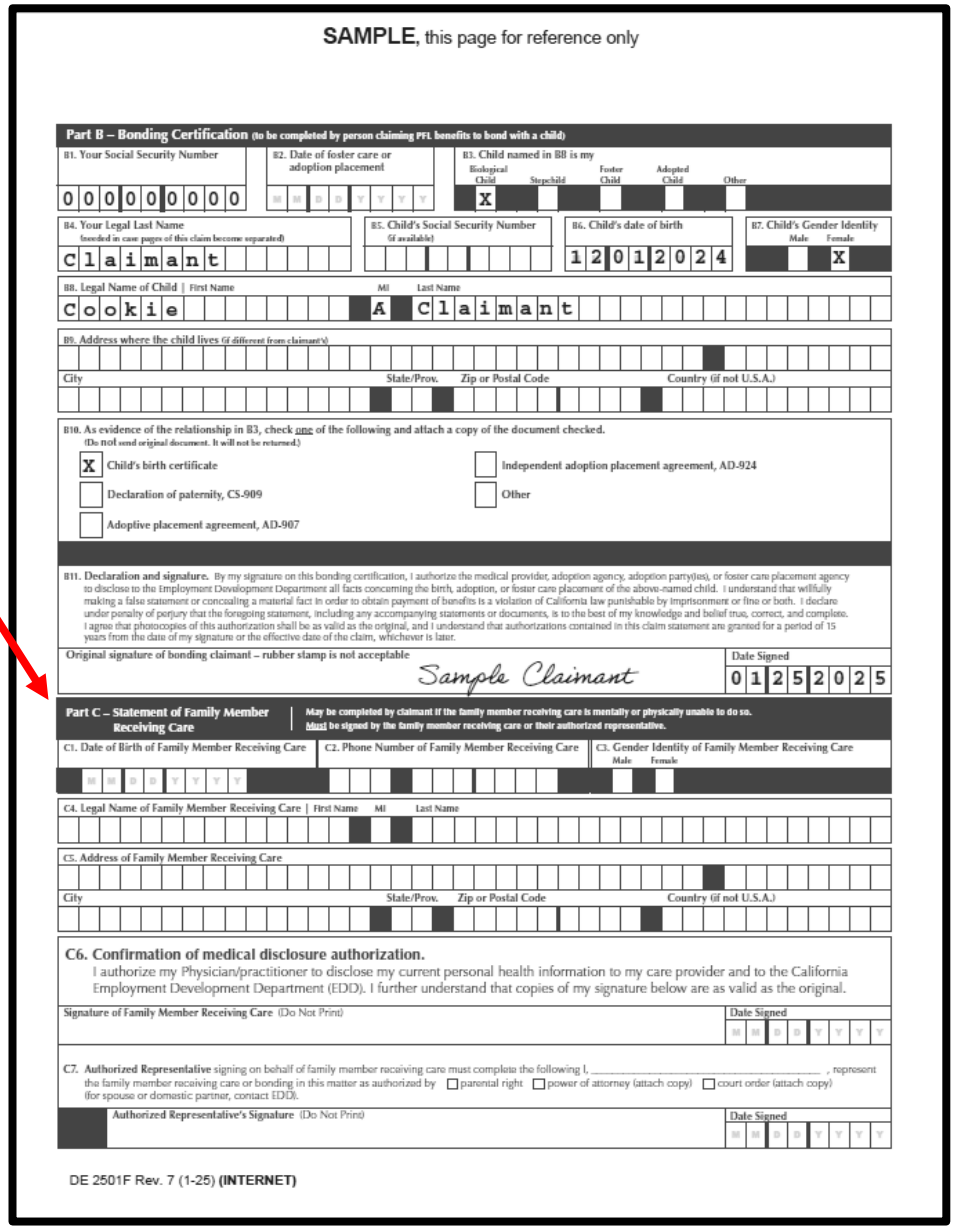
Part C - Statement of Care Recipient:

- If you are filing a care claim, you or the care recipient must complete this section.
- The care recipient or their authorized representative must sign the form.

Complete either Part B or Part C – **but never both** sections for one claim.

Note

Part B and Part C are not needed for military assist claims.



