Employment Development Department
State of California

SDI ONLINE TUTORIAL

File a Paid Family Leave Claim

Last Updated: May 2025

CONTENTS

Employment Development Department
State of California

File a Bonding Claim - New Mothers

Learn more about how individuals apply for bonding benefits after a pregnancy-related disability claim.

Get Started

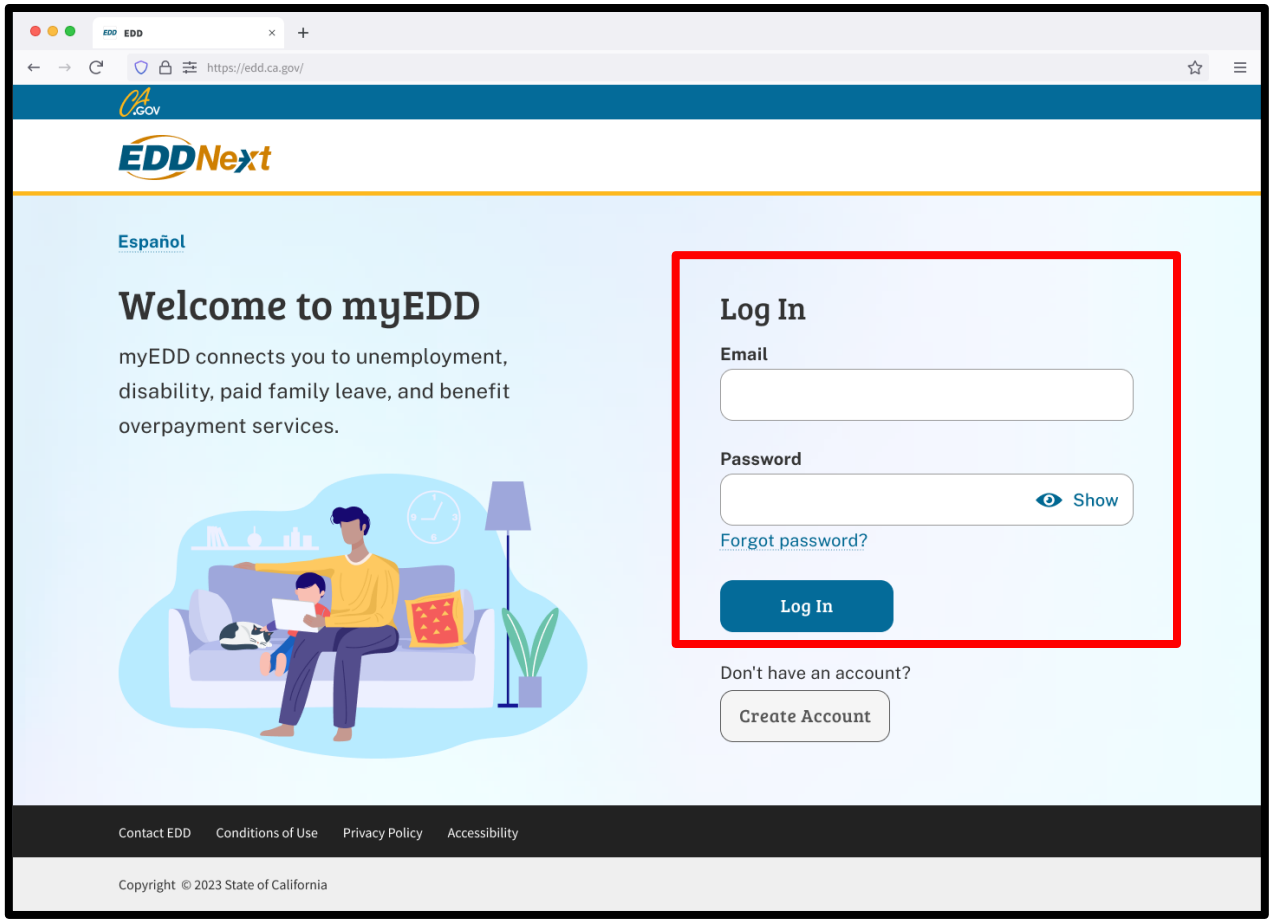
Applying for bonding benefits after a pregnancy-related disability claim

If you applied for a disability claim by:

- **Mail:** We automatically mail you a *Claim for Paid Family Leave (PFL) Benefits – New Mother* (DE 2501FP) form when your final disability payment is delivered.
- **Online:** We automatically send a link to the DE 2501FP form to your account inbox when your final disability payment is issued.

Note

If you are a birth mother who did not have a pregnancy-related disability claim, or a new father, or a foster or adoptive parent, refer to File a Bonding Claim for New Mothers (without a pregnancy-related disability claim), Fathers, and Foster or Adoptive Parents.

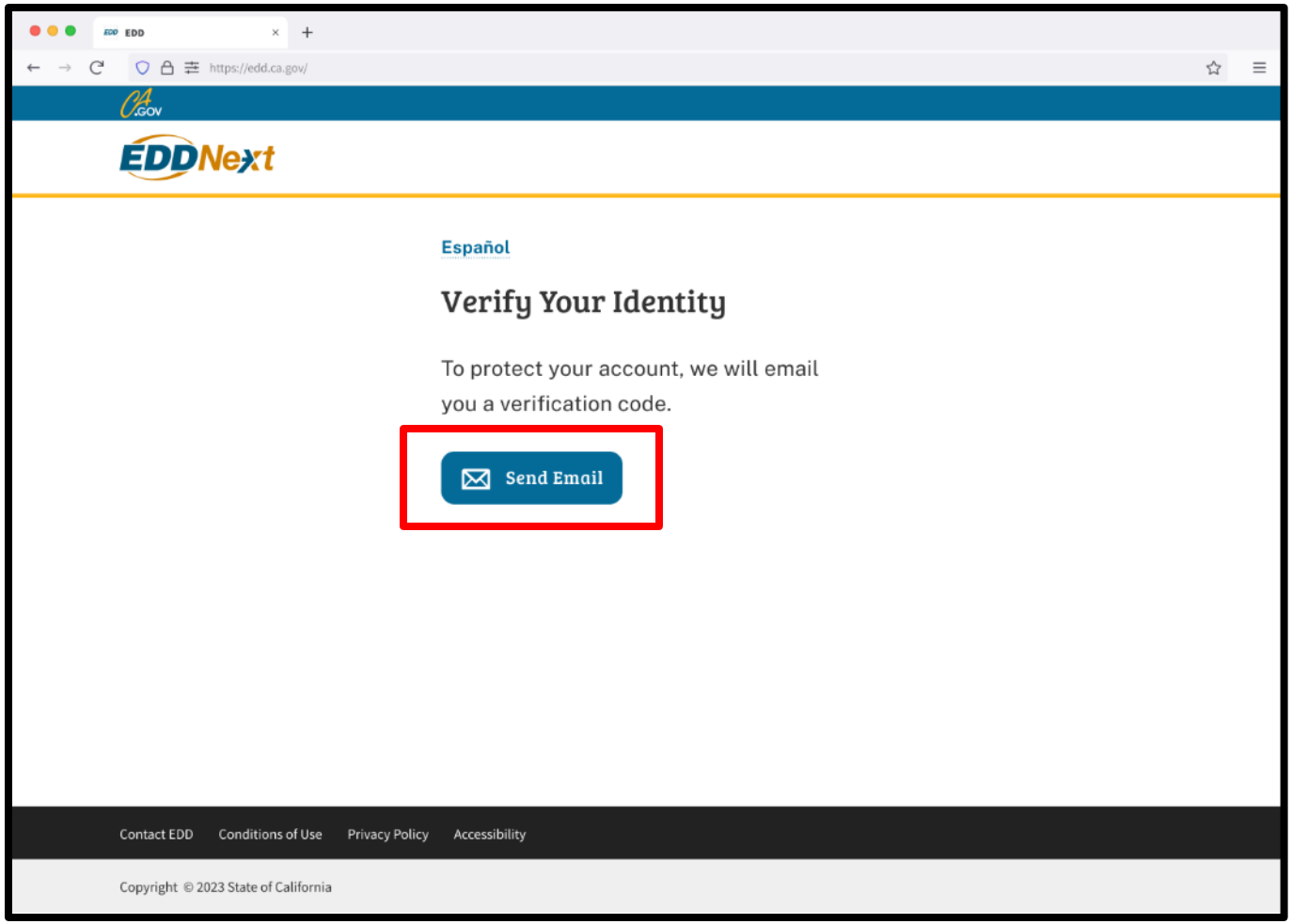


Note

For Spanish, select **Español**.

