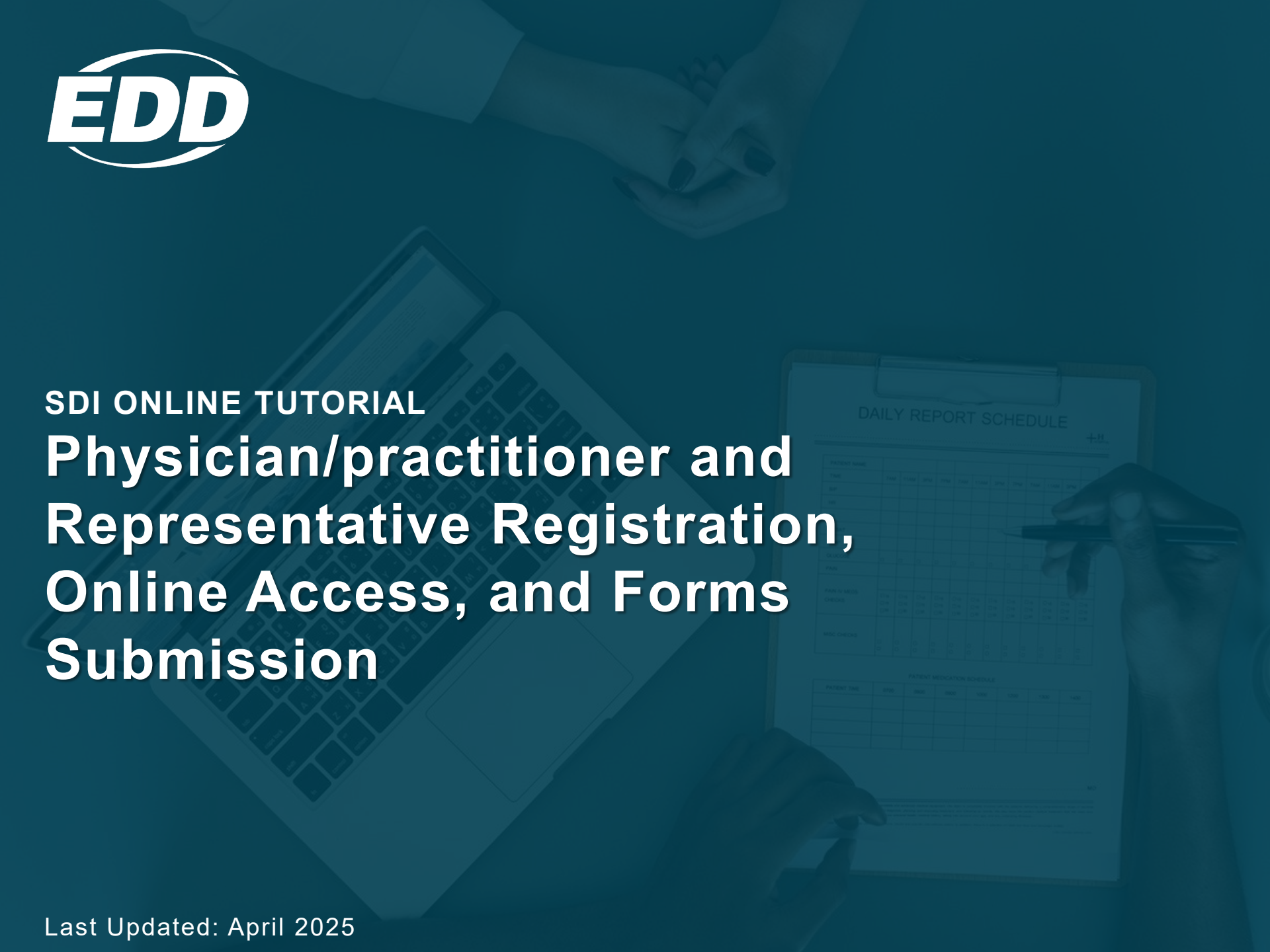



SDI ONLINE TUTORIAL

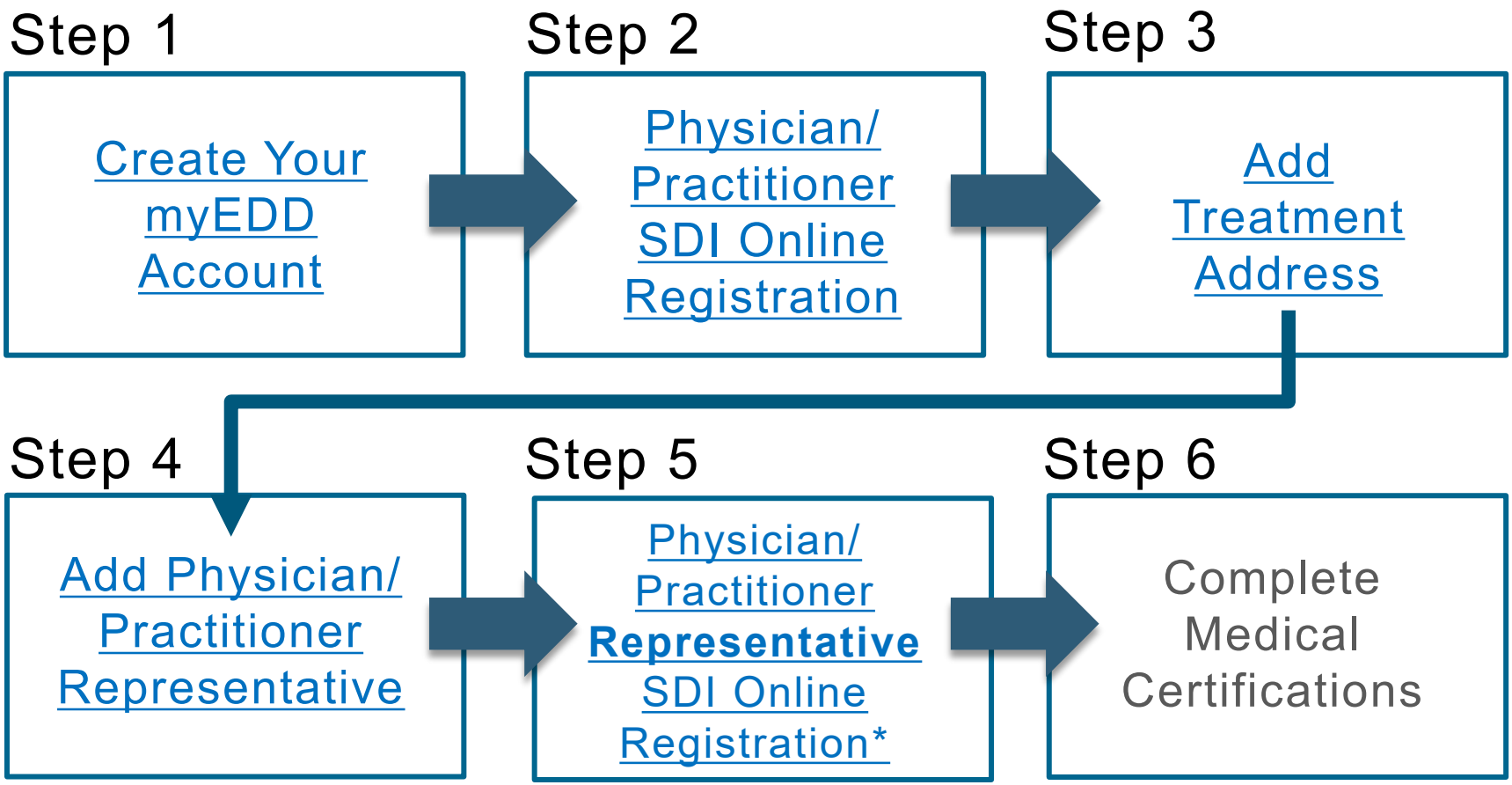
# Physician/practitioner and Representative Registration, Online Access, and Forms Submission

Last Updated: April 2025

# Physicians/practitioners can use SDI Online to:

- Complete medical certifications for disability and paid family leave benefits.
- Assign medical representatives to complete medical certifications for benefits on behalf of the physician/practitioner.
  - A medical representative can create an account after the physician/practitioner has added them to their SDI Online profile.
  - A physician/practitioner may have an unlimited number of authorized medical representatives.
  - An individual can be an authorized medical representative for an unlimited number of physicians or practitioners.
- Complete our electronic requests for additional medical information.
- Update contact information.

# Steps to Register an Authorized Representative:




*The authorized medical **representative** must also complete Step 1.

# CONTENTS

# Create Your myEDD Account

Learn more about how to create your myEDD account.

Get Started

# What is myEDD?

To access Employment Development Department (EDD) benefits services you must complete a one-time registration in myEDD.

myEDD uses a single login to access:

- Unemployment benefits
- Disability benefits
- Paid Family Leave benefits
- Benefit Overpayments

We offer step-by-step instructions on how to create a new myEDD account.

If you already created a myEDD account, you may skip to:

- Register as a Physician/Practitioner in SDI Online
- Register as a Medical Representative in SDI Online

# Create Your myEDD Account

1. Visit myEDD to create your account.

2. Select **Create Account**. To view the screens in Spanish, select **Español**.

3. Enter a company email that is used only by you.

4. Set up a password that is 10 or more characters. The password is case sensitive and must contain:

    - Uppercase and lowercase letters
    - Numbers
    - Symbols such as !@#$

5. Select your preferred language, accept our terms and conditions, and select **Submit**.

6. Next, check your email to confirm your account. Select **Confirm Email** within 48 hours or you will need to start over.

7. Login to your myEDD account. When you log in for the first time, we will email you a verification code to verify your identity. Select, **Send Email**.

# Create Your myEDD Account

8. Enter the verification code and select **Submit**. This code expires in 5 minutes. If you do not receive the verification code email, check your junk or spam folder or **select resend the email**.

9. Next, set up your security question. Select a question, enter the answer, and select **Continue** to save.

10. Now you can select your Login Verification method. You can receive the verification code by text message or phone call. To continue using email, select **Use my email instead**.

11. Enter your phone number then select **Text Code** or **Call My Phone**. Then enter the verification code. This code expires in 5 minutes. A screen will let you know you have successfully set up your login verification method.

12. Select **myEDD Home**, then select **SDI Online**. On the next screen, select the SDI Online registration account type.

**Use myEDD to access SDI Online and submit disability or paid family leave medical certifications.**

# Register as a Physician/Practitioner in SDI Online

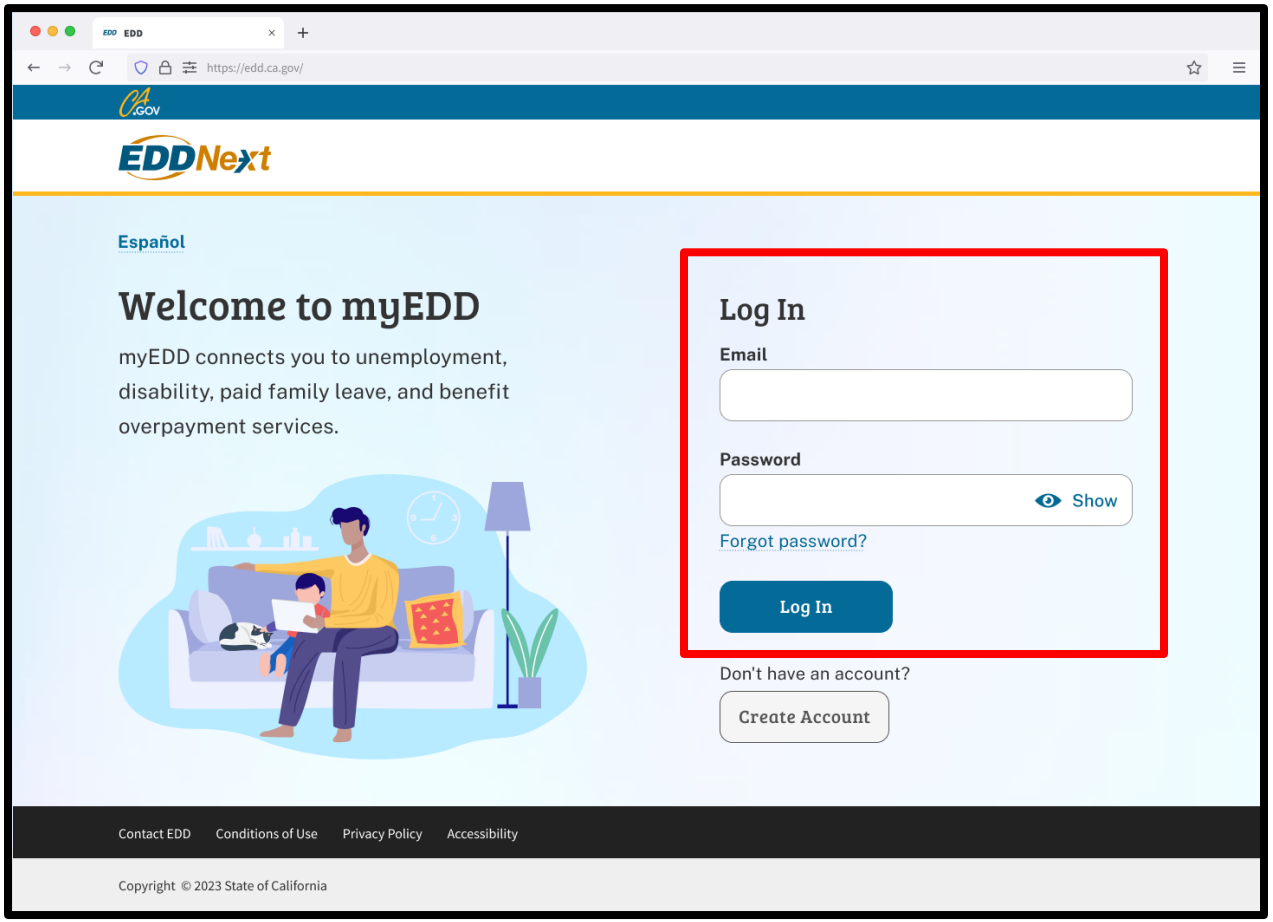
Learn more about how physician/practitioners register in SDI Online.

Get Started

# Step 1: Log in

Log in to myEDD to access SDI Online, update your email, password, security question, or verification option:

1. Visit myEDD.
2. Enter the email and password used to create your myEDD account.
3. Select **Log In**.




**Note**

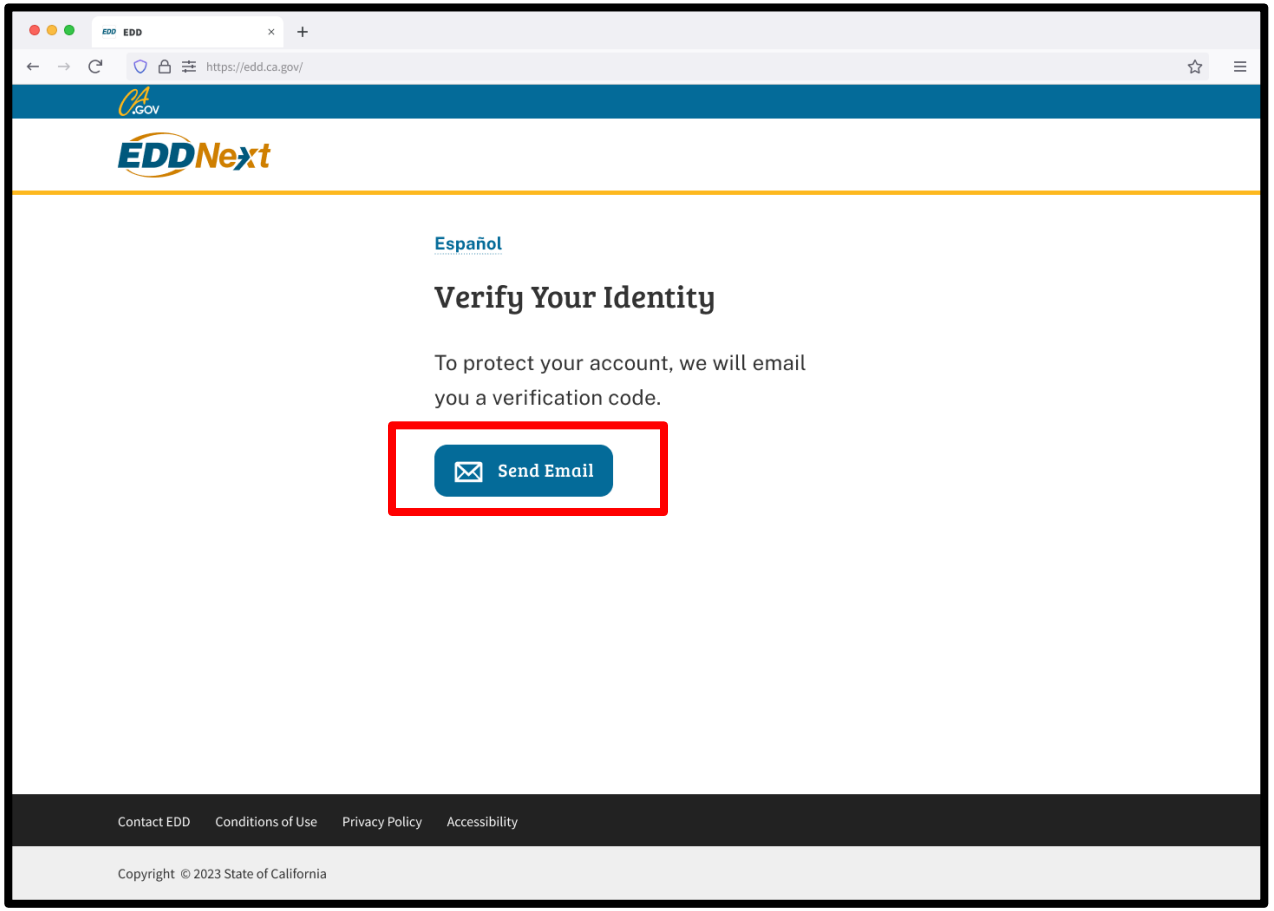
For Spanish, select **Español**.

# Step 2: Verify Your Identity

To protect your account, we ask you to verify your identity every time you log in. In this example, the identity verification option is by email.

Select **Send Email.**

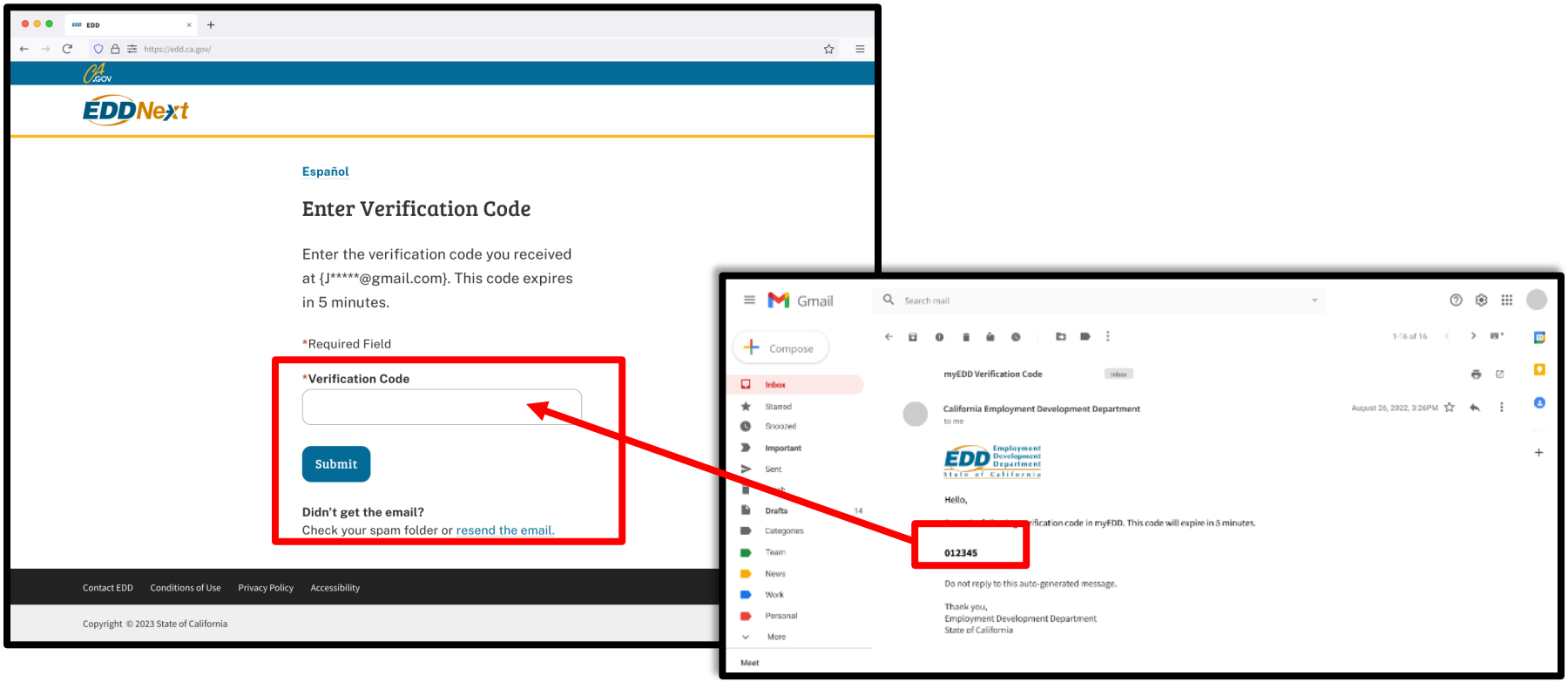
If you set up the login verification option as text message or phone call, follow the instructions based on that option.



# Step 3: Enter Verification Code

Check your email for your verification code. This code expires in five minutes. Check your spam or junk folder if you do not get this email in your inbox.

- Enter your verification code and select **Submit**.
- Select **resend the email** if you do not get a code.

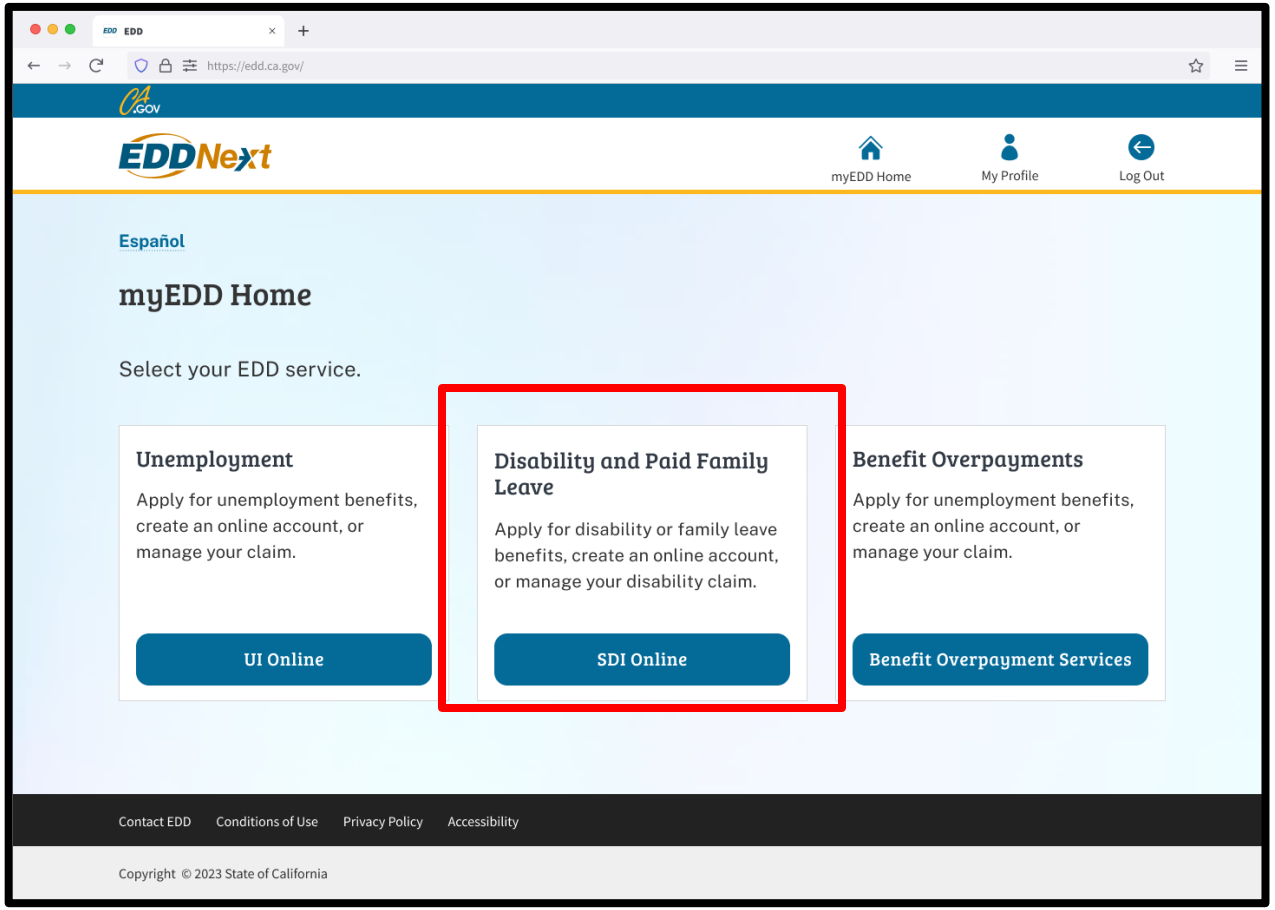


# Step 4: Select SDI Online

From the myEDD homepage, select **SDI Online** to begin your SDI Online registration.

**Note**

Select **Log Out** in the top right corner of any screen to exit your account.

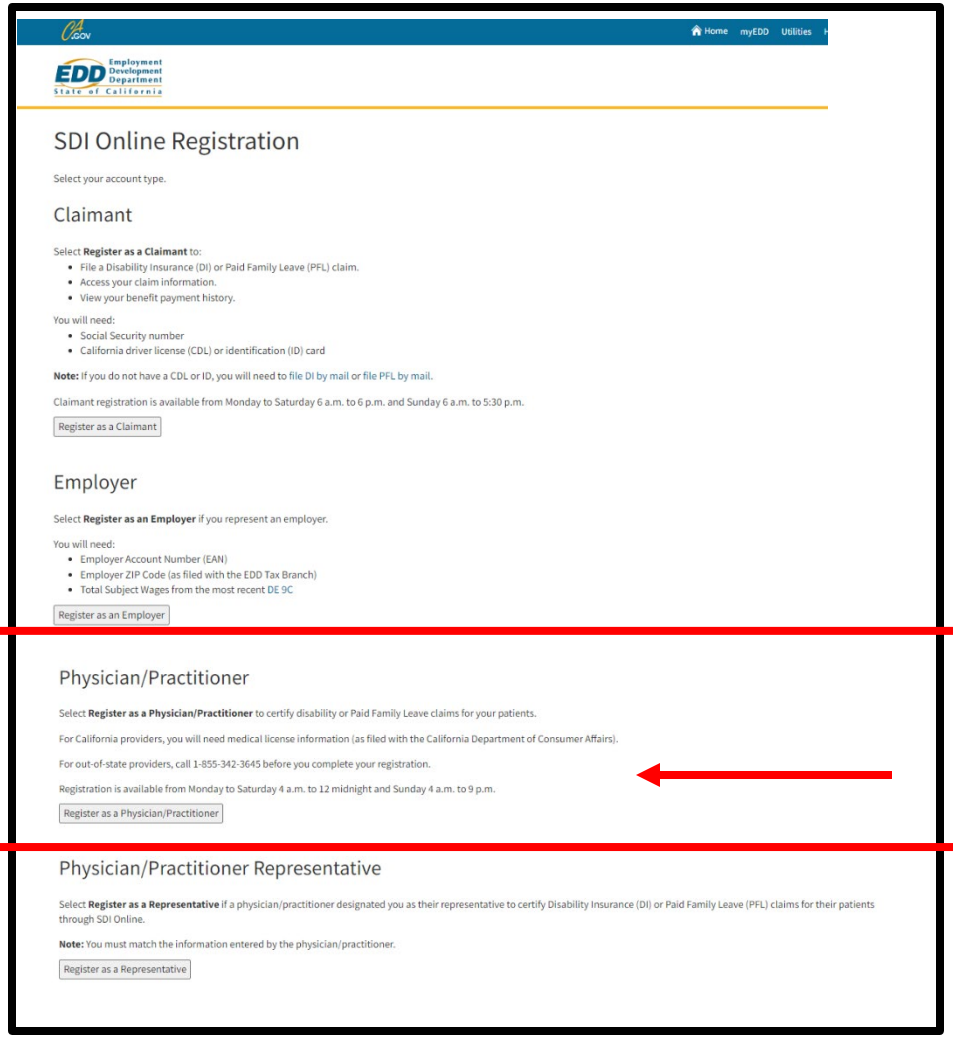


# Step 5: Start Registration

You are sent to the SDI Online Registration Account Type screen.

Read the instructions.

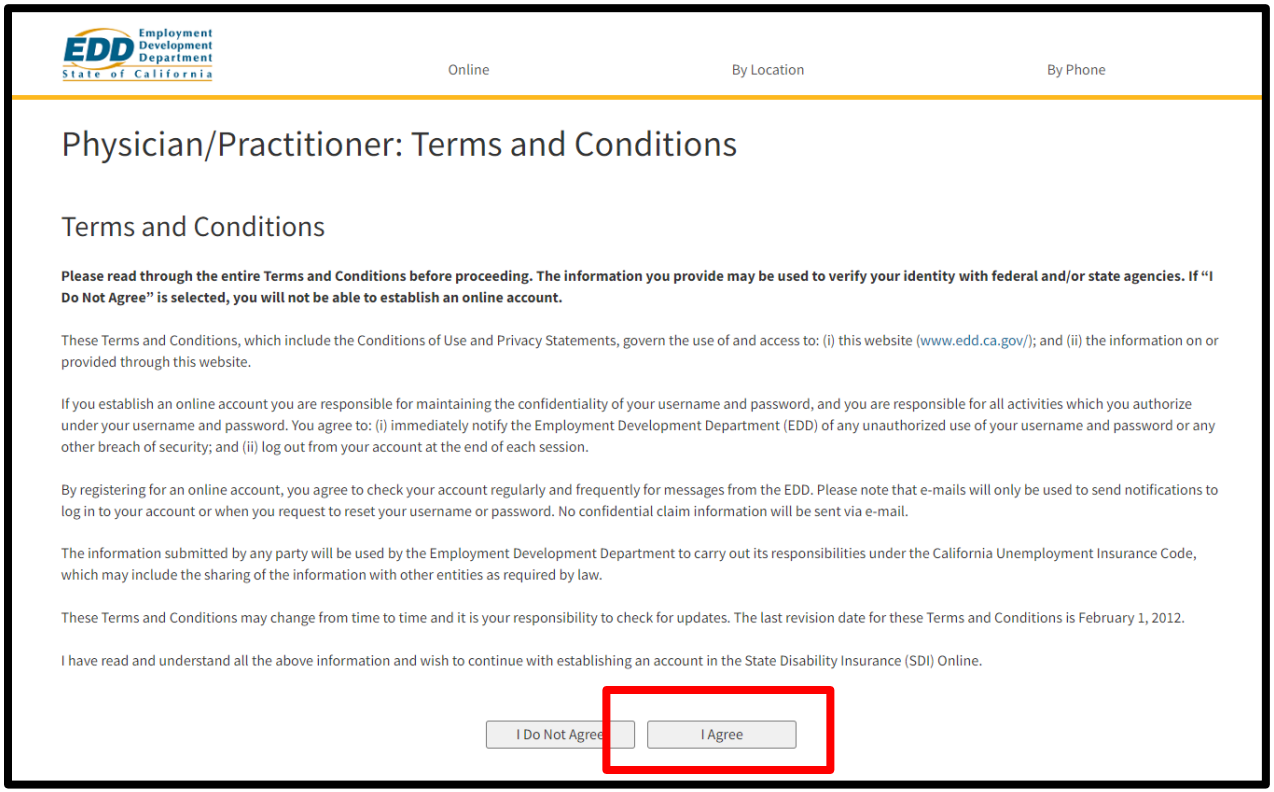
Select **Register as a Physician/Practitioner** link.



# Step 6: Terms and Conditions

Next, review the terms and conditions. Select **I Agree**.

You must agree to these terms and conditions to create an online account.

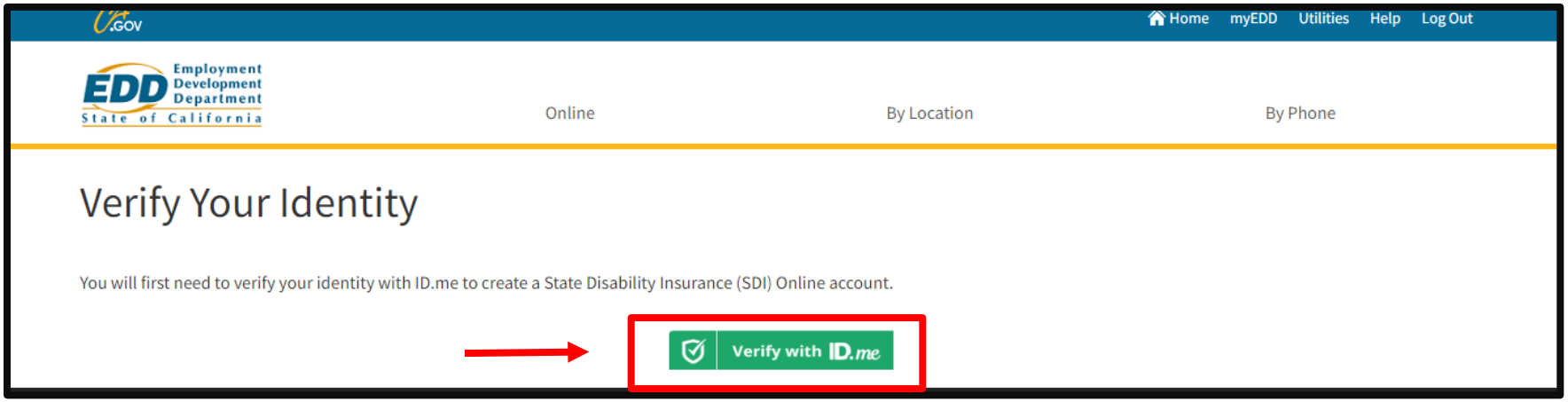


# Step 7: ID.*me*

We are partnered with ID.me to verify the identity of the physician/practitioner.

You must verify your identity with ID.me to create an SDI Online account. Select **Verify with ID.me** to start the ID.me registration and verification process.

For help with ID.me, visit California Disability Insurance and ID.me.



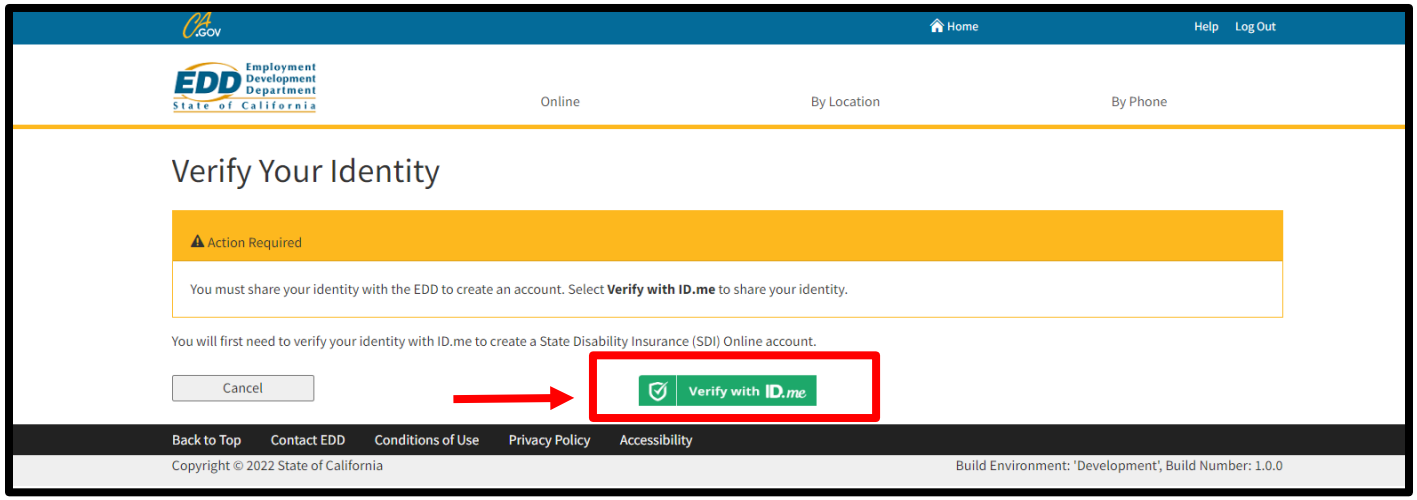
# Step 8: Allow Sharing

Once you complete the ID.me verification process, ID.me will have the option to **Allow** or **Deny** sharing your ID.me identity information with us.

If you deny sharing your ID.me information with us, you will be redirected to SDI Online and the following message will display, “You must share your identity with the EDD to create an account.”

If you select deny by mistake, select **Verify with ID.me** to try again.

If you allow sharing your ID.me information with us, you will be redirected to SDI Online to complete the SDI Online registration.



