



SDI ONLINE TUTORIAL

File a Paid Family Leave Application by Mail

Last Updated: January 2026



Completing Paper Applications

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



[Get Started](#)



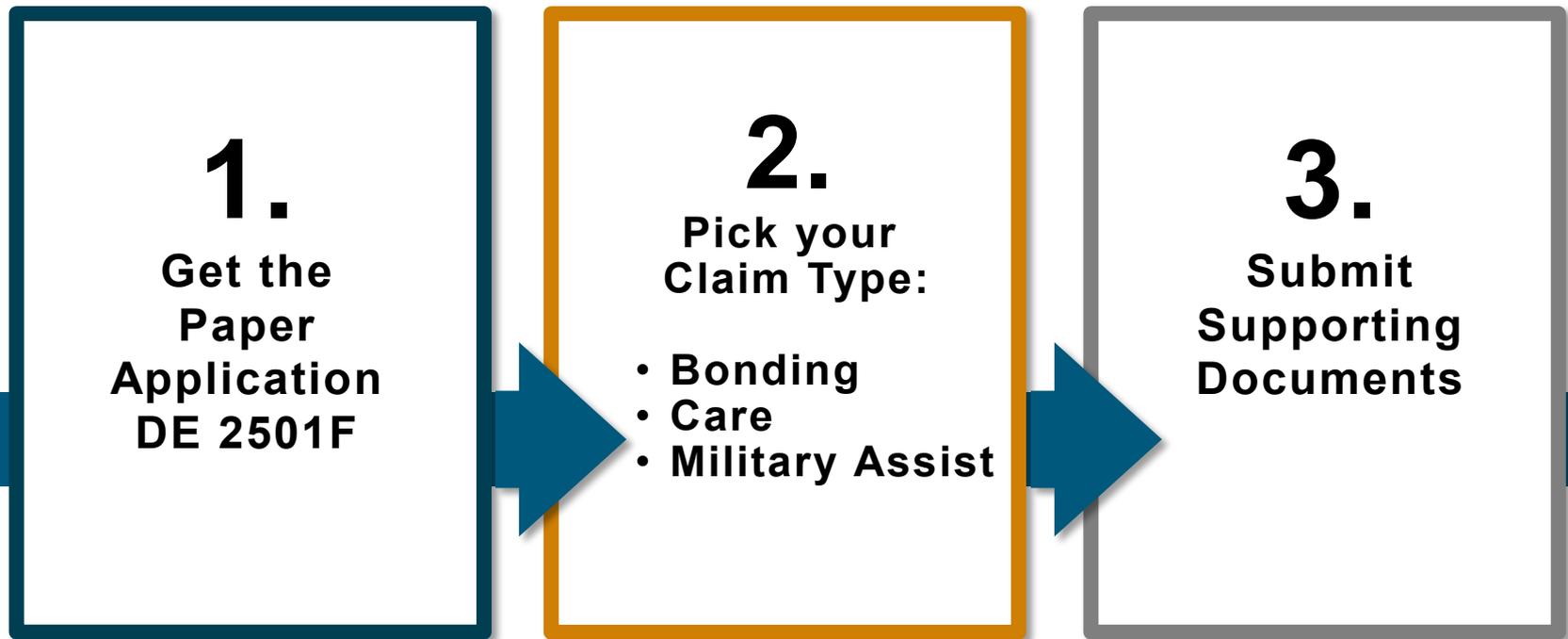
Paper Applications

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

Part A: Personal Information

1. Social Security Number: 0000000000 2. Year date of birth: MMDDYYYY: 01012000 3. Language you prefer to use: English Spanish Other

4. Your Legal Name | First Name: Sample MI: Last Name: Claimant 5. Gender Identity: Male Female

6. Phone Number: 123 4567890 7. If you have worked under any other last names, enter them here (for example, a maiden name or chosen name):

8. Mailing Address (must be a private residential address): 123 Any Street Apt. or Suite #: City: Anytown State: CA Zip or Postal Code: 12345 Country (if not U.S.):

9. Name of your Employer: Roadrunner Pastries 647 Armistice Way City: State: CA Zip or Postal Code: 555 1234567

10. How long have you worked for your employer? MMDDYYYY: 11. How long have you worked for your employer since you started your family leave period? MMDDYYYY: 12. Are you currently working for your employer? Yes No

13. Why did you or will you reduce your work hours or stop working? Care for family Paid sick Military Other reason: 14. Why is your employer requesting this? Paternity Chief Other: 15. Is your employer providing parental payment? Yes No Check

16. Family Member's Legal Name | First Name: Clokie MI: Last Name: Claimant 17. This person was not living with you or your family (state number):

18. This family member is your: Spouse Parent Grandparent Grandchild Sibling Other (specify):

19. Is any other family member read, willing, and able to provide care for the same period you are claiming PFL benefits? Yes No 20. Have you claimed or do you plan to claim workers' compensation benefits for any portion of the period covered by the claim? Yes No

21. Do you have more than one employer? Yes No 22. If your employer(s) continued or will continue to pay you during your family leave, indicate type of pay: Sick Vacation Other (specify): 23. May we disclose benefit payment information to your employer? Yes No