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

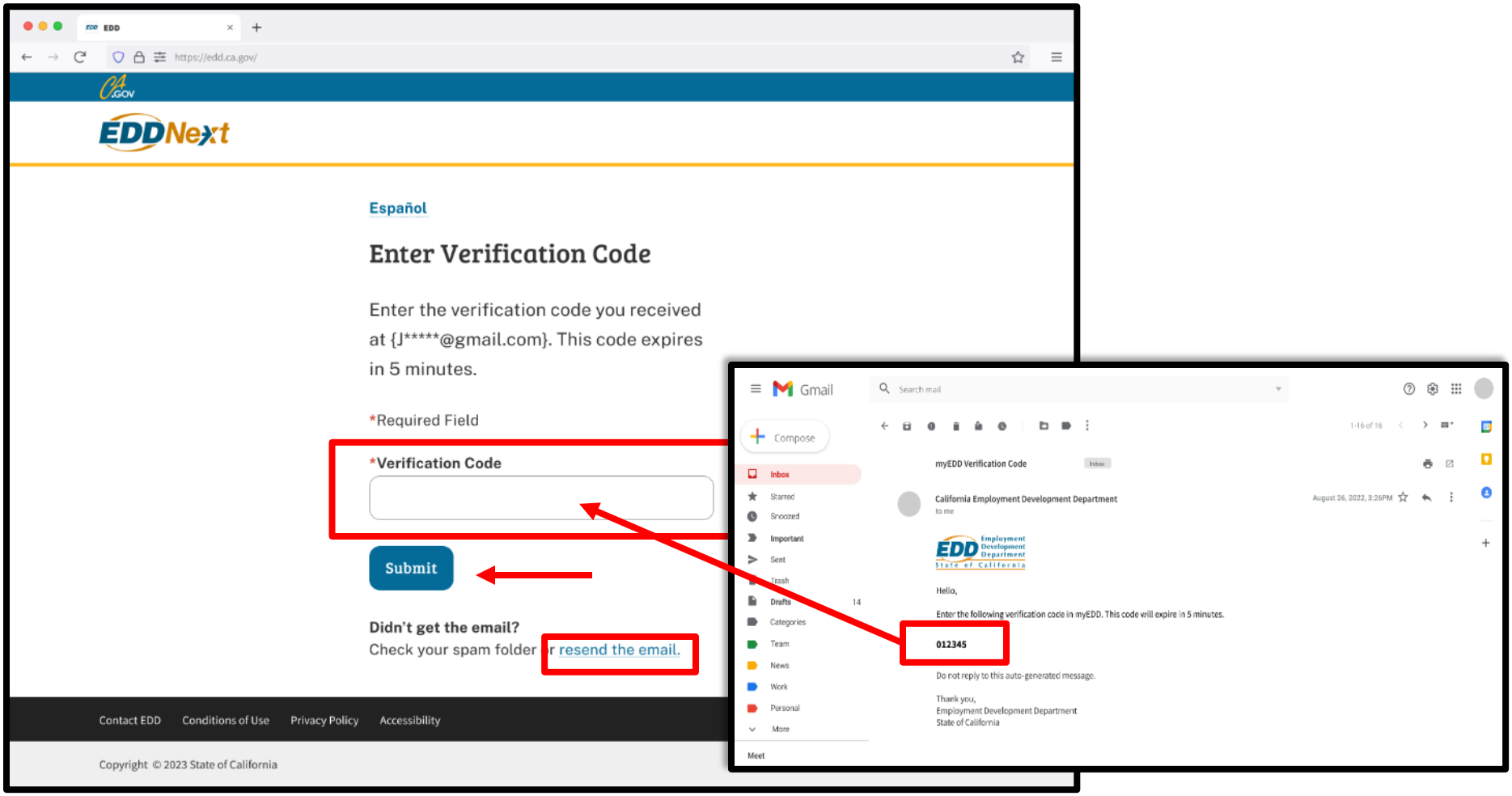
1. Visit myEDD.
2. Enter the email and password used to create your myEDD account.
3. Select **Log In**.



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.

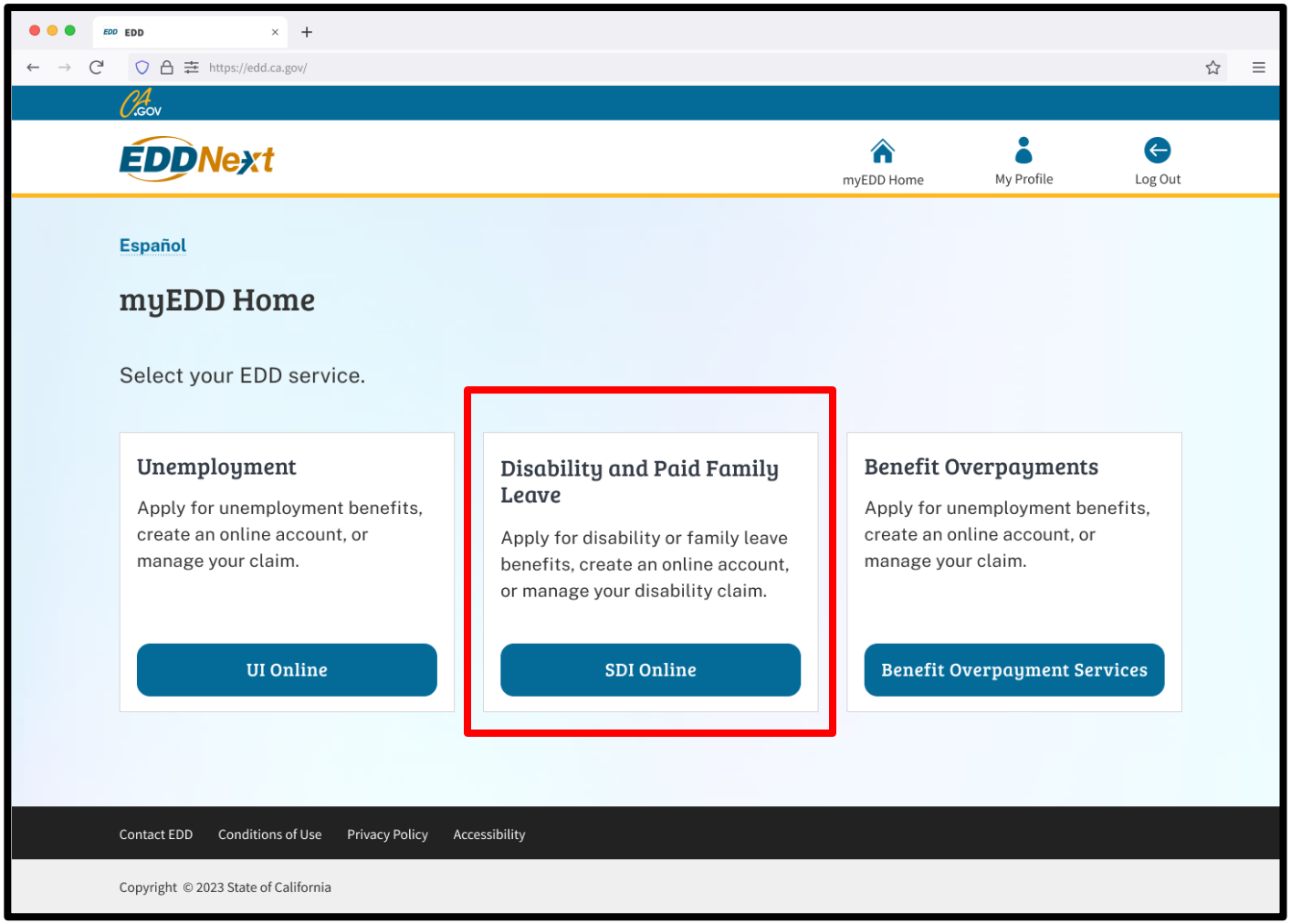
Select **Send Email.**

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.