# Step 9: Enter Your Information

The system automatically fills certain information from ID.me and are read-only fields:

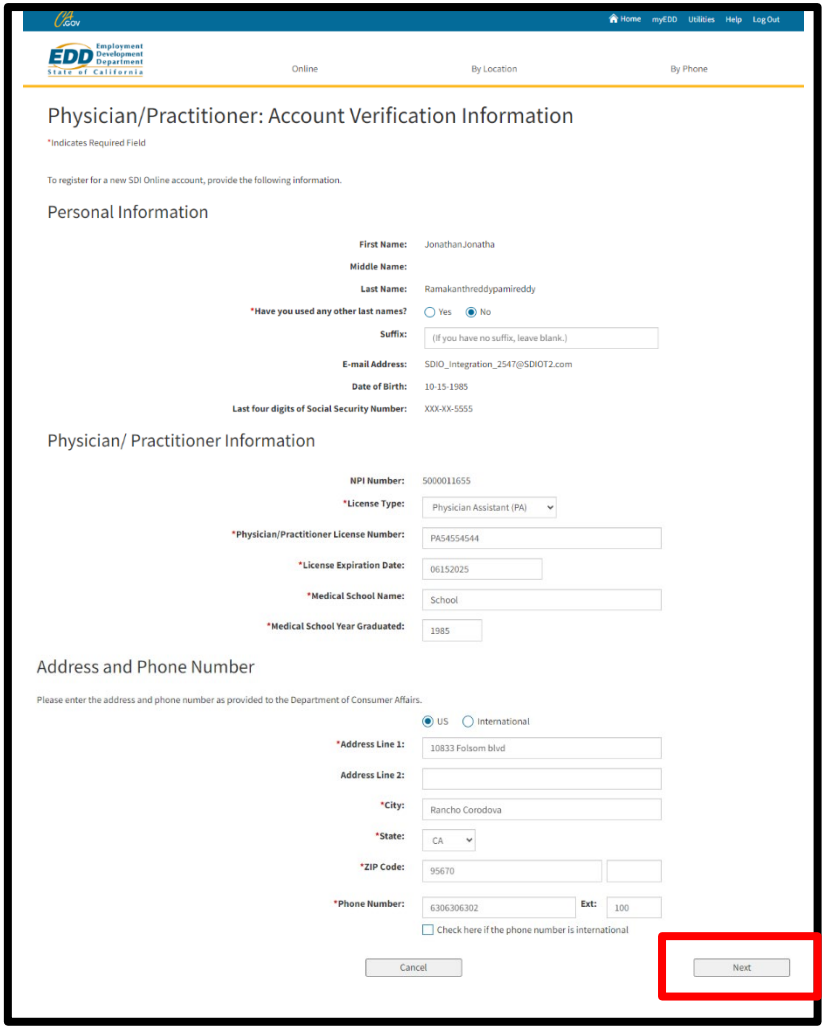
- Your full legal name.
- Date of birth.
- Last four digits of your Social Security number.
- National Provider Identifier or NPI number.

You must enter the following personal and professional information:

- License type, number, and expiration date.
- Medical school name and graduation year.
- Address and phone number as provided to the Department of Consumer Affairs.

You must complete the fields marked with a red asterisk (*).

Select **Next** to proceed.

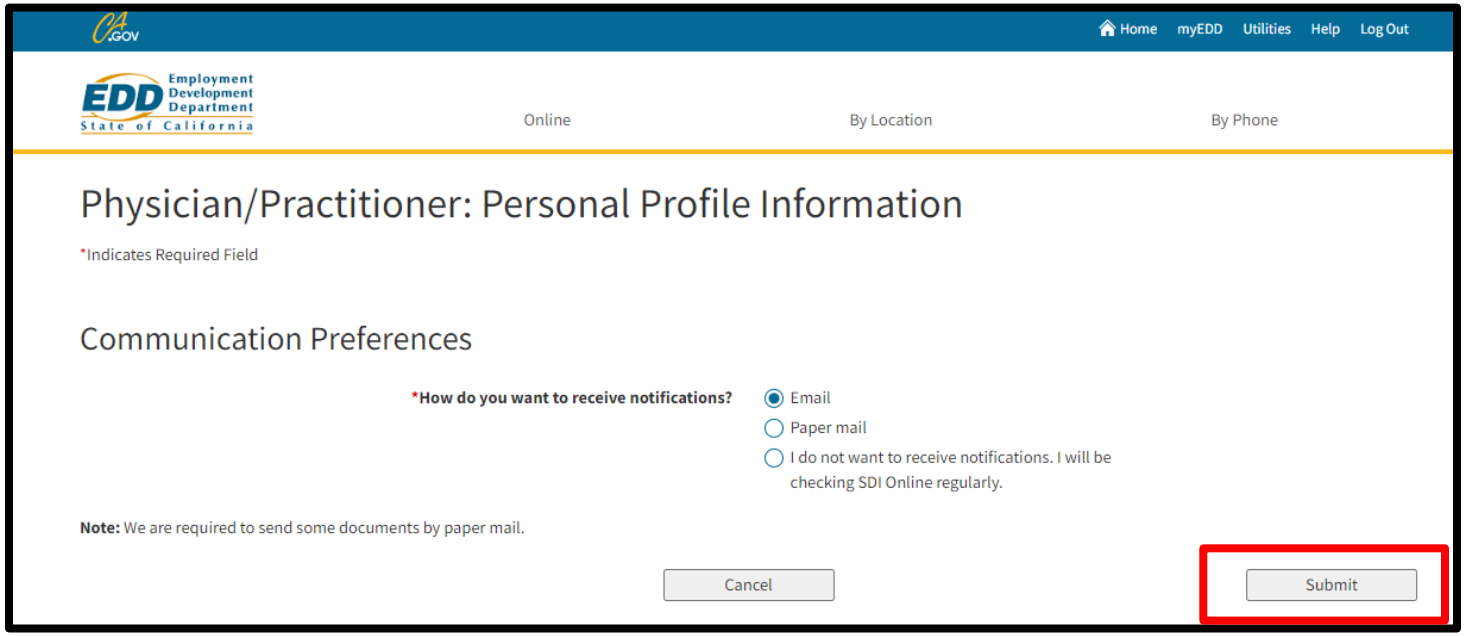


# Step 10: Communication Preference

On the Personal Profile Information screen, select how you want to get notifications.

If you select to get notifications by email, you must log in to your account to access your messages.

Some documents are required to be sent by mail.

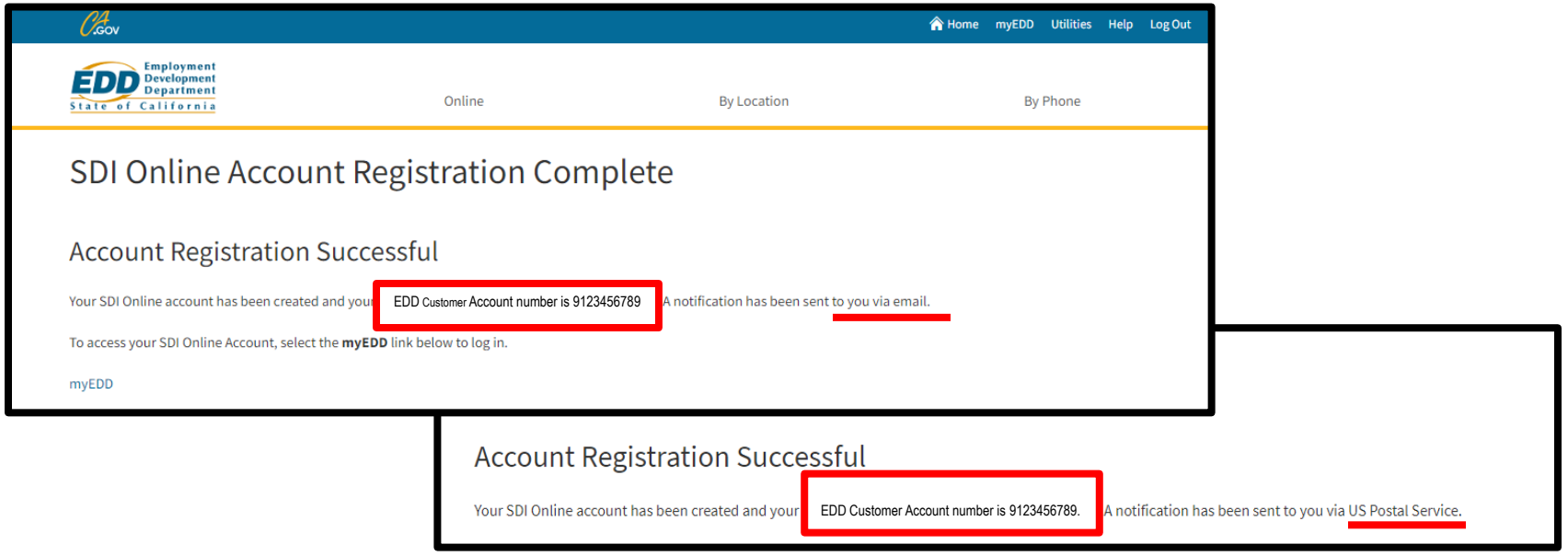


# Step 11: Registration Complete

Be sure to save your EDD Customer Account Number (EDDCAN).

- If you selected electronic communication, a notification confirming your new account is sent to your email.
- If you selected paper communication, a letter confirming your new account is mailed to your address.

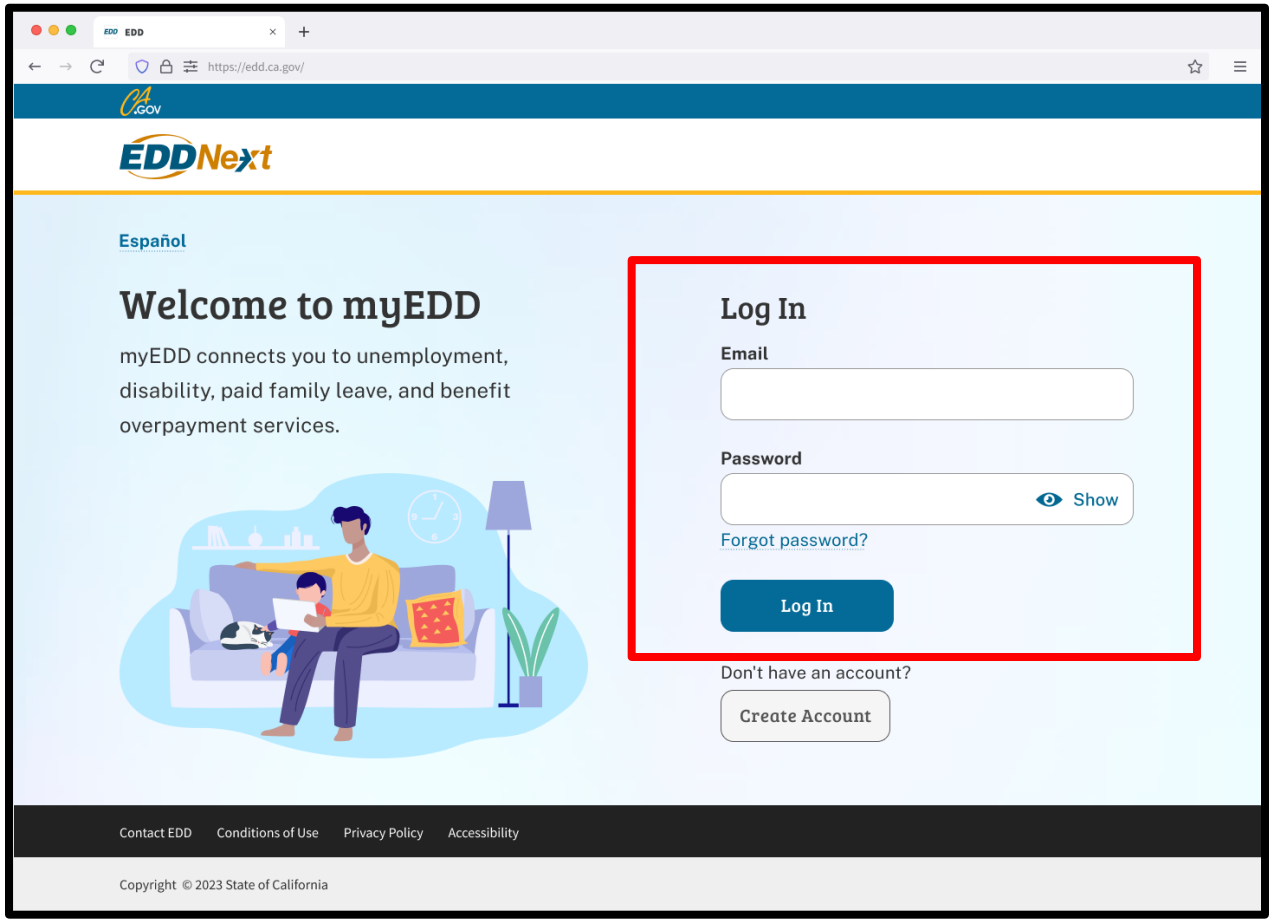
You may now log in to myEDD to access your new SDI Online account.



# Access Your SDI Online Account

Learn more about how to access your online account and update personal information.

Get Started

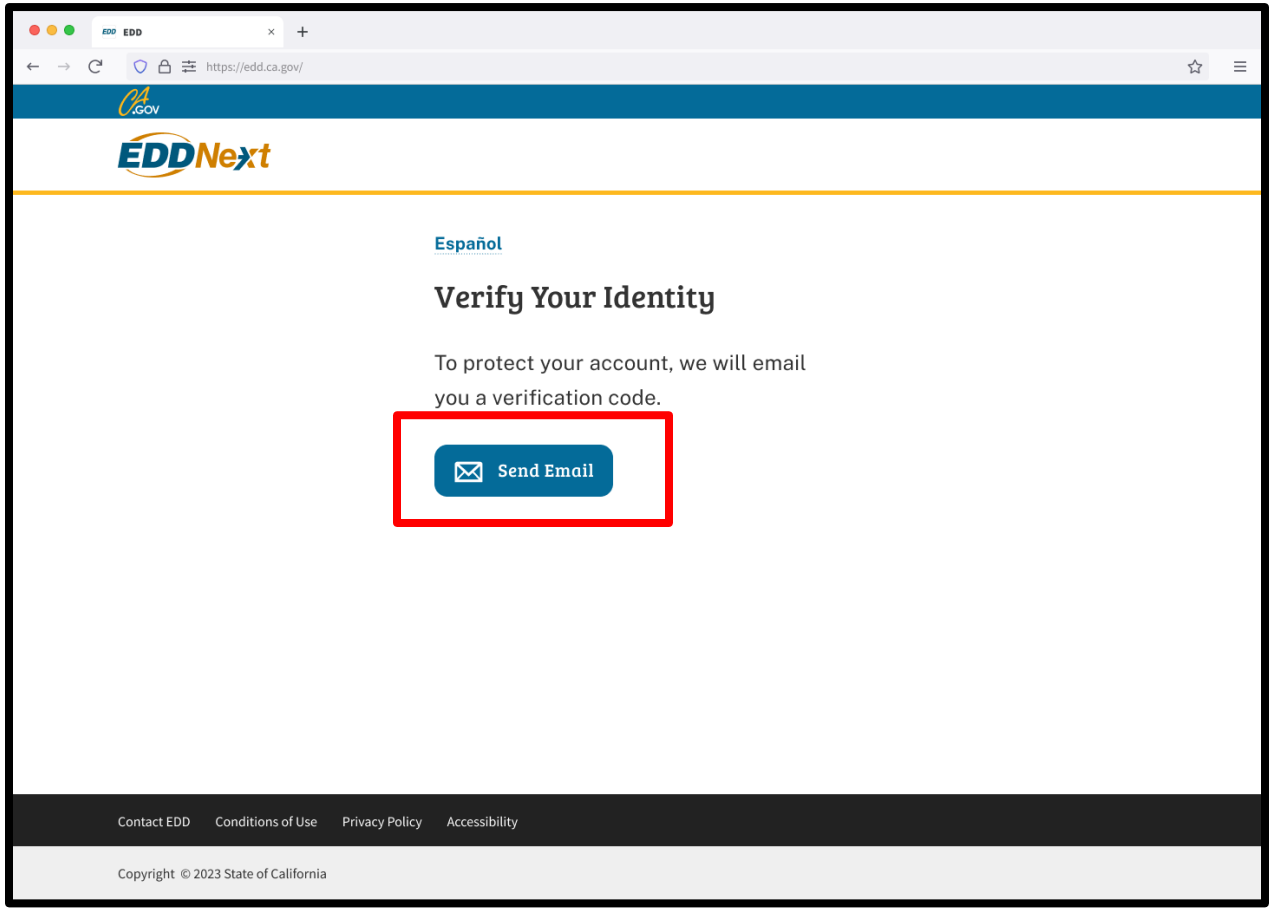



**Note**

For Spanish, select **Español**.

Log in to myEDD to access your SDI Online account and update your email, password, security question, or verification option:

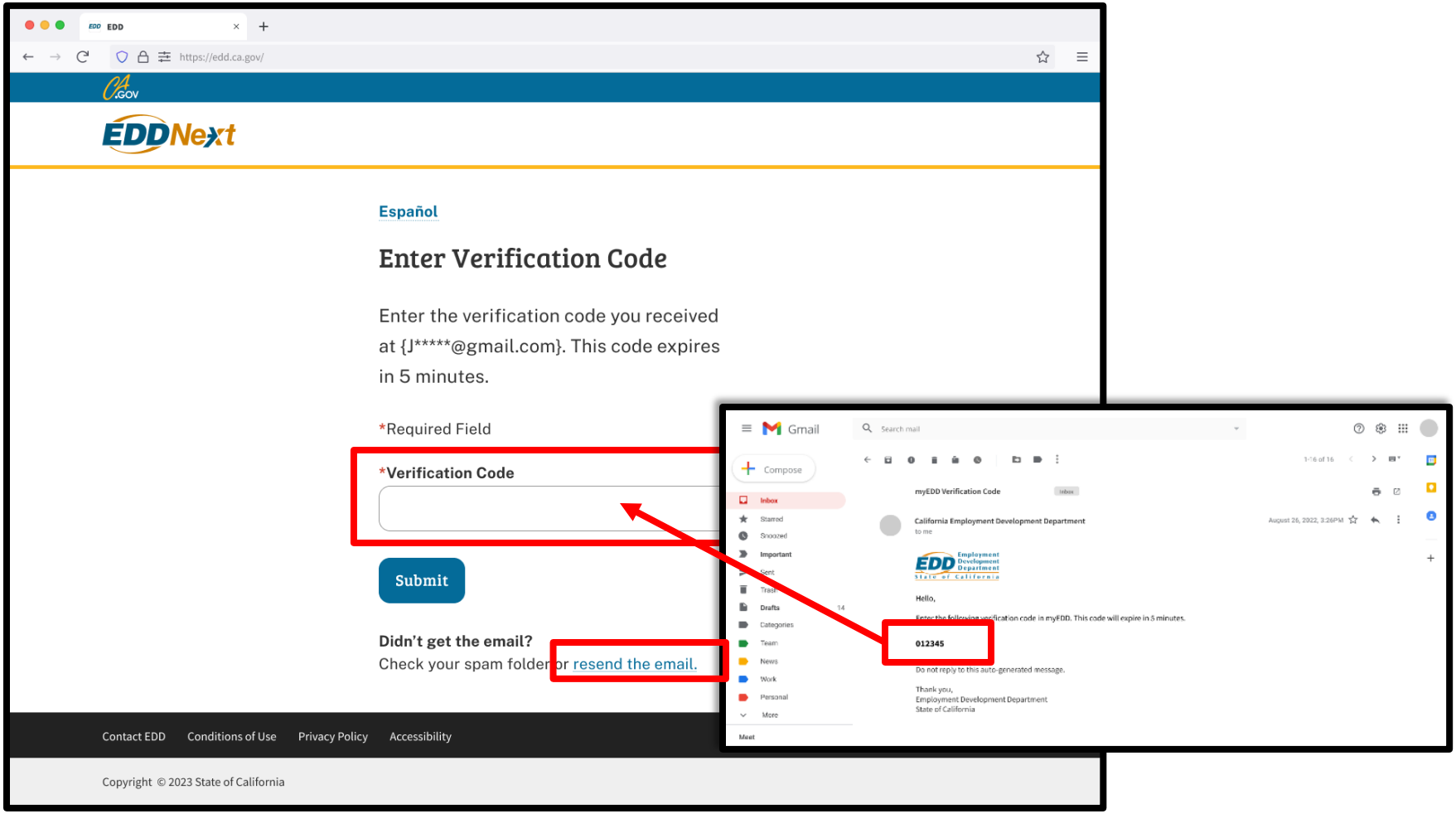
1. Visit myEDD.
2. Enter the email and password used to create your myEDD account.
3. Select **Log In**.




To protect your account, we ask you to verify your identity every time you log in. In this example, the identity verification option is by email.

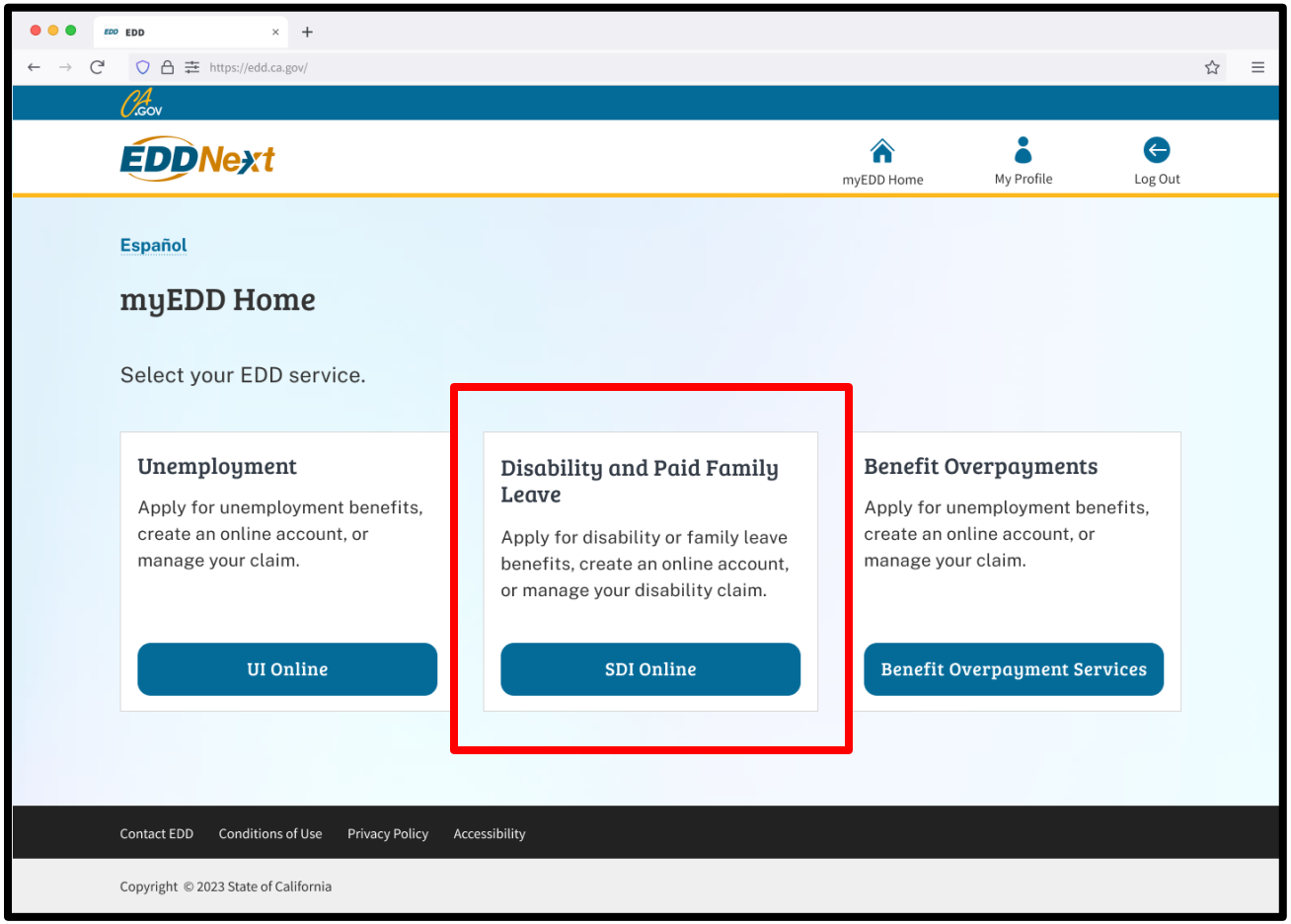
Select **Send Email.**

If you set up the login verification option as text message or phone call, follow the instructions based on that option.




Check your email for your verification code. This code expires in five minutes. Check your spam or junk folder if you do not get this email.

- Enter your verification code and select **Submit**.
- Select **resend the email** if you do not get a code.




**Note**

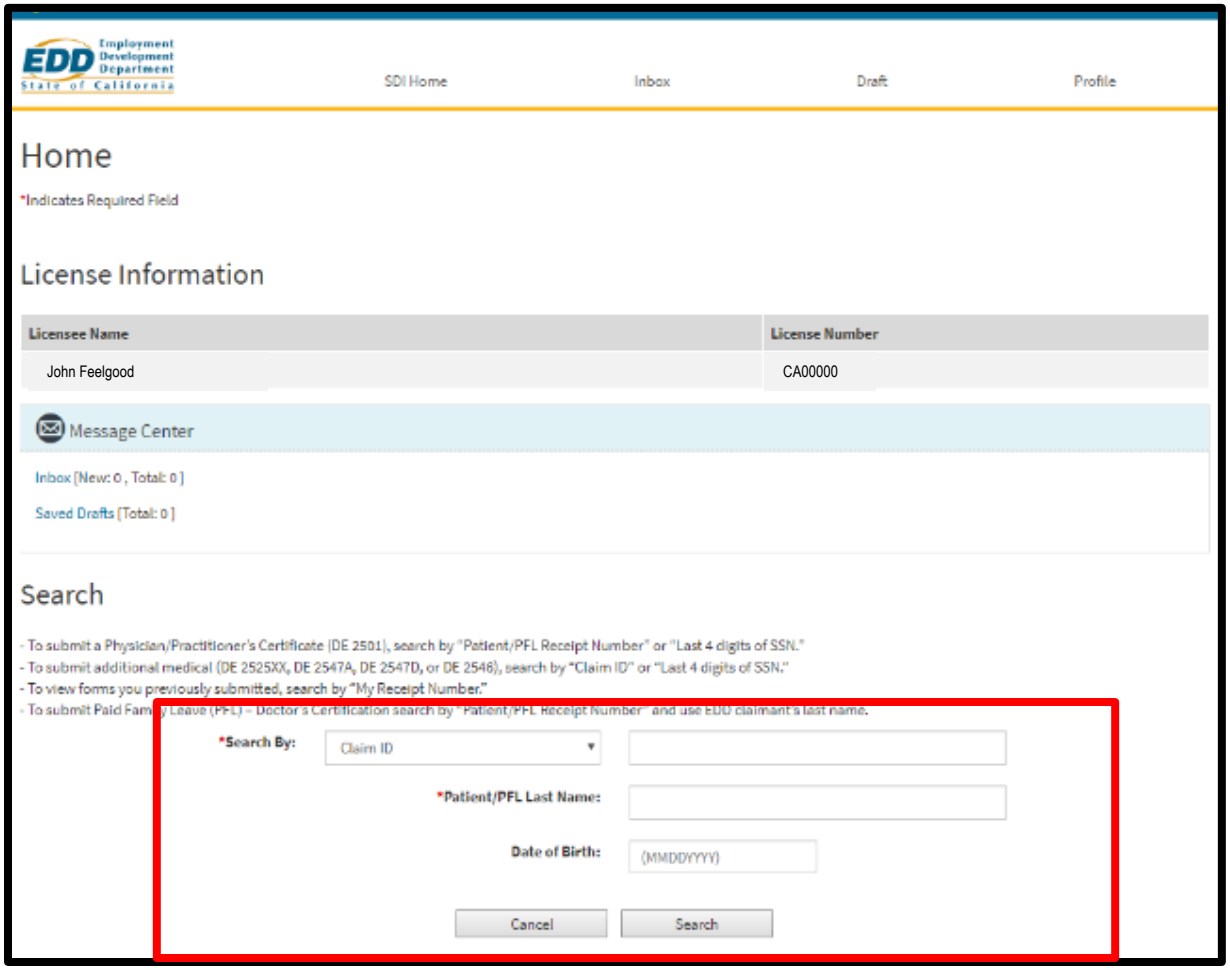
Select **Log Out** in the top right corner of any screen to exit your account.

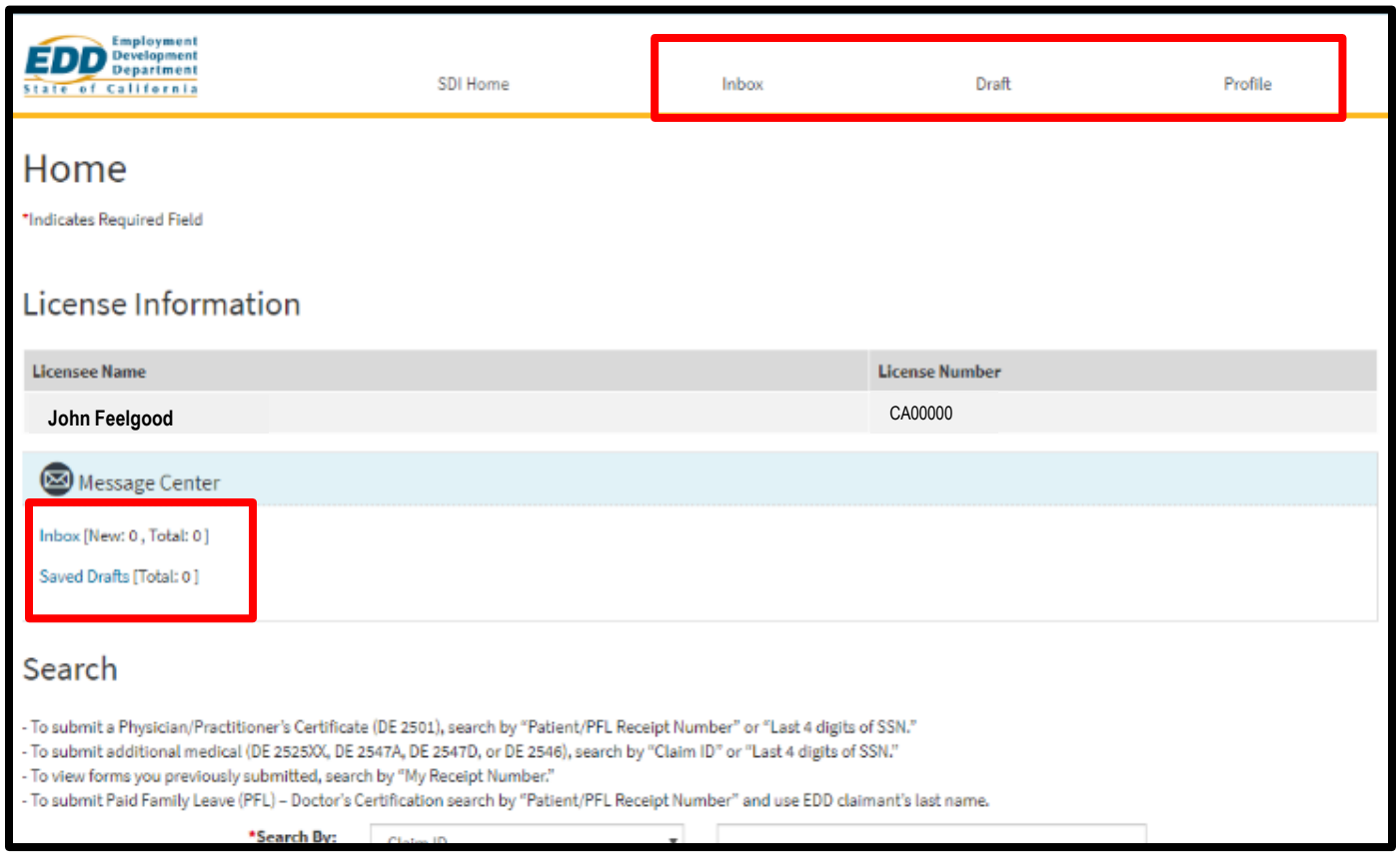
From the myEDD homepage, select **SDI Online** to begin your SDI Online certification.

On your SDI Online homepage, under the Search section, there are four ways to search for forms.

Search by the patient's last name and one of the following:

- The **Last four digits of SSN** or **Patient Receipt Number** and patient's date of birth.
- The **Claim ID** to submit additional medical.
- The **My Receipt Number** to review forms you have submitted.
- The **Patient/PFL Receipt Number** to submit Paid Family Leave forms.






The main menu appears on most screens and has additional options.

- **Inbox:** Access the Message Center for messages from the EDD.
- **Draft:** Locate drafts of forms previously started, but not completed. Saved Drafts are deleted after 30 days.
- **Profile:** Update your phone number and communication preferences.

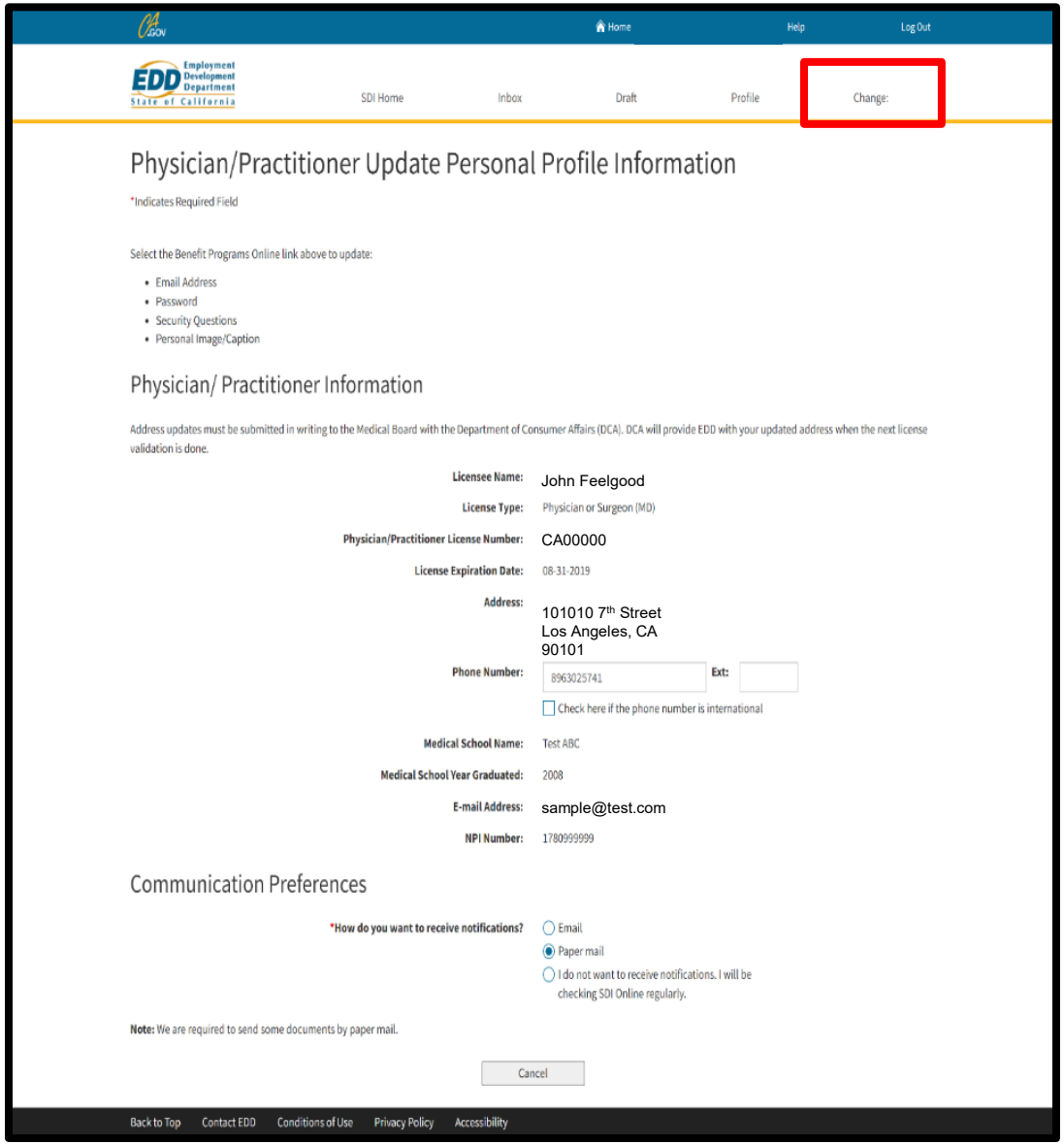
You can only update your phone number and communication preference in your SDI Online profile.

Address updates must be sent to the Medical Board with the Department of Consumer Affairs (DCA). We get this information after the DCA updates your address and we compete a license validation. Contact the DCA if you have trouble updating your address.

Go to your myEDD homepage to update your:

- Email address
- Password
- Security question
- Verification options

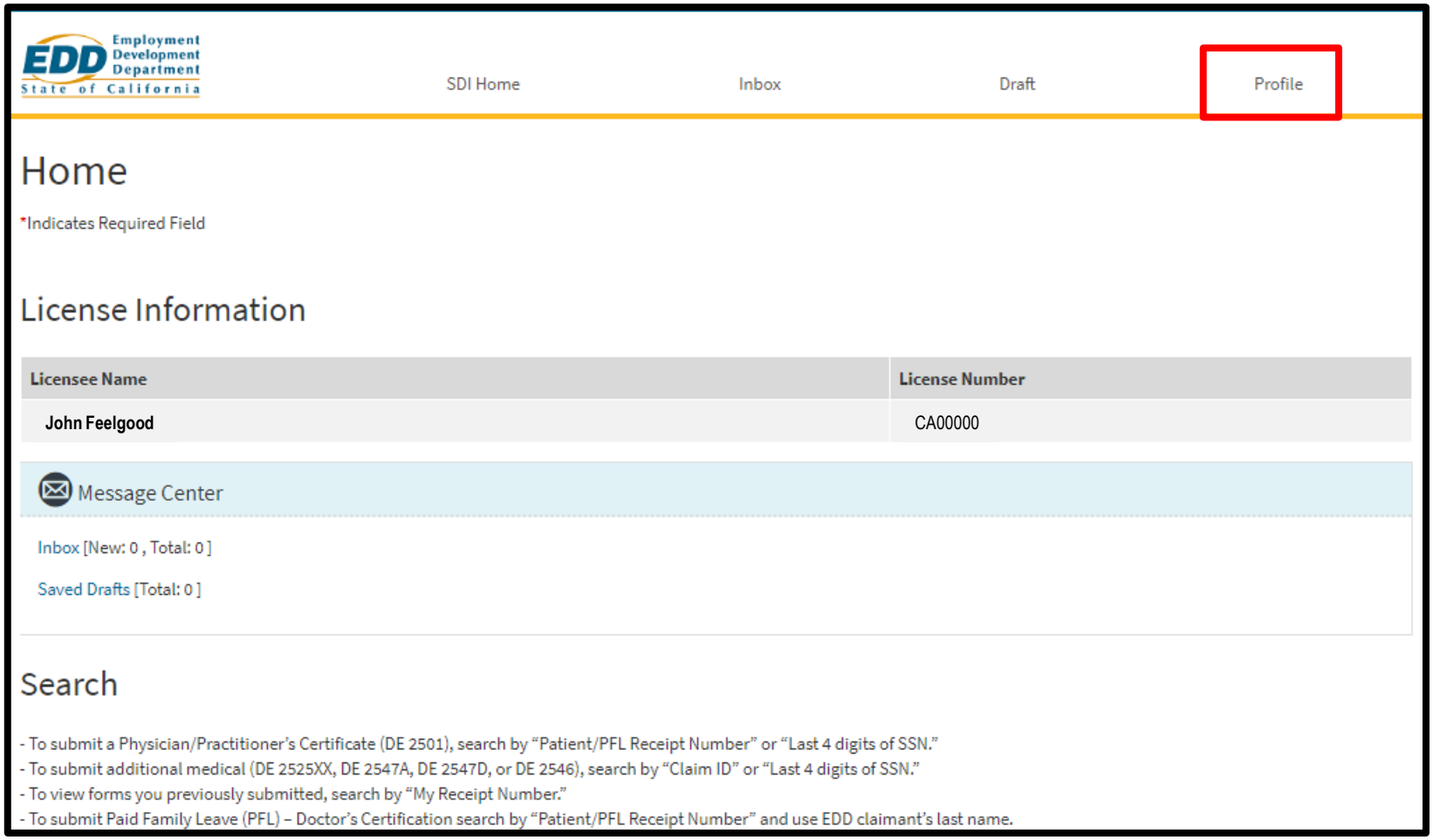
For instructions on adding treatment addresses, continue to the next section.