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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: 12012024

B7. Child's Gender Identity: Male, Female [X]

B8. Legal Name of Child | First Name: Cookie | MI: A | Last Name: Claimant

B9. Address where the child lives (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
- [ ] Declaration of paternity, CS-909
- [ ] Adoptive placement agreement, AD-907
- [ ] Independent adoption placement agreement, AD-924
- [ ] 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 15 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: 01252025

Part C – Statement of Family Member Receiving Care | May be completed by claimant if the family member receiving care is mentally or physically unable to do so. Must be signed by the family member receiving care or their authorized representative.

C1. Date of Birth of Family Member Receiving Care: M M D D Y Y Y Y

C2. Phone Number of Family Member Receiving Care

C3. Gender Identity of Family Member Receiving Care: Male, Female

C4. Legal Name of Family Member Receiving Care | First Name | MI | Last Name

C5. Address of Family Member Receiving Care

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

C6. Confirmation of medical disclosure authorization.
I authorize my Physician/practitioner to disclose my current personal health information to my care provider and to the California Employment Development Department (EDD). I further understand that copies of my signature below are as valid as the original.

Signature of Family Member Receiving Care (Do Not Print) | Date Signed: M M D D Y Y Y Y

C7. Authorized Representative signing on behalf of family member receiving care must complete the following I, _____, represent the family member receiving care or bonding 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

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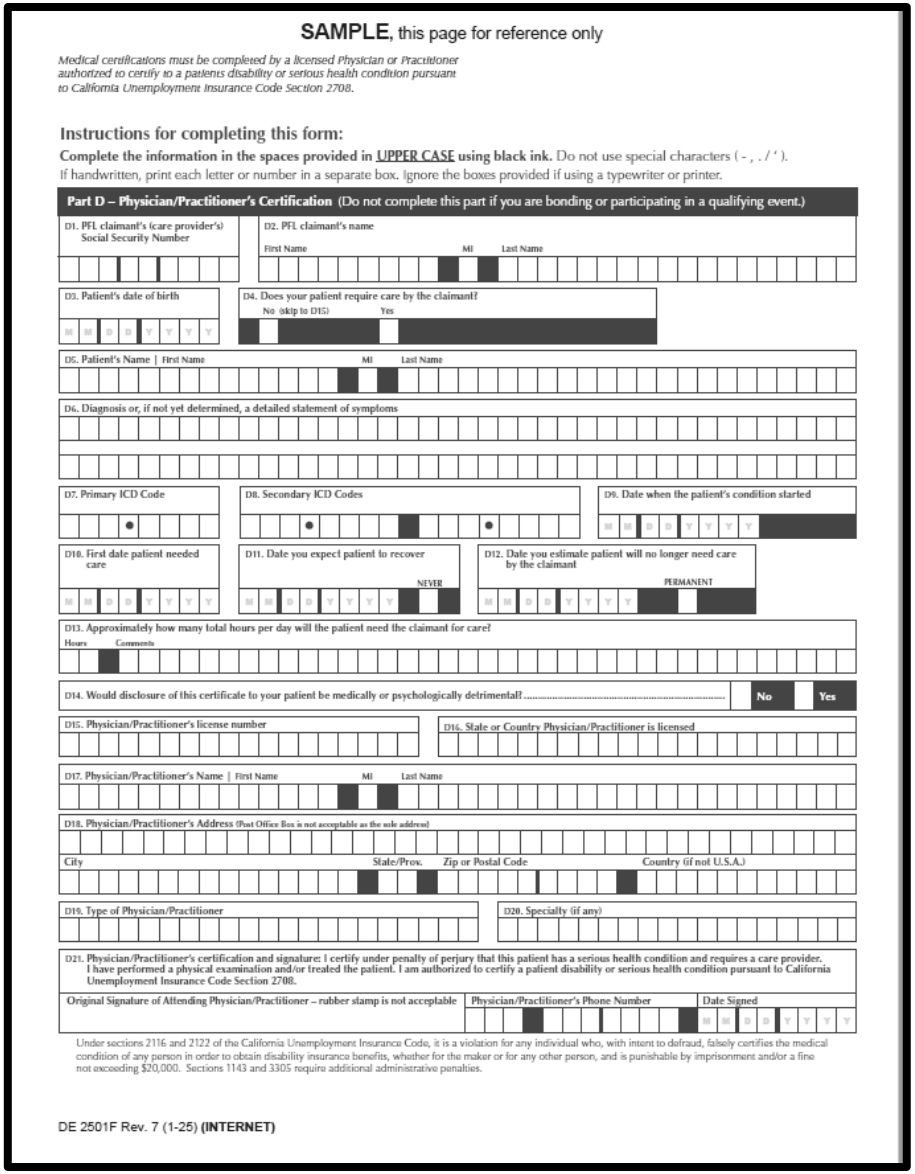
Care Claims