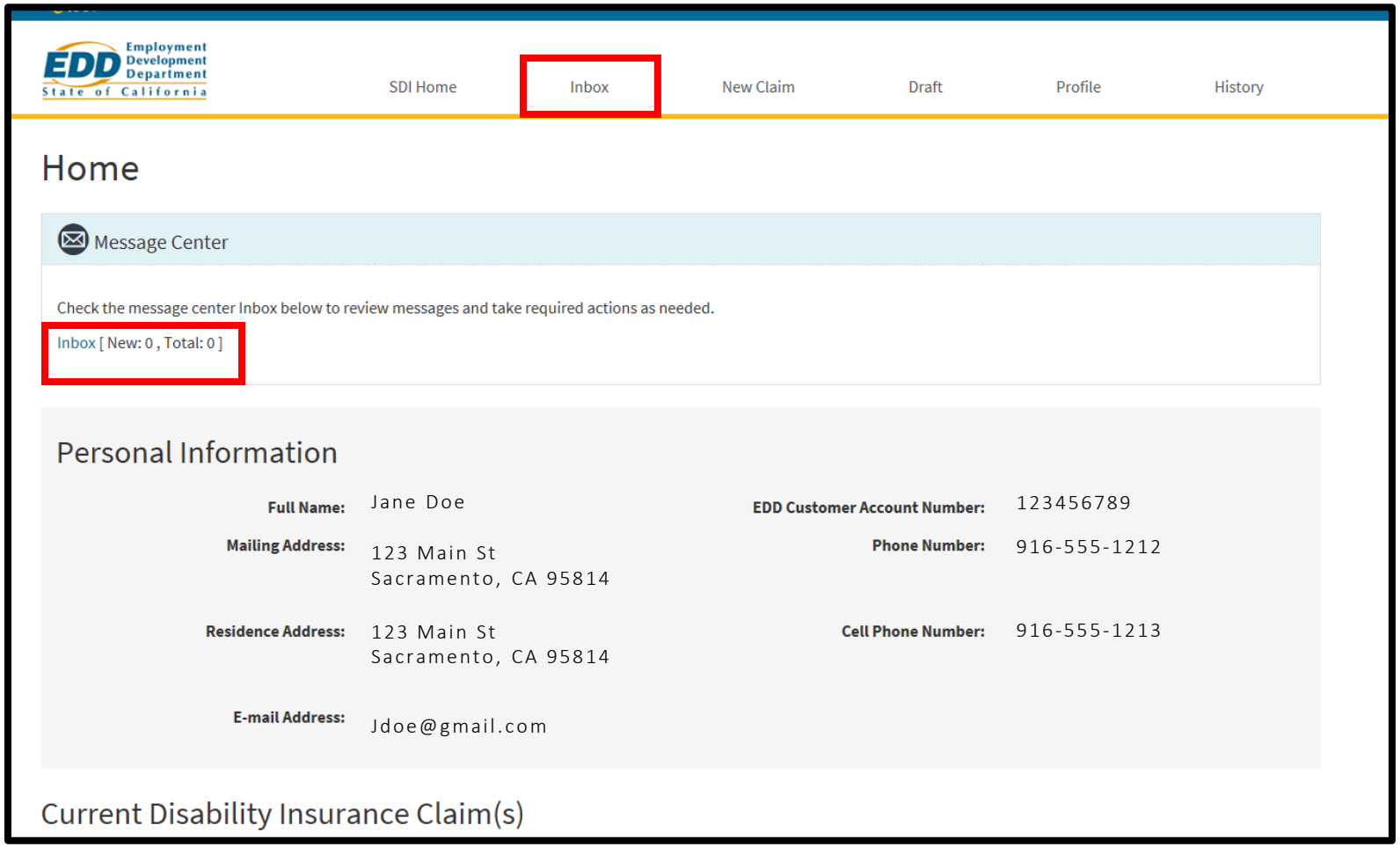
- Enter your verification code and select **Submit**.
- Select **resend the email** if you do not get a code.