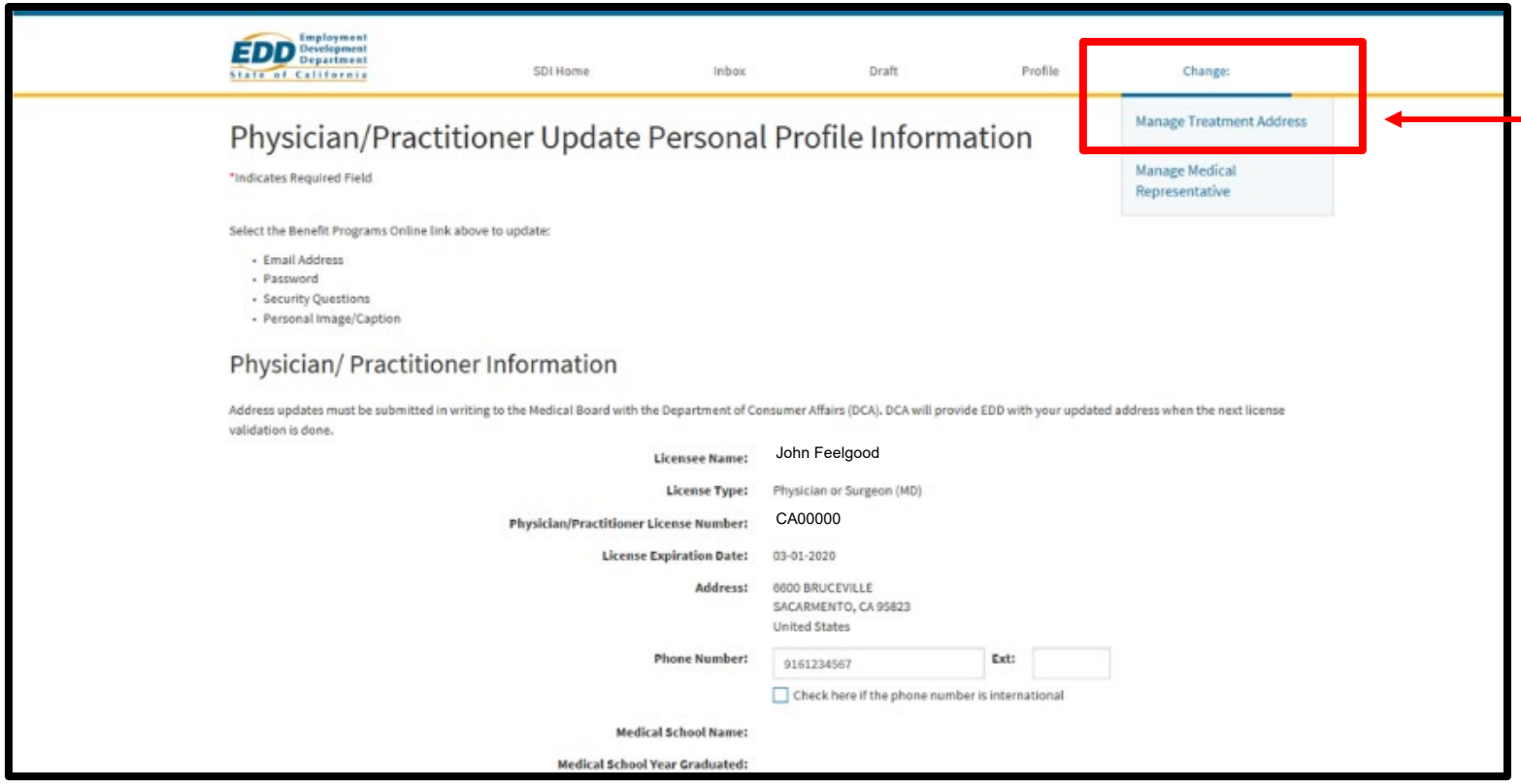
# Add a Treatment Address

Learn more about how to add treatment addresses to your account.

Get Started

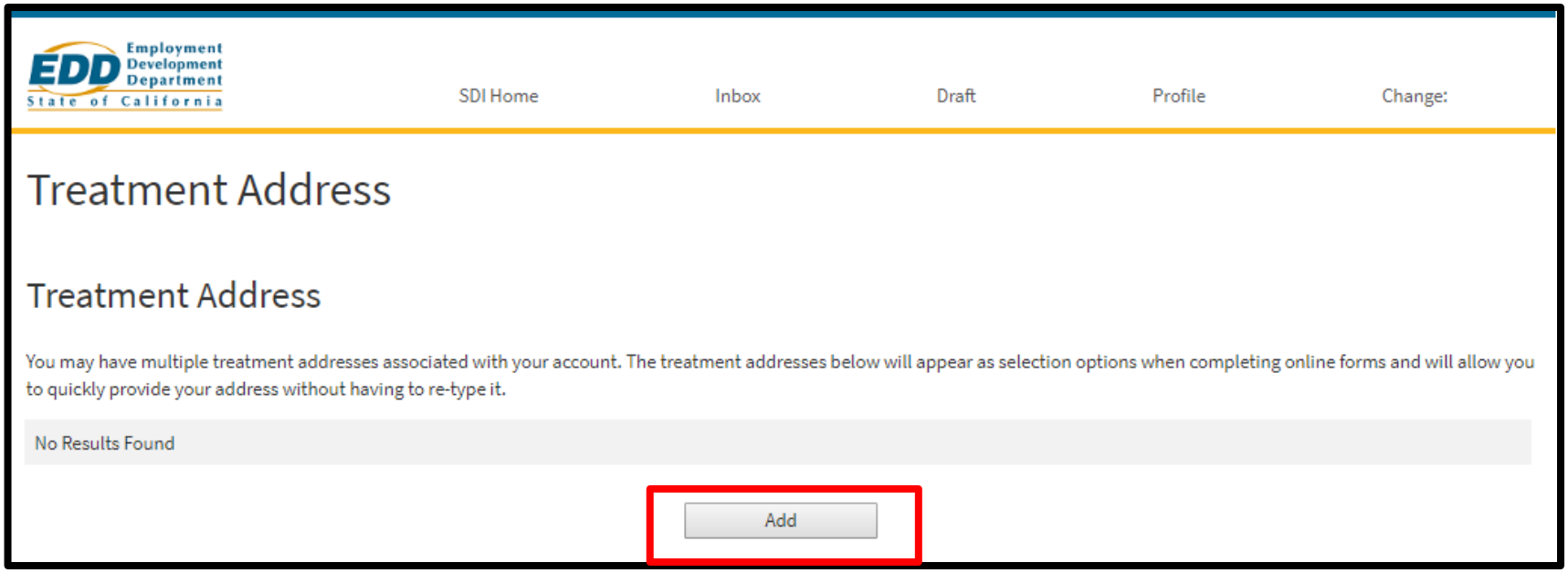



To add a treatment address, select the **Profile** link on your SDI Online homepage.

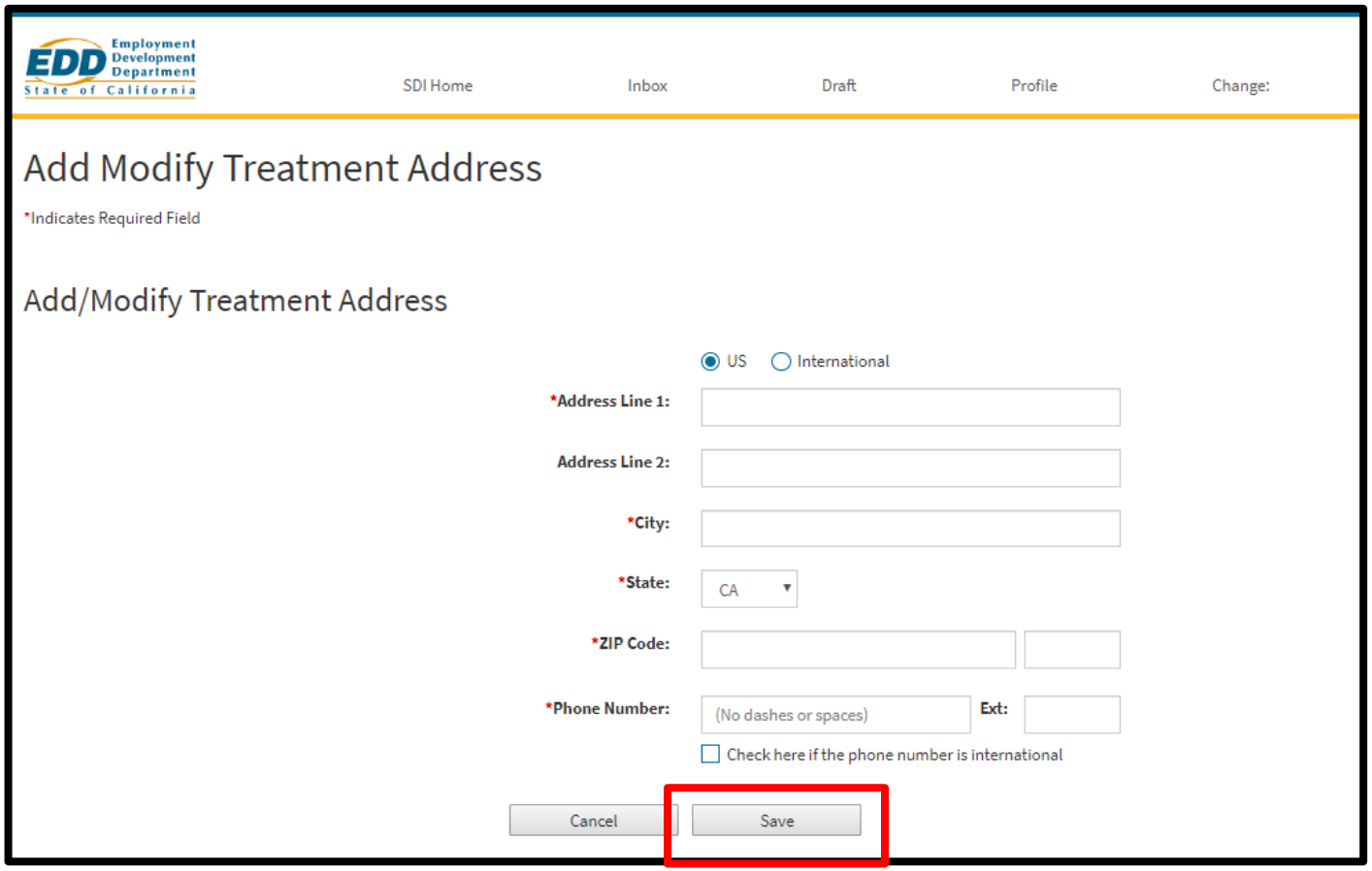



From the menu:

- Hover your cursor over **Change (**this option is only available after selecting **Profile**).
- Select **Manage Treatment Address** from the Physician/Practitioner Update Personal Profile Information screen.
- You will be sent to the Treatment Address screen.




Select the **Add** button to be sent to the Add Modify Treatment Address screen.



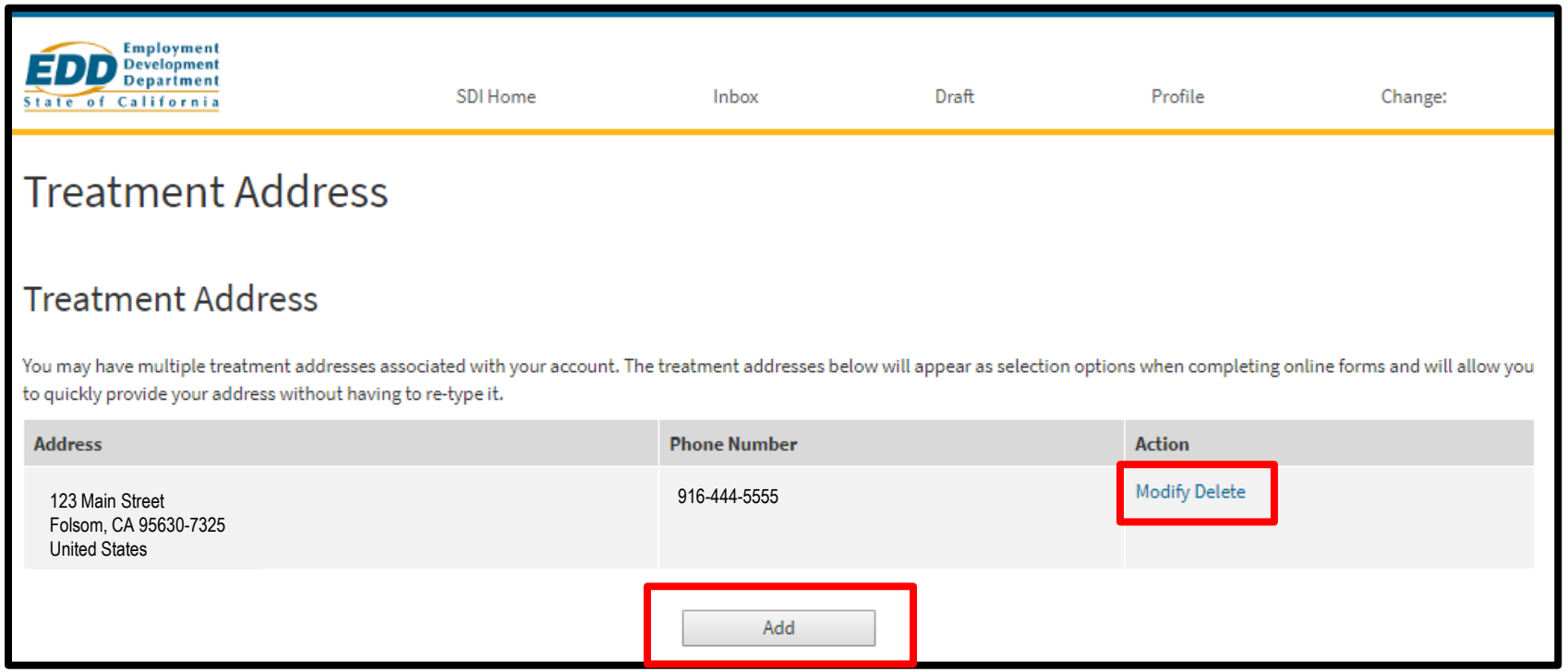

Complete the open fields on the Add Modify Treatment Address screen.

You must complete the fields marked with a red asterisk (*).

Select **Save**.

**Note**

If you practice at multiple locations, repeat this process to add more treatment addresses.




All treatment addresses you enter are displayed on the Treatment Address screen.

- Select **Modify** or **Delete** to manage each treatment address.
- To add additional treatment addresses, select **Add**.

**Note**

Treatment addresses will appear as selection options when you or your authorized representatives complete online medical forms.

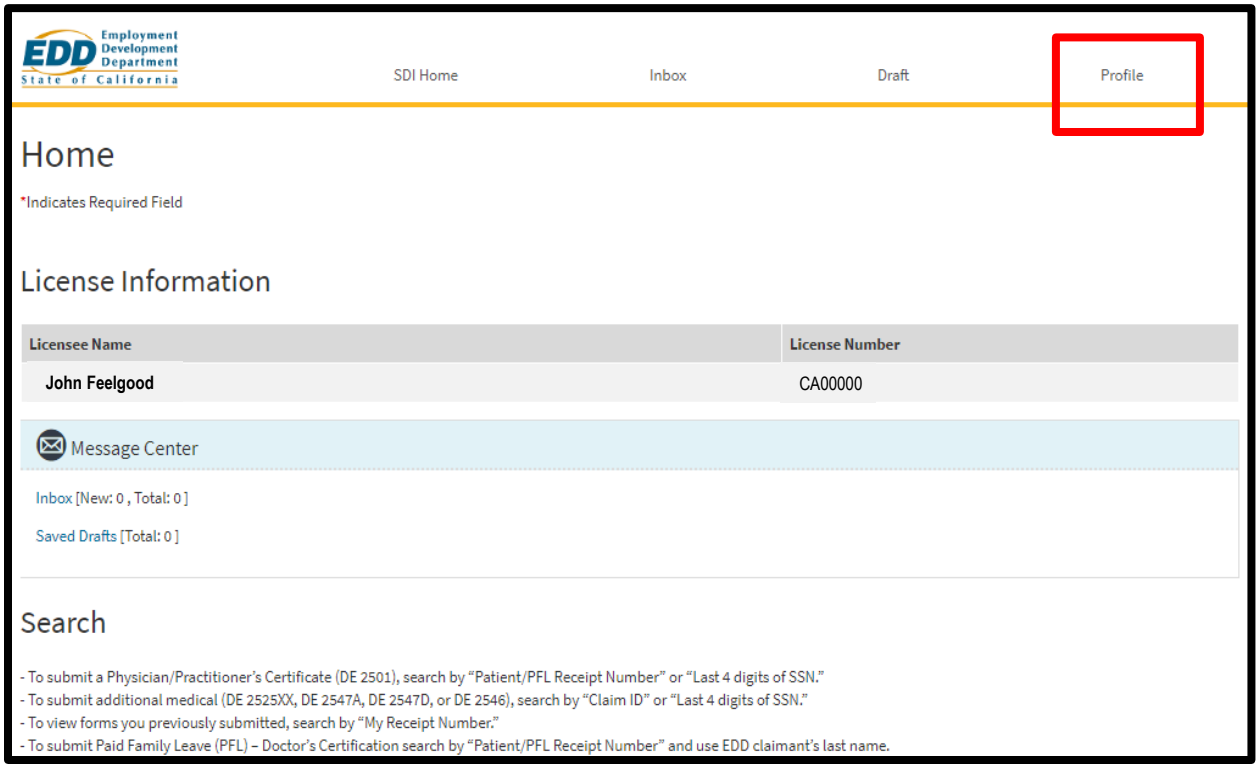
# Assign a Medical Representative

Learn more about how to add your medical representatives to your account.

Get Started

Physicians /practitioners may assign an unlimited number of representatives to complete and submit medical forms on their behalf.

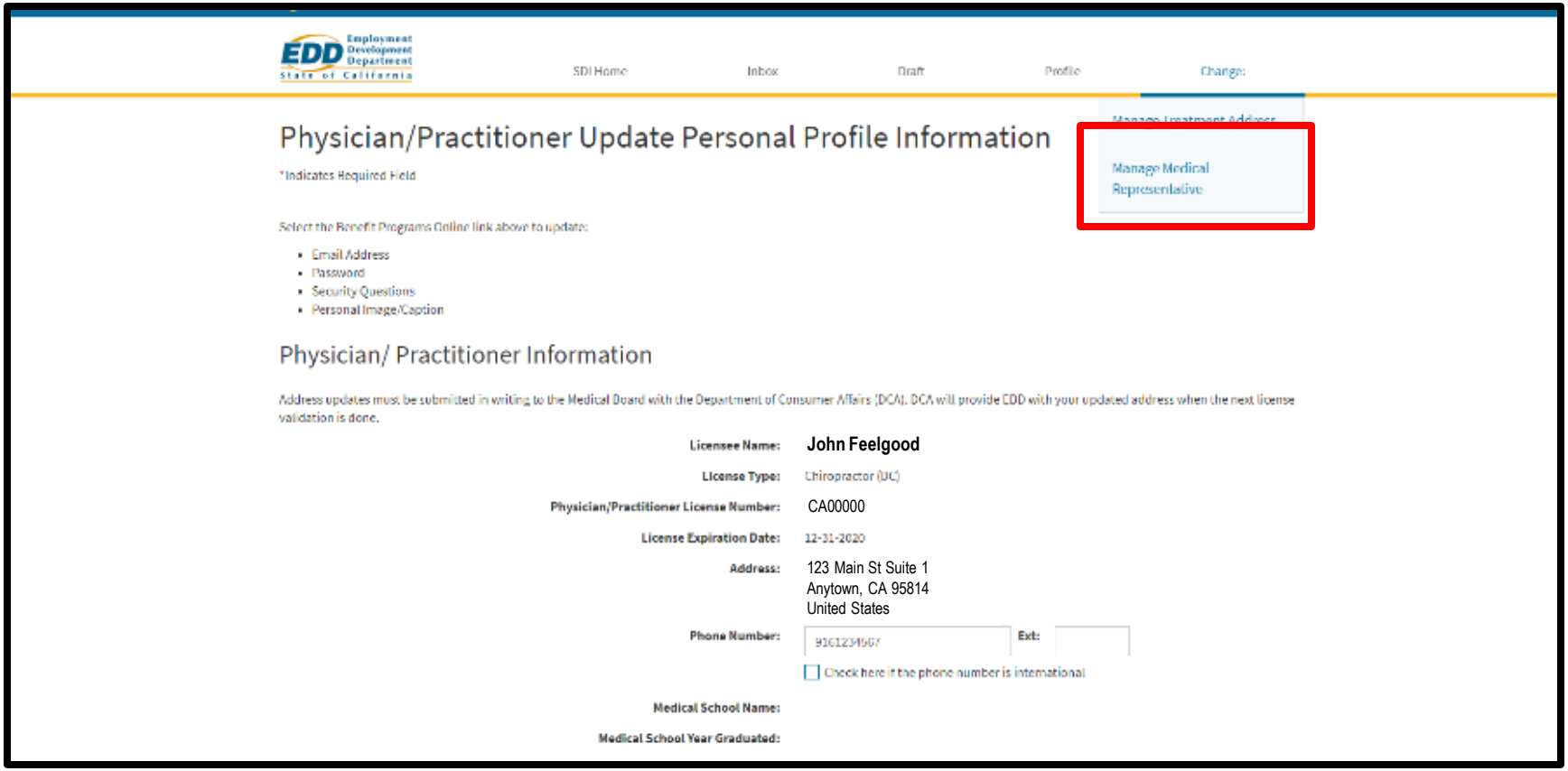
It is the physician/practitioner's responsibility to remove representatives that no longer work in their medical offices.




Before the medical representative can register for an SDI Online account, the physician/practitioner must add the medical representative's personal information and treatment address in their SDI Online profile.

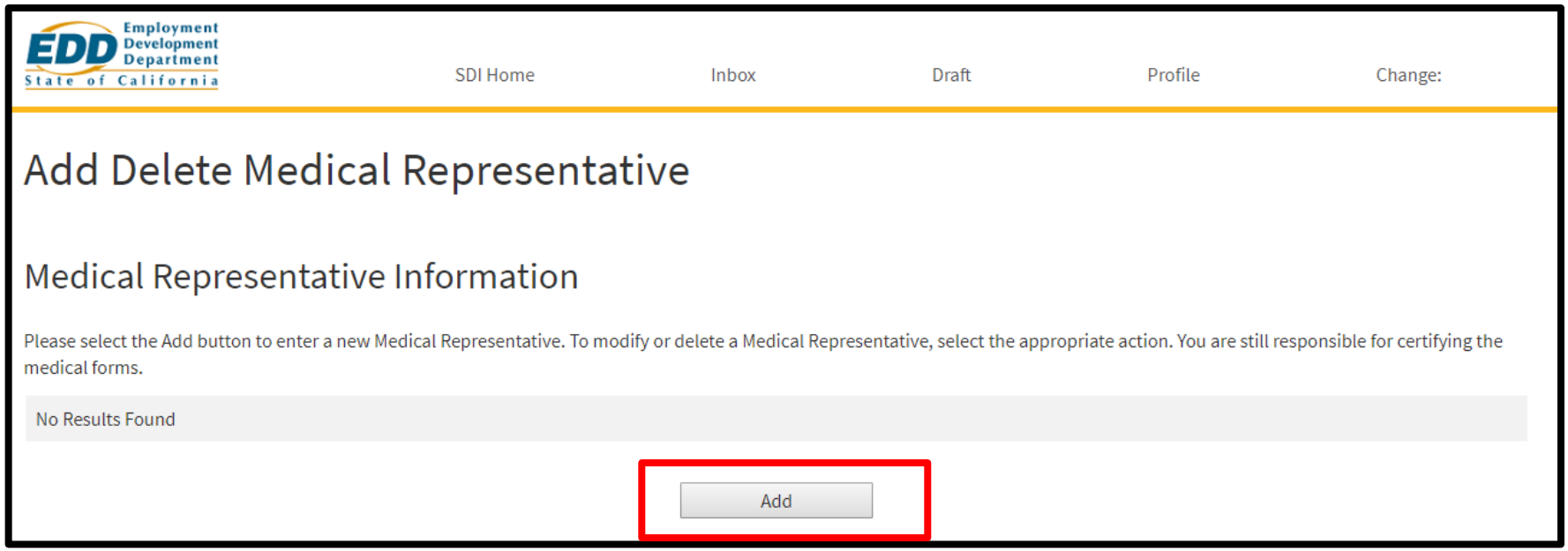
To add a physician/practitioner representative:

- Select **Profile** from the main menu.



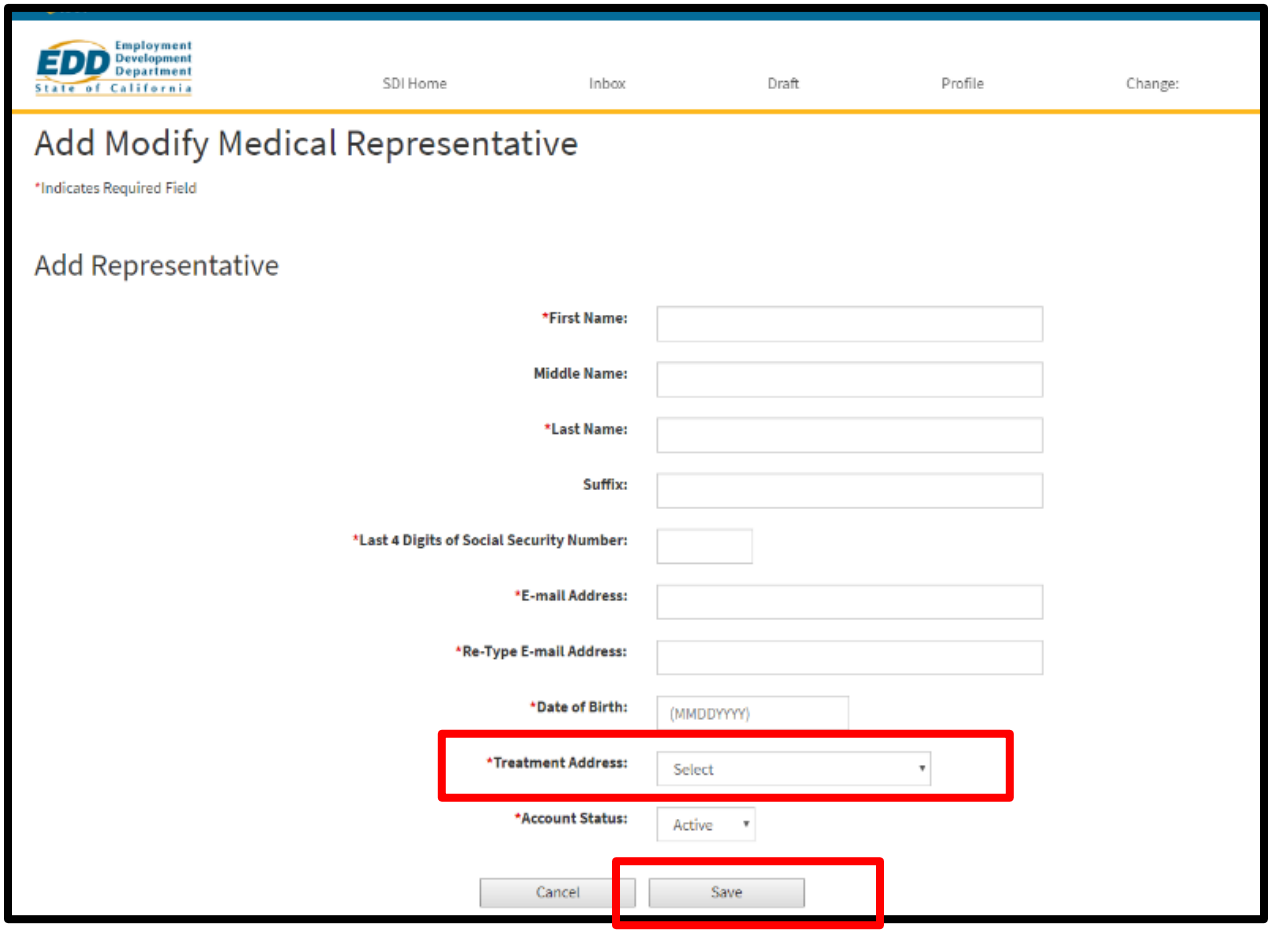

From the Physician/Practitioner Update Personal Profile Information screen:

- Hover over **Change** on the main menu (this option is only available after selecting **Profile**).
- Select **Manage Medical Representative**.




On the Add Delete Medical Representative screen:

- Select **Add.**



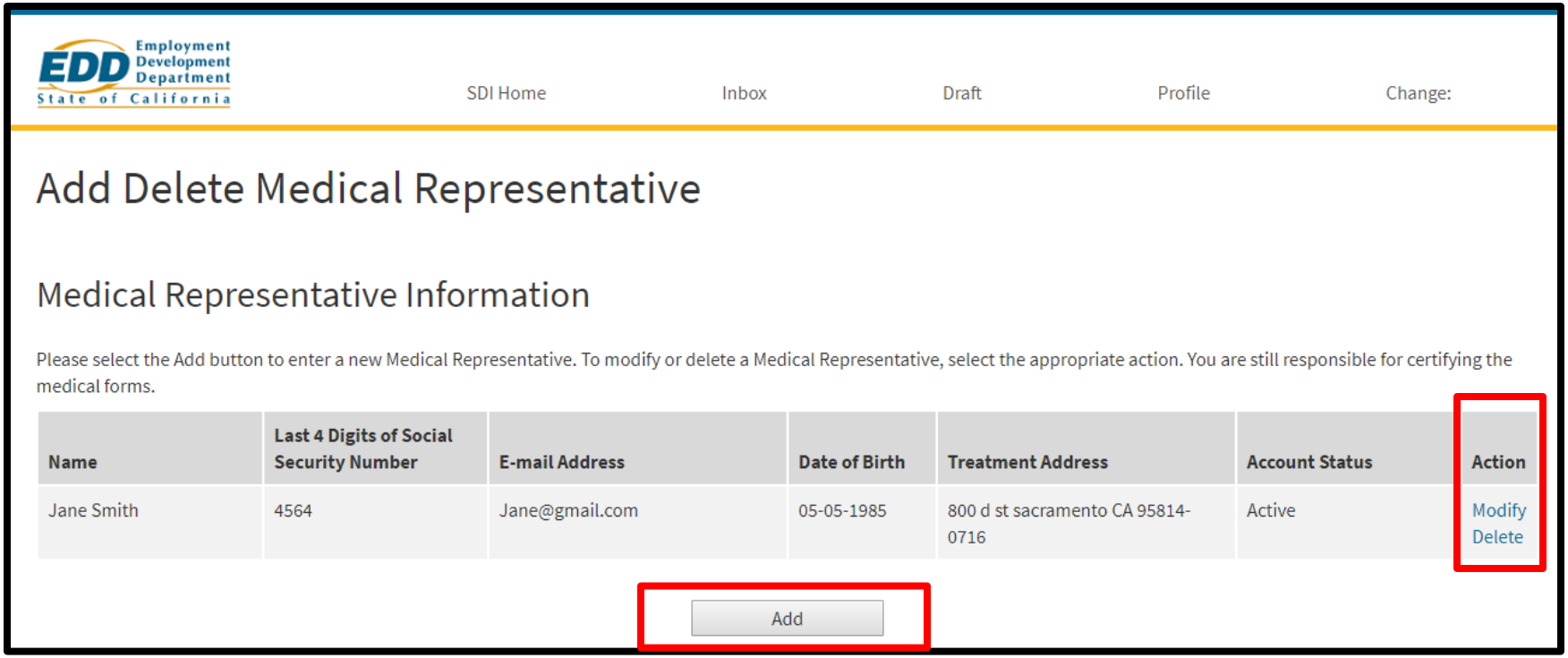

On the Add Modify Medical Representative screen:

- Complete all open fields. You must complete the fields marked with a red asterisk (*).
- Select a treatment address.
- Select **Save** to add your representative.

## Note

If the treatment address for your medical representative is not listed, you must select **Cancel** and add the treatment address to your profile.

Your medical representative must enter the same personal information you enter here when registering for their representative SDI Online account or they will get an error.



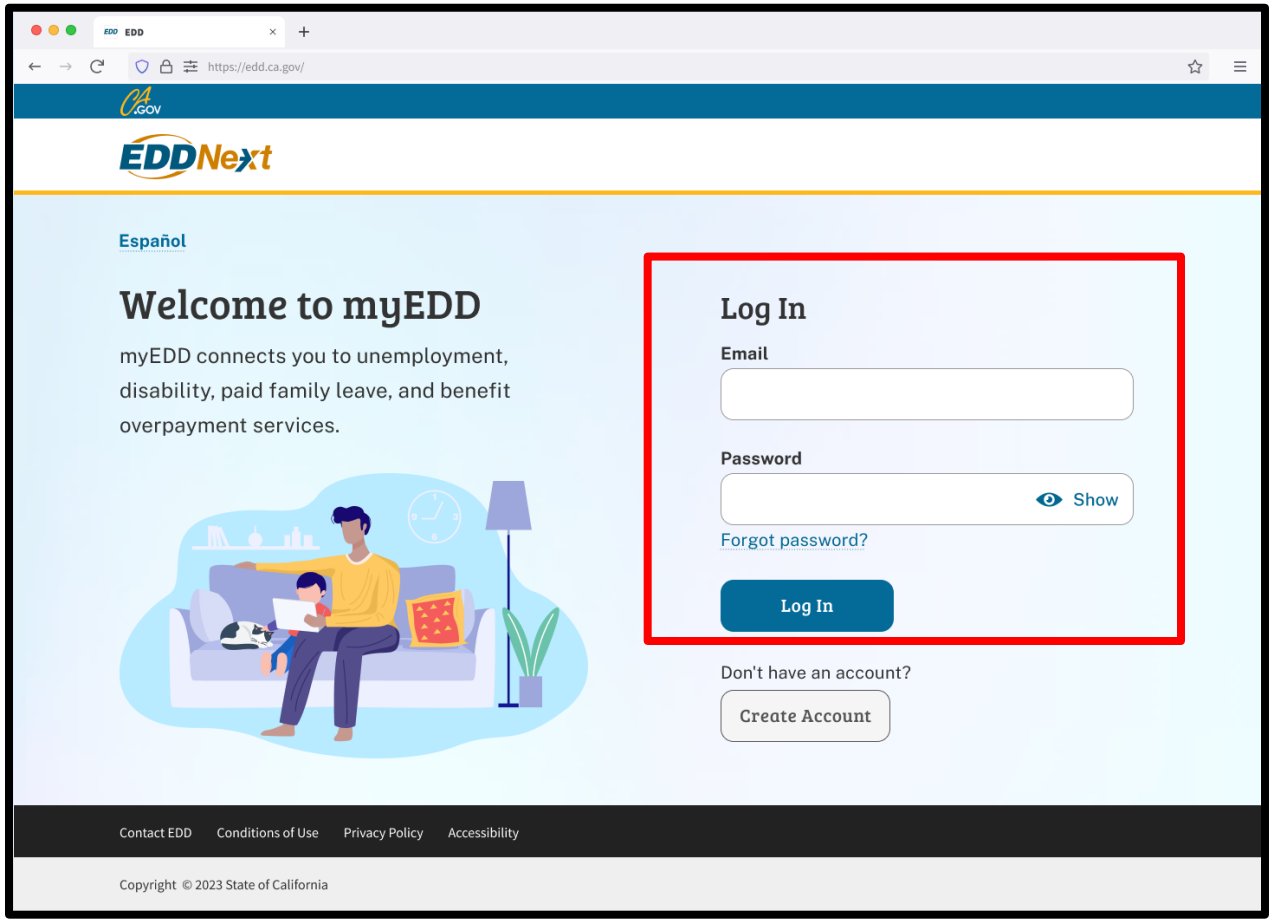

Added medical representatives are displayed on the Add Delete Medical Representative screen.

- Select **Modify** to update information for a specific medical representative.
- Select **Delete** to delete a specific medical representative.
- Select **Add** to add additional representatives.

# Register as a Medical Representative in SDI Online

Learn more about how representatives of physicians/practitioners register in SDI Online.

Get Started




To register for a new SDI Online account type (Claimant, employer, physician, representative, etc.) you must first complete a one-time registration in myEDD.