24. At any time during your PFL leave, were you in the custody of law enforcement authorities because you were convicted of violating a law or ordinance? No Yes

25. Declaration and Signature: By my signature on this application, I declare that I am eligible for and entitled to receive Paid Family Leave benefits and certify that throughout the period covered by this application I was providing care for bonding with or participating in qualifying activities with my dependent child(ren) as defined by the law. I authorize EDD to release any personal information on this application to the state's employer(s) if they are required to do so under the law. I authorize EDD to advise my employer(s) of this application and to facilitate my employer(s) in providing information to the state regarding my knowledge and understanding of the law. I understand that this application will be subject to audit by the state and that I may be required to provide additional information or documentation including any accompanying evidence to the state of my knowledge and belief in, correct, and complete. I agree that photographs of the dependent child to be used for the initial and subsequent applications submitted to the state are necessary for a period of 12 months from the date of my signature on this application and the effective date of my application, which have a date.

Claimant's Signature: Sample Claimant If signature is made by mark (X), please place mark here: Date Entered: 01252025

1. Witness Signature and Address: 2. Witness Signature and Address:

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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

SAMPLE, this page for reference only


Application for Paid Family Leave Benefits

Part A - Statement of Claimant (Care, Bonding, Or Military Assist Provider)

A1. Your Social Security Number: 0000000000

A2. Your date of birth: MMDDYYYY (Sample: 1234567890)

A3. Language you prefer to use (If Other, Print Below): English Spanish Other

A4. Your Legal Name | First Name | MI | Last Name: Sample | | | Claimant

A5. Gender Identity: Male Female

A6. Phone Number: 123 456 7890

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: 555 123 4567

A10. Last day you worked: MMDDYYYY

A11. Date you want your PFL claim to start: MMDDYYYY

A12. Date you returned or will return to work: MMDDYYYY

A13. Did you work or will you continue to work during your family leave period? No Yes

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

A15. What is your usual occupation? Pastry chef

A16. Select your preferred payment method: Debit Card Check

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

A18. This family member is your: Child 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 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 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

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? No Yes

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 its authority 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 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: *Sample Claimant* (Date Signed: 01252025)

*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.

SAMPLE, this page for reference only

Part B – Bonding Certification (to be completed by person claiming PFL benefits to bond with a child)			
B1. Your Social Security Number 0 0 0 0 0 0 0 0 0 0	B2. Date of foster care or adoption placement M M M M D D Y Y Y Y	B3. Child named in B1 is my Biological Child <input checked="" type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Adopted Child <input type="checkbox"/> Other <input type="checkbox"/>	
B4. Your Legal Last Name C l a i m a n t	B5. Child's Social Security Number (if available)	B6. Child's date of birth 1 2 0 1 2 0 2 4	B7. Child's Gender Identity Male <input type="checkbox"/> Female <input checked="" type="checkbox"/>
B8. Legal Name of Child First Name MI Last Name C o o k i e A C l a i m a n t			
B9. Address where the child lives (if different from claimant) City State/Prov. Zip or Postal Code Country (if not U.S.A.)			
B10. As evidence of the relationship in B3, check <u>one</u> of the following and attach a copy of the document checked. (Do not send original document. It will not be returned.) <input checked="" type="checkbox"/> Child's birth certificate <input type="checkbox"/> Independent adoption placement agreement, AD-924 <input type="checkbox"/> Declaration of paternity, CS-909 <input type="checkbox"/> Other <input type="checkbox"/> Adoptive placement agreement, AD-907			
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 0 1 2 5 2 0 2 5
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 M M D D Y Y Y Y	C2. Phone Number of Family Member Receiving Care M M M M D D D D	C3. Gender Identity of Family Member Receiving Care Male <input type="checkbox"/> Female <input type="checkbox"/>	
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 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 <input type="checkbox"/> parental rights <input type="checkbox"/> power of attorney (attach copy) <input type="checkbox"/> court order (attach copy) (for spouse or domestic partner, contact EDD).			
Authorized Representative's Signature (Do Not Print)			Date Signed M M M M D D Y Y Y Y

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.