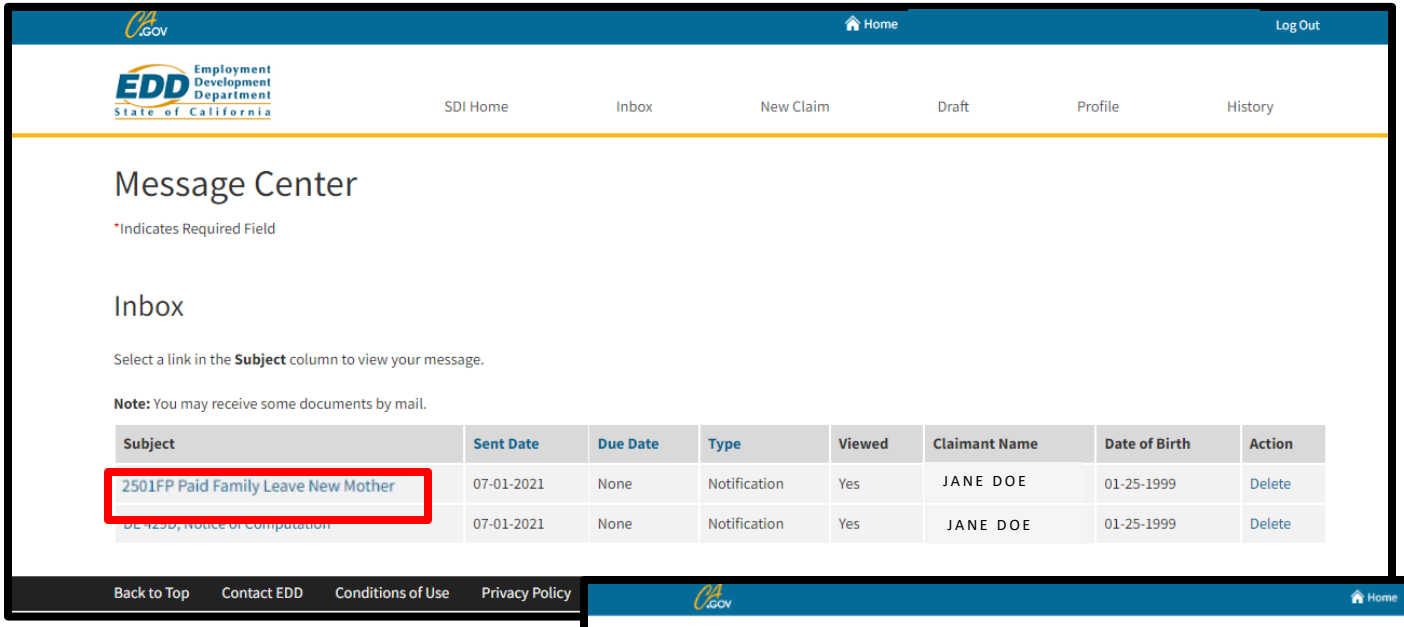
Note

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

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

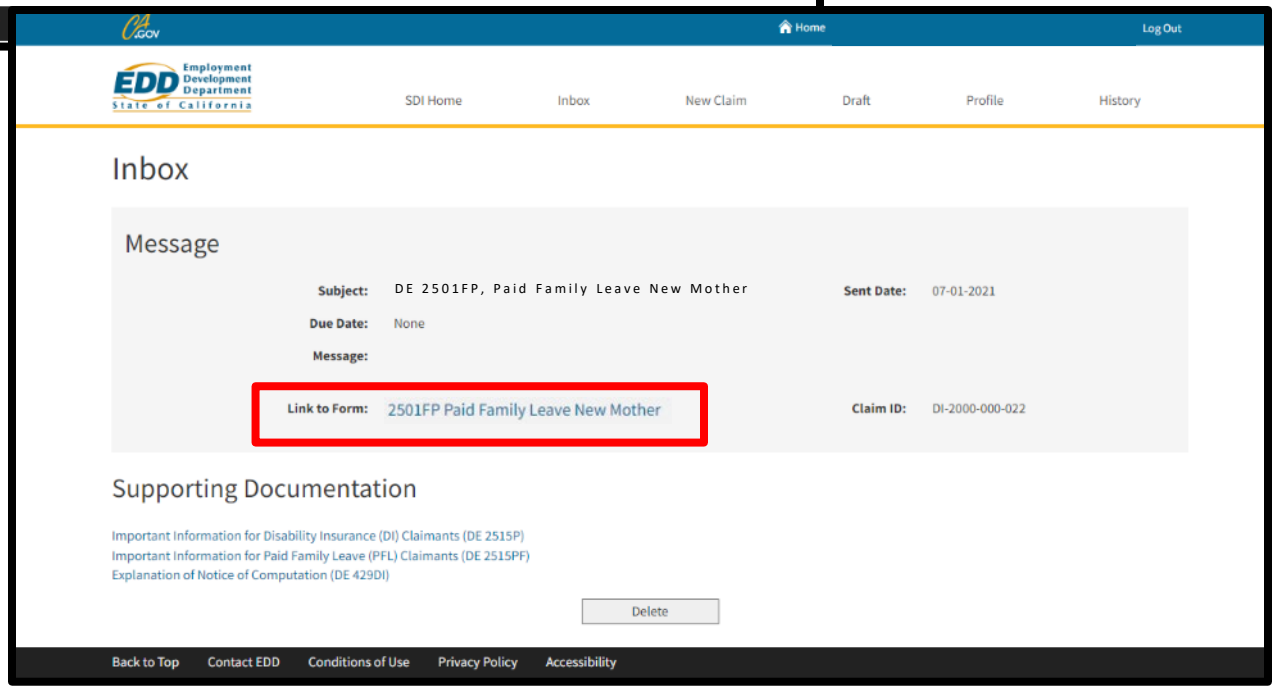


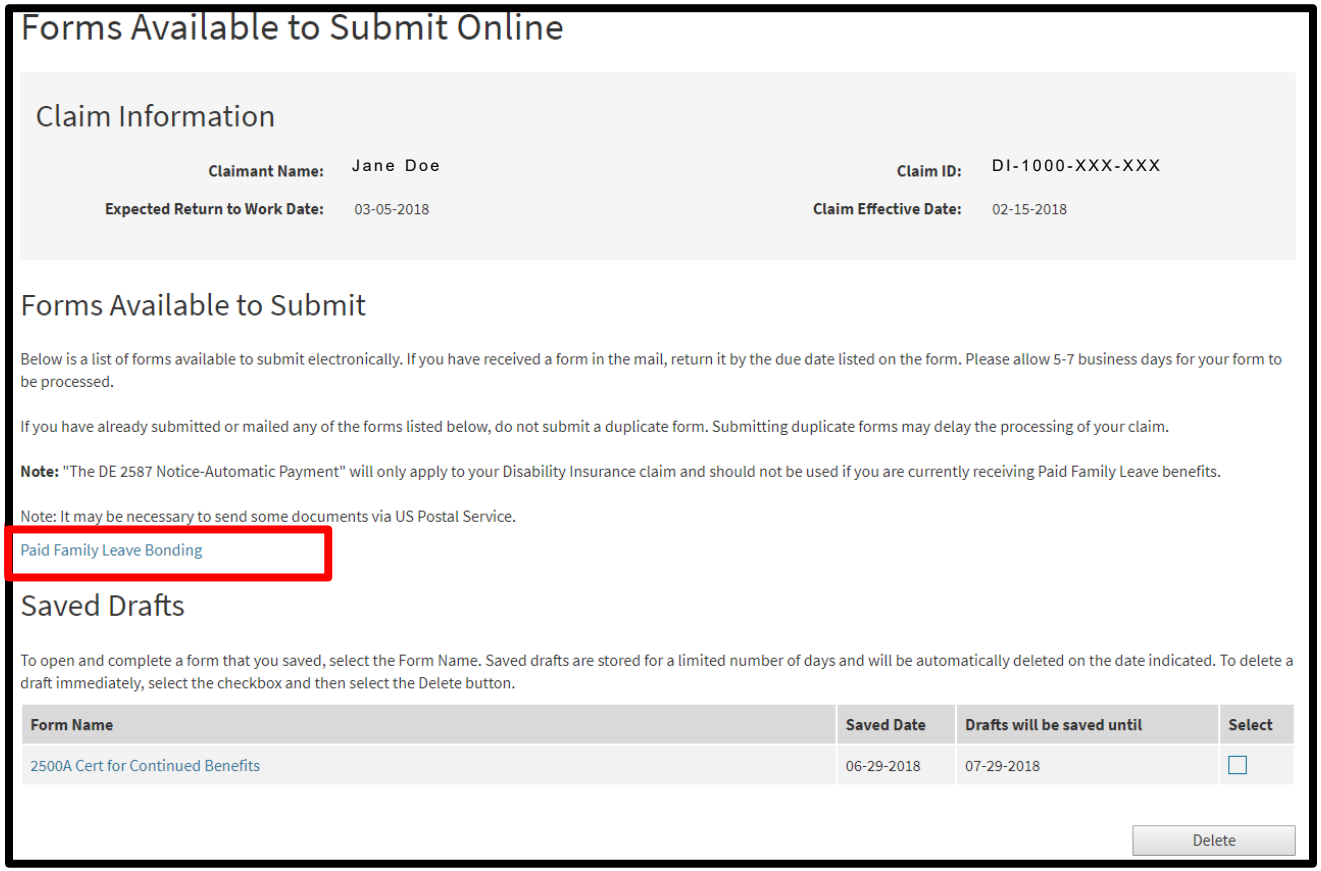
Select **Inbox** from the main menu or the Message Center.



On the Message Center screen, select **DE 2501FP Paid Family Leave New Mother** to access the message.

Next, on the Inbox screen, select **DE 2501FP Paid Family Leave New Mother** to access the form.





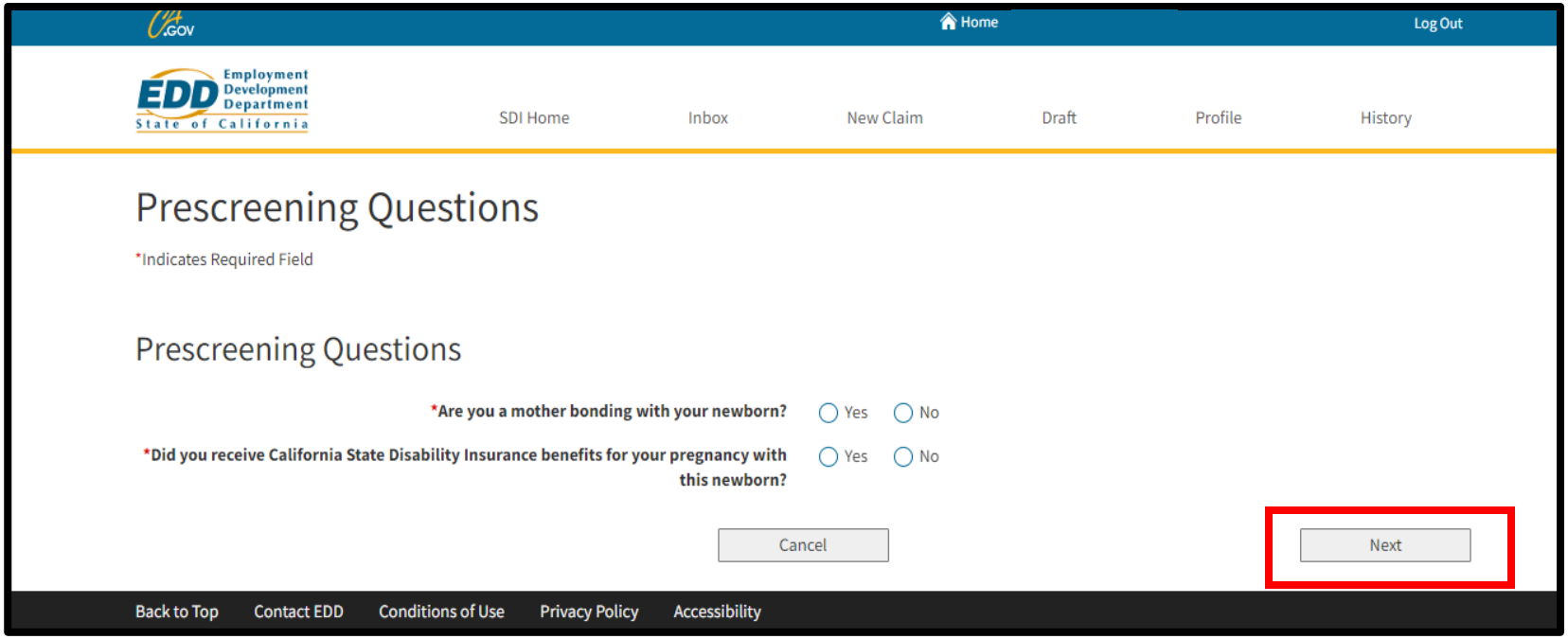
Select **Paid Family Leave Bonding** under Forms Available to Submit.

Note

Submit your claim no earlier than the first day your family leave begins, but no later than 41 days after your family leave begins, or you may lose benefits.

Important

If you already submitted a claim, do not submit another claim. It may take up to 14 days for your claim to be reviewed and processed.