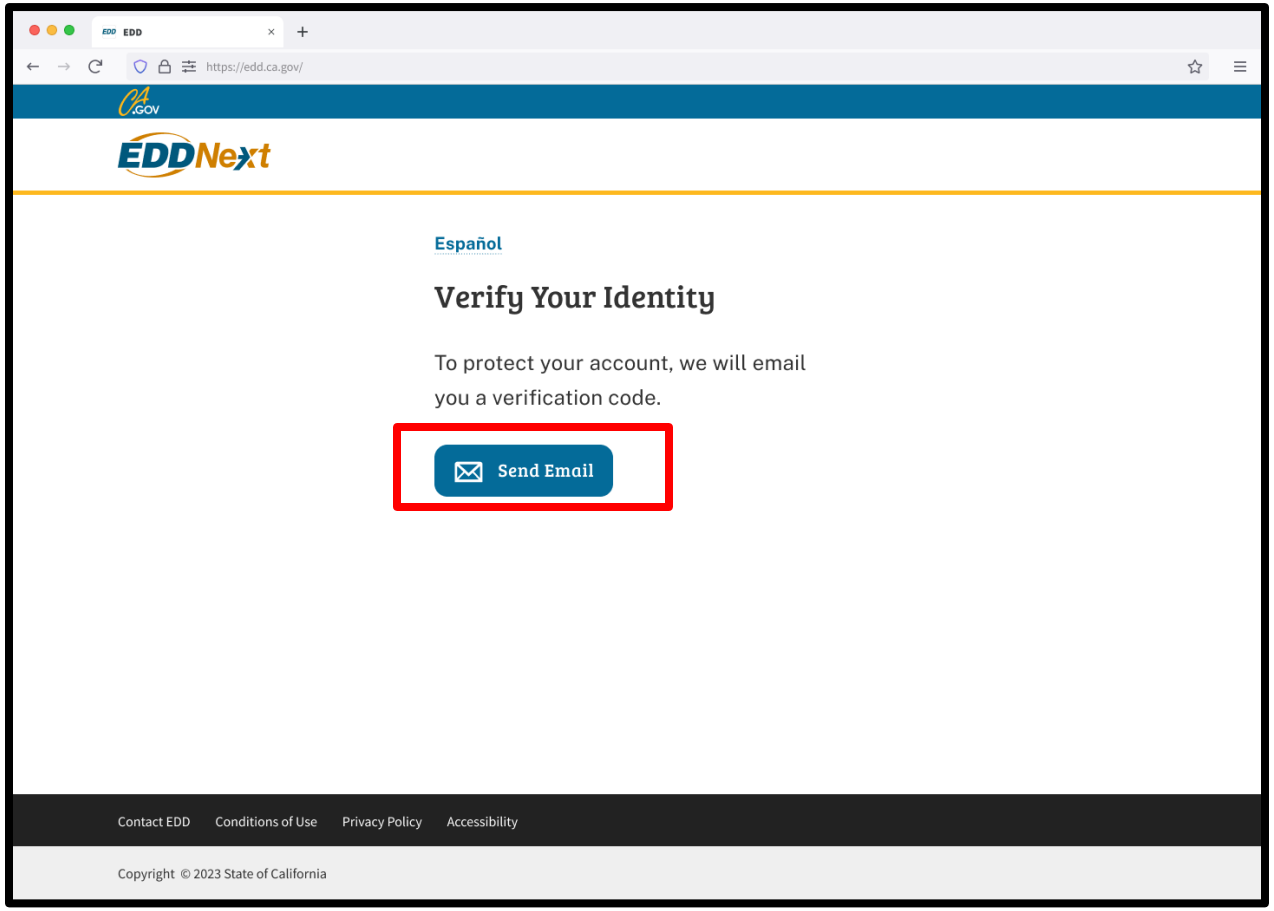
Use the Create Your myEDD Account section of this tutorial for instructions.

**Note**

For Spanish, select **Español**.

Log in to myEDD to register as a physician/practitioner representative in SDI Online:

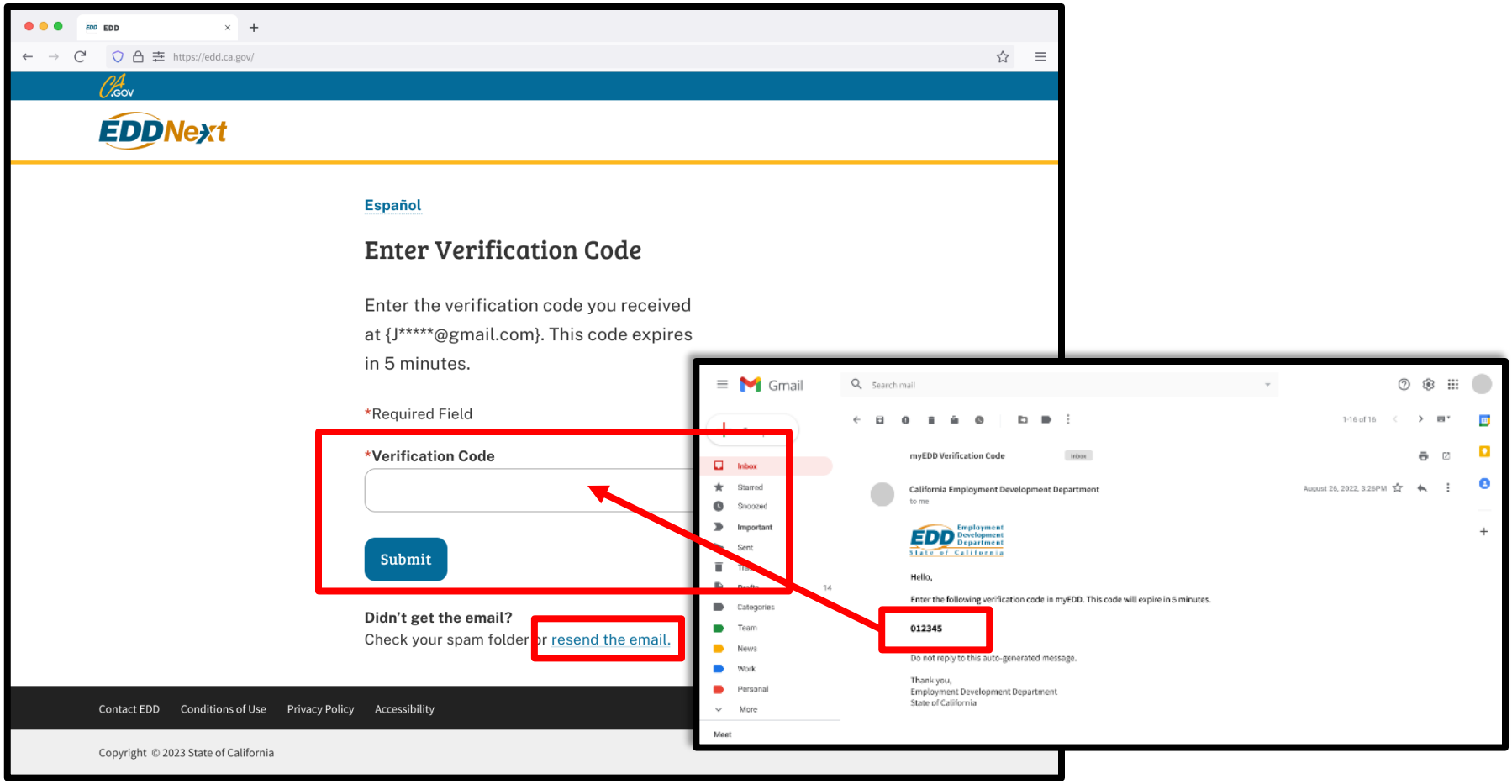
1. Visit myEDD.
2. Enter the email and password used to create your myEDD account.
3. Select **Log In**.




To protect your account, we ask you to verify your identity every time you log in. In this example, the identity verification option is by email.

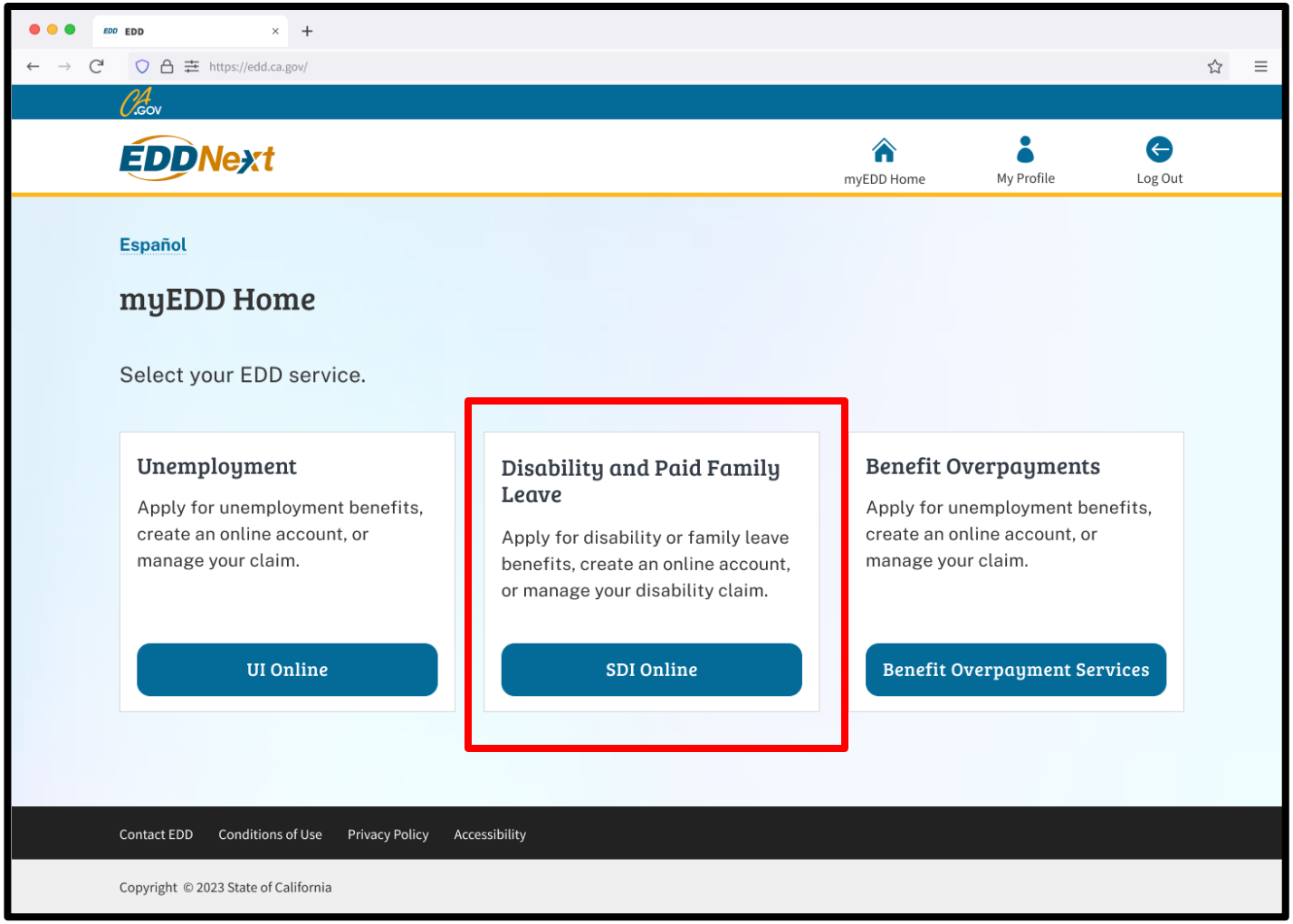
Select **Send Email.**

If you set up the login verification option as text message or phone call, follow the instructions based on that option.




Check your email for your verification code. This code expires in five minutes. Check your spam or junk folder if you do not get this email in your inbox.

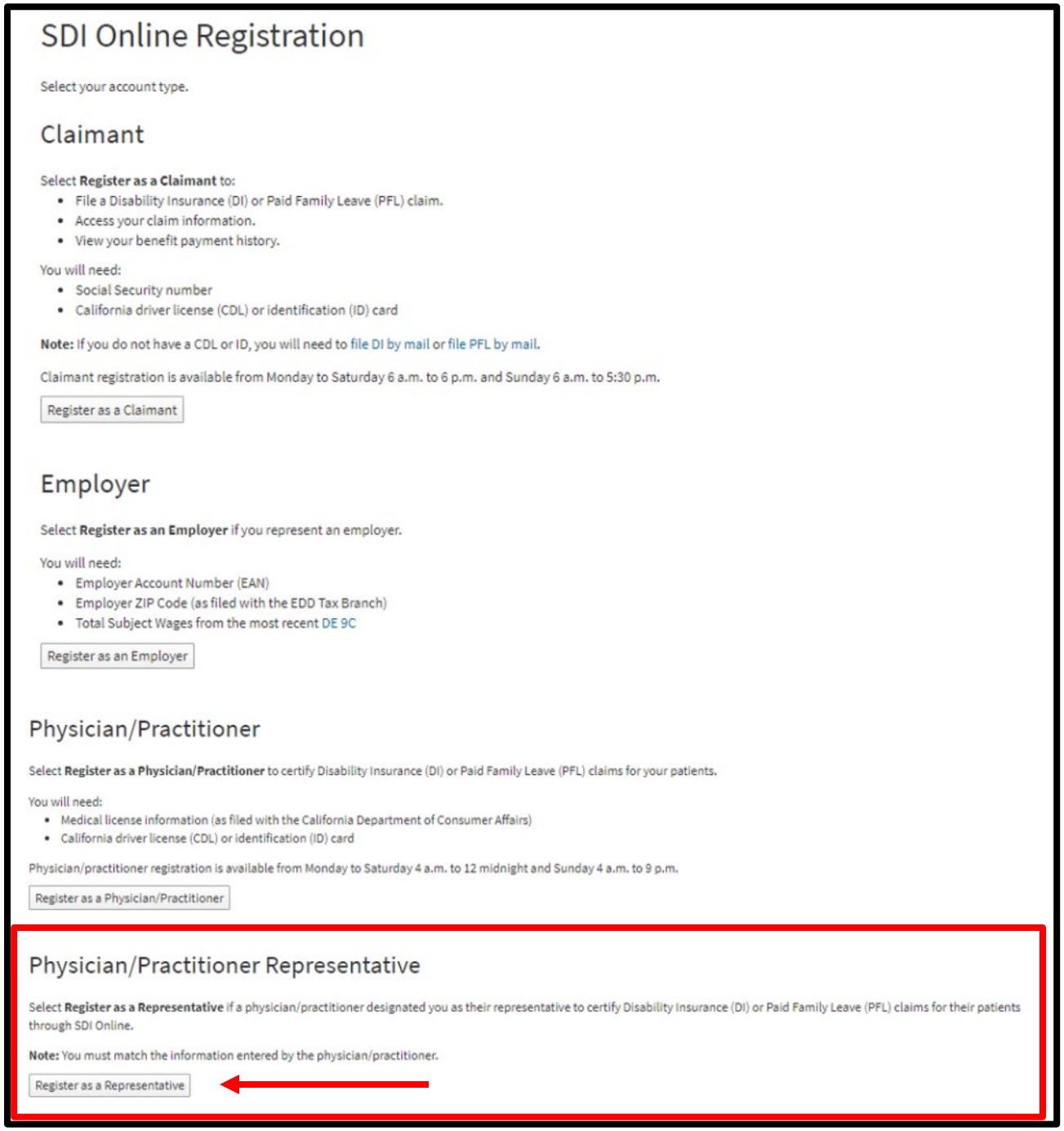
- Enter your verification code and select **Submit**.
- Select **resend the email** if you do not get a code.




**Note**

Select **Log Out** in the top right corner of any screen to exit your account.

From the myEDD homepage, select **SDI Online** to begin your SDI Online registration.

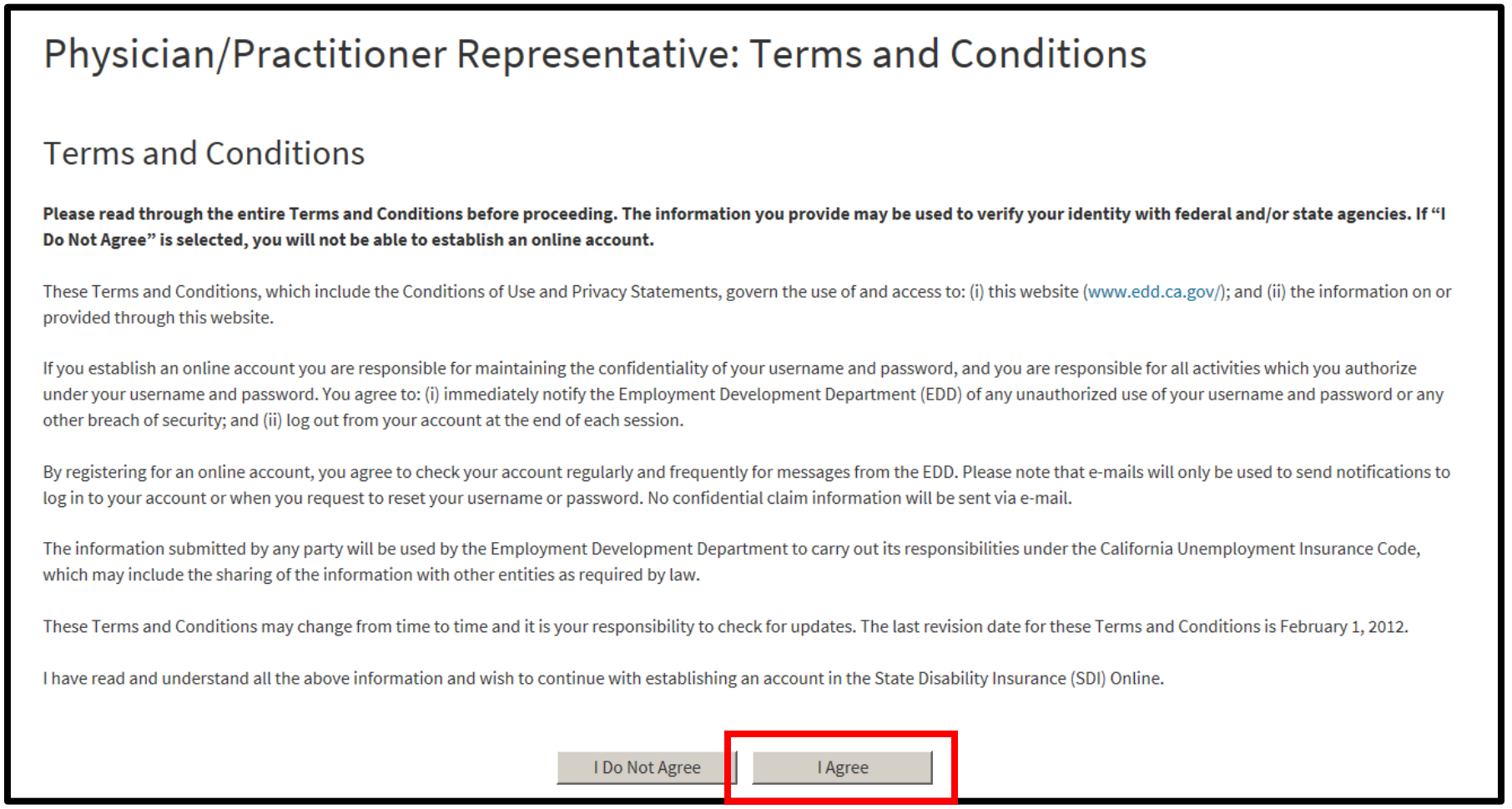



You will be sent to the SDI Online Registration Account Type screen.

Select the **Register as a Representative** link.

**Note**

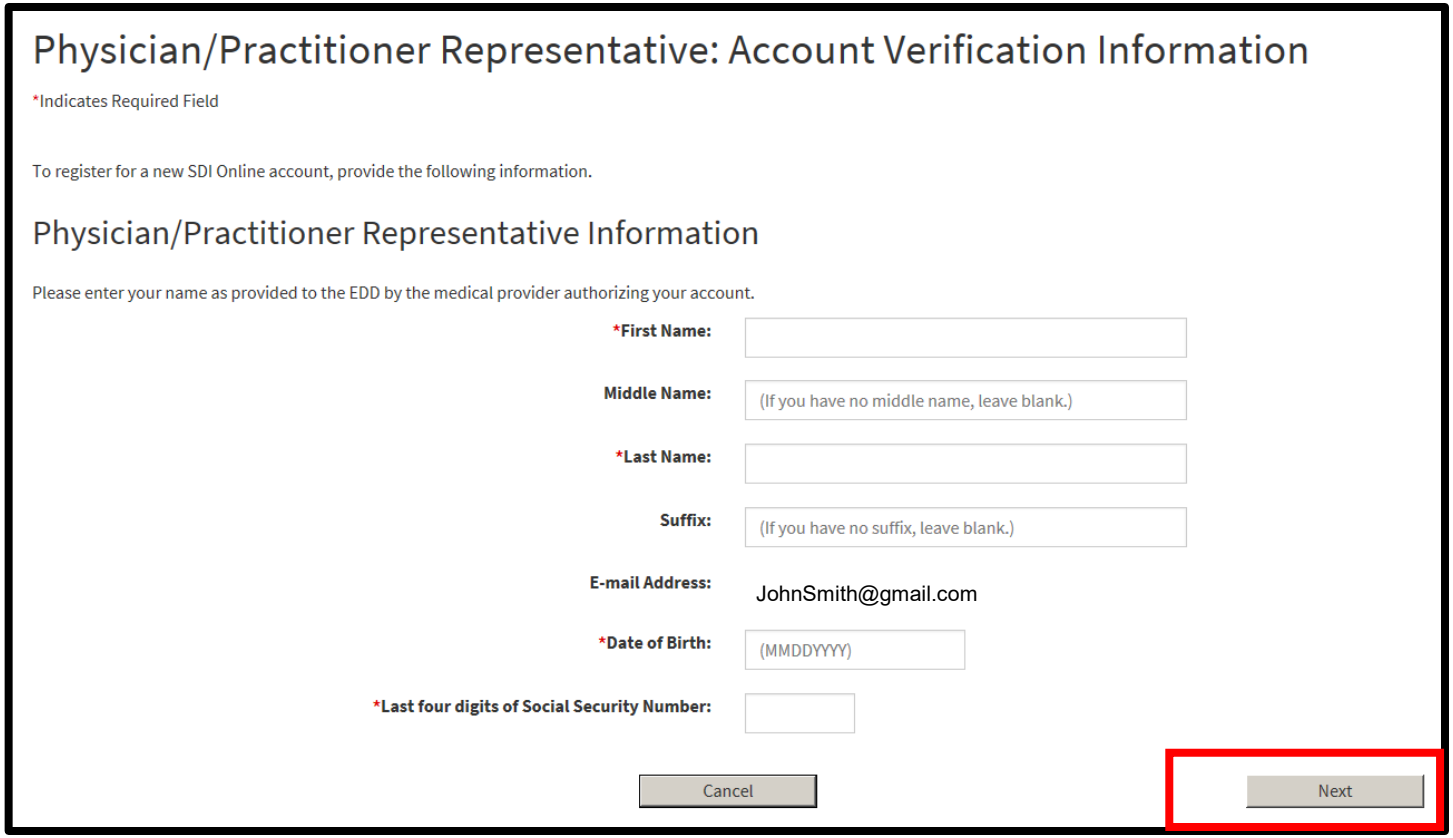
You will not be able to register as a representative until the licensed health professional authorizing your account has added your information to their SDI Online profile.




Next, review our terms and conditions.

Select **I Agree**.

You must agree to these terms and conditions to create an account.

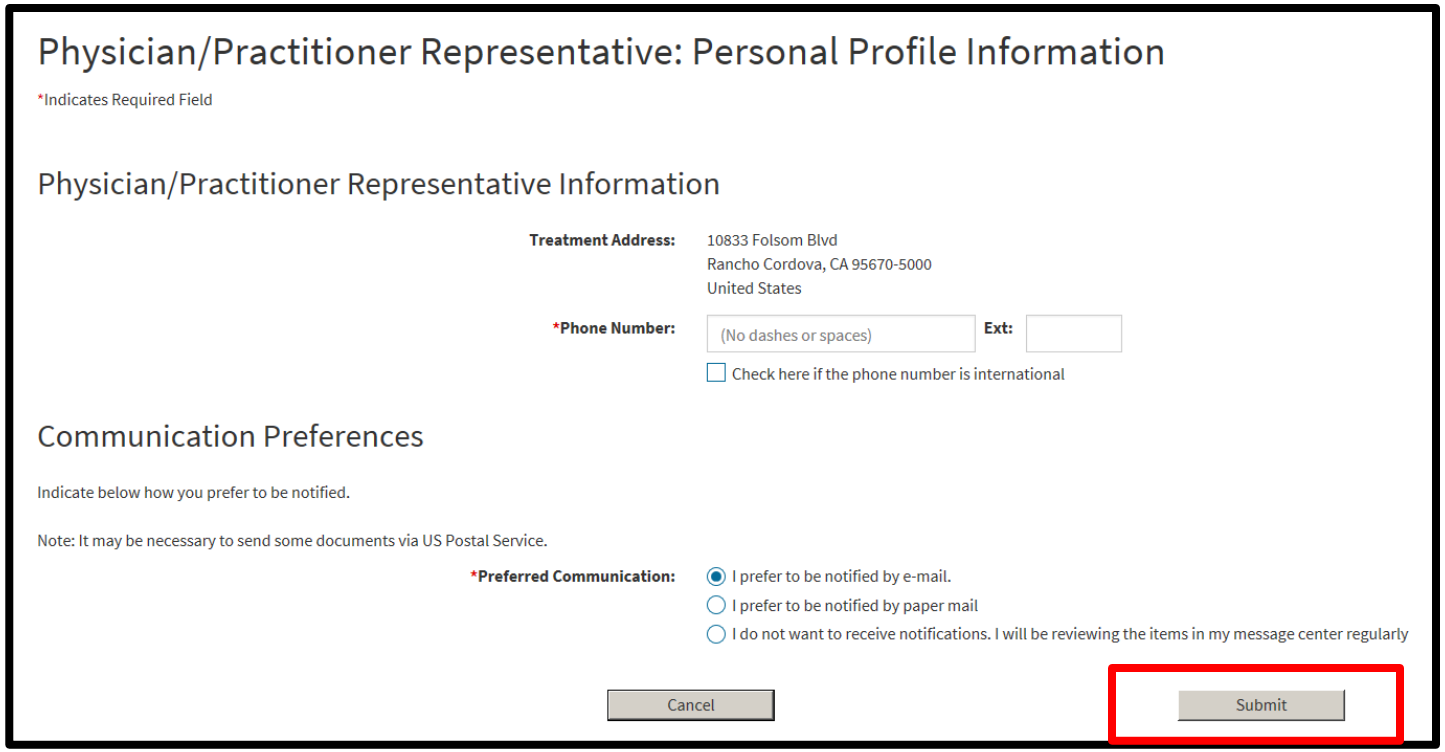



Enter the following personal information. You must complete the fields marked with a red asterisk (*).

- Your full legal name.
- Date of birth.
- Last four digits of your Social Security number.

If you get an error after entering your information, contact the physician/practitioner authorizing your account to make sure your entries match.

Select **Next**.




**Note**

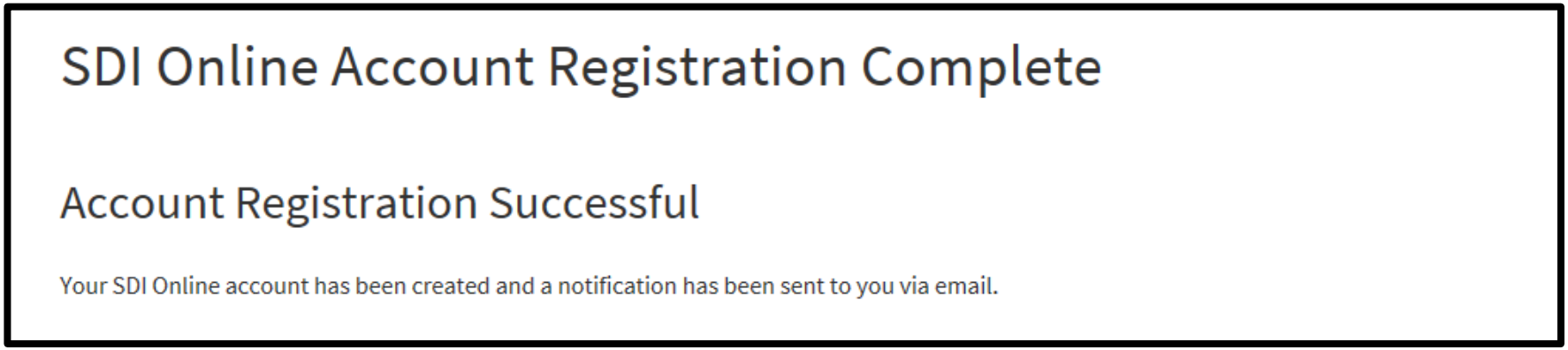
If you select to get notifications by email, we send you emails to notify you that messages are available in your account. However, it may be necessary to send some documents by mail.

On the Personal Profile Information screen:

- Verify the treatment address.

  If an incorrect treatment address is listed, the physician/practitioner authorizing your account must update the address from their SDI Online account profile.

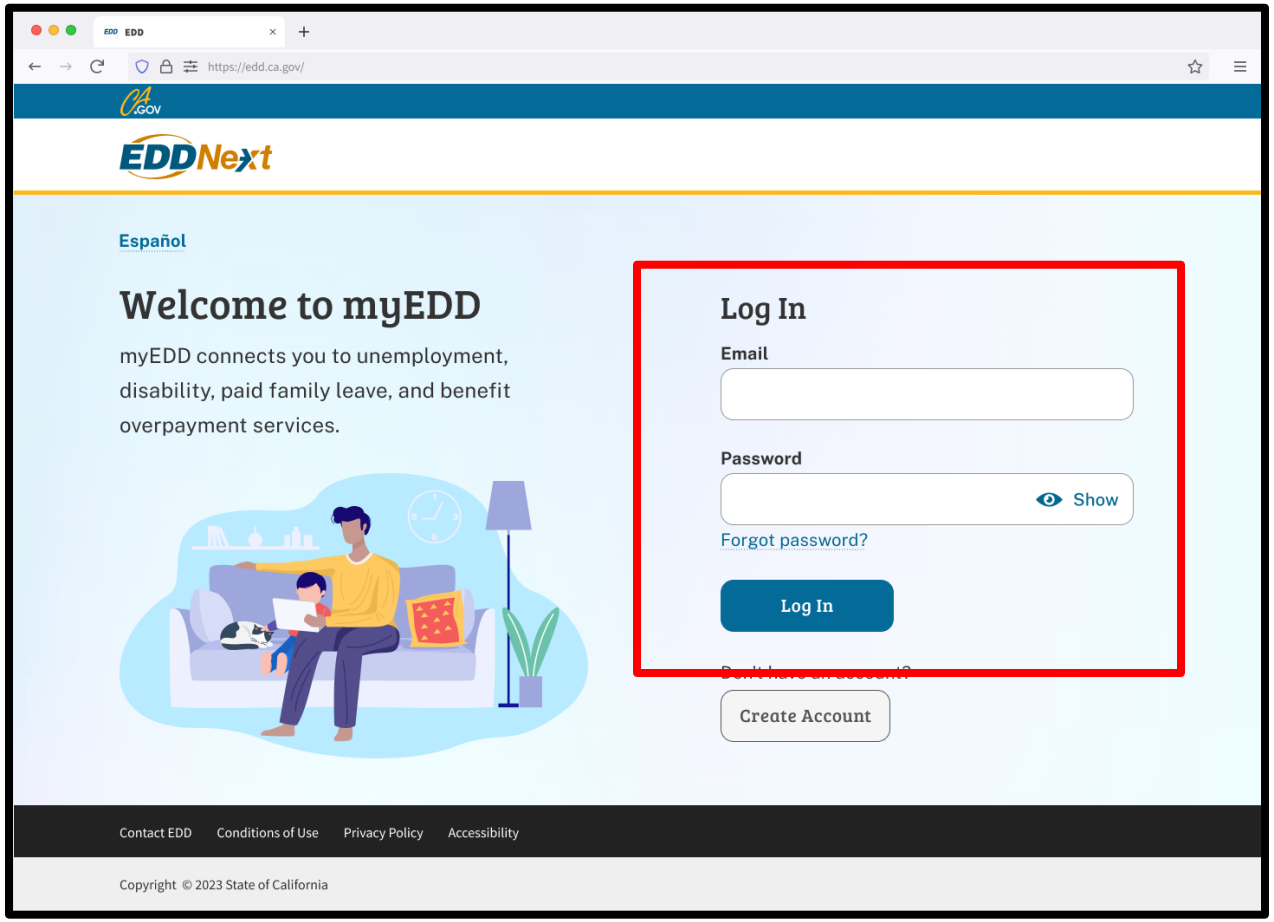
- Enter a phone number so we can contact you during business hours, if needed.
- Select your communication preference.
- Select **Submit.**




Your registration is now complete.

- If you selected electronic communication, a notification confirming your new account is sent to your email.
- If you selected paper communication, a letter confirming your new account is mailed to your address.

You may now log in to myEDD to access your new SDI Online account.

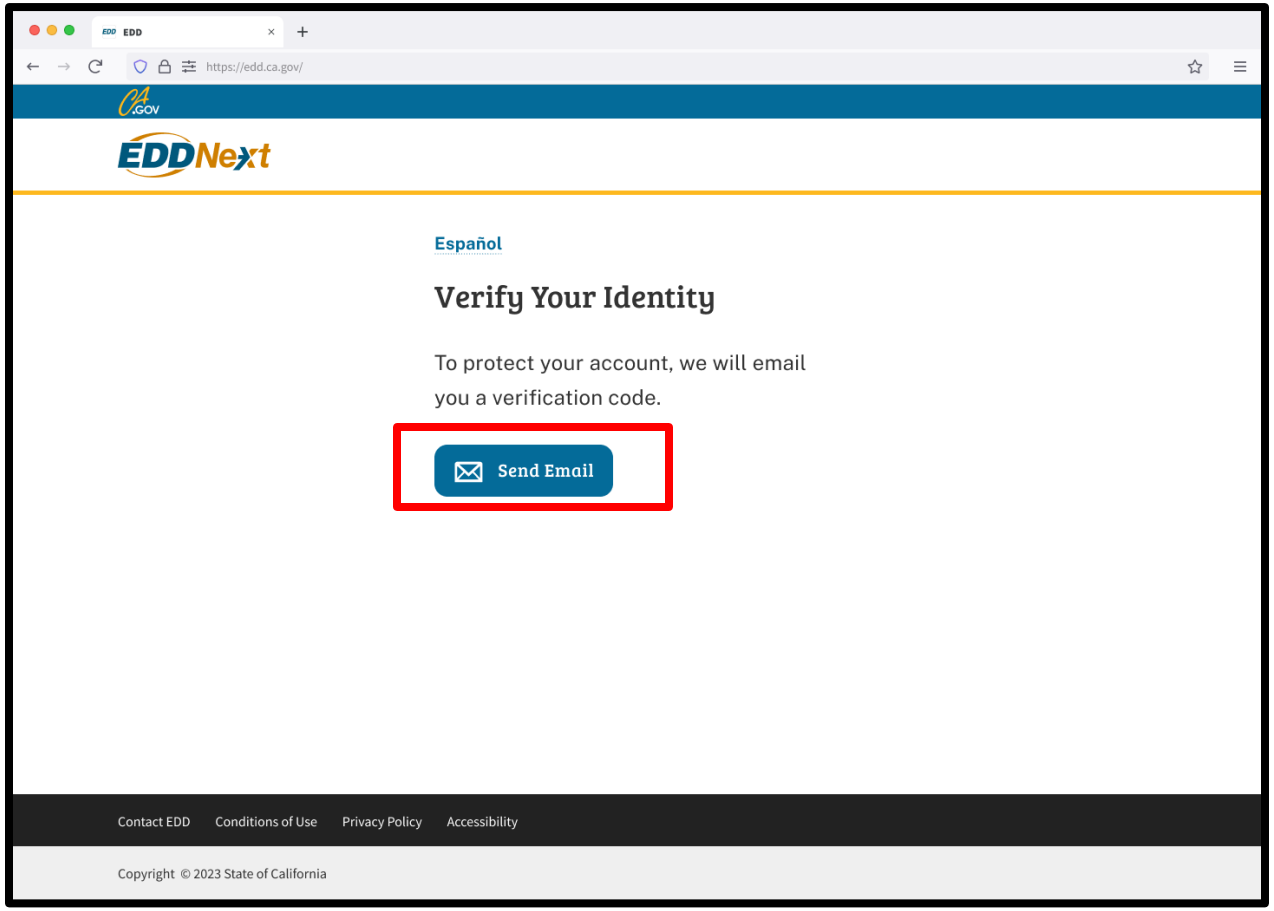



**Note**

For Spanish, select **Español**.

Log in to myEDD to access SDI Online:

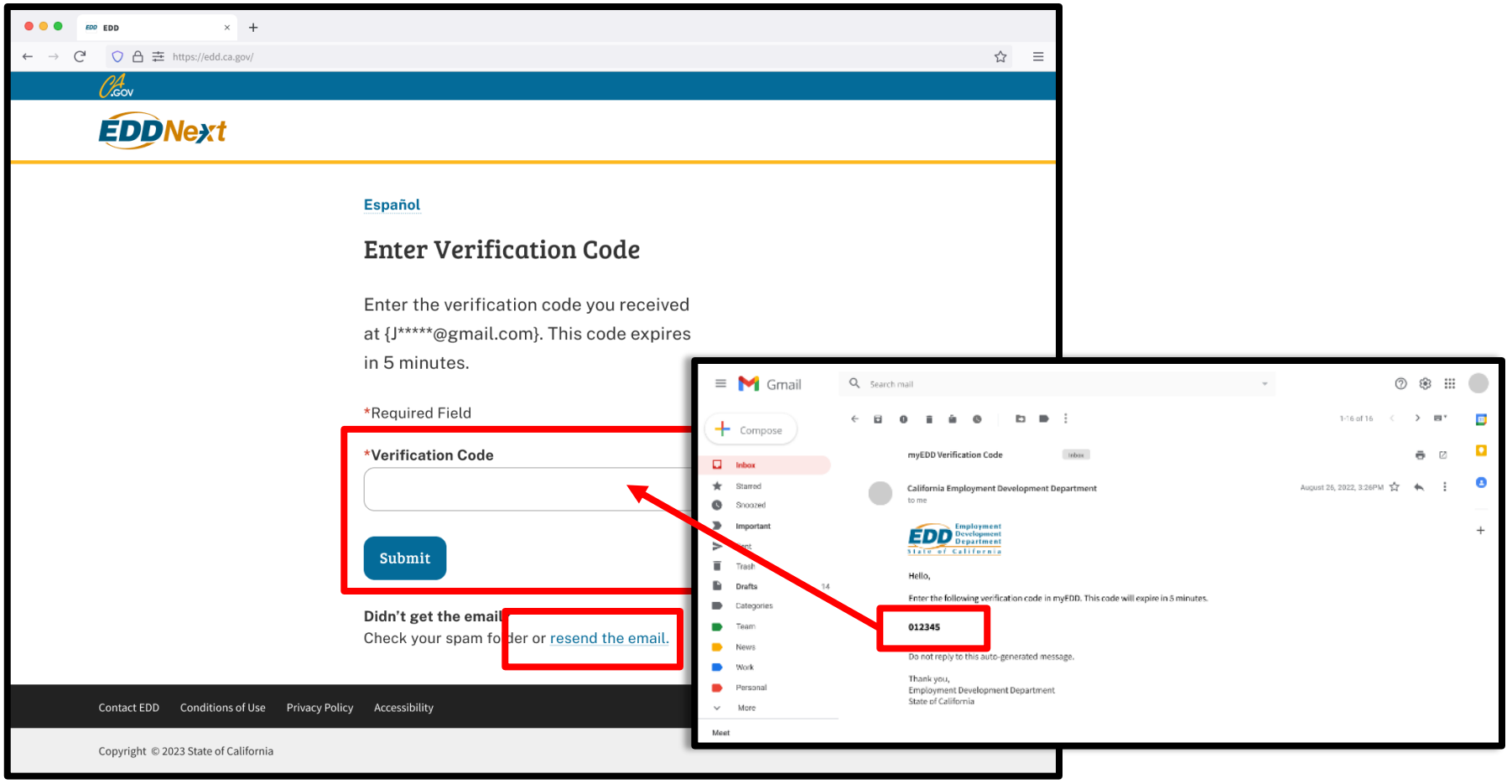
1. Visit myEDD.
2. Enter the email and password used to create your myEDD account.
3. Select **Log In**.