SAMPLE, this page for reference only

Part B – Bonding Certification (to be completed by person claiming PFL benefits to bond with a child)		
B1. Your Social Security Number 0 0 0 0 0 0 0 0 0 0	B2. Date of foster care or adoption placement M M M M D D Y Y Y Y	B3. Child named in B1 is my Biological Child <input checked="" type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Adopted Child <input type="checkbox"/> Other <input type="checkbox"/>
B4. Your Legal Last Name (needed in case pages of this claim become separated) C l a i m a n t	B5. Child's Social Security Number (if available)	B6. Child's date of birth 1 2 0 1 2 0 2 4
B7. Child's Gender Identity Male <input type="checkbox"/> Female <input checked="" type="checkbox"/>		
B8. Legal Name of Child First Name MI Last Name C o o k i e A C l a i m a n t		
B9. Address where the child lives (if different from claimant) City State/Prov. Zip or Postal Code Country (if not U.S.A.)		
B10. As evidence of the relationship in B3, check <u>one</u> of the following and attach a copy of the document checked. (Do not send original document. It will not be returned.) <input checked="" type="checkbox"/> Child's birth certificate <input type="checkbox"/> Independent adoption placement agreement, AD-924 <input type="checkbox"/> Declaration of paternity, CS-909 <input type="checkbox"/> Other <input type="checkbox"/> Adoptive placement agreement, AD-907		
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 <i>Sample Claimant</i>		Date Signed 0 1 2 5 2 0 2 5
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 M M D D Y Y Y Y	C2. Phone Number of Family Member Receiving Care M M M M M M M M M M	C3. Gender Identity of Family Member Receiving Care Male <input type="checkbox"/> Female <input type="checkbox"/>
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 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 <input type="checkbox"/> parental rights <input type="checkbox"/> power of attorney (attach copy) <input type="checkbox"/> court order (attach copy) (for spouse or domestic partner, contact EDD).		
Authorized Representative's Signature (Do Not Print)		Date Signed M M 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 patient's 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

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

D10. First date patient needed care

D11. Date you expect patient to recover
 NEVER PERMANENT

D12. Date you estimate patient will no longer need care by the claimant
 NEVER 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

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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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.

SAMPLE, this page for reference only

Qualifying Event for Leave – Documentation			
<small>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.</small>			
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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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.)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Describe nature of meeting, include dates, if known:			
<input type="text"/>			

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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](#)



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[Help Fight Fraud](#)



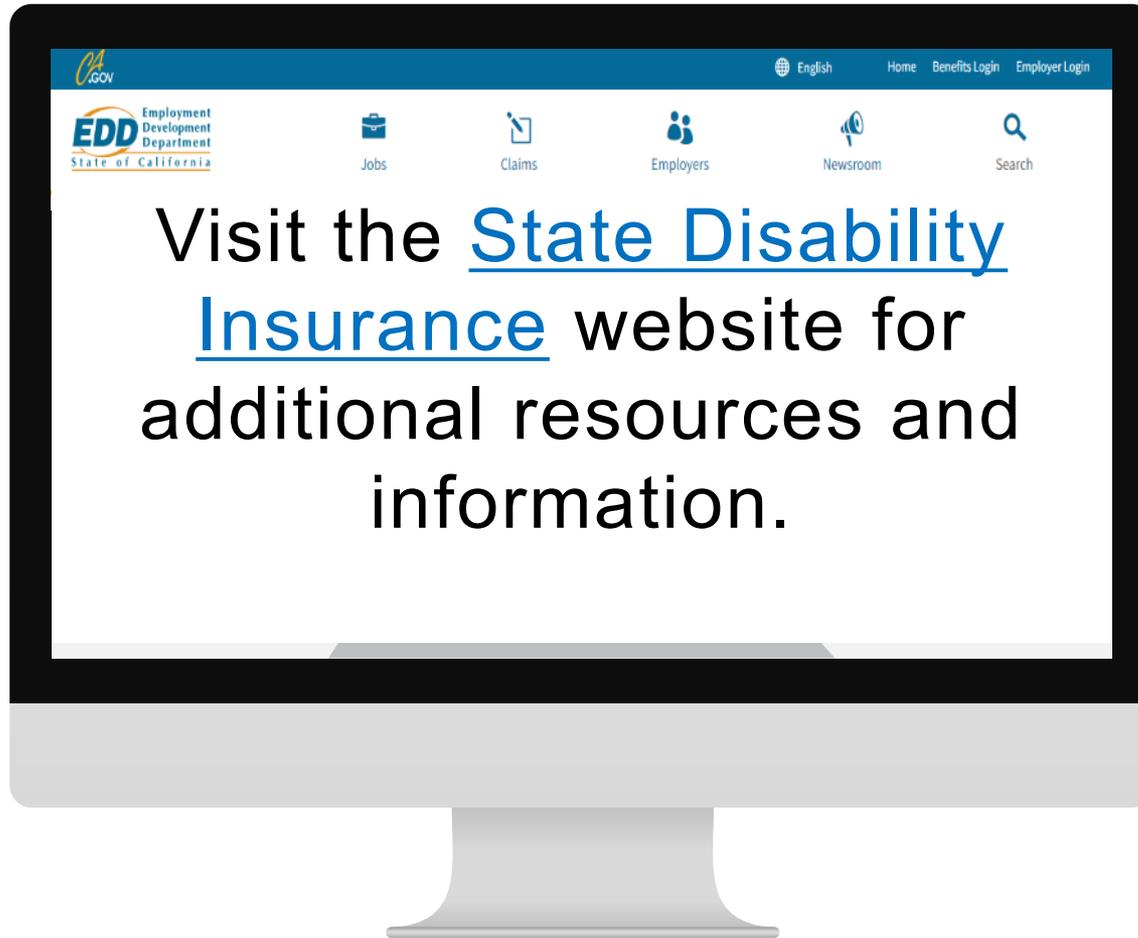
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EDD is an equal opportunity department for this information. If you need help or services because of a disability, call 1-866-490-8879. TTY users, please call the California Relay Service at 711.