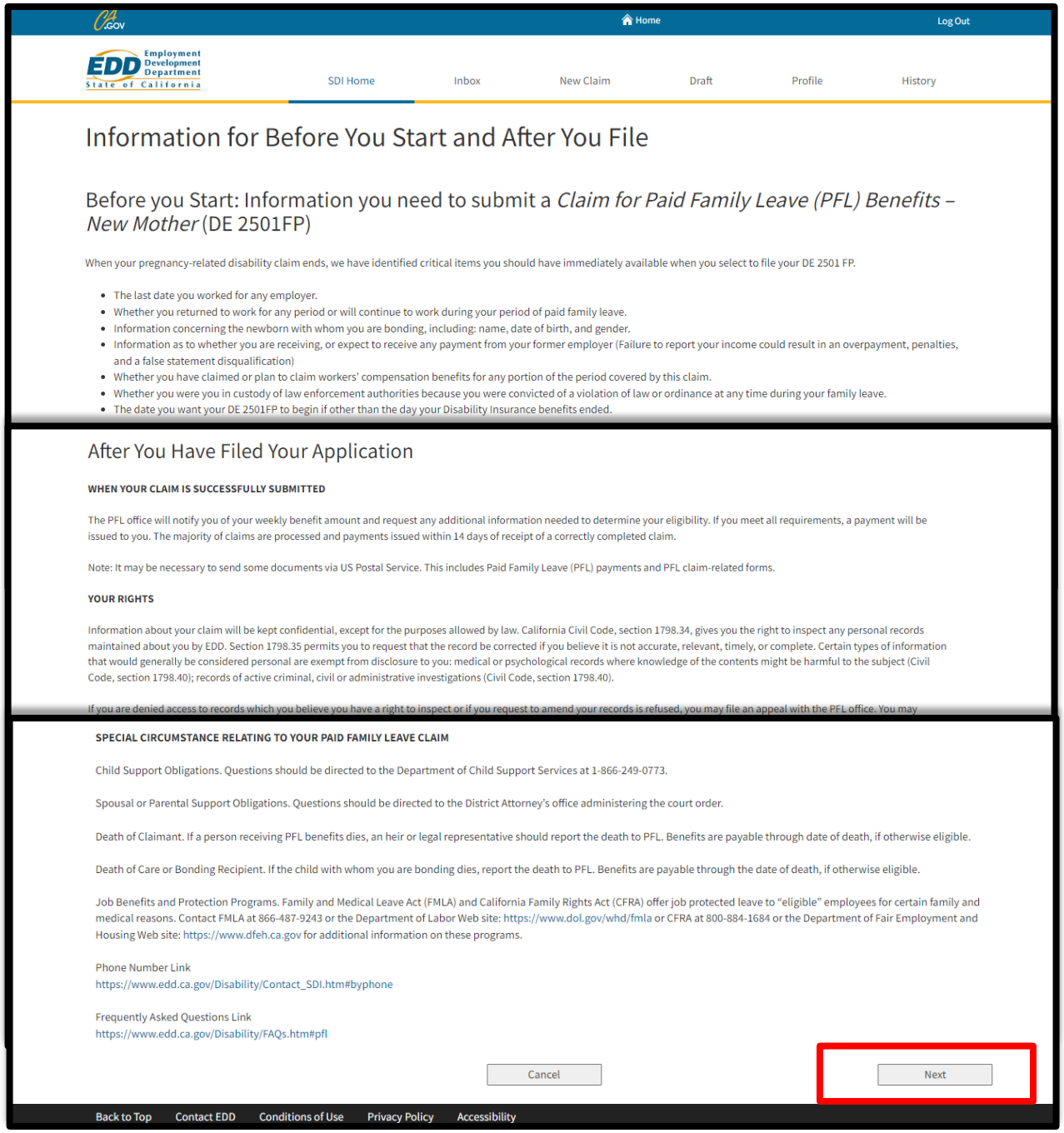


Next, answer the prescreening questions.

New mothers applying for bonding benefits who are transitioning from a pregnancy-related disability claim will select **Yes** for both questions and select **Next**.