To protect your account, we ask you to verify your identity ever time you log in. In this example, the identity verification option is by email.

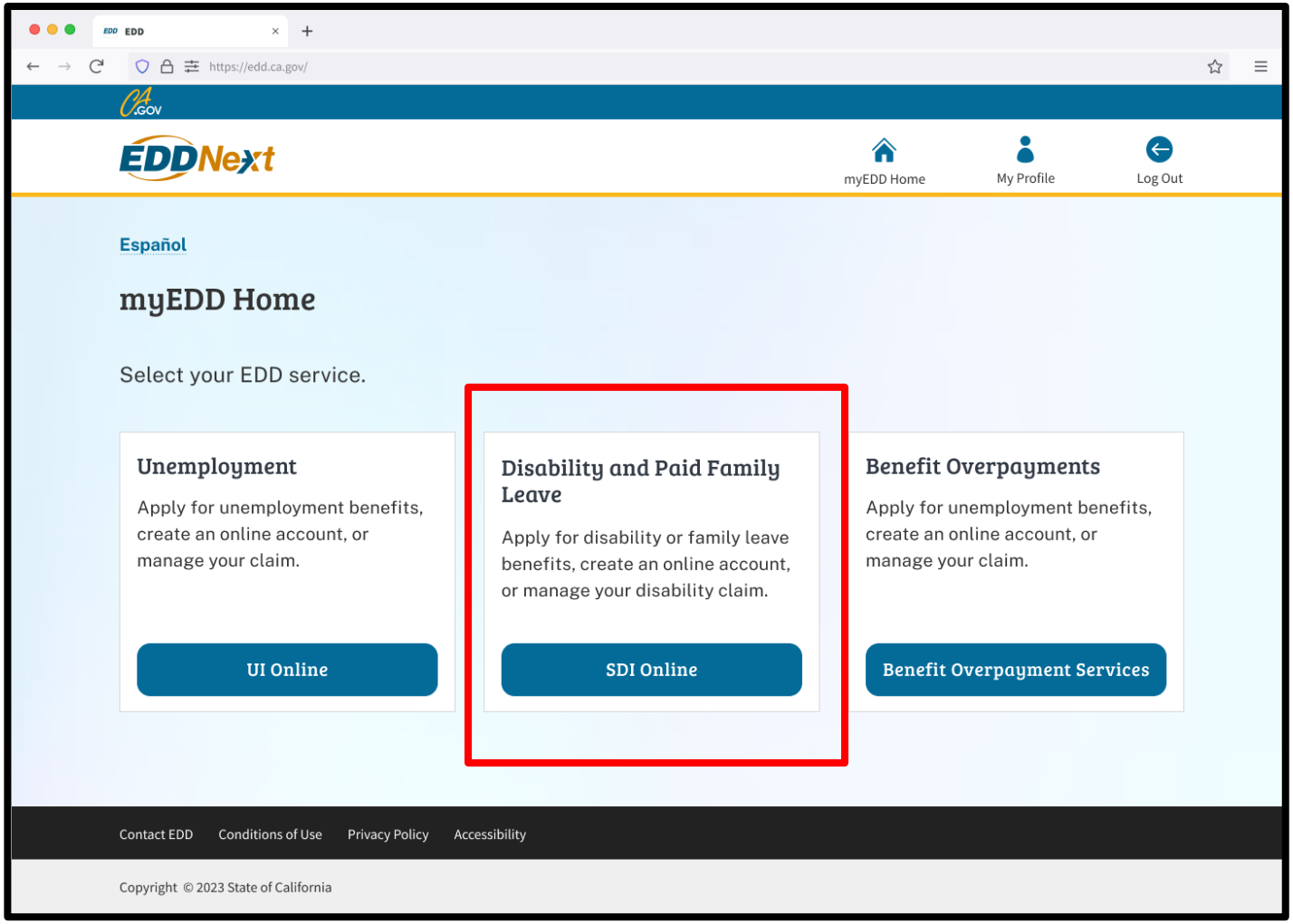
Select **Send Email.**

If you set up the login verification option as text message or phone call, follow the instructions based on that option.




Check your email for your verification code. This code expires in five minutes. Check your spam or junk folder if you do not get this email.

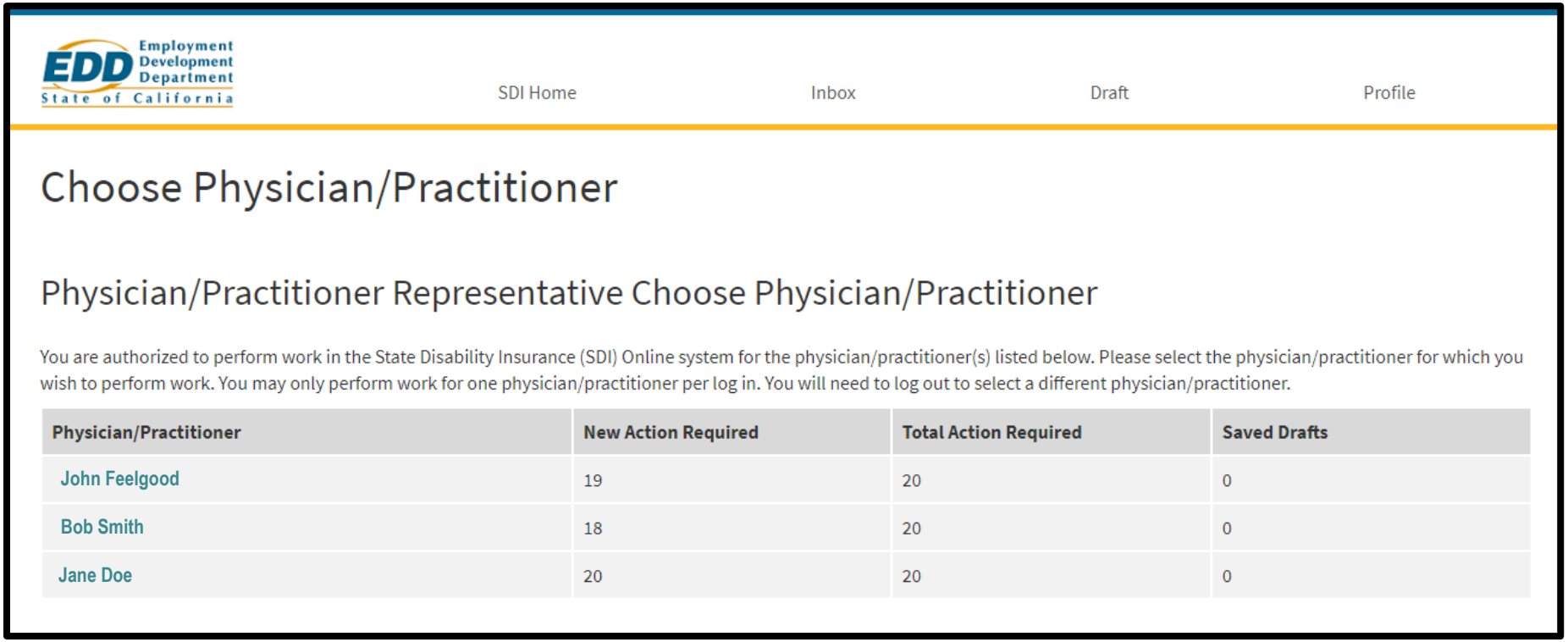
- Enter your verification code and select **Submit**.
- Select **resend the email** if you do not get a code.




**Note**

Select **Log Out** in the top right corner of any screen to exit your account.

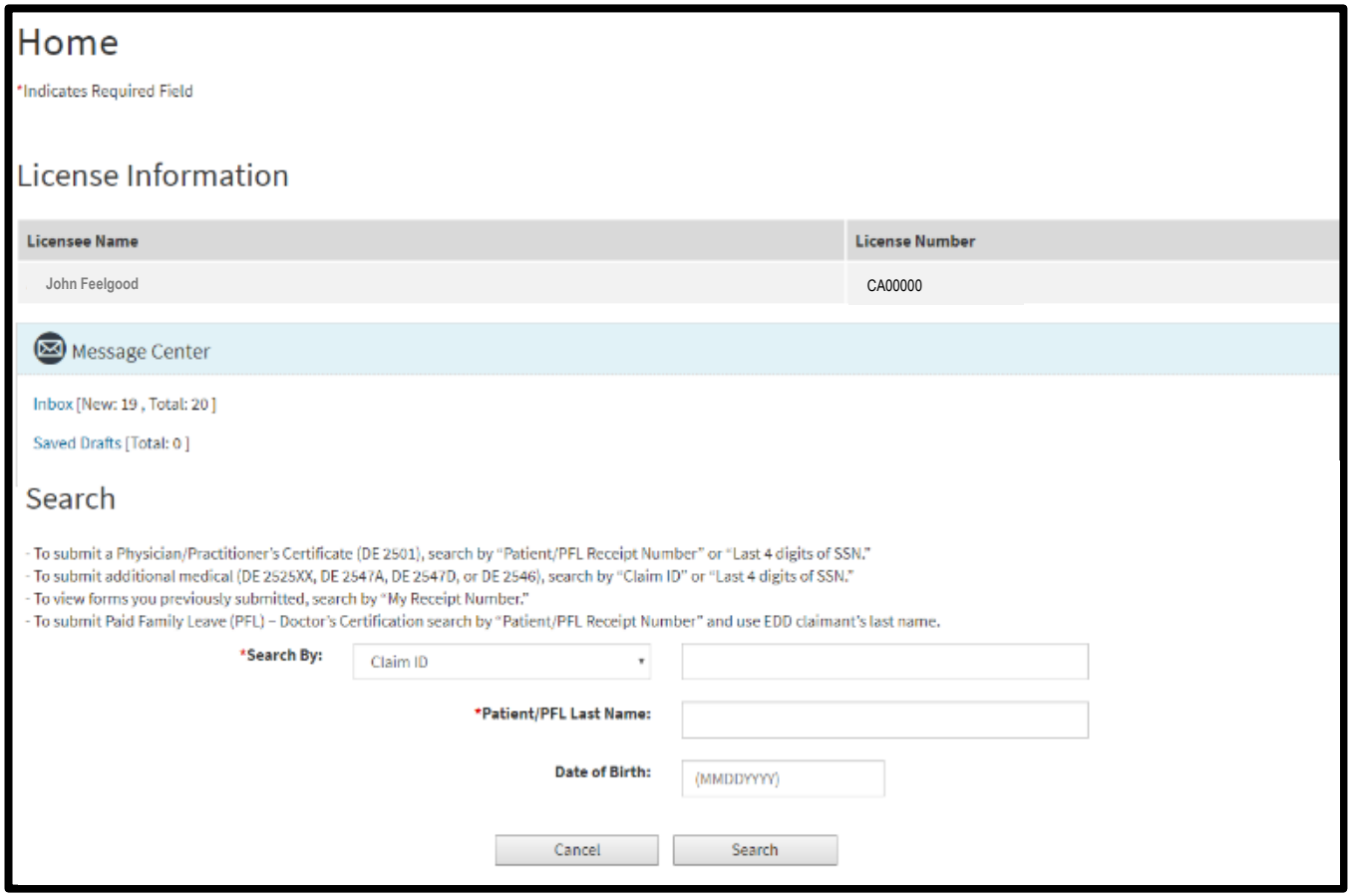
From the myEDD homepage, select **SDI Online.**




If you are an authorized medical representative for multiple physicians/practitioners, you have the option to choose from a list of physicians/practitioners.

Select the licensed health professional's name under the Physician/Practitioner column to complete medical certifications on behalf of that licensed health professional.

You can only complete medical certifications for one physician/practitioner per log in. You must log out to select a different physician/practitioner.




You will be sent to the Physician/ Practitioner homepage.

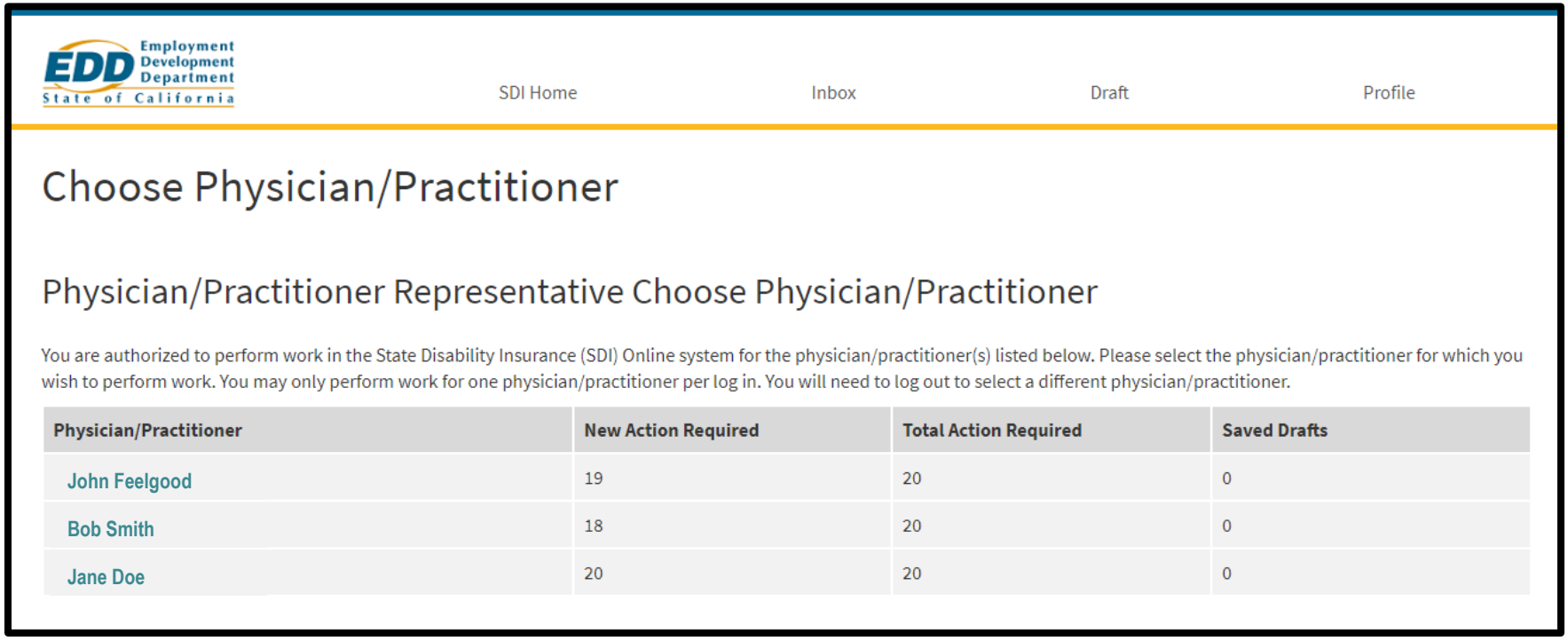
Review the following sections of this tutorial for instructions on submitting medical forms:

- Submit a *Claim for Disability Insurance (DI) Benefits* (DE 2501) Part B
- Submit a *Physician/Practitioner's Supplementary Certificate* (DE 2525XX)
- Submit a *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F) Part D

# Submit a *Claim for Disability Insurance (DI) Benefits* (DE 2501) – Part B

Learn more about how to submit the DE 2501 Part B – Physician/Practitioner's Certificate

**Get Started**



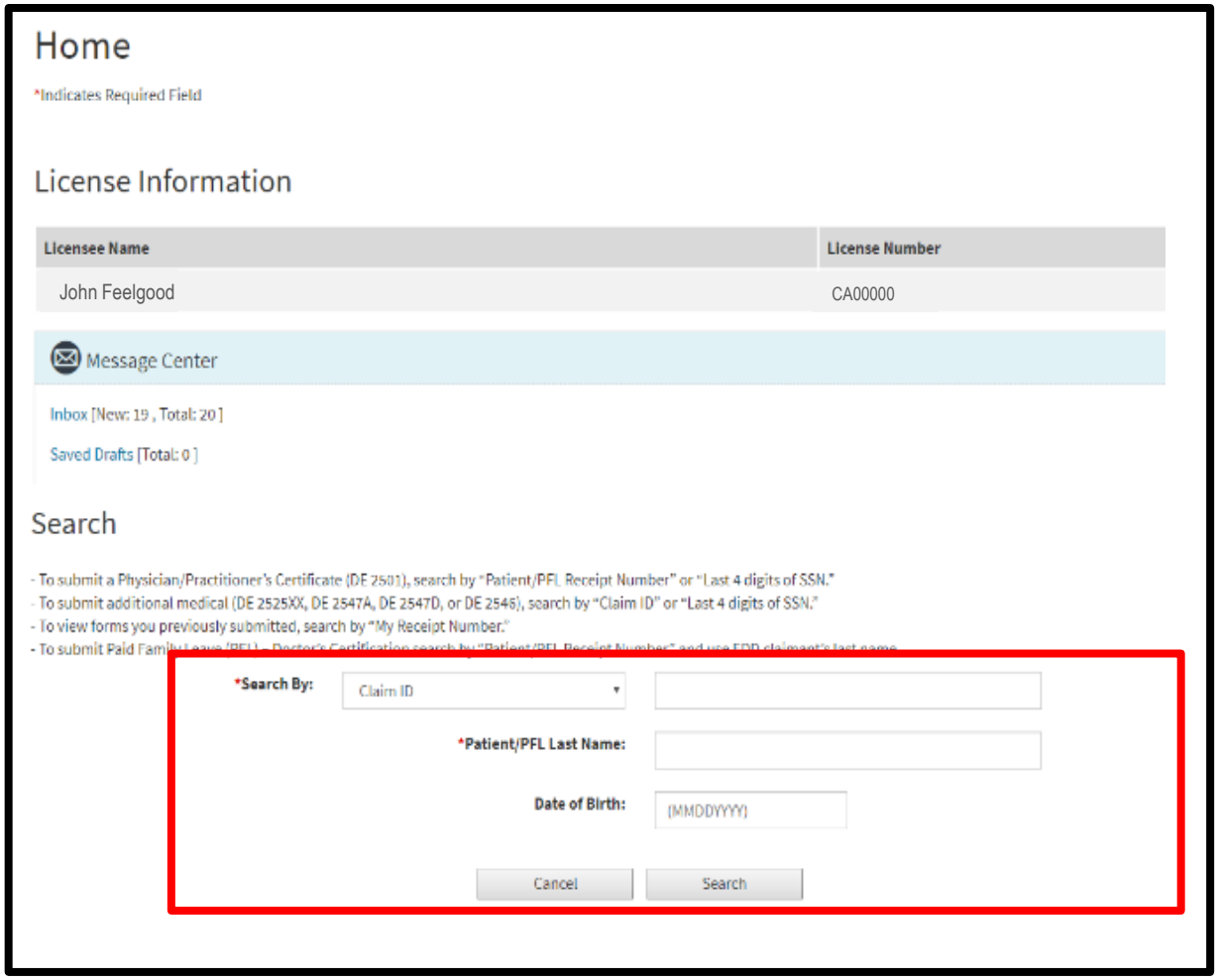

The Choose Physician/Practitioner screen only displays for medical representatives completing medical certifications on behalf of a licensed health professional. Physicians/practitioners should skip to the next page.

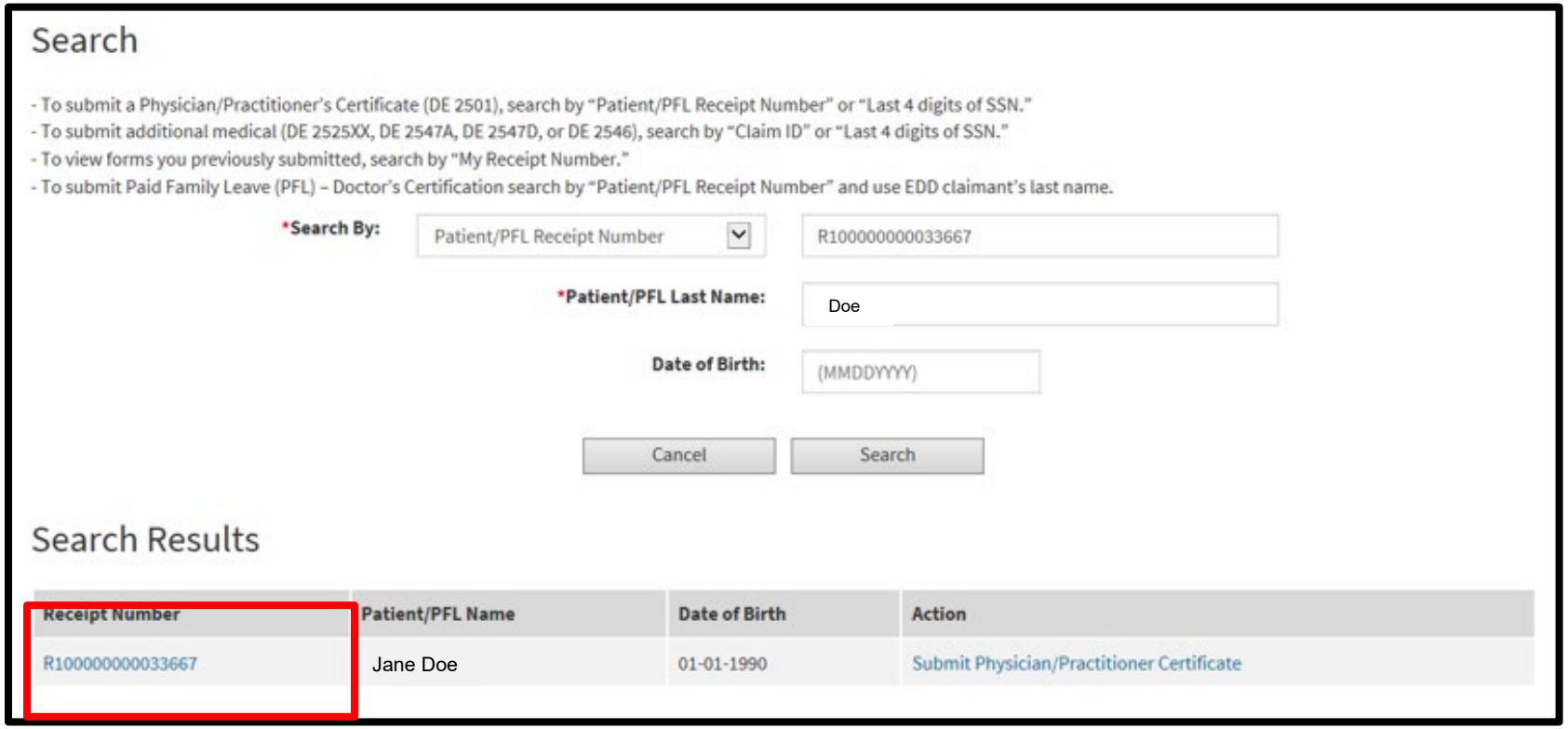
- On this screen, select the physician/practitioner which you are submitting the *Claim for Disability Insurance (DI) Benefits* (DE 2501), Part B on behalf.
- You can only select one physician/practitioner at a time.
- You can switch to a different physician/practitioner account by selecting **Log Out** and logging back into myEDD.

On the homepage, under the Search section, there are two ways to search for your patient's claim. Search by the patient's last name and one of the following:

- The patient's Receipt Number.
- The last four digits of the patient's Social Security number and date of birth.

To submit the Physician/Practitioner Certificate of the DE 2501 online, your patient must have already submitted Part A – Claimant's Statement of the DE 2501.



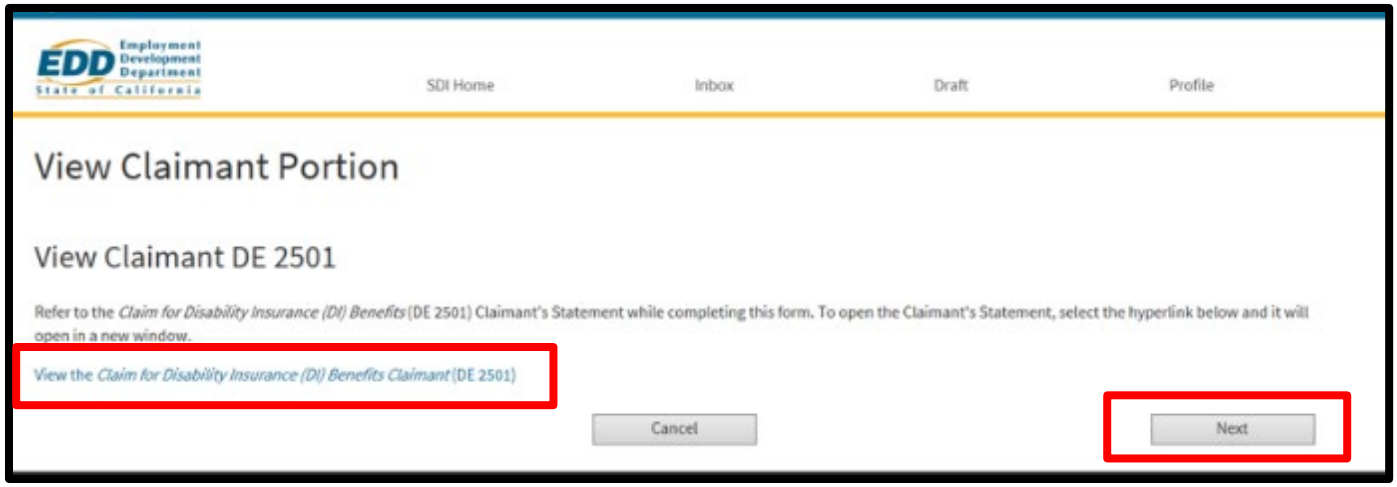



Verify the information in the Search Results section matches the patient's records.

- The **Receipt Number** link allows you to review the information your patient submitted on the DE 2501, Part A – Claimant's Statement.
- Select **Submit Physician/Practitioner Certificate** under the Action column to proceed.

**Note**

The Submit Physician/Practitioner Certificate link is not available if the certificate was submitted by another user (e.g., your representative or another doctor). Review the Submit a Physician/Practitioner's Supplementary Certificate (DE 2525XX) section to extend a disability period for your patient.

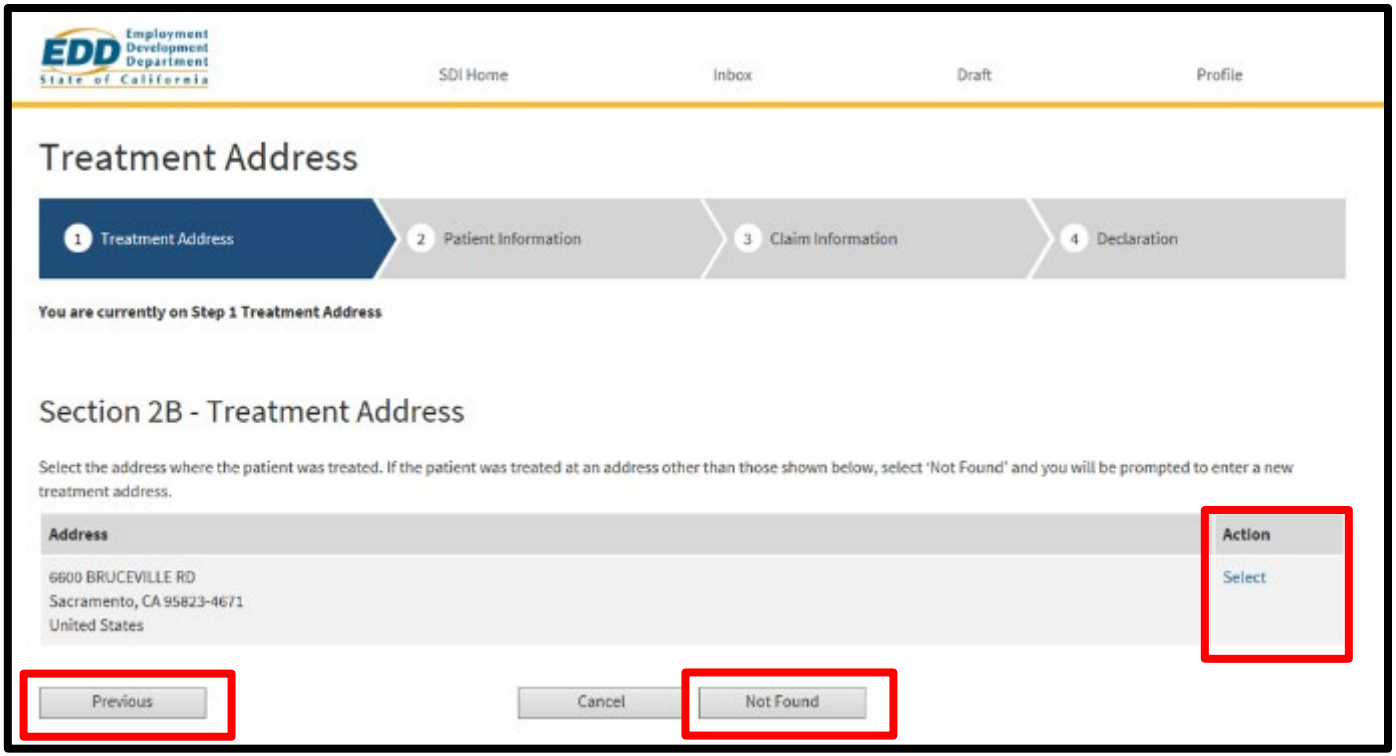



On the View Claimant Portion screen, you can select the link to review the information your patient submitted to us.

Select **Next** to complete the medical certificate.

**Note**

Selecting **Cancel** at any time cancels the medical certificate and returns you to your homepage.



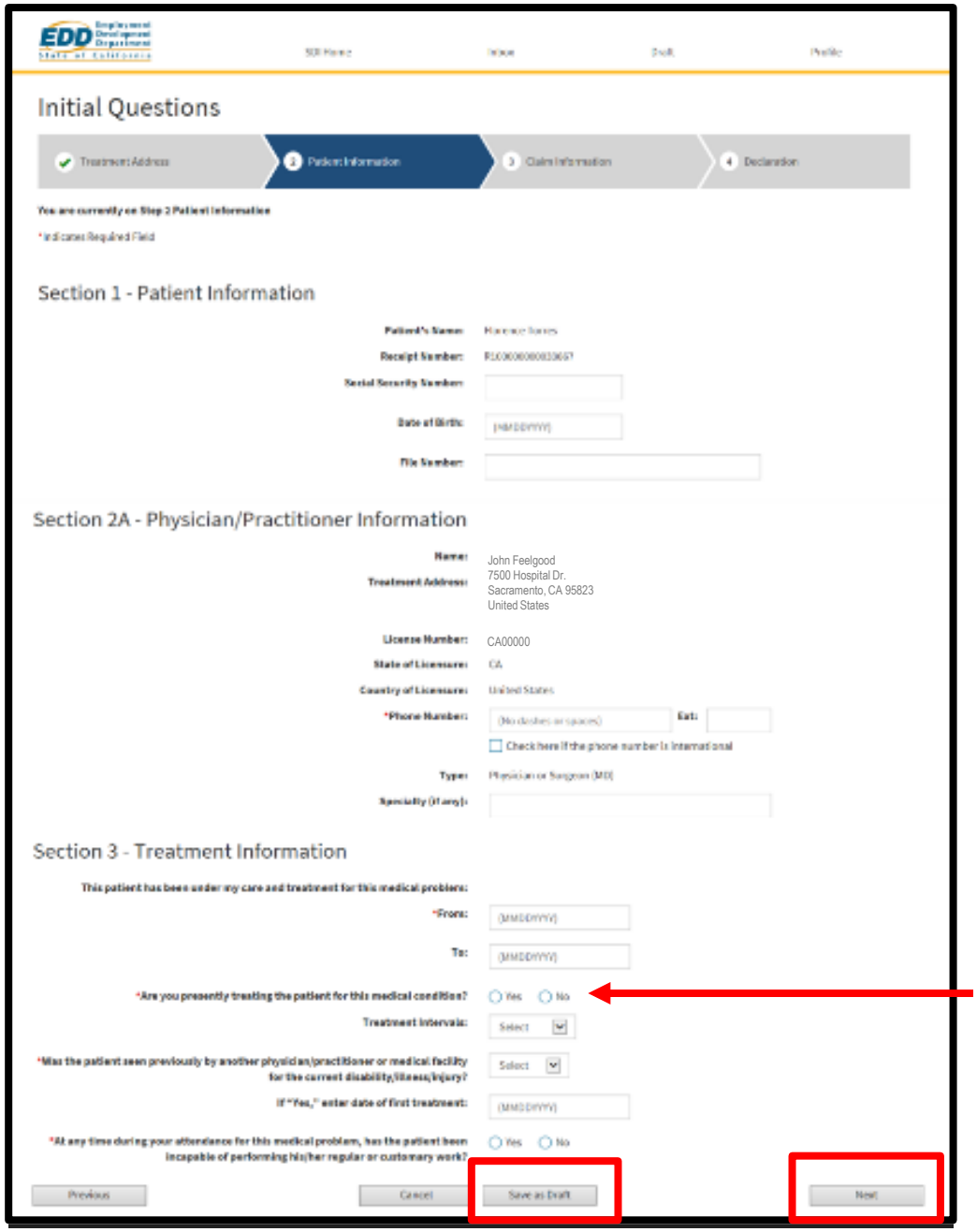

On the Treatment Address screen, select the address where the patient is being treated.

## Note

If the patient was treated at an address other than those shown, select **Not Found.**

## Important

**Do not use the Back button on your browser**. If you need to go to a previous screen, select **Previous**.




Complete the following sections:

- Section 1 - Patient Information
- Section 2A – Physician/Practitioner Information
- Section 3 – Treatment Information

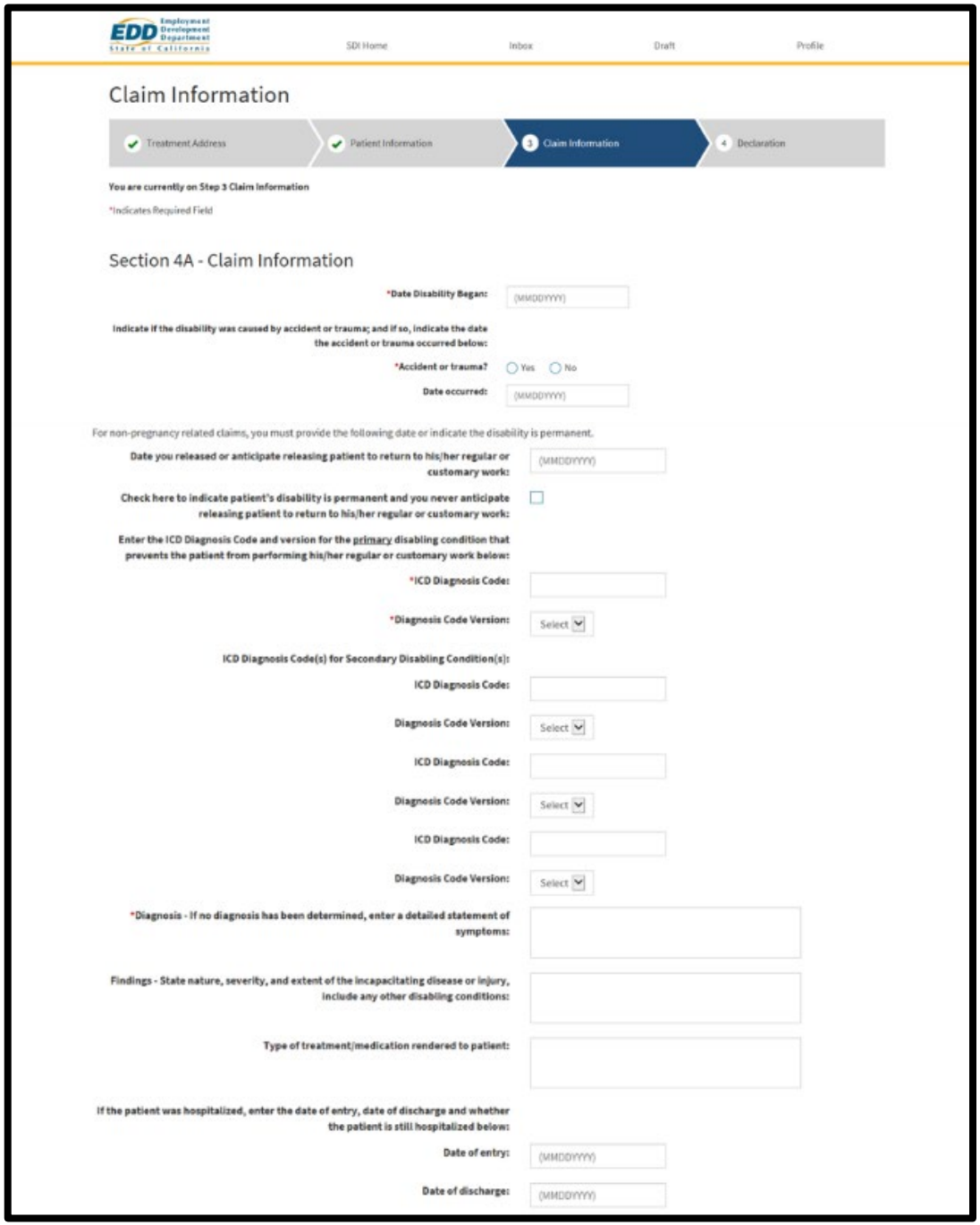
You must complete the fields marked with a red asterisk (*).

Select **Next** to continue.

**Note**

Select **Save as Draft** at any time to complete the form later.

**Tip:** Selecting **No** to "Are you presently treating the patient for this medical certificate?" ends your submission and makes your patient ineligible for benefits.