Part D - Physician/Practitioner's Certification:

- Your care recipient's physician/practitioner must complete all patient information including dates, diagnosis codes.
- Make sure the physician/practitioner signs the bottom of the form.

Note

Part D is not needed for bonding or military assist claims. It is only for care claims.



SAMPLE, this page for reference only

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

Instructions for completing this form:

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 or participating in a qualifying event.)

D1. PFL claimant's (care provider's) Social Security Number

D2. PFL claimant's name — First Name | MI | Last Name

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 Name | MI | Last Name

D6. Diagnosis or, if not yet determined, a detailed statement of symptoms

D7. Primary ICD Code

D8. Secondary ICD Codes

D9. Date when the patient's condition started (M M D D Y Y Y Y)

D10. First date patient needed care (M M D D Y Y Y Y)

D11. Date you expect patient to recover (M M D D Y Y Y Y) NEVER

D12. Date you estimate patient will no longer need care by the claimant (M M D D Y Y Y Y) PERMANENT

D13. Approximately how many total hours per day will the patient need the claimant for care? 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 Name | MI | Last Name

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

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.

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Application for Paid Family Leave Benefits (DE 2501F) - Page 4

Military Assist Claims

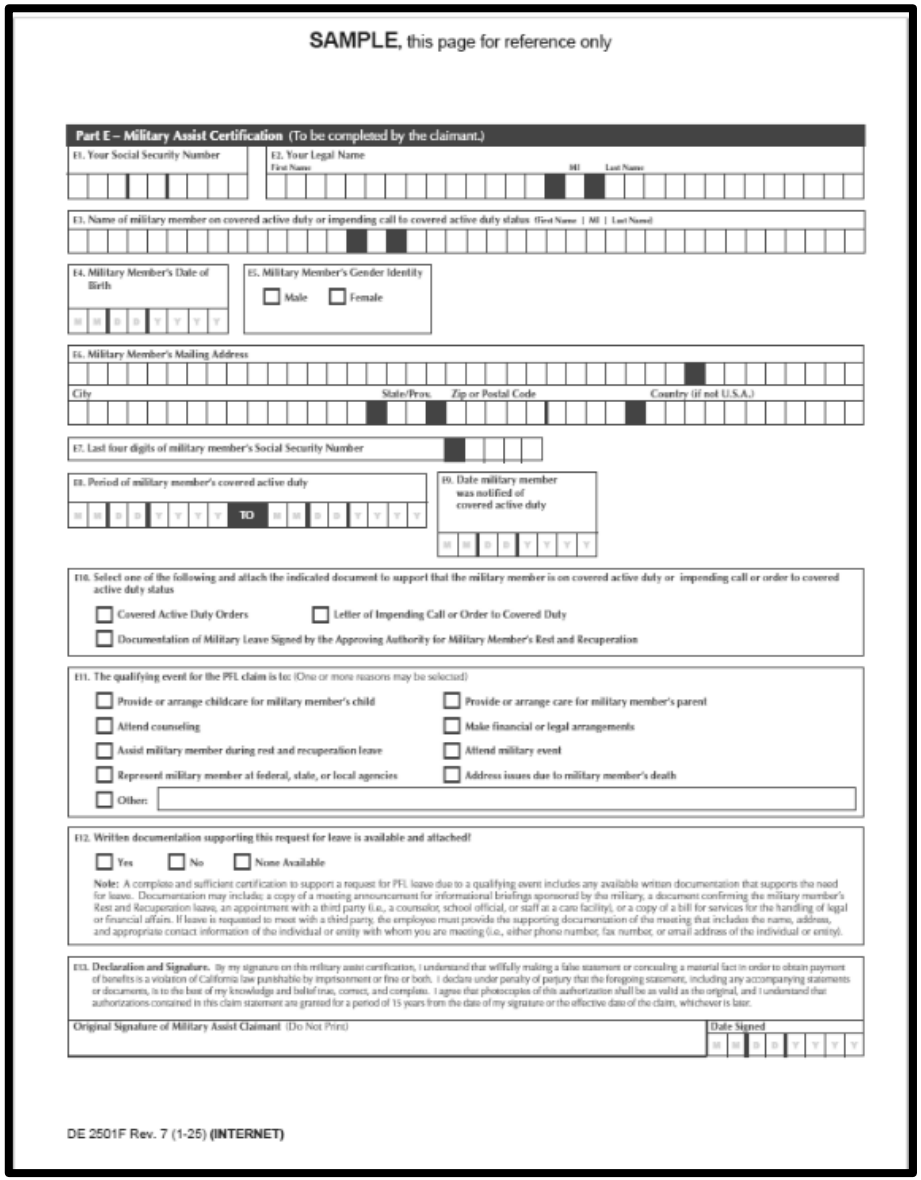
Part E – Military Assist Certification:

You must complete all information under Part E, including:

- The military member's personal information
- Dates of covered duty
- Qualifying event information
- Your signature

Note

Part E is not needed for bonding or care claims. It is only for military assist claims.



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Part E – Military Assist Certification (To be completed by the claimant.)

E1. Your Social Security Number

E2. Your Legal Name (First Name, MI, Last Name)

E3. Name of military member on covered active duty or impending call to covered active duty status (First Name | MI | Last Name)

E4. Military Member's Date of Birth (M M D D Y Y Y Y)

E5. Military Member's Gender Identity ☐ Male ☐ Female

E6. Military Member's Mailing Address

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

E7. Last four digits of military member's Social Security Number

E8. Period of military member's covered active duty (M M D D Y Y Y Y TO M M D D Y Y Y Y)

E9. Date military member was notified of covered active duty (M M D D Y Y Y Y)

E10. Select one of the following and attach the indicated document to support that the military member is on covered active duty or impending call or order to covered active duty status

☐ Covered Active Duty Orders ☐ Letter of Impending Call or Order to Covered Duty

☐ Documentation of Military Leave Signed by the Approving Authority for Military Member's Rest and Recuperation

E11. The qualifying event for the PFL claim is to: (One or more reasons may be selected)

☐ Provide or arrange childcare for military member's child ☐ Provide or arrange care for military member's parent

☐ Attend counseling ☐ Make financial or legal arrangements

☐ Assist military member during rest and recuperation leave ☐ Attend military event

☐ Represent military member at federal, state, or local agencies ☐ Address issues due to military member's death

☐ Other:

E12. Written documentation supporting this request for leave is available and attached!

☐ Yes ☐ No ☐ None Available

Note: A complete and sufficient certification to support a request for PFL leave due to a qualifying event includes any available written documentation that supports the need for leave. Documentation may include; a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming the military member's Rest and Recuperation leave, an appointment with a third party (i.e., a counselor, school official, or staff at a care facility), or a copy of a bill for services for the handling of legal or financial affairs. If leave is requested to meet with a third party, the employee must provide the supporting documentation of the meeting that includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either phone number, fax number, or email address of the individual or entity).

E13. **Declaration and Signature.** By my signature on this military assist certification, 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 15 years from the date of my signature or the effective date of the claim, whichever is later.

Original Signature of Military Assist Claimant (Do Not Print) | Date Signed (M M D D Y Y Y Y)

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Application for Paid Family Leave Benefits (DE 2501F) - Page 5

Military Assist Claims

Part E - Qualifying Event for Leave Documentation:

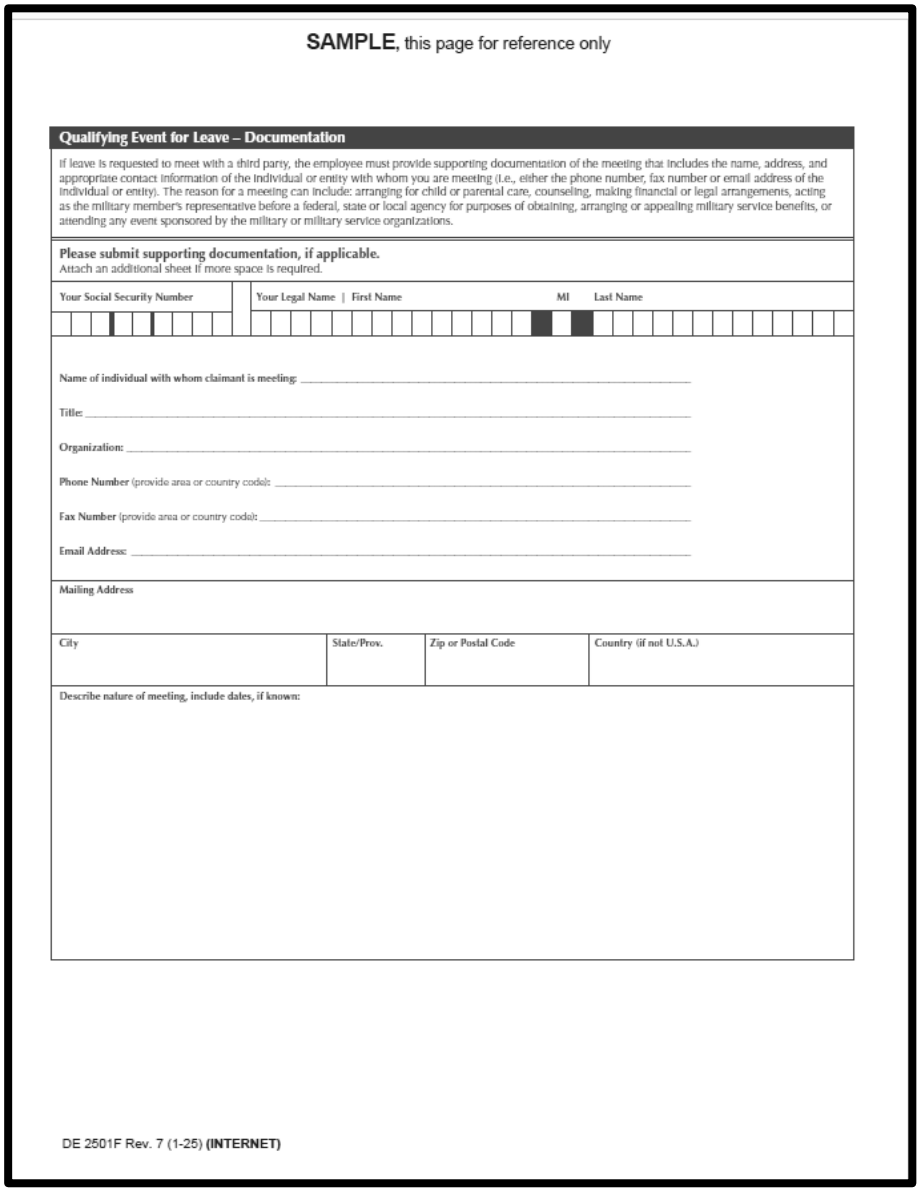
If you're requesting leave to meet with a third party, you must include:

- Third party contact information.
- Description of the event, including dates.

Make sure to complete all pages needed and sign the claim form before mailing to us.

Note

The Qualifying Event for Leave Documentation is not needed for bonding or care claims.



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Qualifying Event for Leave – Documentation

If leave is requested to meet with a third party, the employee must provide supporting documentation of the meeting that includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the phone number, fax number or email address of the individual or entity). The reason for a meeting can include: arranging for child or parental care, counseling, making financial or legal arrangements, acting as the military member's representative before a federal, state or local agency for purposes of obtaining, arranging or appealing military service benefits, or attending any event sponsored by the military or military service organizations.

Please submit supporting documentation, if applicable.
Attach an additional sheet if more space is required.