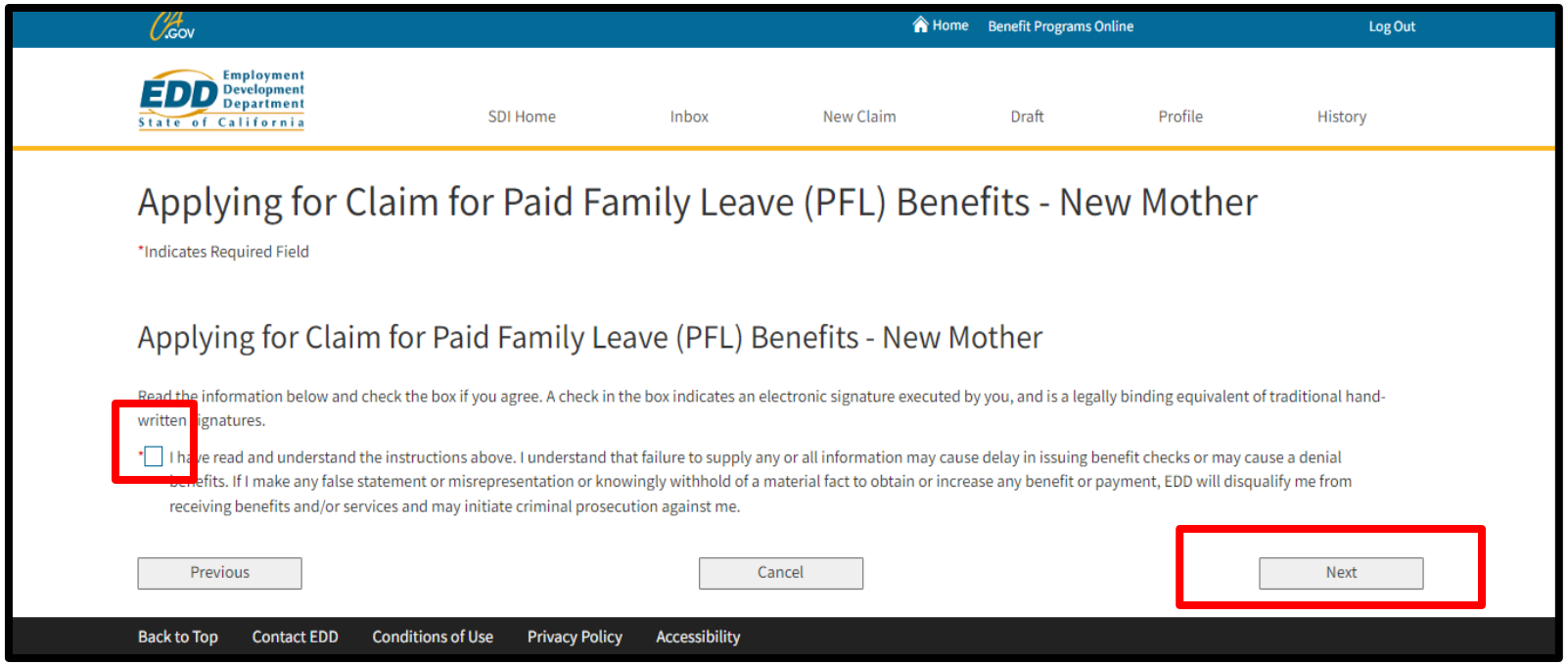
Note

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



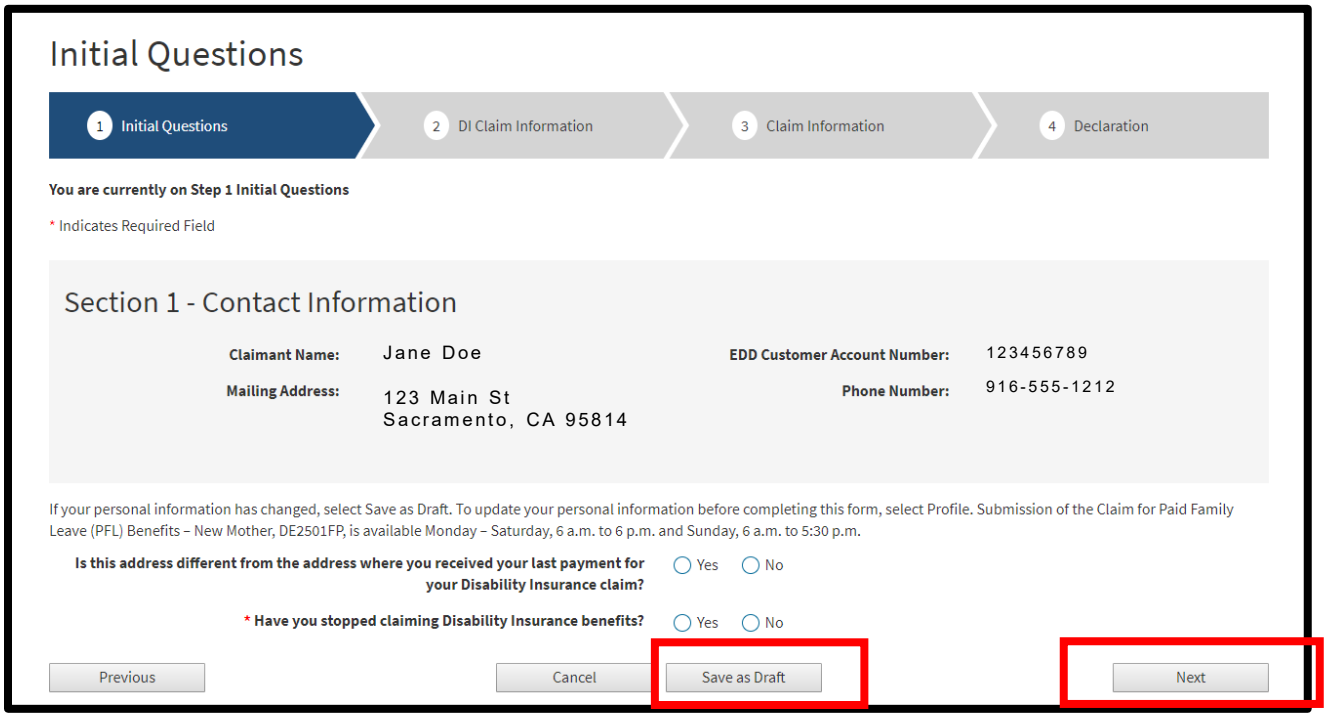
Carefully review the Information for Before You Start and After You File. It has important information you need to file a bonding claim.

Select **Next**.



Select the box to authorize an electronic signature.

Select **Next**.



Note

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

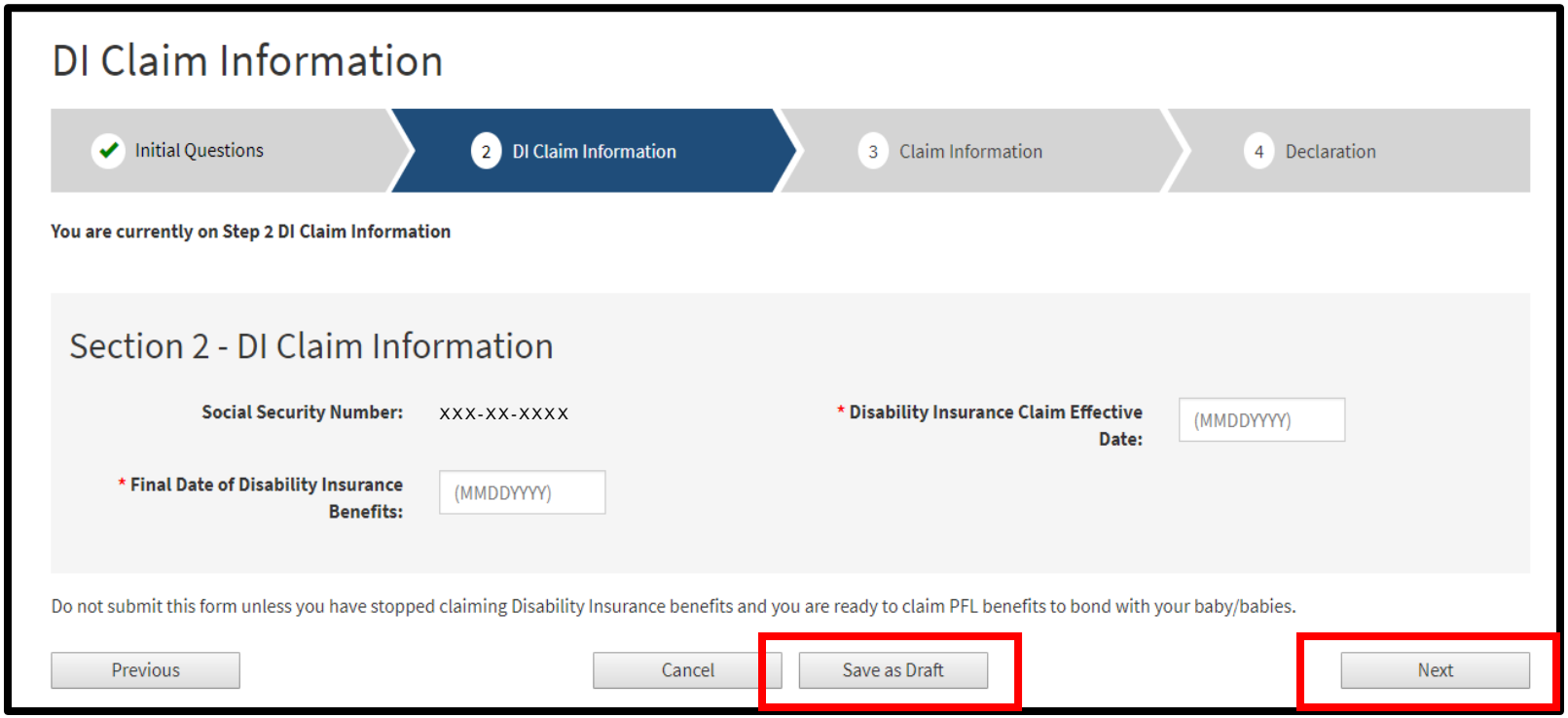
Select **Previous** to return to the previous screen.

The system automatically fills certain portions of the claim form.

- Make sure the information is correct. If your personal information has changed, select **Save as Draft** and update your SDI Online profile.
- Select **Next** to continue.

Important

If you are still claiming disability benefits, you cannot submit this claim form. Complete this form after your final disability payment is issued.



As a reminder, do not file for bonding benefits until you have fully recovered from childbirth and received your final disability payment.

- If you're still claiming disability benefits, select **Save as Draft** and complete the form later.
- To continue, make sure the prefilled information is correct. Next, enter the dates your disability claim started and ended to ensure your bonding claim is processed correctly.
- Select **Next** to continue.

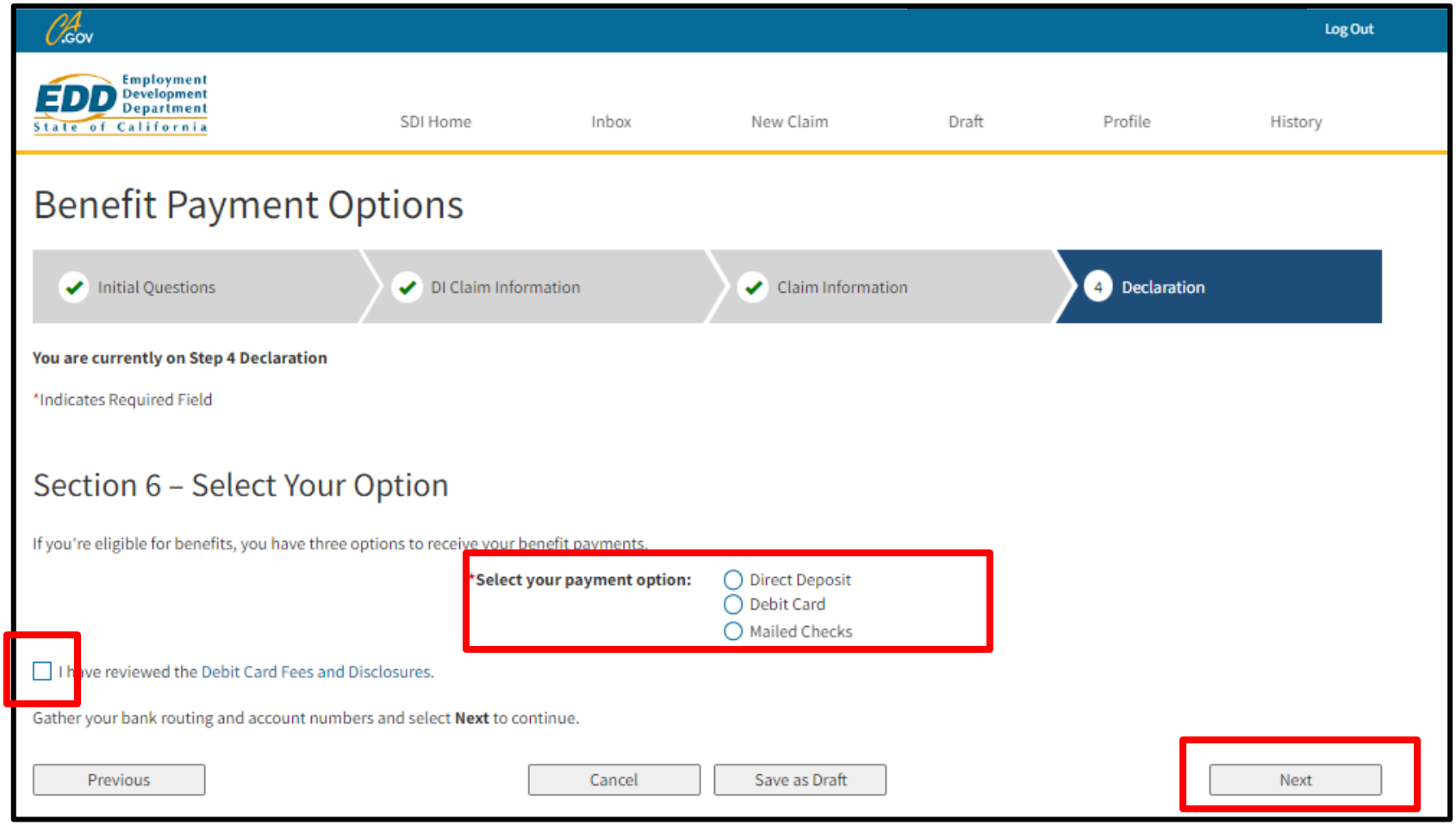
You must complete the following sections:

- Section 3 - Baby Information
- Section 4 - Paid Family Leave Claim Information
- Section 5 - Employer Information

Confirm the information and dates you enter are correct to avoid a possible delay of benefits.

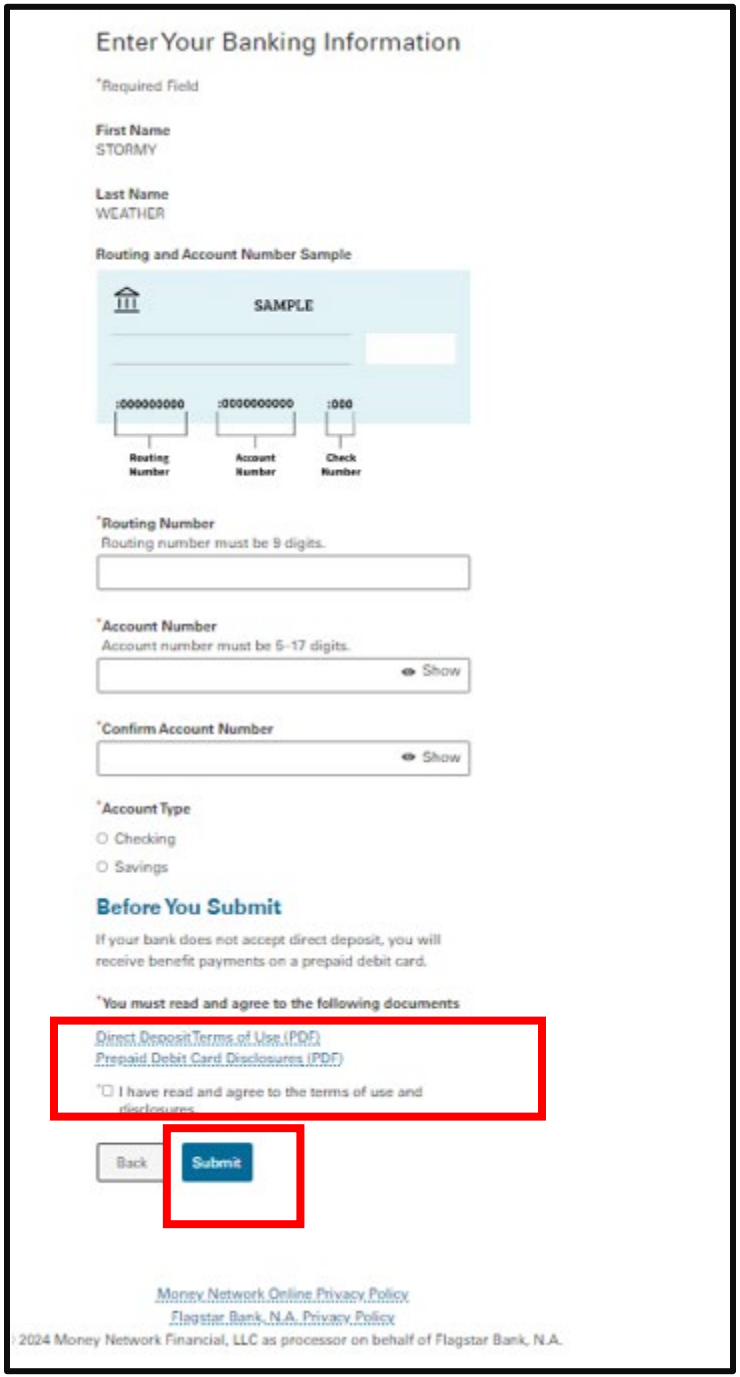
You must complete all required fields marked with a red asterisk (*).

Select **Next** to continue.



Complete Section 6 to choose your benefit payment option.

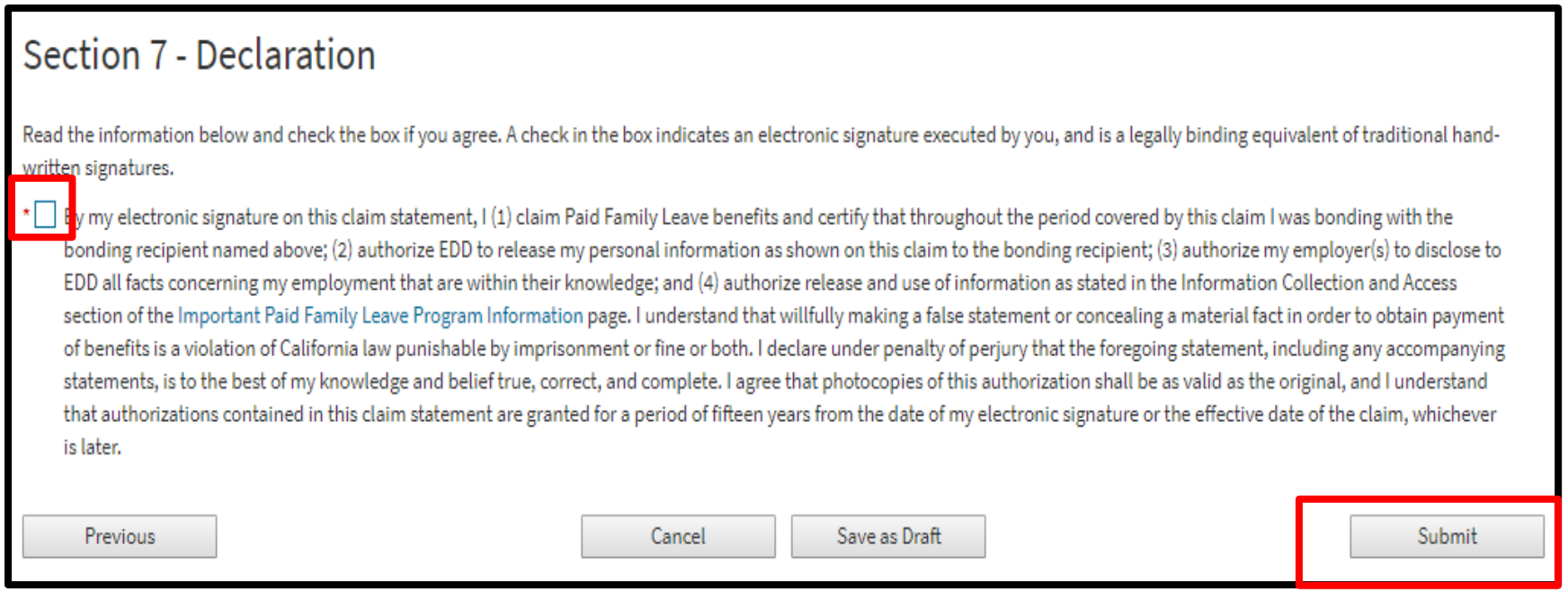
Select the **"I have reviewed..."** box to confirm you have read the disclosures, then select Next.