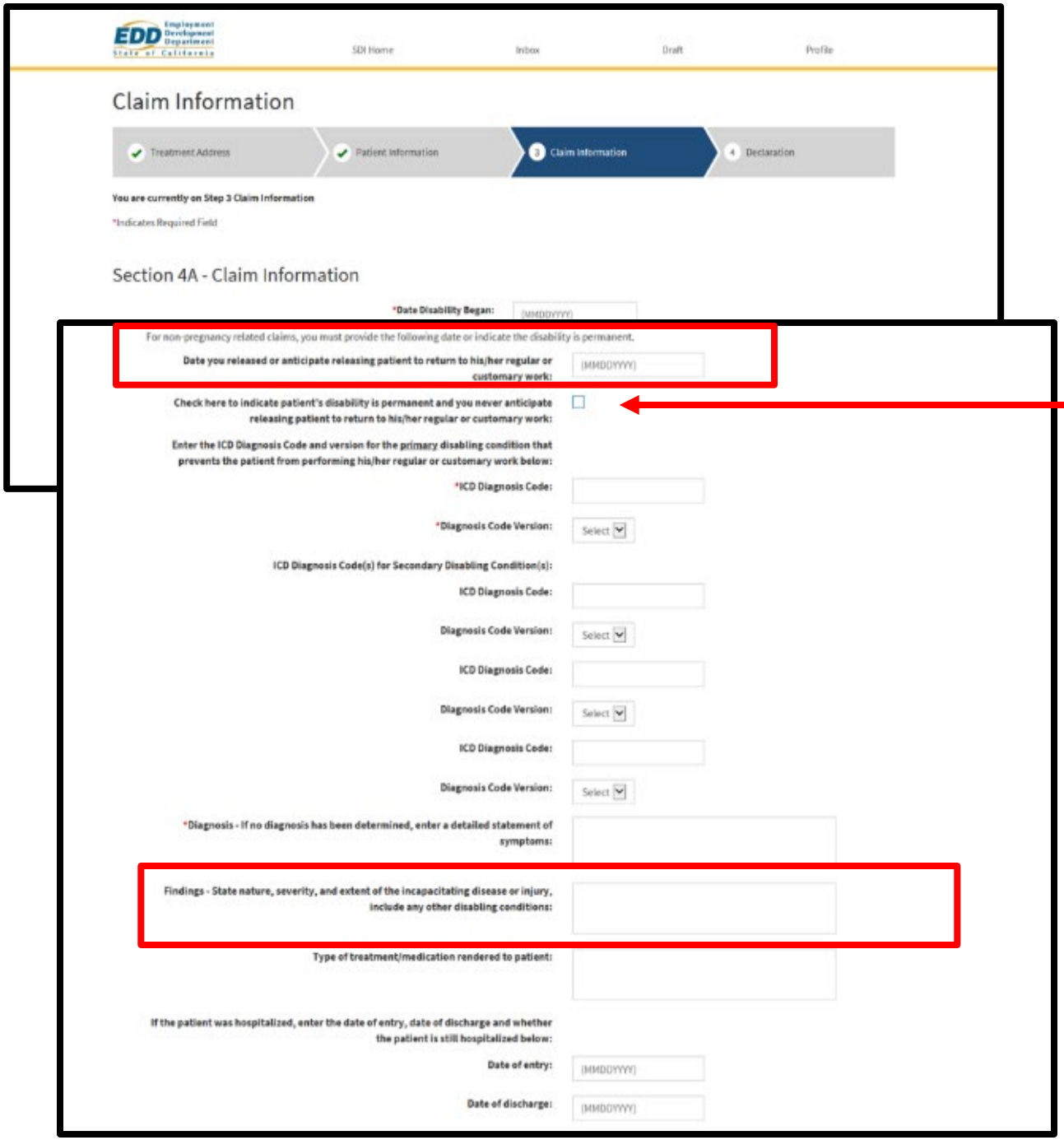



Complete Section 4A - Claim Information.

You must complete the fields marked with a red asterisk (*).

You must provide the following information:

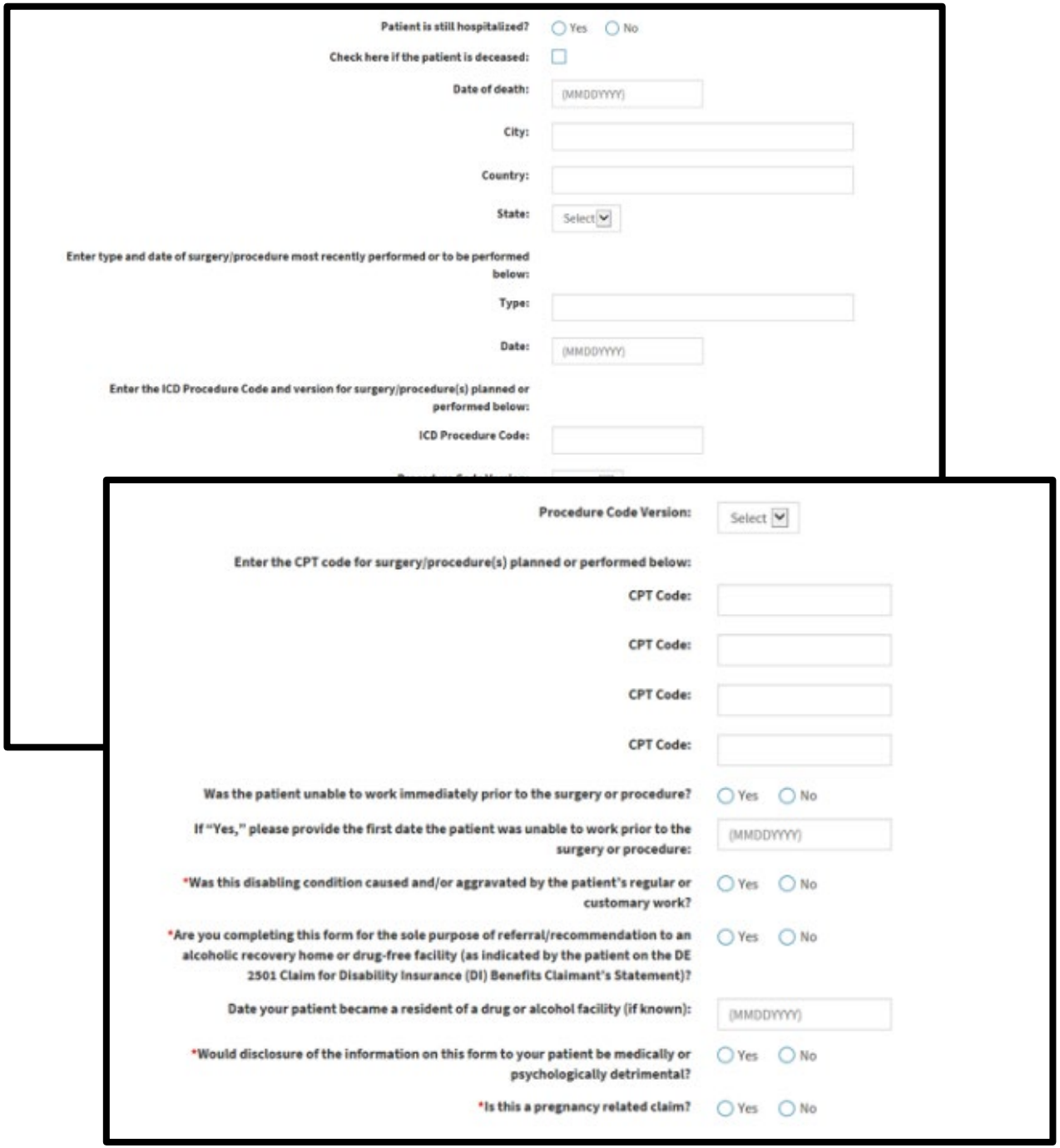
- Date disability began.
- Estimated return to work date (this may not be required for pregnancy or permanent disabilities).
- ICD codes and version.
- Diagnosis or detailed list of symptoms.




**Section 4A Tip:** Permanent Disability

If the patient's disability is diagnosed as permanent and you have selected the **permanent disability** box, you do **not** need to provide an estimated return to work date.

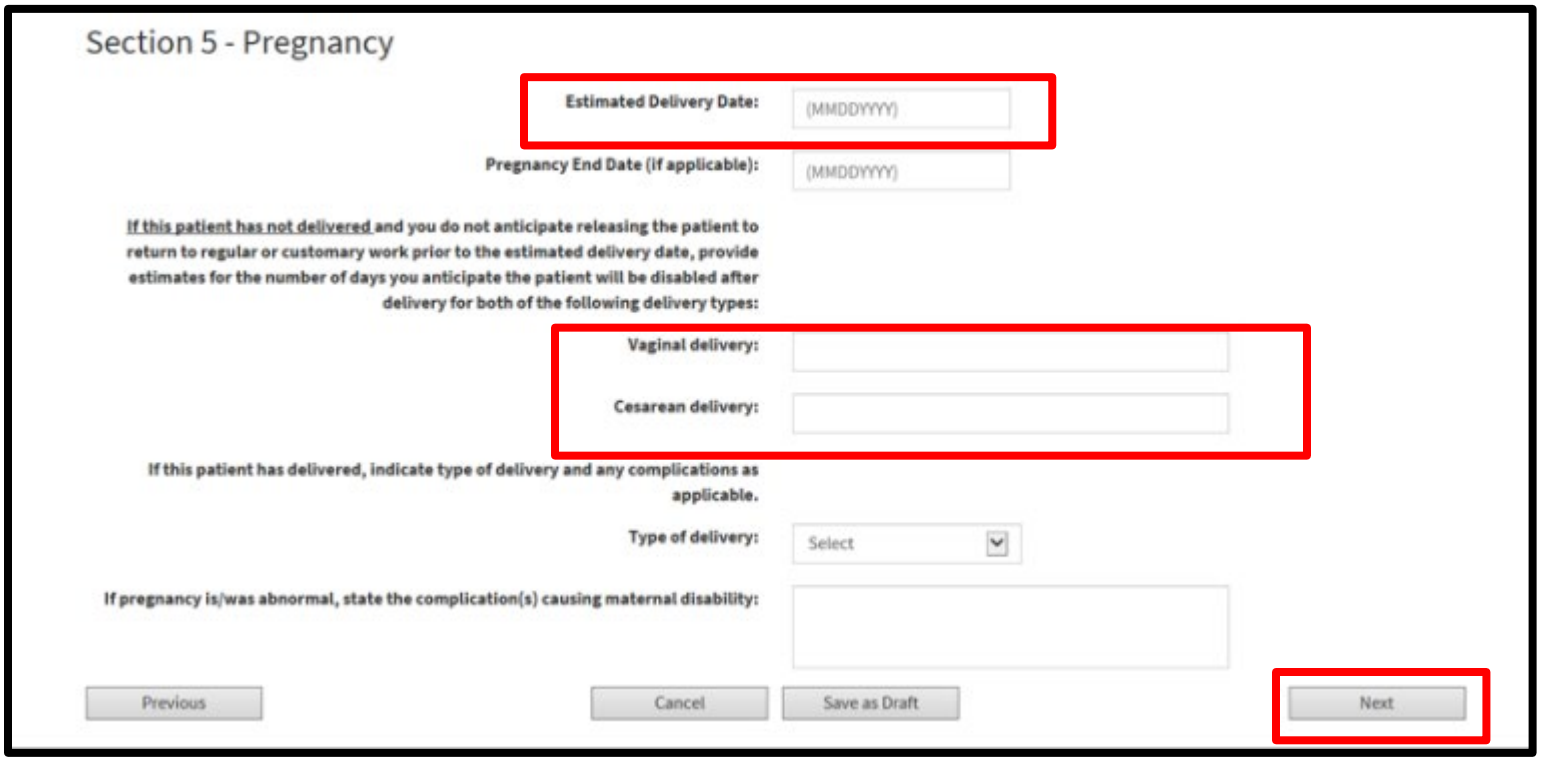
In the Findings field, enter a detailed description of why you consider the disability to be permanent.




Continue completing Section 4A - Claim Information.

You must complete the fields marked with a red asterisk (*).

**Tip:** Providing as much information as possible prevents claim processing delays and the need for us to reach out to you for additional details.



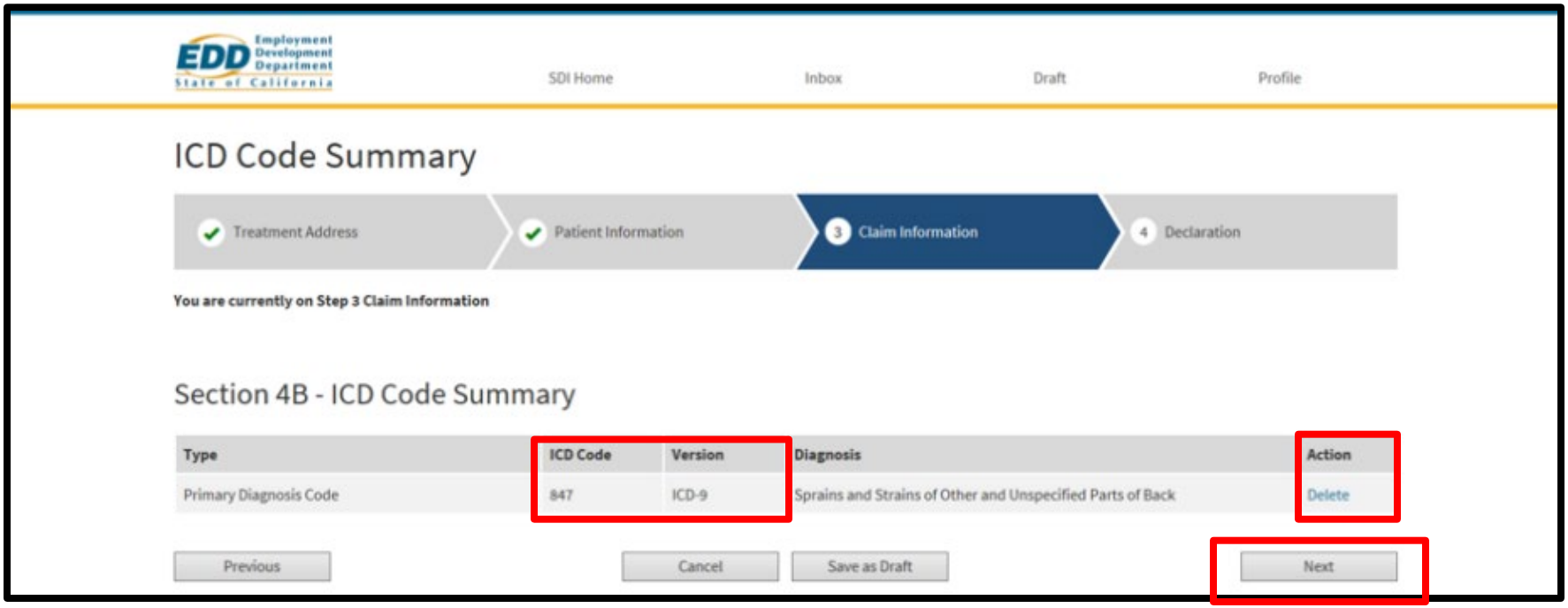

Complete Section 5 – Pregnancy, if applicable.

**Tip: Pregnancy-related disability claims**

If the patient has not delivered, enter the number of days you expect the patient to be disabled postpartum for each delivery type (six weeks for vaginal delivery and eight weeks for cesarean delivery), instead of entering an estimated return to work date.

- Enter the Estimated Delivery Date.
- Enter the number 42 in the Vaginal Delivery field.
- Enter the number 56 in the Cesarean Delivery field.

Select **Next**.

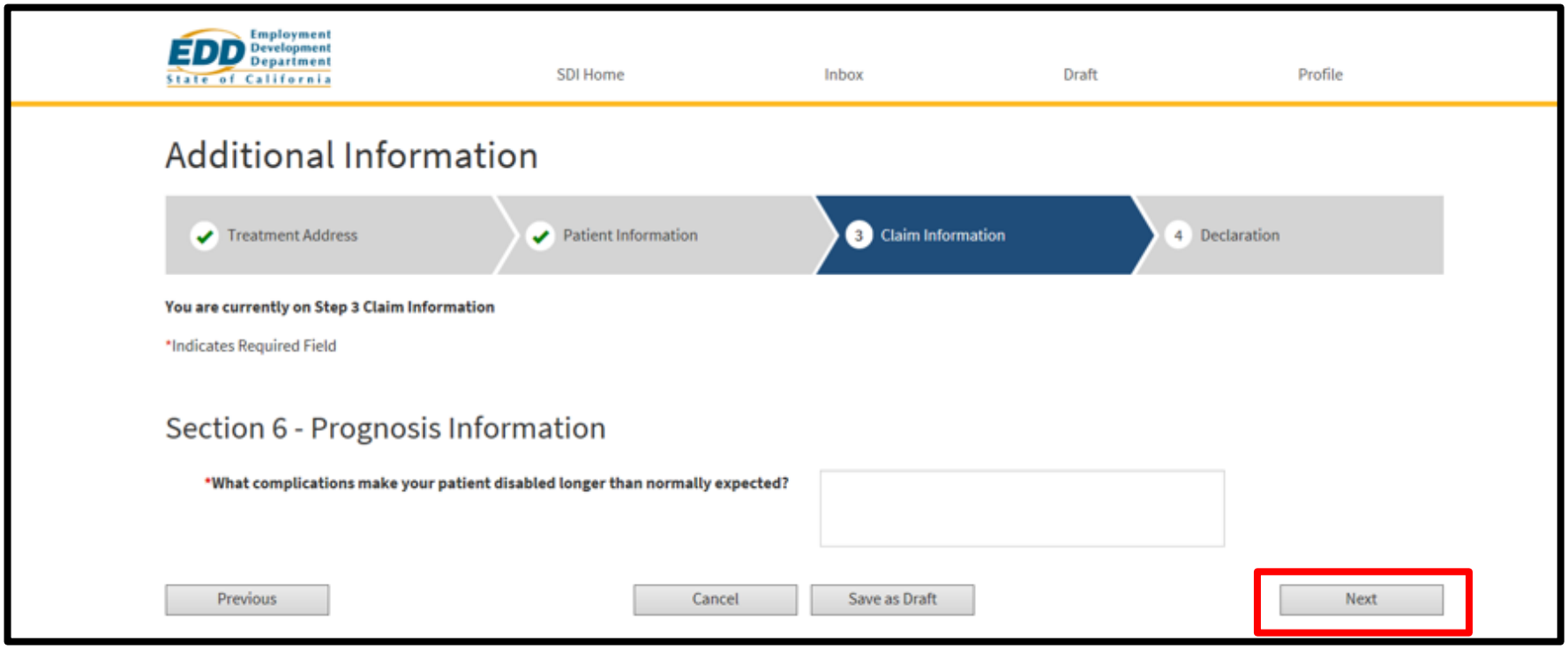



Verify the ICD codes are correct.

If an ICD code is incorrect:

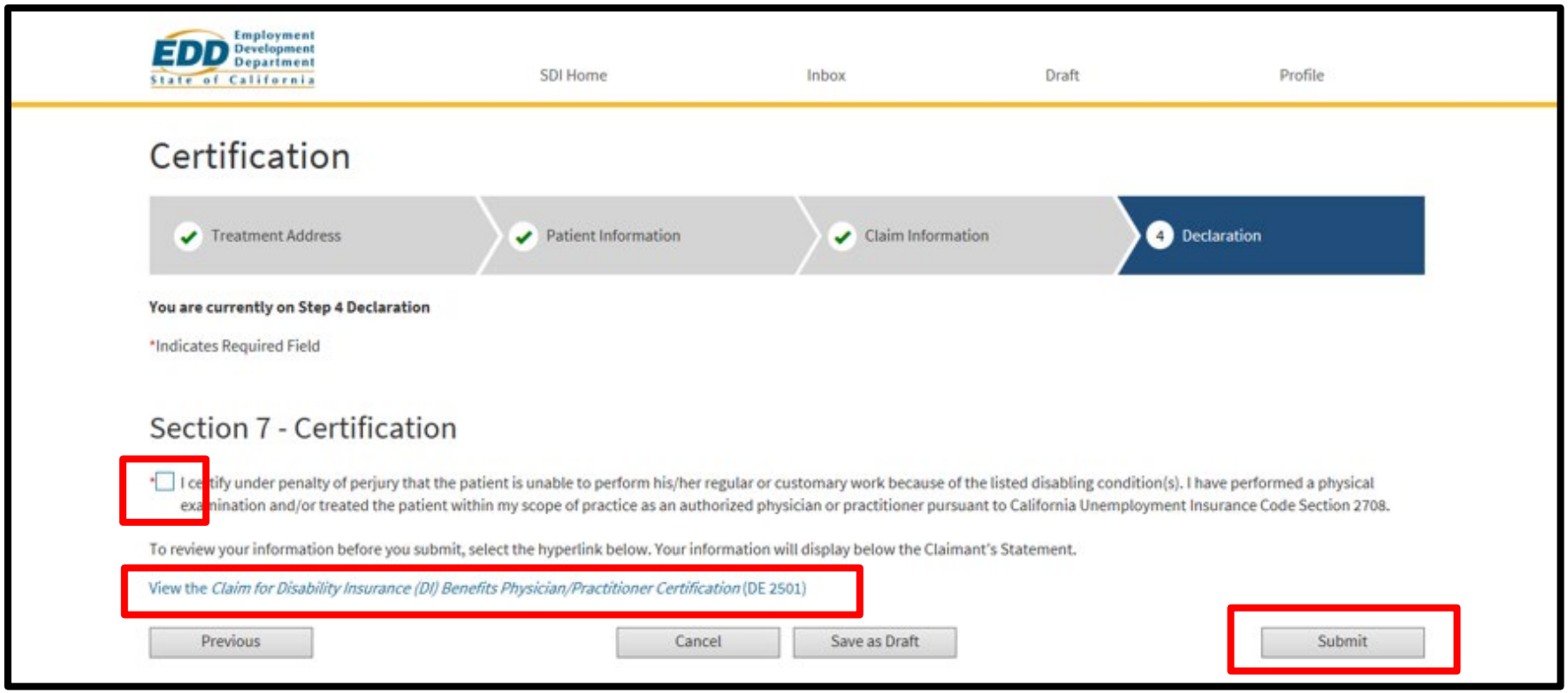
- Select **Delete**.
- Re-enter the correct code in the Claim Information section.

Select **Next** to continue.




Complete Section 6 – Prognosis Information and select **Next**.

**Tip:** Entering as much information as possible prevents claim processing delays and the need for us to contact you for additional details.

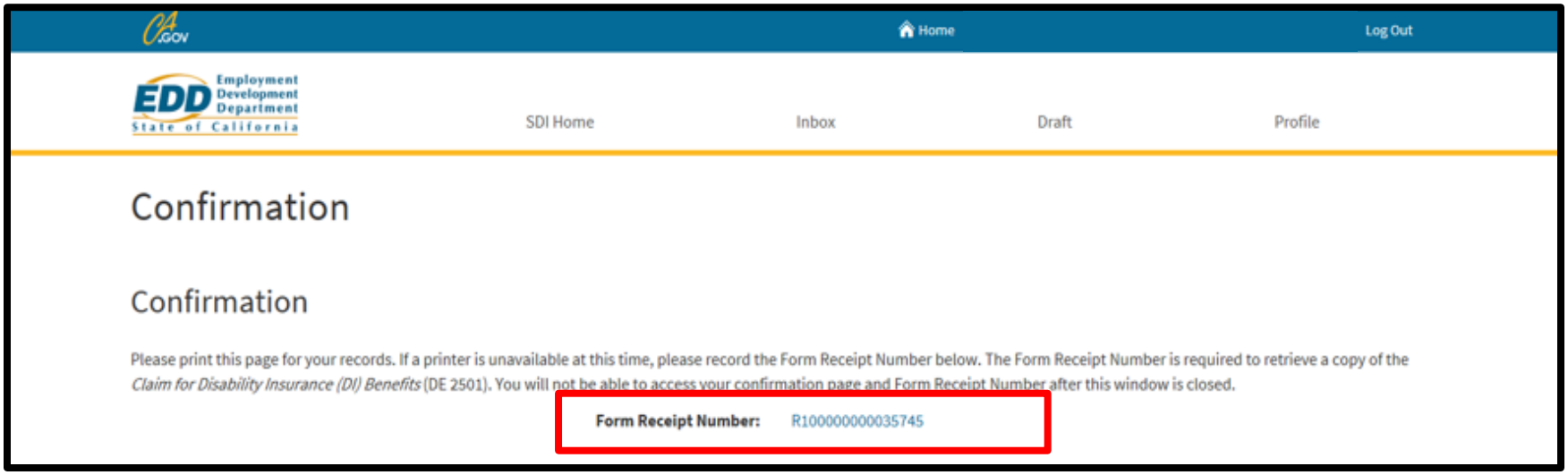



Select the check box in Section 7 - Certification to confirm the information you entered.

Review the information before you submit by selecting the **View the *Claim for Disability Insurance (DI) Benefits Physician/Practitioner Certification* (DE 2501)** link.

**Note:** You cannot modify the form after you select Submit.

Select **Submit**.




On the Confirmation screen, your submission is assigned a Form Receipt Number.

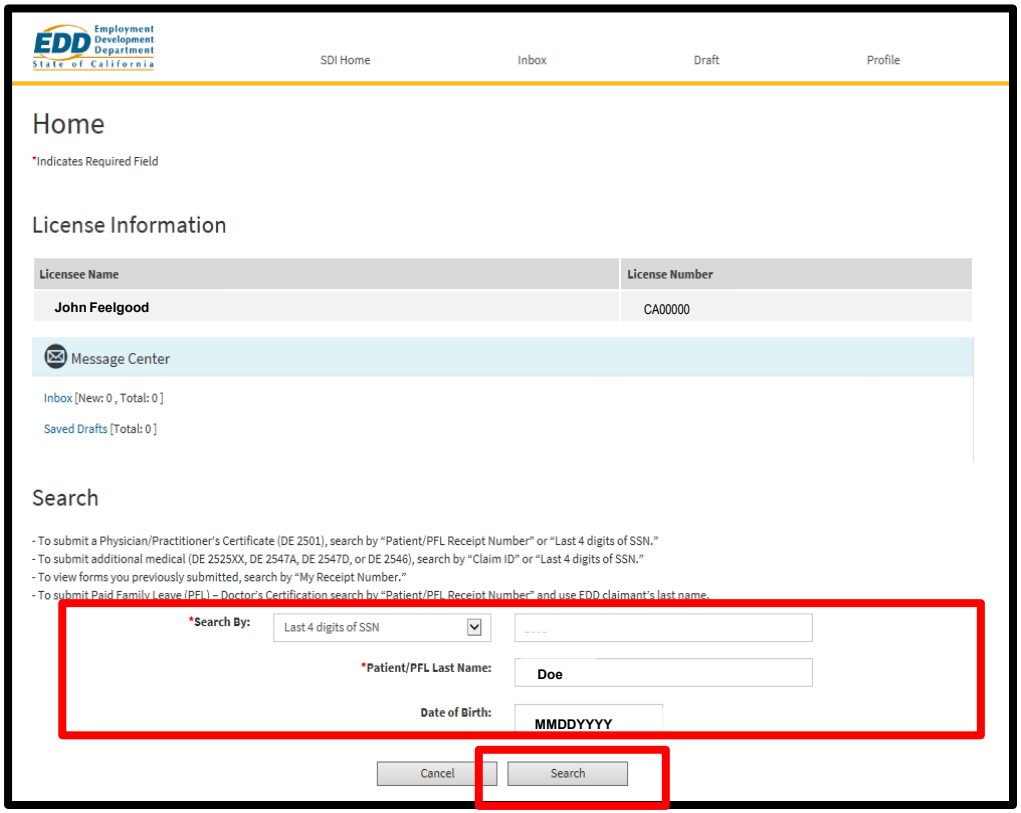
- Save this Form Receipt Number. Your patient can request this number to prove the medical certificate was sent to us.
- Select the **Form Receipt Number** link to open a PDF printer-friendly version of the information you sent.

You have now completed Part B – Physician/Practitioner's Certificate of your patient's *Claim for Disability Insurance (DI) Benefits* (DE 2501) form. It can take up to 14 days to process your patient's claim.

# Submit a *Physician/Practitioner's Supplementary Certificate* (DE 2525XX)

Learn more about how to submit the DE 2525XX and extend the disability period for your patient.

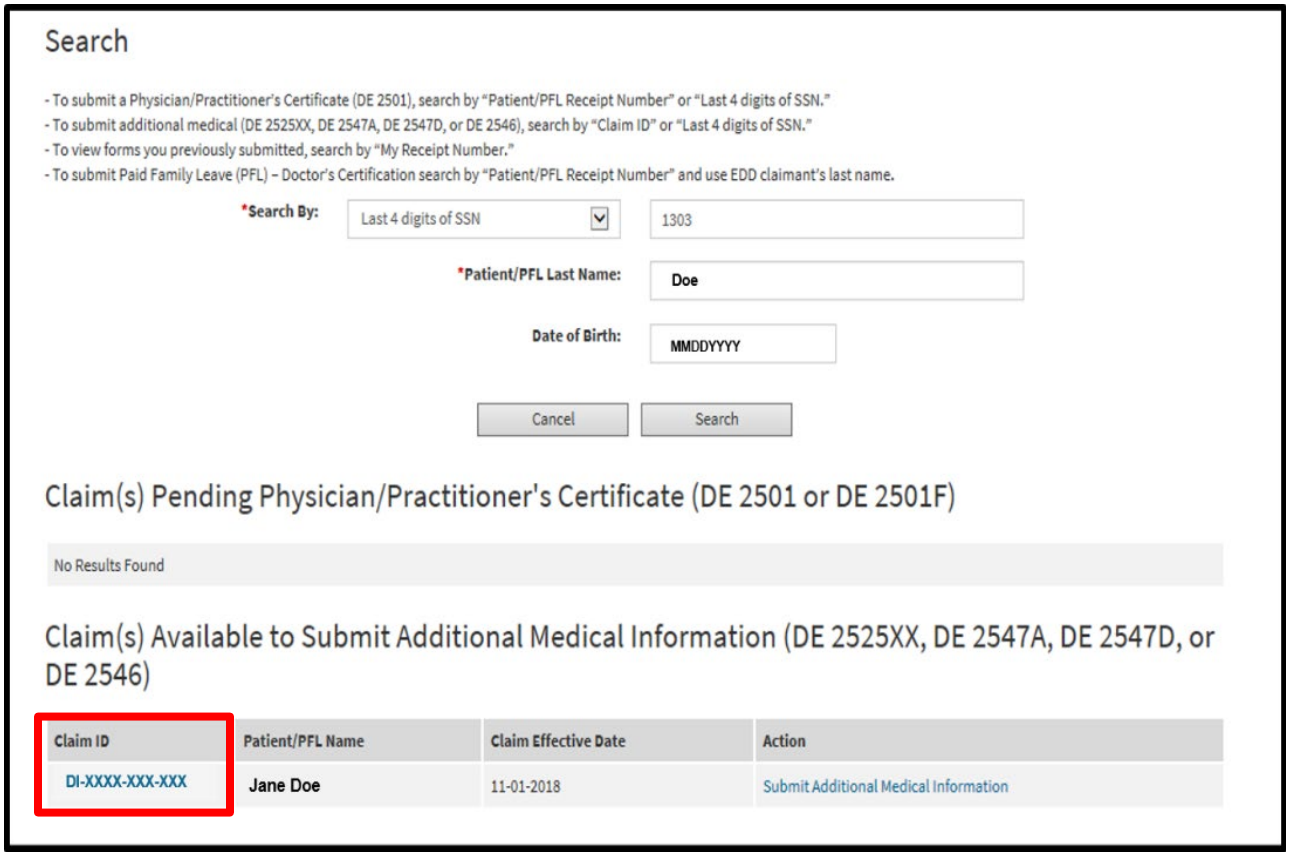
**Get Started**




To submit a Physician/Practitioner's Supplemental Certificate from your SDI Online homepage:

- Select **Claim ID** or **Last four digits of SSN** from the Search By drop down menu.
- Enter the Claim ID or last four of the SSN for the patient.
- Enter the patient's last name.
- Enter the patient's date of birth (no dashes).

Select **Search** to continue.

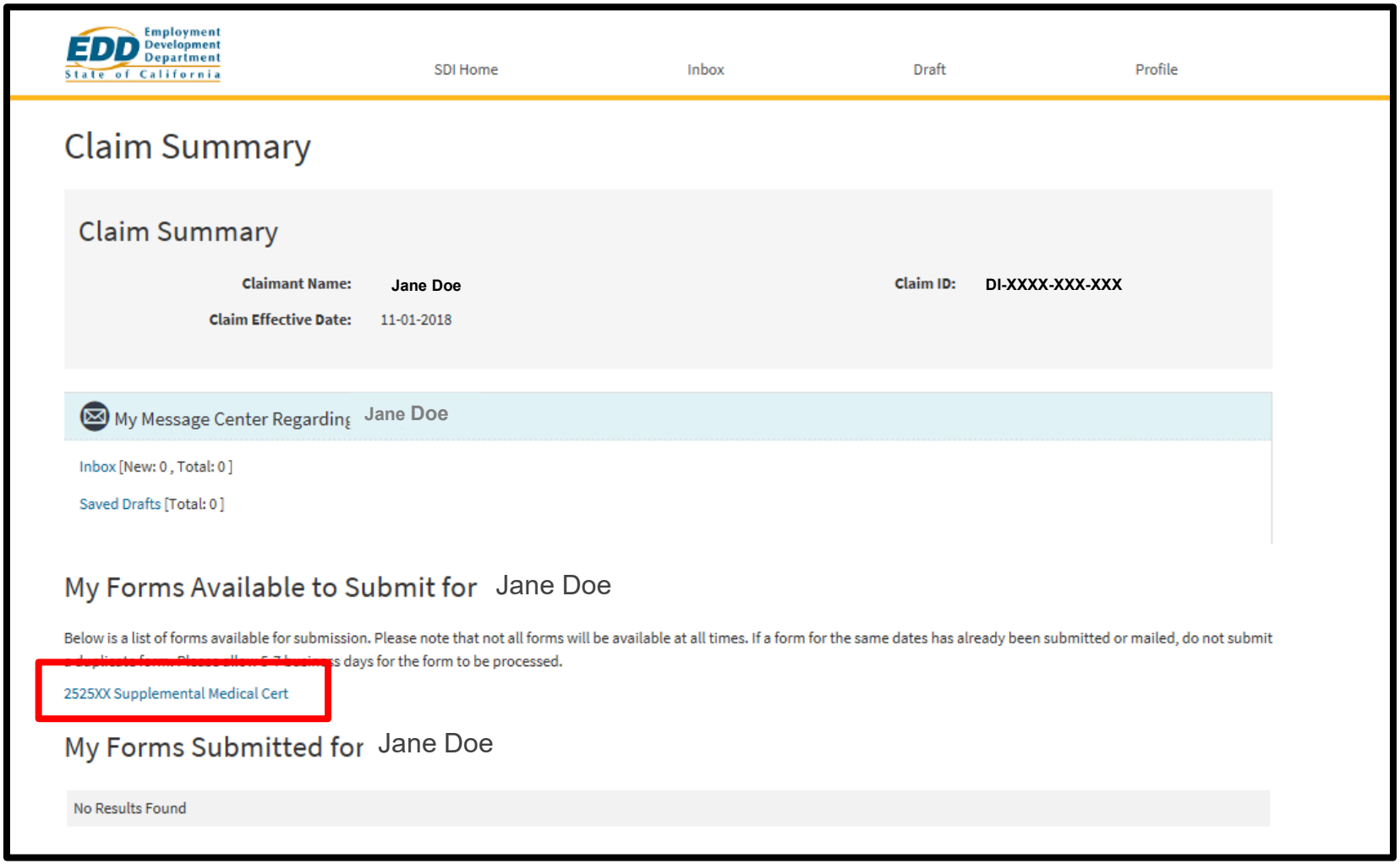



**Note**

Claims must be approved to allow submission of additional medical information.

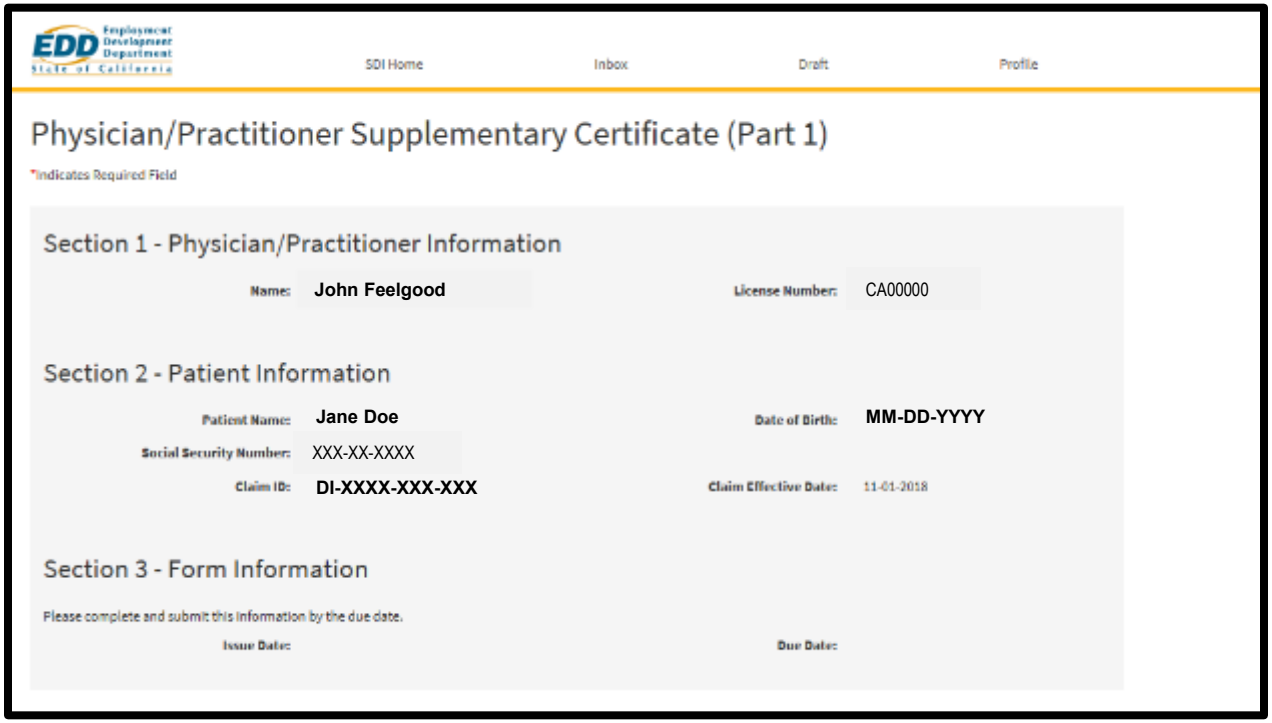
Verify the patient's information under the Claim(s) Available to Submit Additional Medical Information search results matches the patient's records.

- If they match, select the **Claim ID** link or the link provided in the Action column.
- If they do not match, return to the Search section, and try again.