Your Social Security Number | Your Legal Name | First Name | MI | Last Name

Name of individual with whom claimant is meeting: _____

Title: _____

Organization: _____

Phone Number (provide area or country code): _____

Fax Number (provide area or country code): _____

Email Address: _____

Mailing Address

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

Describe nature of meeting, include dates, if known:

DE 2501F Rev. 7 (1-25) **(INTERNET)**

Complete and review your DE 2501F application

Bonding claims are complete when the following documents are received:

- Part A: Statement of Claimant
- Part B: Bonding Certification
- Supporting Bonding Documentation

Care claims are complete when the following documents are received:

- Part A: Statement of Claimant
- Part C: Statement of Care Recipient
- Part D: Physician/Practitioner's Certification

Military assist claims are complete when the following documents are received:

- Part A: Statement of Claimant
- Part E: Military Assist Certification
- Supporting Military Documentation

Mail your completed application

Use the pre-addressed envelope to mail to:

State of California
Employment Development Department
P.O. Box 989315
West Sacramento, CA 95798-9315

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

CONTACT US

1-877-238-4373

– Helpful Links –

Order Forms

Schedule a Webinar

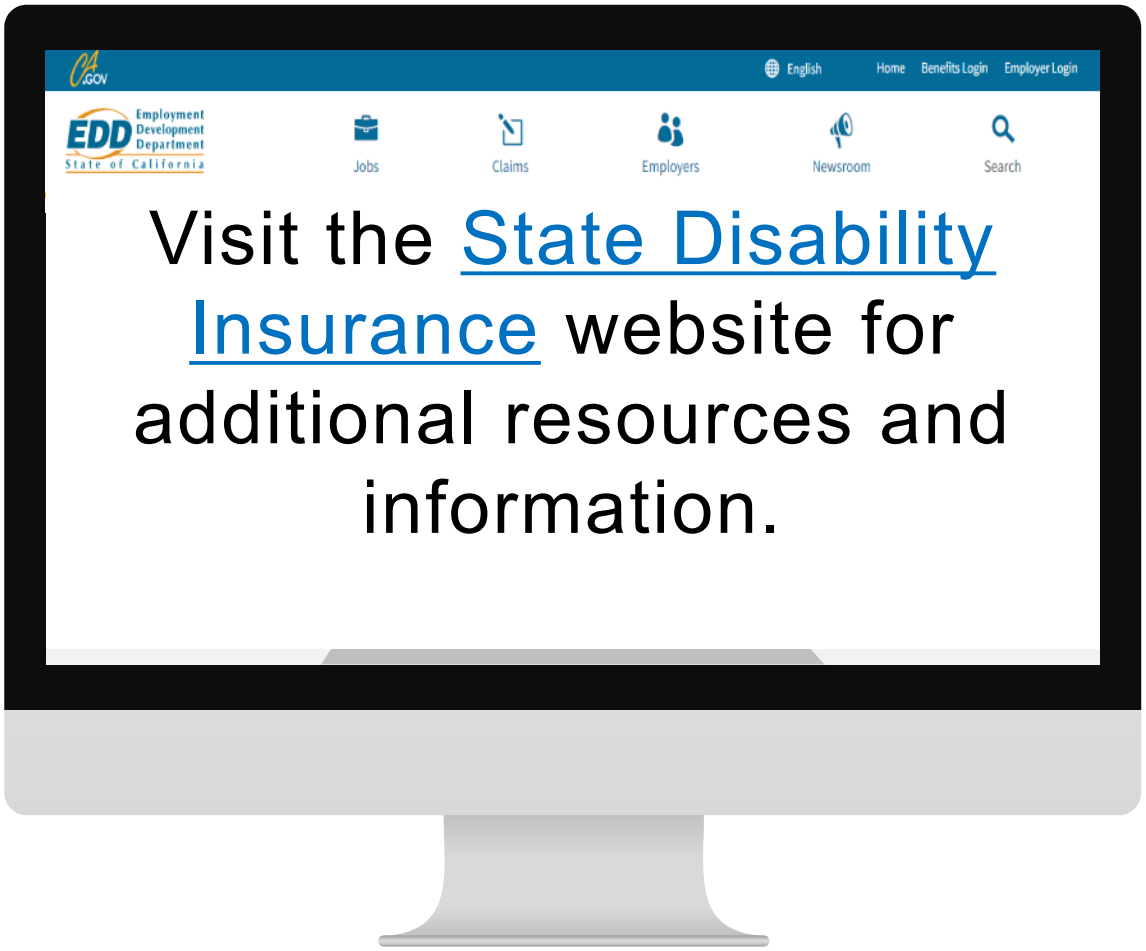
Help Fight Fraud

Contact Us

Accessibility

Language Resources

– Follow us –



EDD is an equal opportunity department for this information. If you need help or services because of a disability, call 1-866-490-8879. TTY users, please call the California Relay Service at 711.