Under the My Forms Available to Submit section:

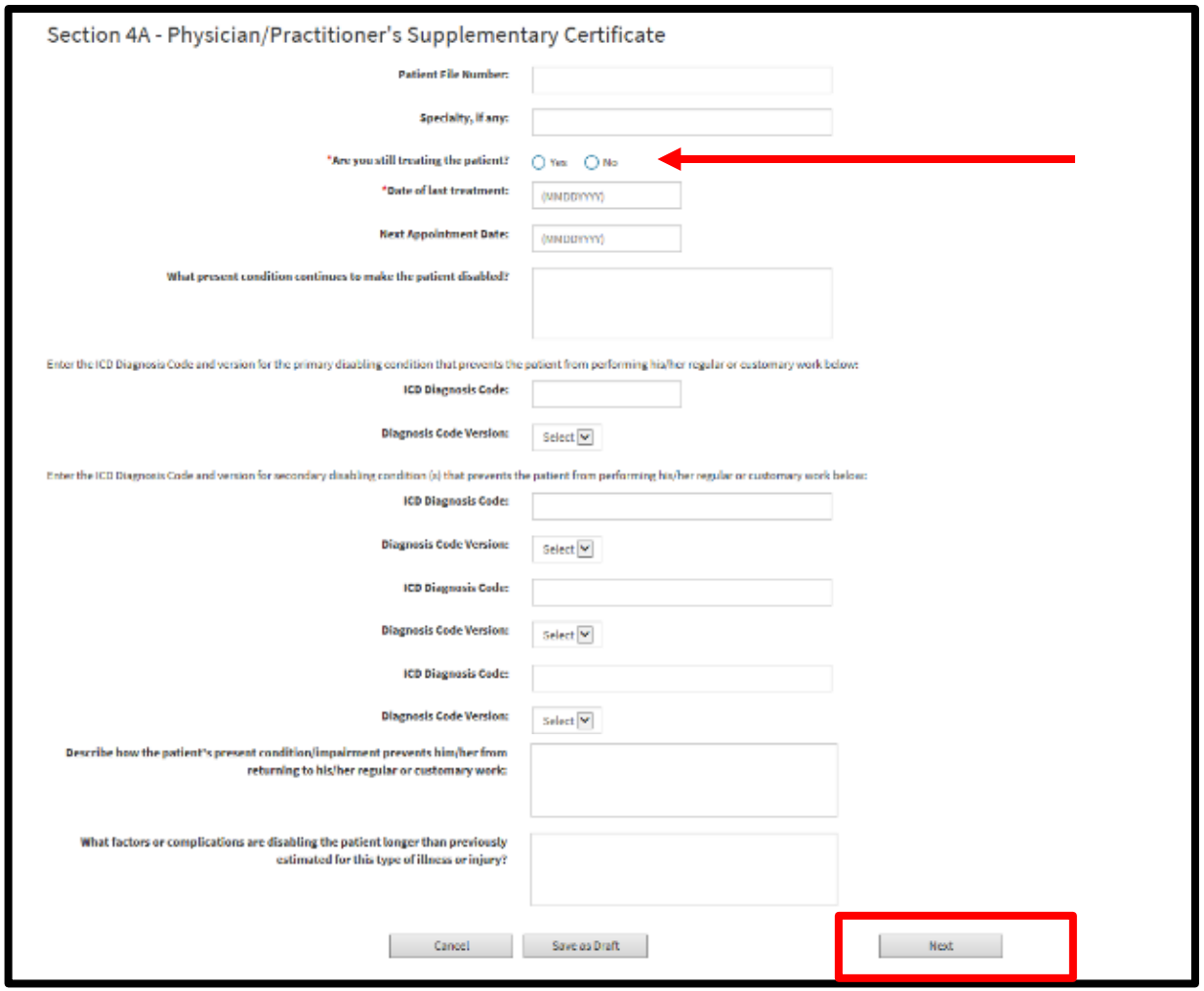
- Select the **2525XX Supplemental Medical Cert** form link.




The SDI Online system automatically populates certain portions of the application.

Review the following sections:

- Section 1 – Physician/Practitioner Information
- Section 2 – Patient Information
- Section 3 – Form Information



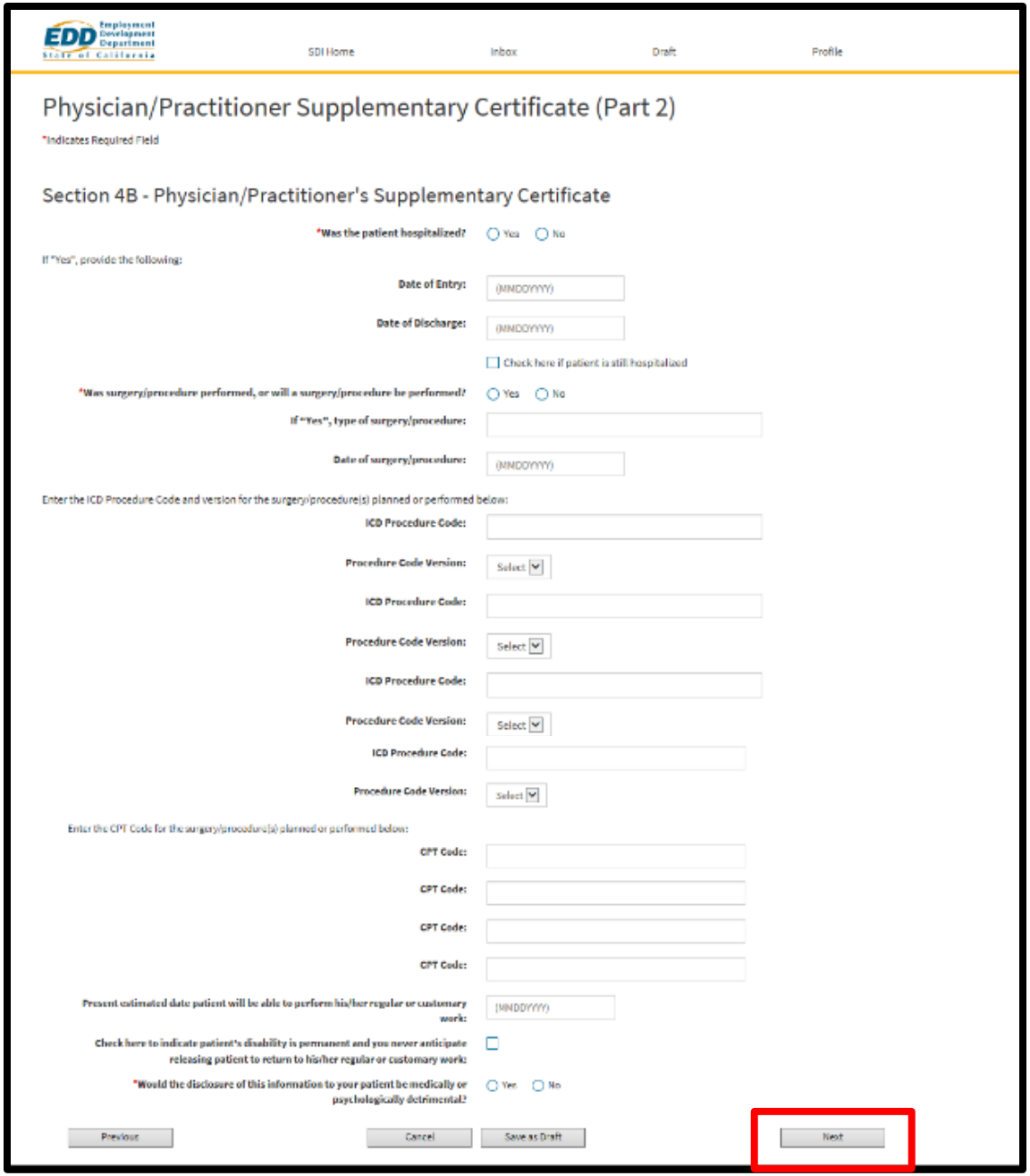

**Note**

Selecting **No** to "Are you still treating this patient?" ends your submission and makes your patient ineligible for further benefits.

Complete Section 4A - Physician/Practitioner's Supplementary Certificate (Part 1).

You must complete the fields marked with a red asterisk (*).

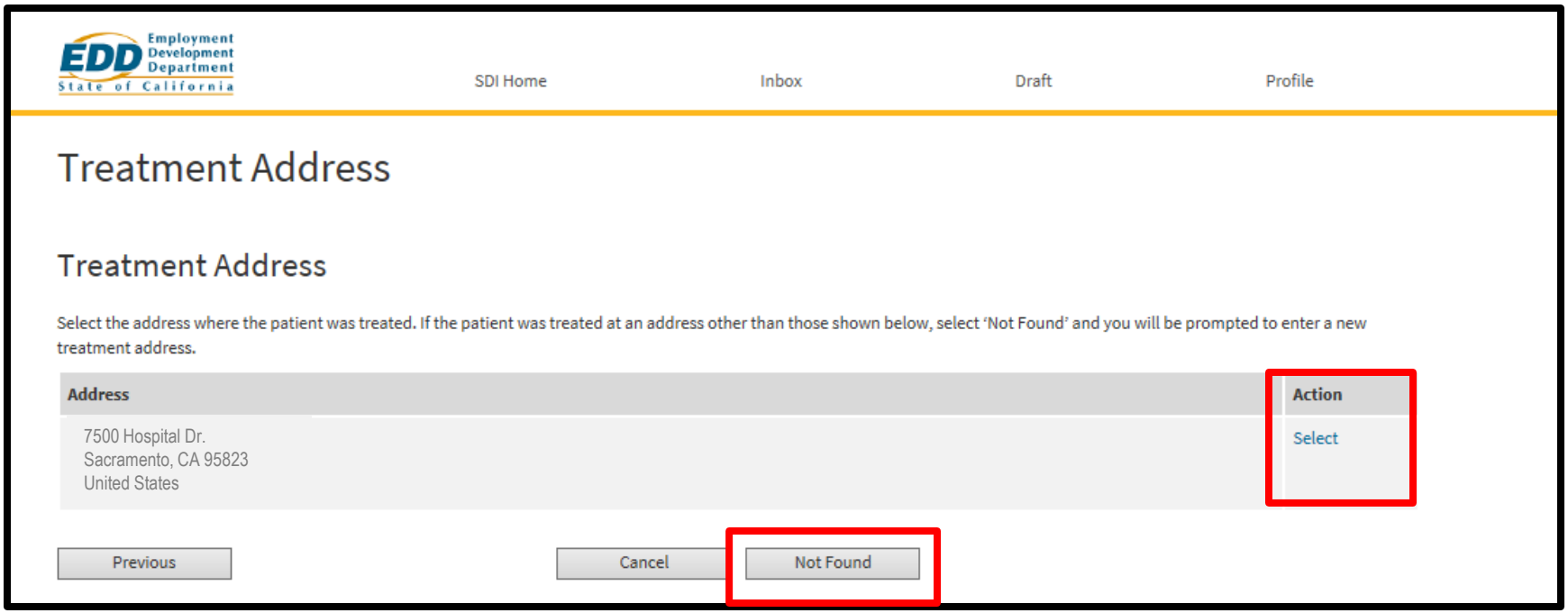
Select **Next** to continue.




Complete Section 4B - Physician/Practitioner Supplementary Certificate (Part 2).

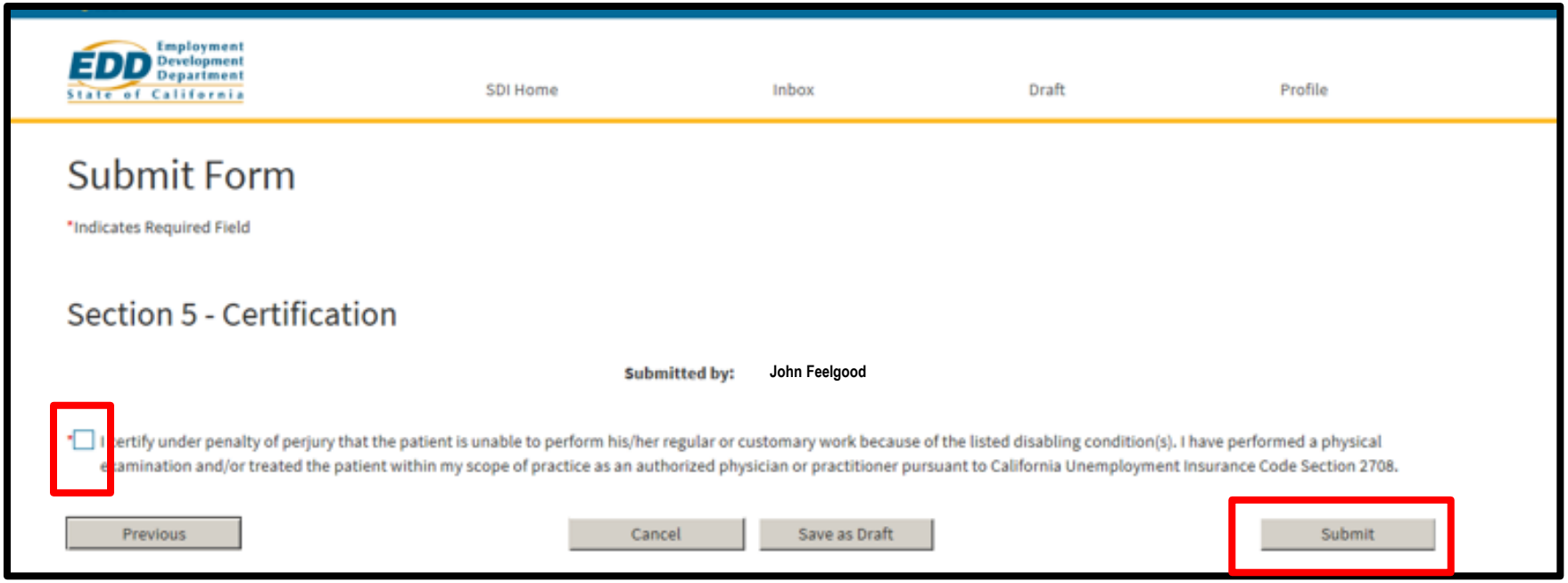
You must complete the fields marked with a red asterisk (*).

Select **Next** to continue.




On the Treatment Address screen:

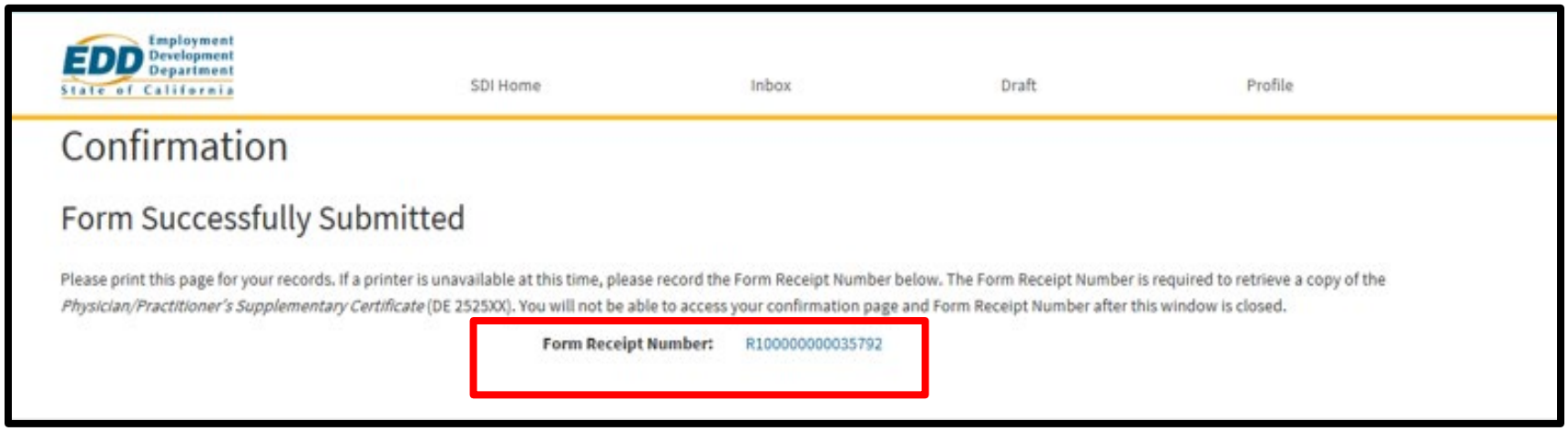
- Select the patient's treatment address from the Action column.
- If the patient was treated at an address other than those listed, select **Not Found**.




Select the check box in Section 5 – Certification.

**Note:** You cannot modify the form after you select Submit.

Select **Submit** to complete your form.




On the Confirmation screen:

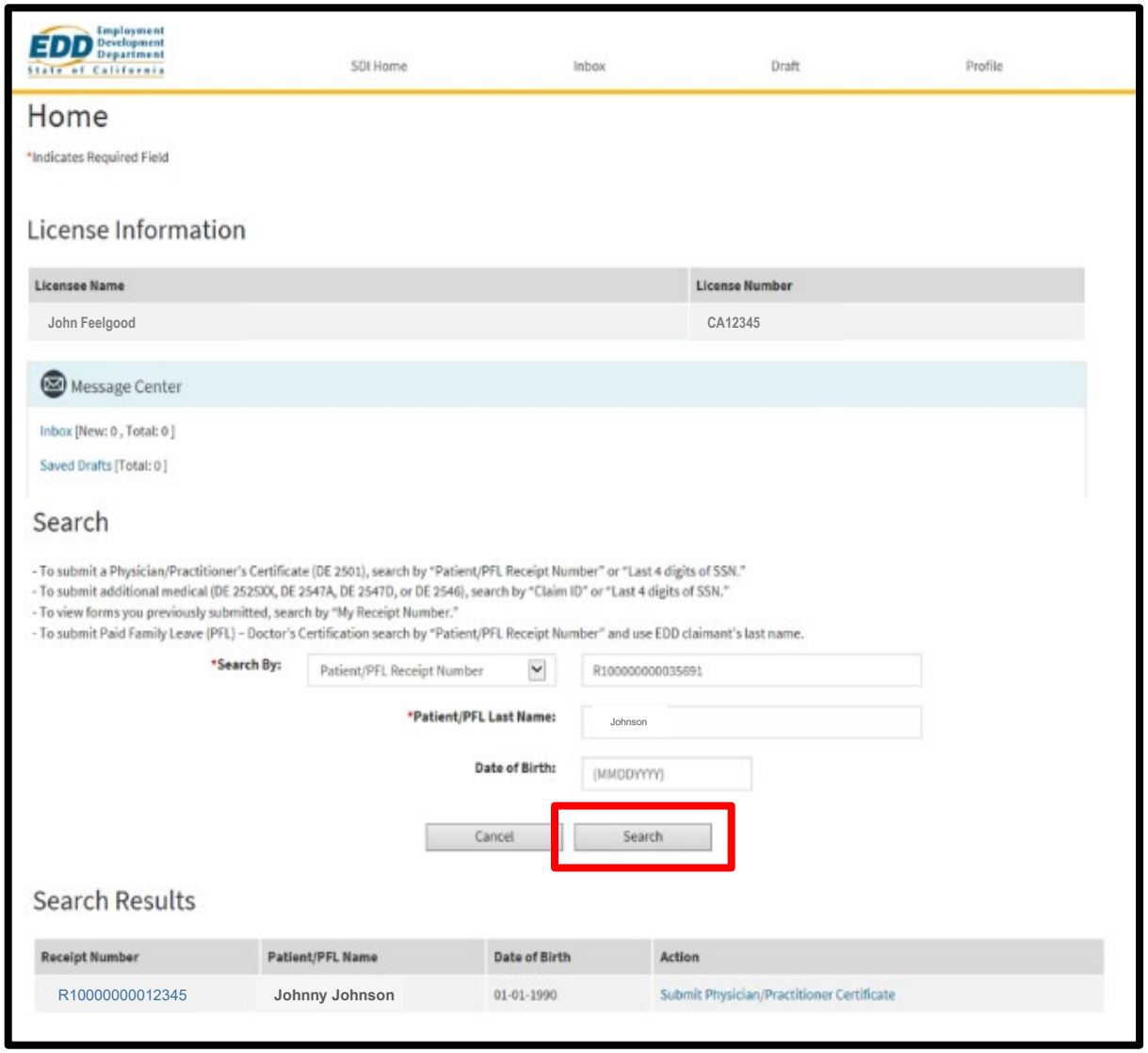
- Save the Form Receipt Number for your records. Your patient can request this number to prove the medical certificate was sent to us.
- Select the **Form Receipt Number** link to open a PDF printer-friendly version of the information you sent.

You have now completed the *Physician/Practitioner's Supplementary Certificate* (DE 2525XX) to extend your patient's disability benefits. Allow up to 10 days for the EDD to process this form.

# Submit a *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F) – Part D

Learn more about how to submit the DE 2501F Part D – Physician/Practitioner's Certification

Get Started



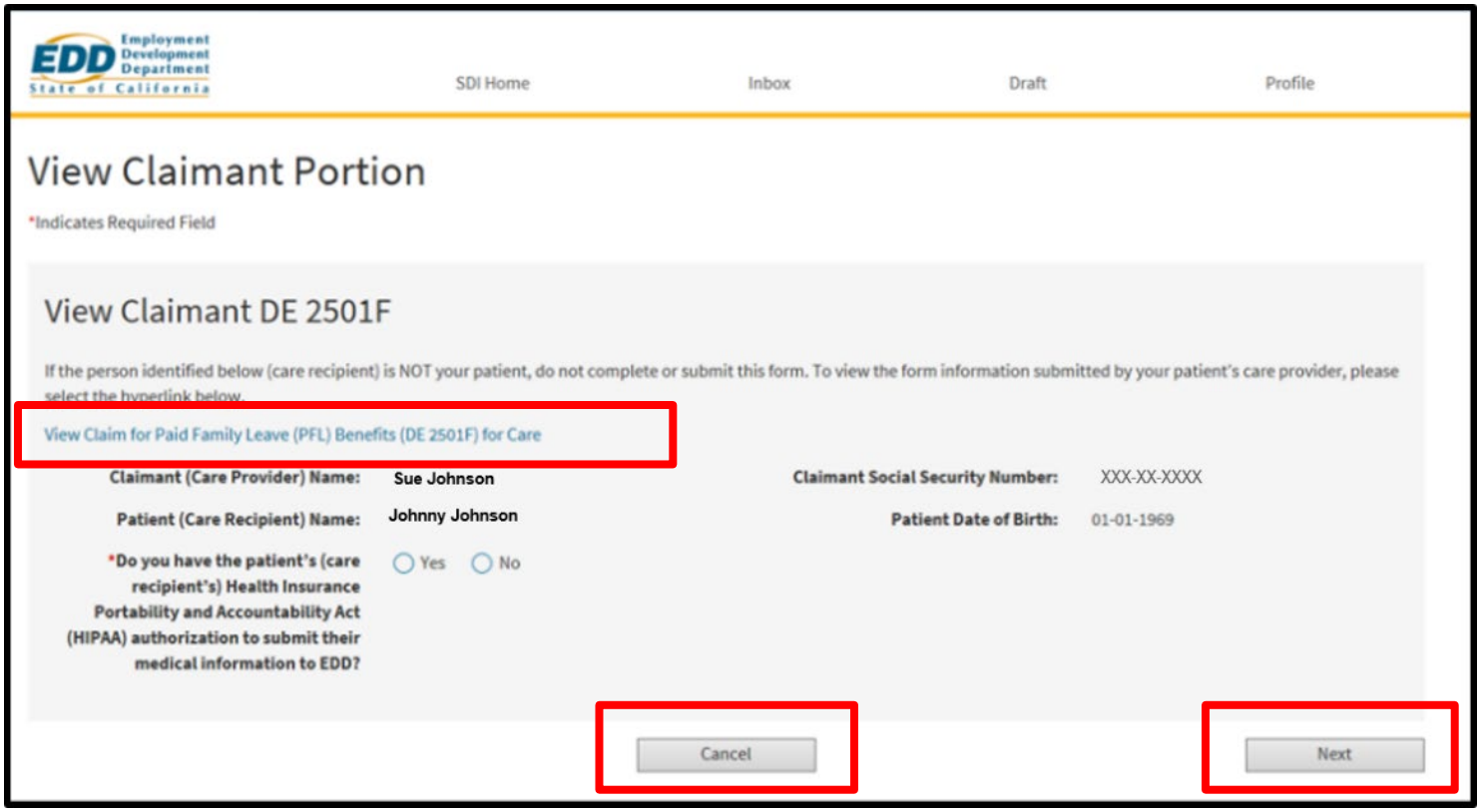

From your homepage, use the Search section to look up Part D - Physician/Practitioner's Certification of the DE 2510F form.

Search by:

- The **Patient/PFL Receipt Number**.
- Enter the Receipt Number (provided by the individual filing for benefits) and their last name.
- Select **Search**.

**Note**

To submit Part D of the *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F) online, your patient's caregiver must have submitted Part A of the DE 2501F online.

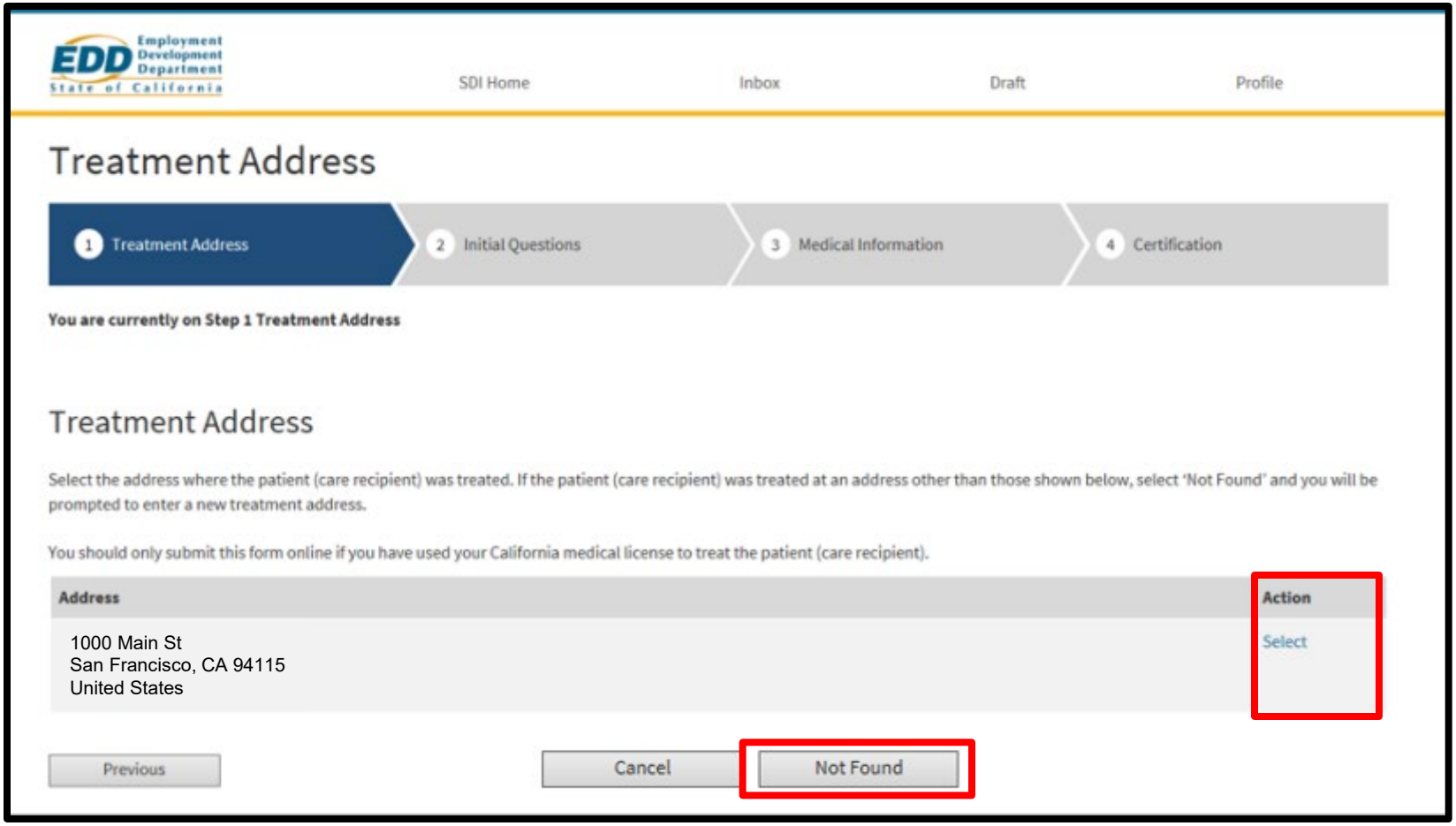



**Note**

Select **Cancel** at any time to cancel the claim and return to your homepage.

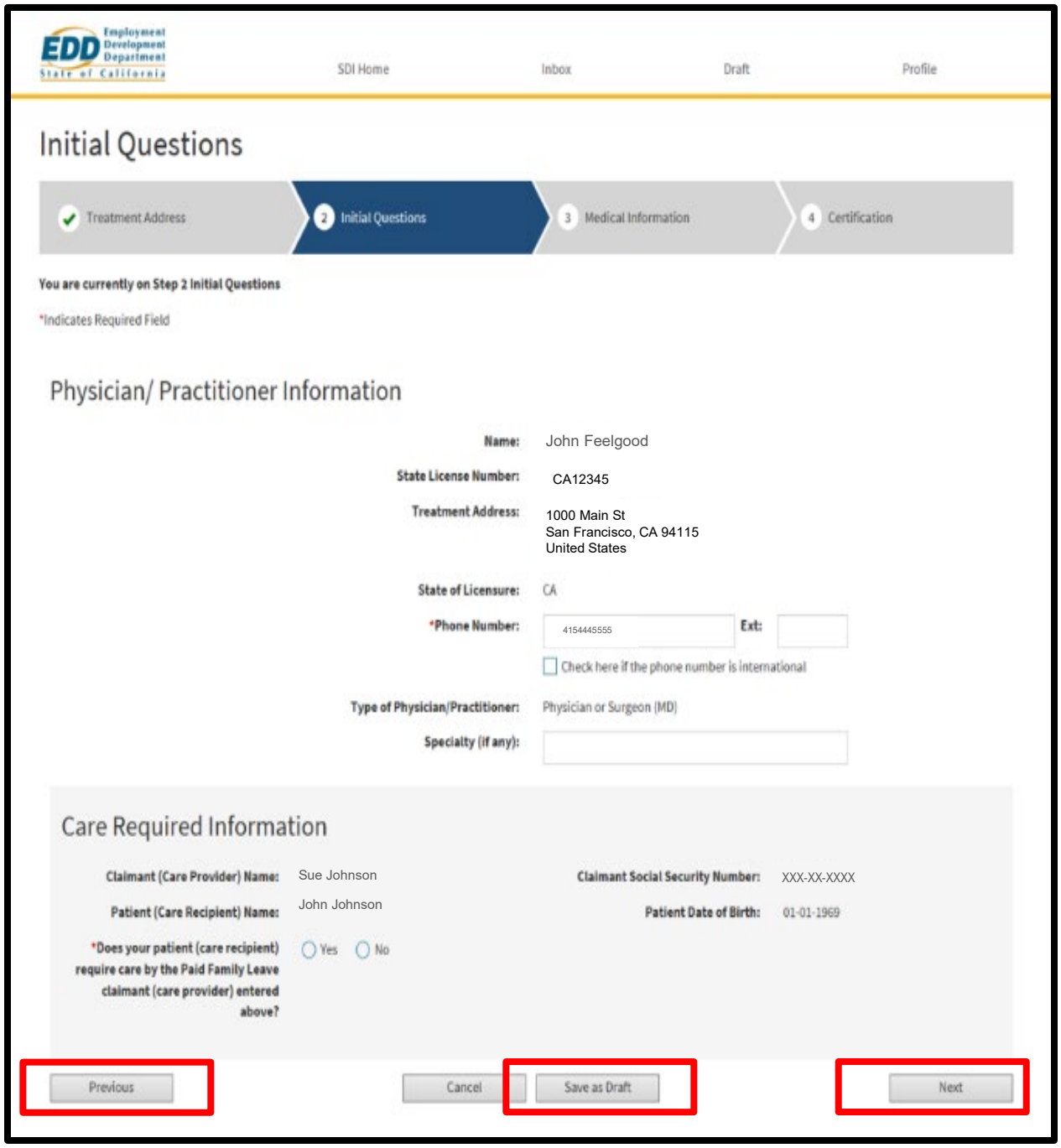
In the View Claimant DE 2501F section:

- Select the **View Claim for Paid Family Leave (PFL) Benefits (DE 2501F) for Care** link to review the claimant's section of the form.
- Select **Next** to complete the certificate.




On the Treatment Address screen:

- Select your patient's treatment address from the Action column.
- If the patient was treated at an address other than those listed, select **Not Found.**




The SDI Online system automatically populates certain sections of the application.

Complete the Physician/Practitioner Information section.

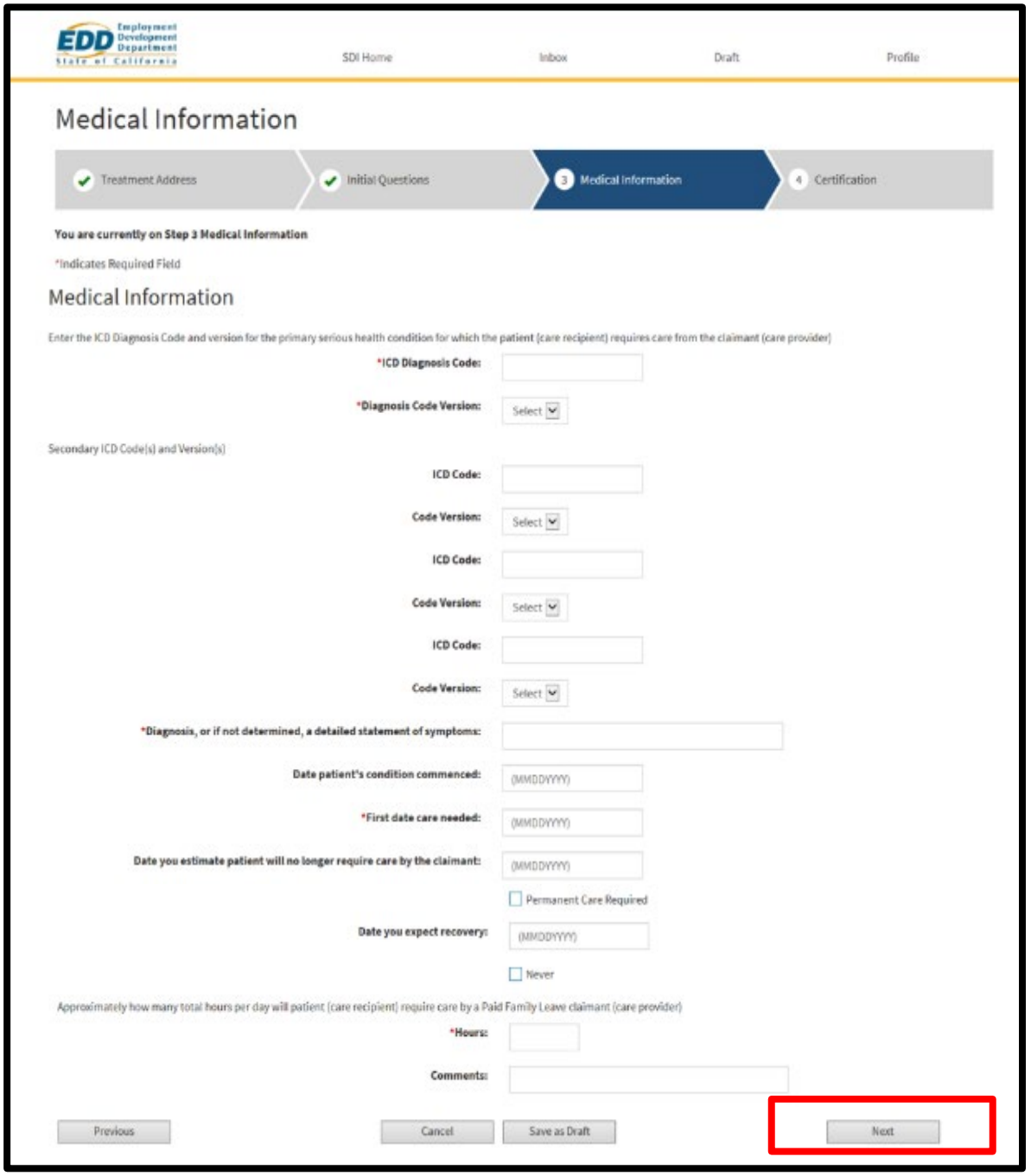
You must complete the fields marked with a red asterisk (*).

Select **Next** to proceed.

**Note**

Select **Save as Draft** at any time to complete the form later.

Select **Previous** to return to the previous screen.



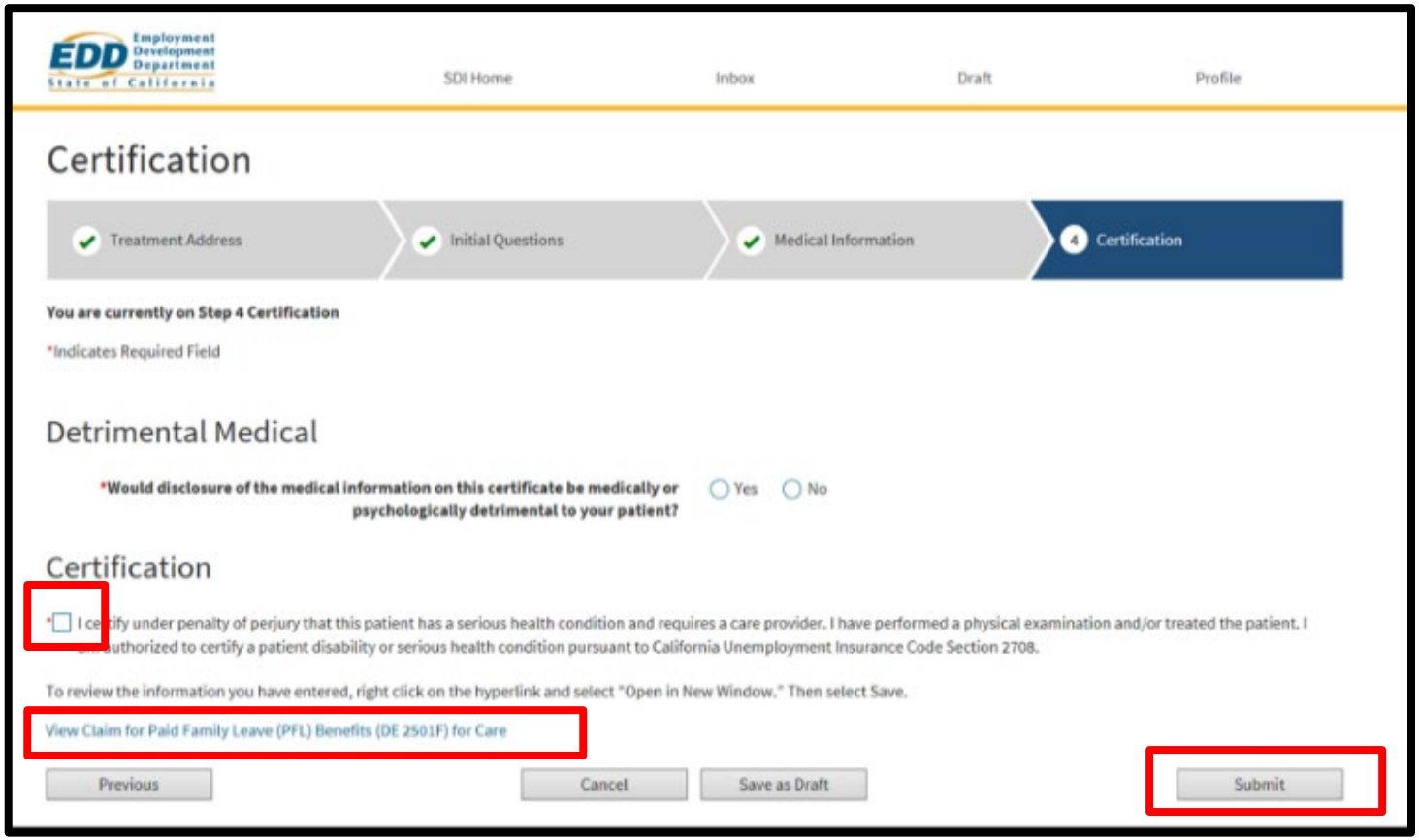

Complete the Medical Information section.

You must provide the following information:

- Valid ICD codes.
- Diagnosis or detailed list of symptoms.
- First date care is needed.
- Estimated date care is no longer needed.
- Hours your patient will require care each day.

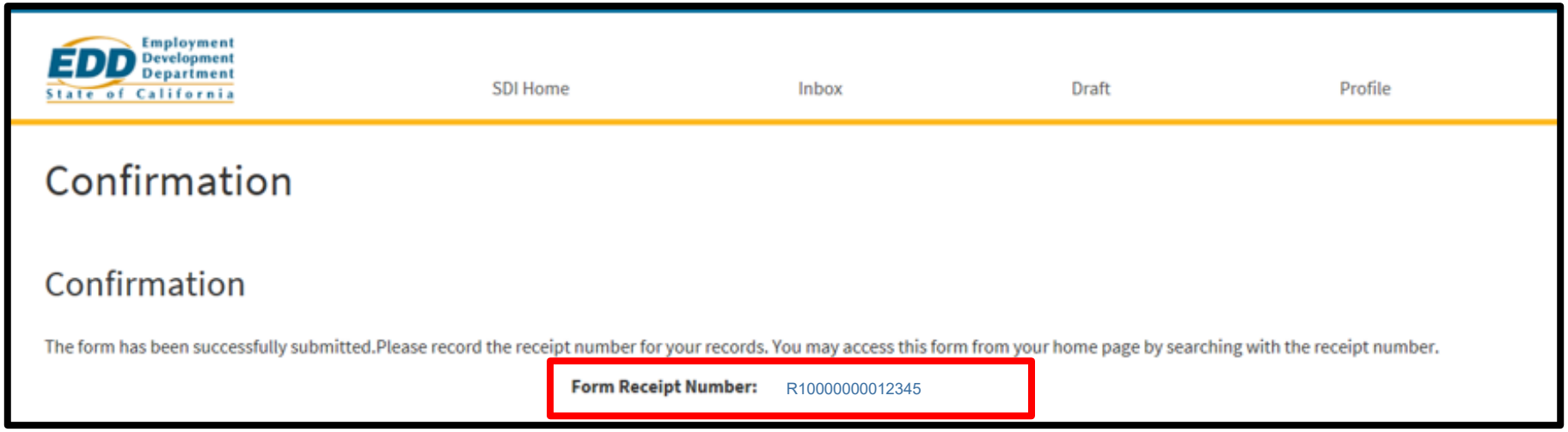
You must complete the fields marked with a red asterisk (*).

Select **Next**.




In the Certification section:

- Select the check box to confirm the information you entered.
- Select **View *Claim for Paid Family Leave (PFL) Benefits*** **(DE 2501F) for Care** to review the information you entered.
- **Note:** You cannot modify the form after you select Submit.
- Select **Submit**.




On the Confirmation screen:

- Save the Form Receipt Number for your records. The individual filing for benefits can request this number to prove the medical certificate was submitted to us.
- Select the **Form Receipt Number** link to open a PDF printer-friendly version of the information you submitted.

You have now completed Part D - Physician/Practitioner's Certificate of the *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F) for the caregiver's Paid Family Leave care claim. Allow up to 14 days to process this form.

# Complete Paper Claim Forms

Learn more about how to complete and submit a paper claim form for disability or family leave benefits.

Get Started

# Common situations that require individuals to apply by paper form:

It is strongly recommended that you complete a paper *Claim for Disability Insurance (DI) Benefits* (DE 2501), Part B form when your patient applies by paper form. Submitting all forms together helps prevent errors and reduces processing time.

**Patients/Claimants:**

- Who are undocumented workers
- Without a valid California Driver's license or California identification card
- Name exceeds SDI Online character limitation

**Health Professionals:**

- Licensed out of state
- Licensed out of country
- Working in facilities
- Who are religious practitioners
- Name exceeds SDI Online character limitation

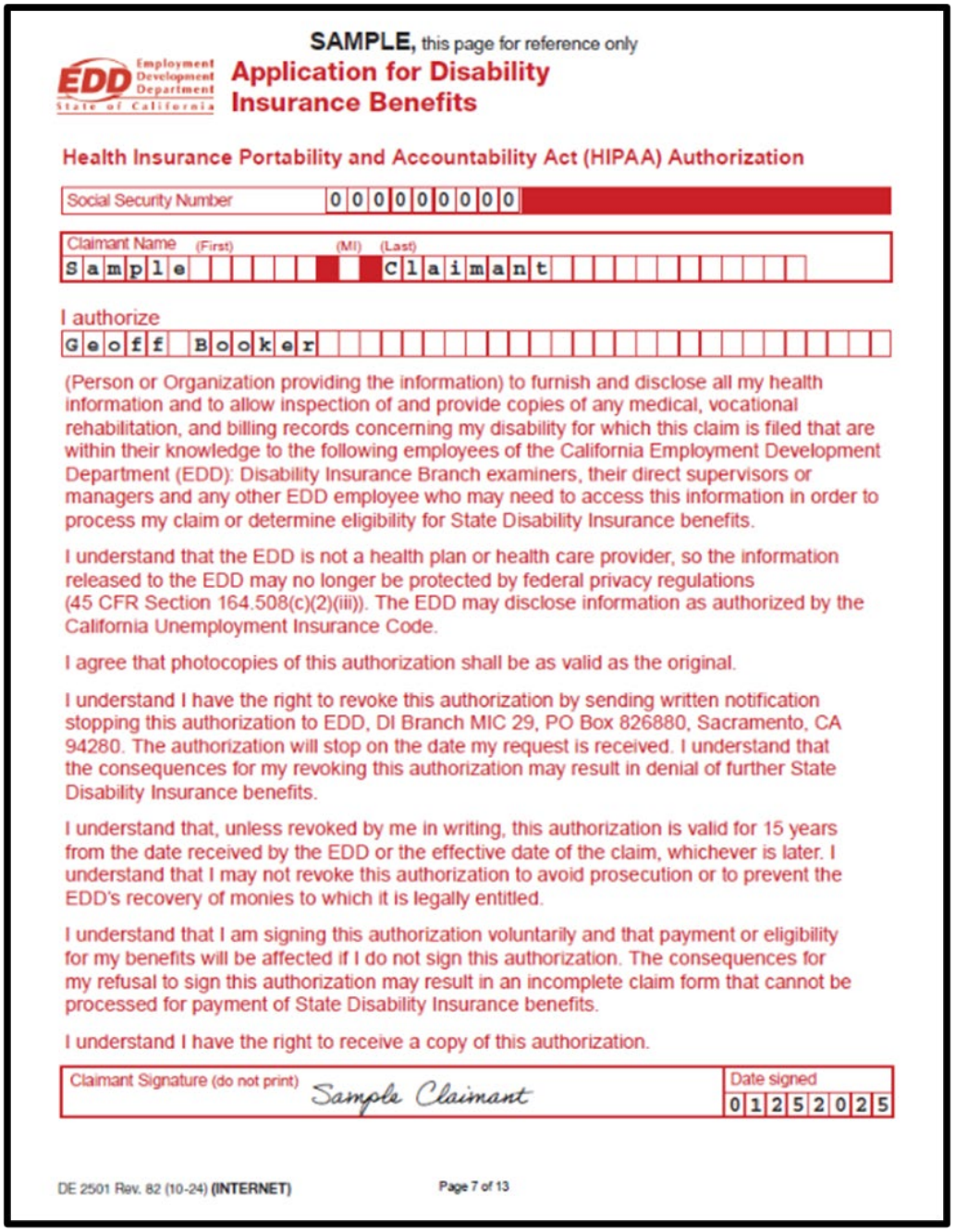
# To avoid processing delays when completing a paper claim form:

## 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 previously submitted it 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.

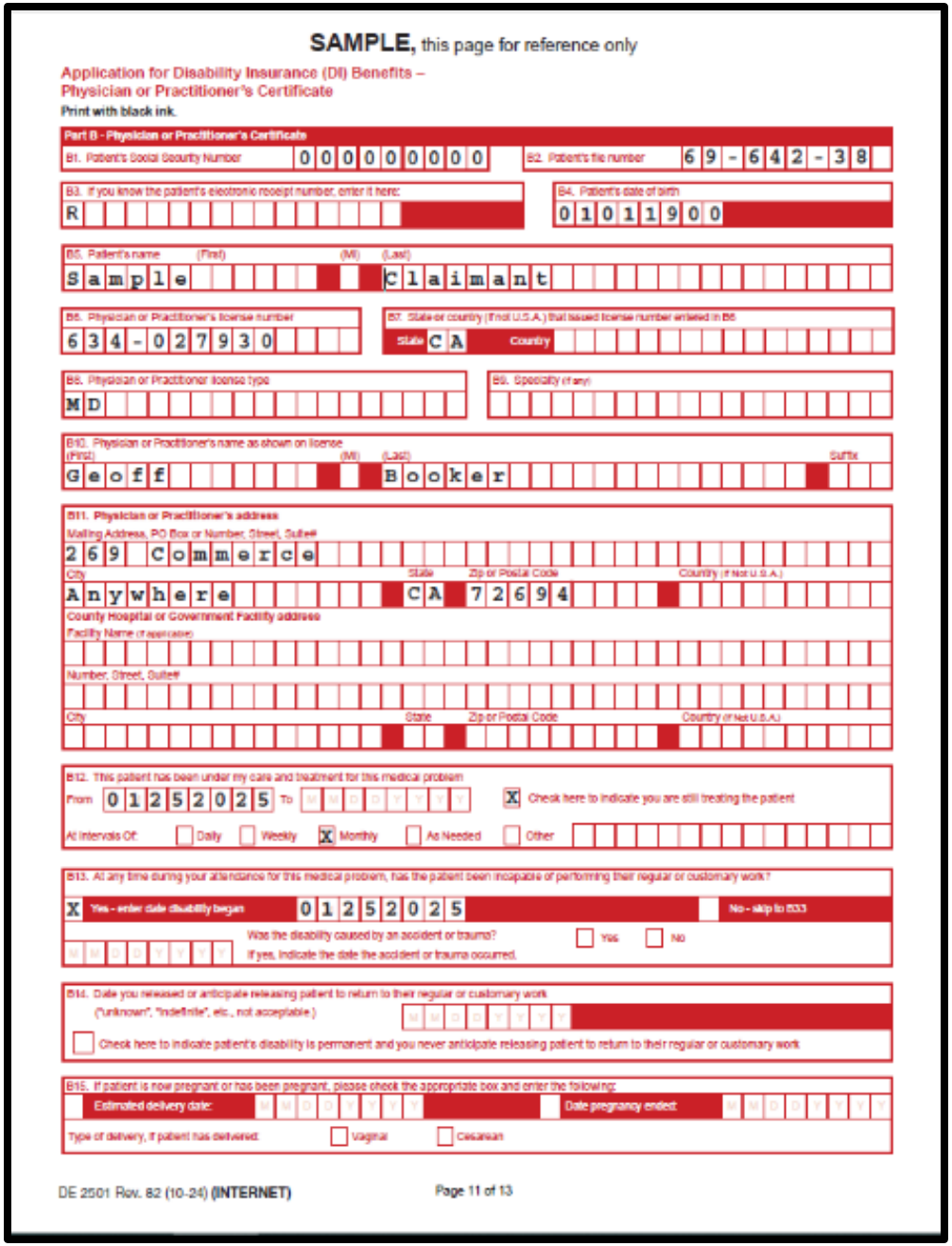
Claimant Signature (do not print): Sample Claimant — Date signed: 01252025

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

# *Claim for Disability Insurance (DI) Benefits* (DE 2501)

The Health Insurance Portability and Accountability (HIPAA) Authorization must be completed and signed by the individual filing for disability benefits (page 1).

Part A - Claimant's Statement is completed by the individual filing for disability benefits (pages 1-4).



**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: [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 B13

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.)

[ ] 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: Date pregnancy ended:

Type of delivery, if patient has delivered: [ ] Vaginal [ ] Cesarean

DE 2501 Rev. 82 (10-24) **(INTERNET)** Page 11 of 13

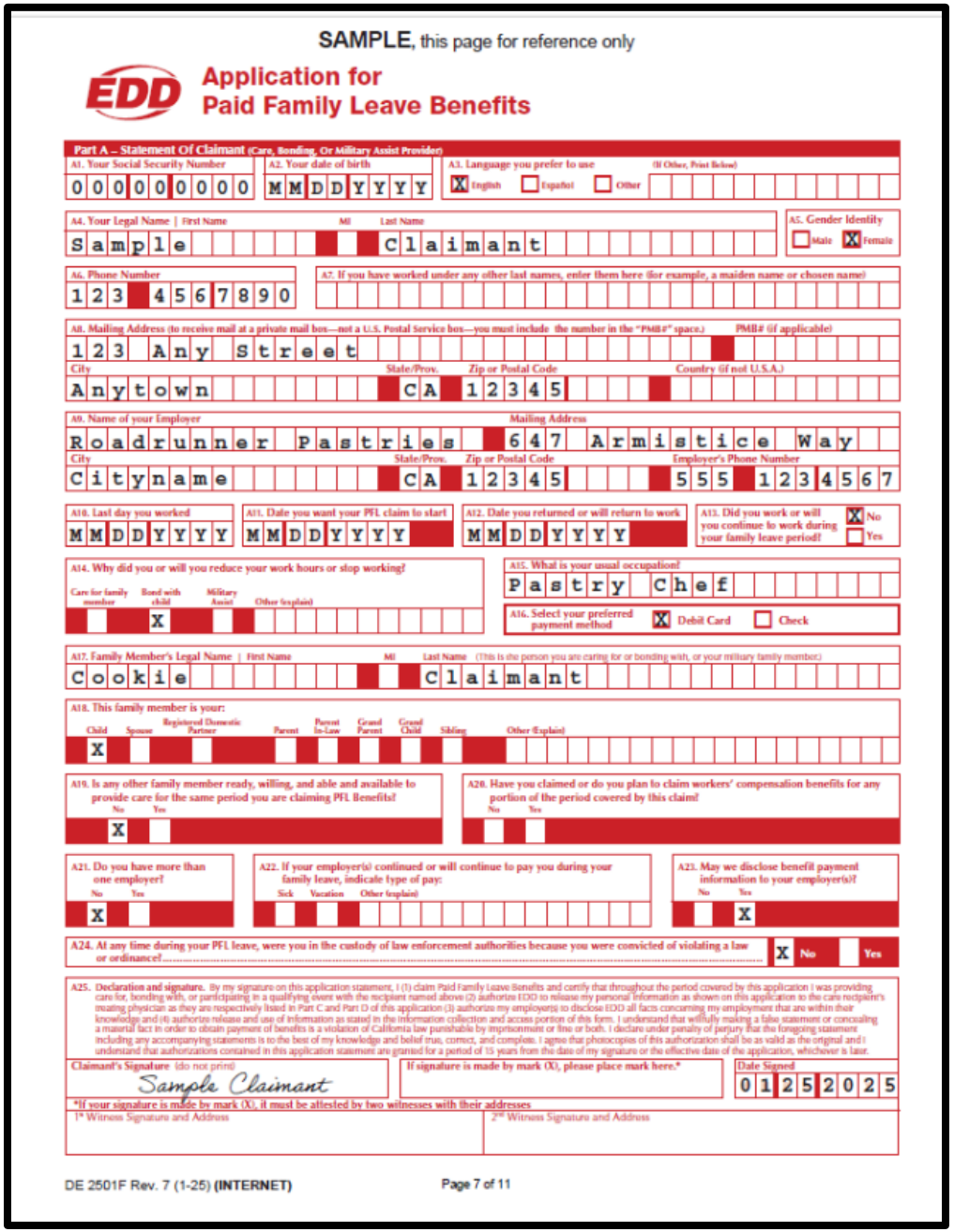
Part B - Physician's/Practitioner's Certificate (pages 5-7).

As the physician/practitioner, you must complete all applicable information, including:

- Care and treatment dates.
- Date disability began.
- Estimated return to work date.
- Diagnosis or a list of symptoms.
- ICD codes.
- In the case of pregnancy, the estimated delivery date and number of days for recovery per delivery type (42/56) or the pregnancy end date and delivery type.
- License and personal information.
- Your signature.

**Note**

Provide only one medical license number. If licensed in multiple scopes of practice, use the license for the type of disability you are certifying for.



SAMPLE, this page for reference only

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: MMDDYYYY
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: 1234567890
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.): 123 Any Street PMB# (if applicable)
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: 5551234567
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? [X] No [ ] Yes
A14. Why did you or will you reduce your work hours or stop working? Care for family member [ ] Bond with child [X] 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: 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

DE 2501F Rev. 7 (1-25) (INTERNET) Page 7 of 11

# *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F)

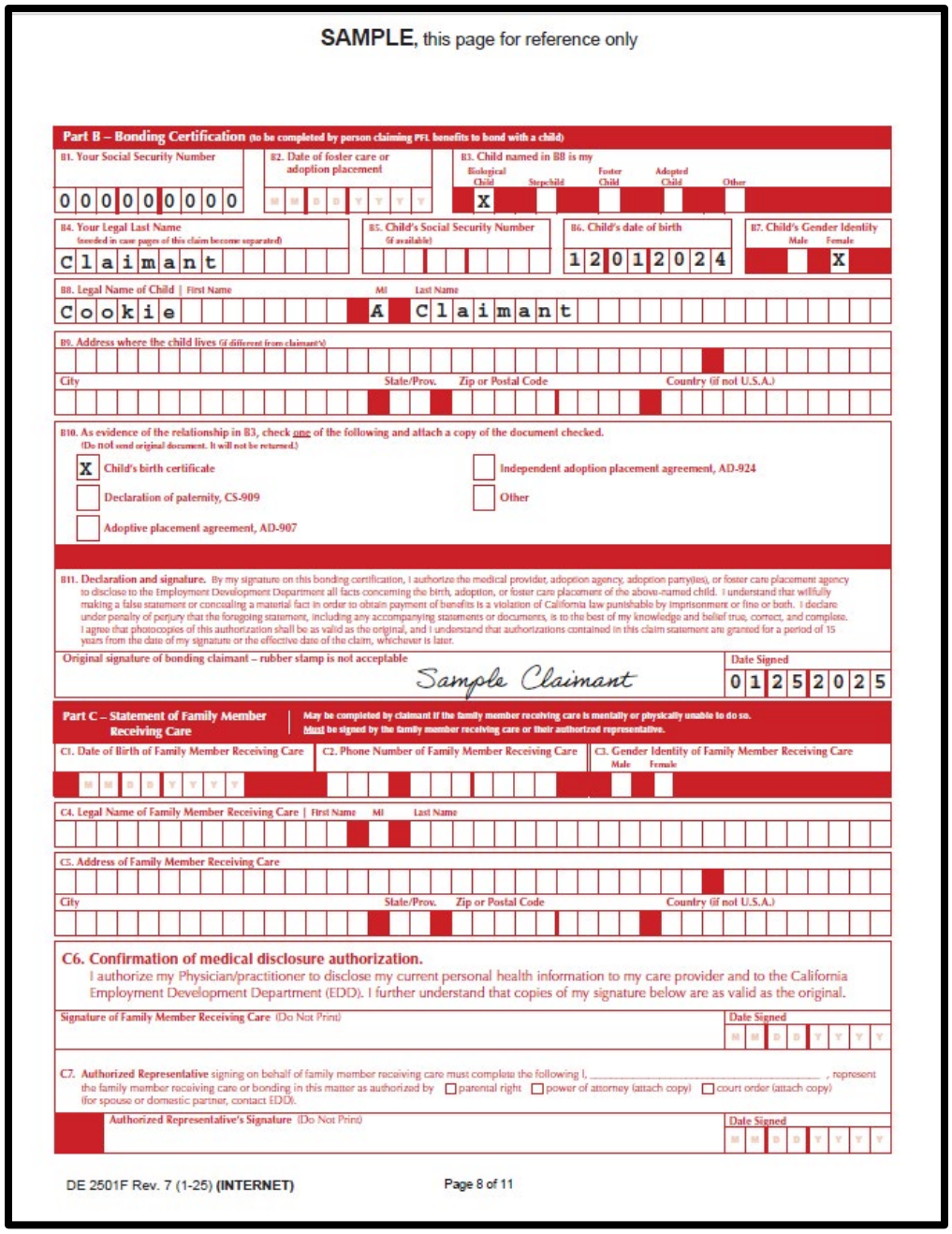
**Page 1:** Part A - Statement of Claimant:

The individual filing for benefits must complete all applicable information, including:

- Personal Information
- Last day worked
- Date the family leave began
- Employer information
- Signature

**Part A is required for all claim types:**

- Bonding
- Care
- Military Assist



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: 000000000

B2. Date of foster care or adoption placement: MM DD YYYY

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 statements, 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: MM DD YYYY

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: MM DD YYYY

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: MM DD YYYY

DE 2501F Rev. 7 (1-25) **(INTERNET)** Page 8 of 11

## Page 2:

Part B – Bonding Certification:

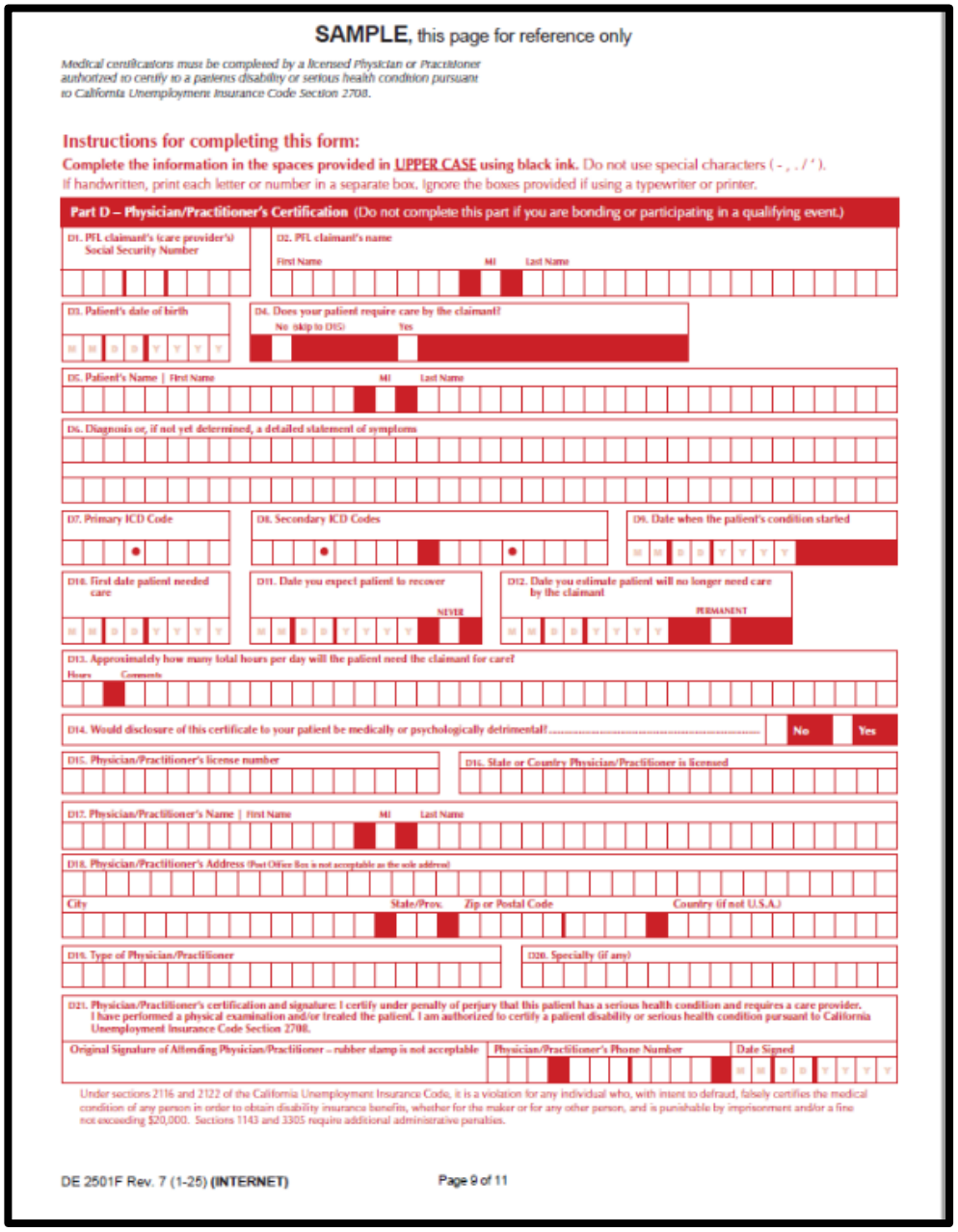
- For bonding claims only. The individual filing for benefits must complete all bonding information and sign the form.

Part C – Statement of Care Recipient:

- For care claims only. Your patient/care recipient or the individual filing for benefits must fill out the appropriate care information. The care recipient or their authorized representative must sign the form.

The individual filing for benefits completes either Part B or Part C – **but never both.**

**Note:** Part B and Part C are not needed for military assist 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.

DE 2501F Rev. 7 (1-25) **(INTERNET)** Page 9 of 11

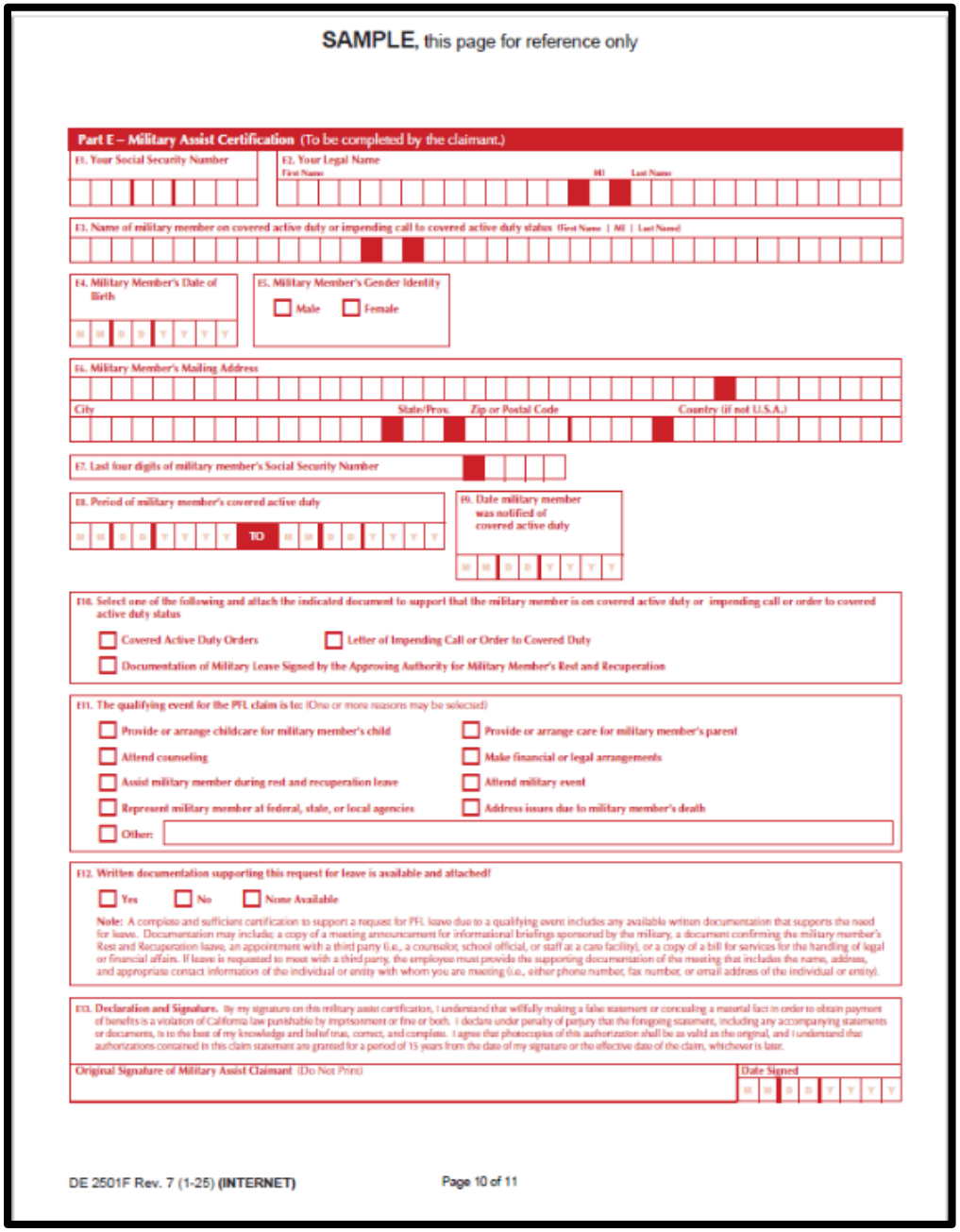
**Page 3:** Part D – Physician/Practitioner's Certification

As the physician/practitioner, you must complete all applicable information for care claims, including:

- Date disability began.
- First date care was needed.
- Date you expect recovery.
- Number of hours per day care is required.
- Diagnosis or a list of symptoms.
- ICD codes.
- Your information and license.
- Signature.

**Note**

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



SAMPLE, this page for reference only

**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

DE 2501F Rev. 7 (1-25) **(INTERNET)** Page 10 of 11

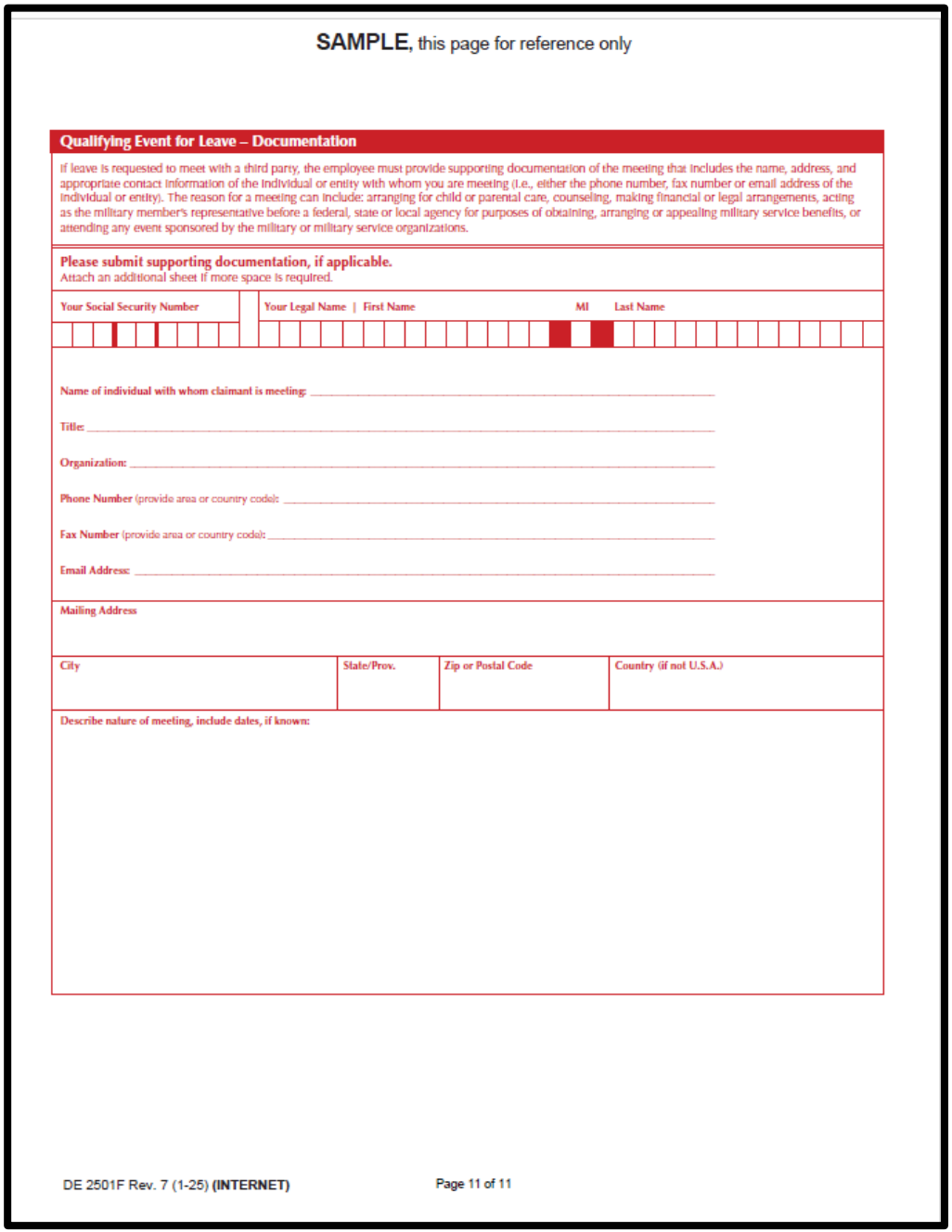
**Page 4:** Part E – Military Assist Certification

The individual filing for benefits must complete all information for military assist claims, including:

- The military member's personal information.
- Dates of covered duty.
- Qualifying event information.
- Signature.

**Note**

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



SAMPLE, this page for reference only

**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)** Page 11 of 11

## **Page 5:** Qualifying Event for Leave Documentation

Military assist claims to meet with a third party must have supporting documentation that includes contact information for the third party and a description of the event with dates.

Individuals should make sure all pages are completed and all signatures are obtained before the claim is mailed to us for processing.

**Note**

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

# CONTACT US

# 1-855-342-3645

This number is for licensed health professionals only.

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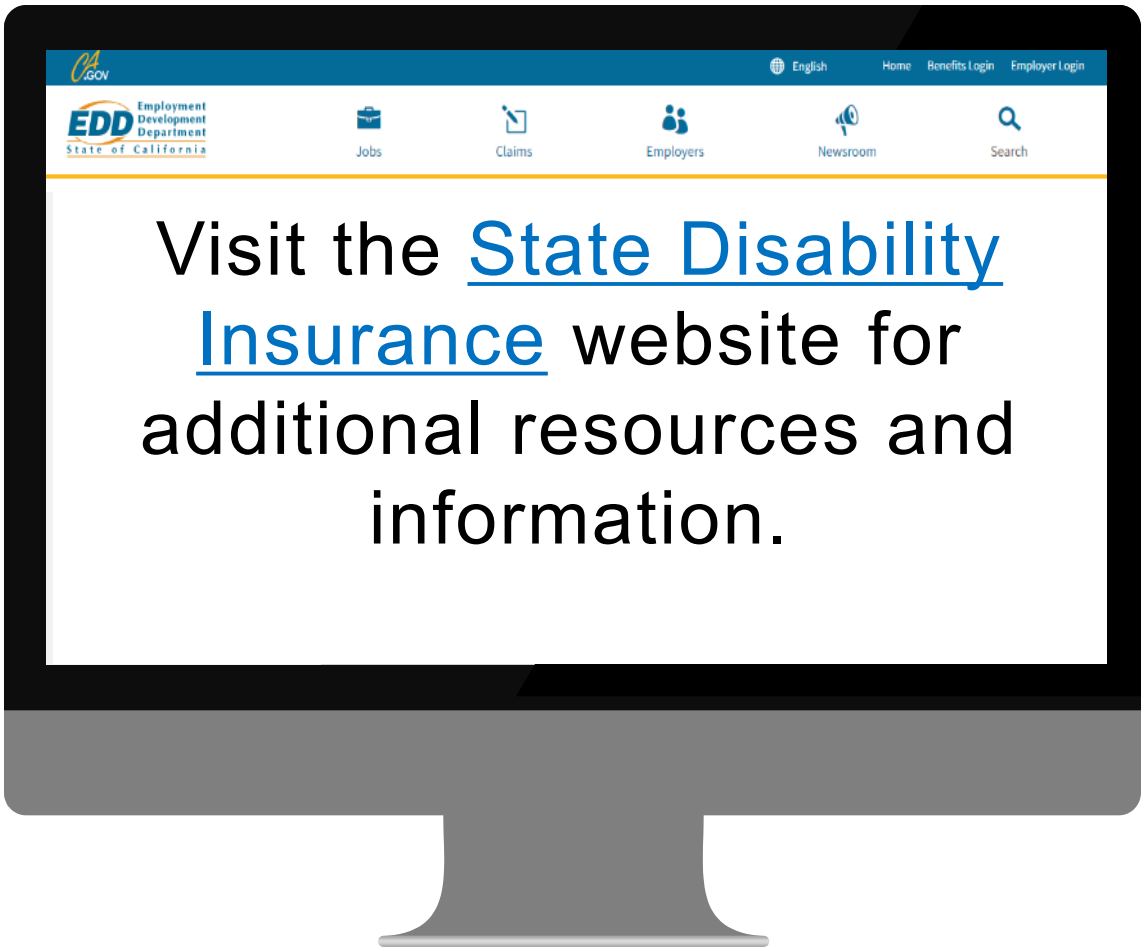


The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and alternate formats need to be made by calling 1-866-490-8879 (voice), or through the California Relay Service at 711.