If you selected Direct Deposit, you will be asked to provide your banking information.

You must select and open the “terms of use” documents and disclosures before you can submit your information.

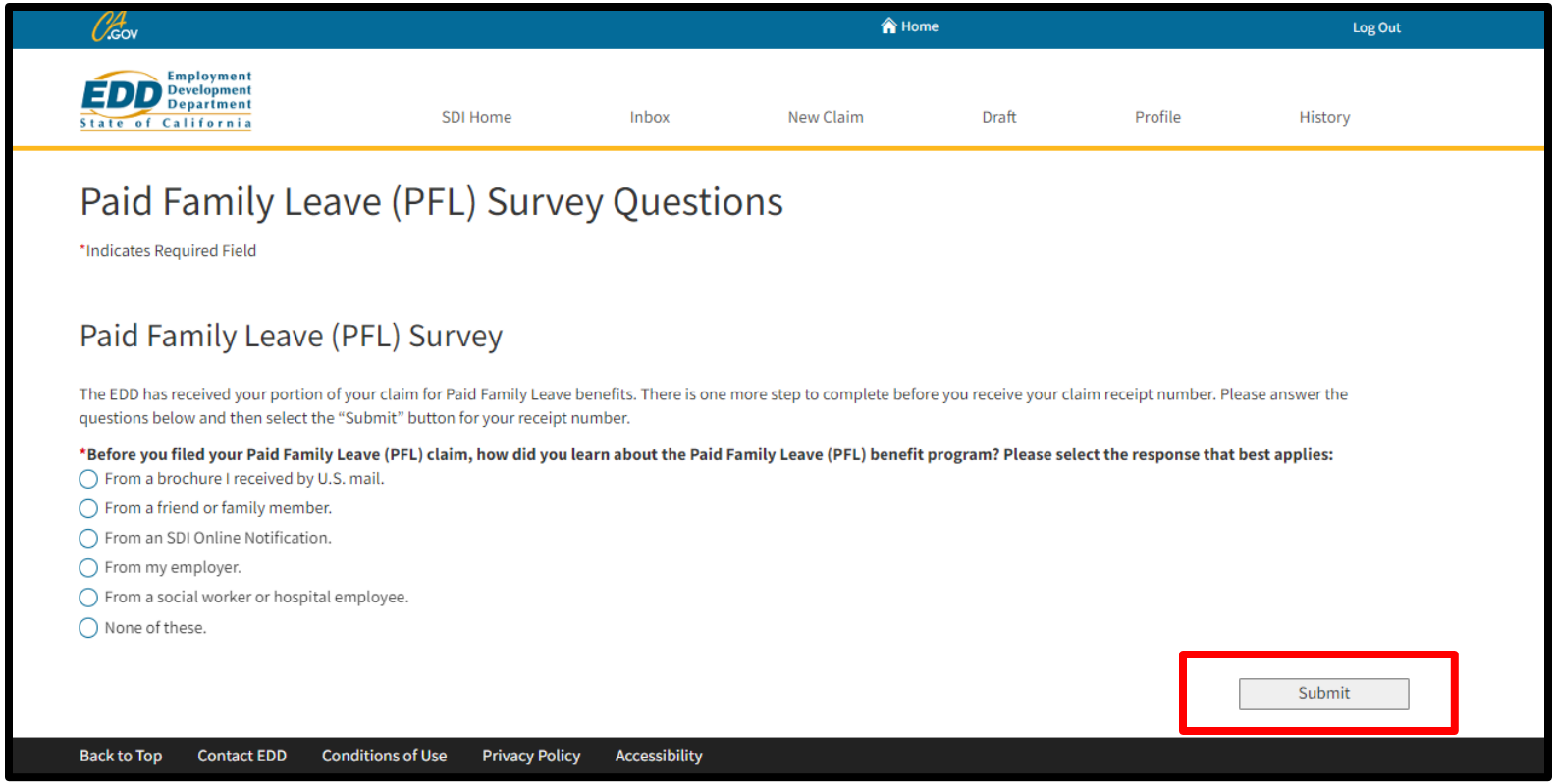
Select Submit to continue.



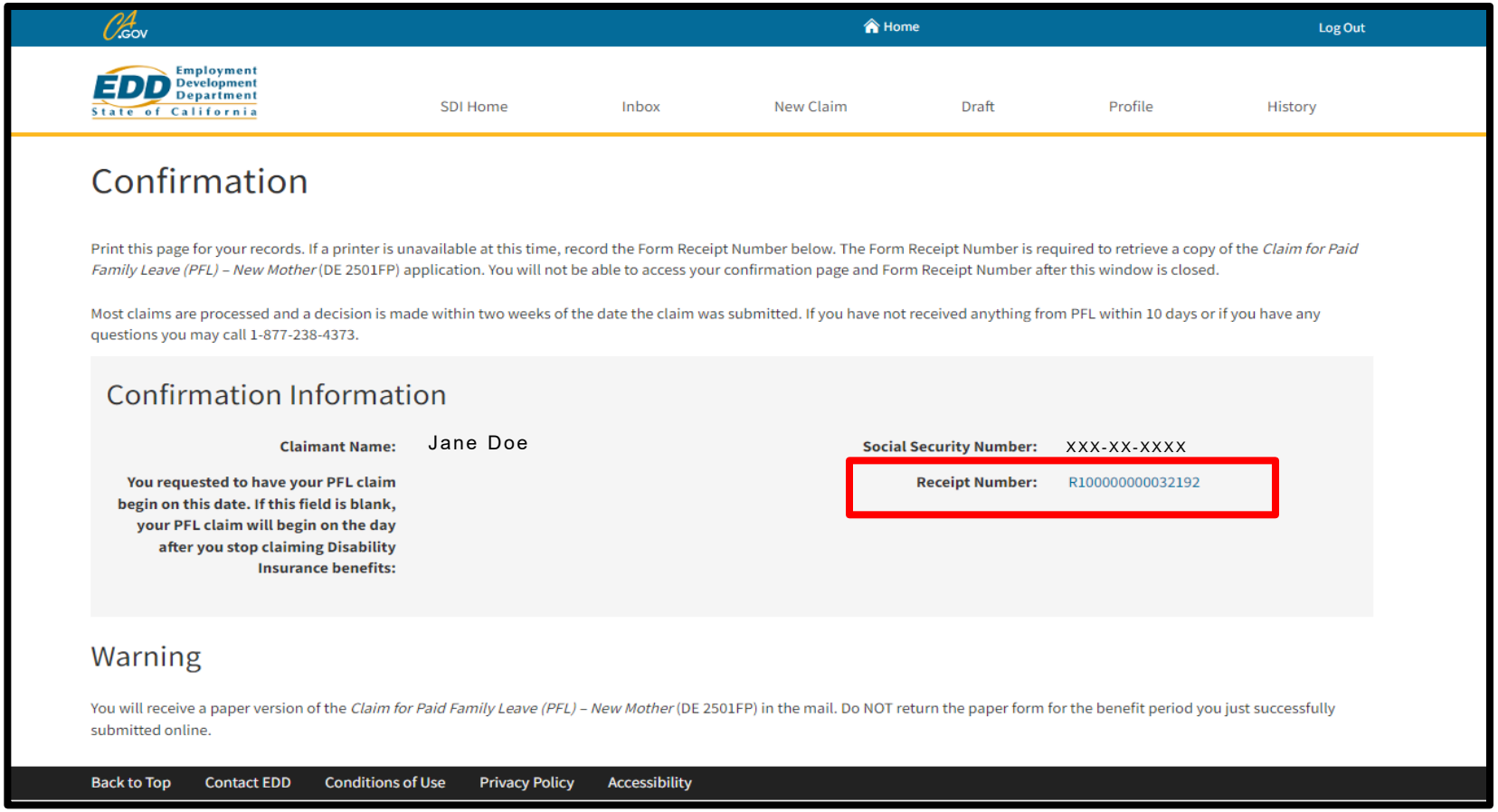
Next, select the box to authorize an electronic signature and the release of your information.

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

Select **Submit** to send your claim form to us.



Complete the survey and select **Submit**.



On the Confirmation screen we assign your claim a **Receipt Number**. Save your Receipt Number for future reference. We will ask for it when you contact us.

Most claims are processed within 14 days. Do not submit another claim because it can delay your benefits.

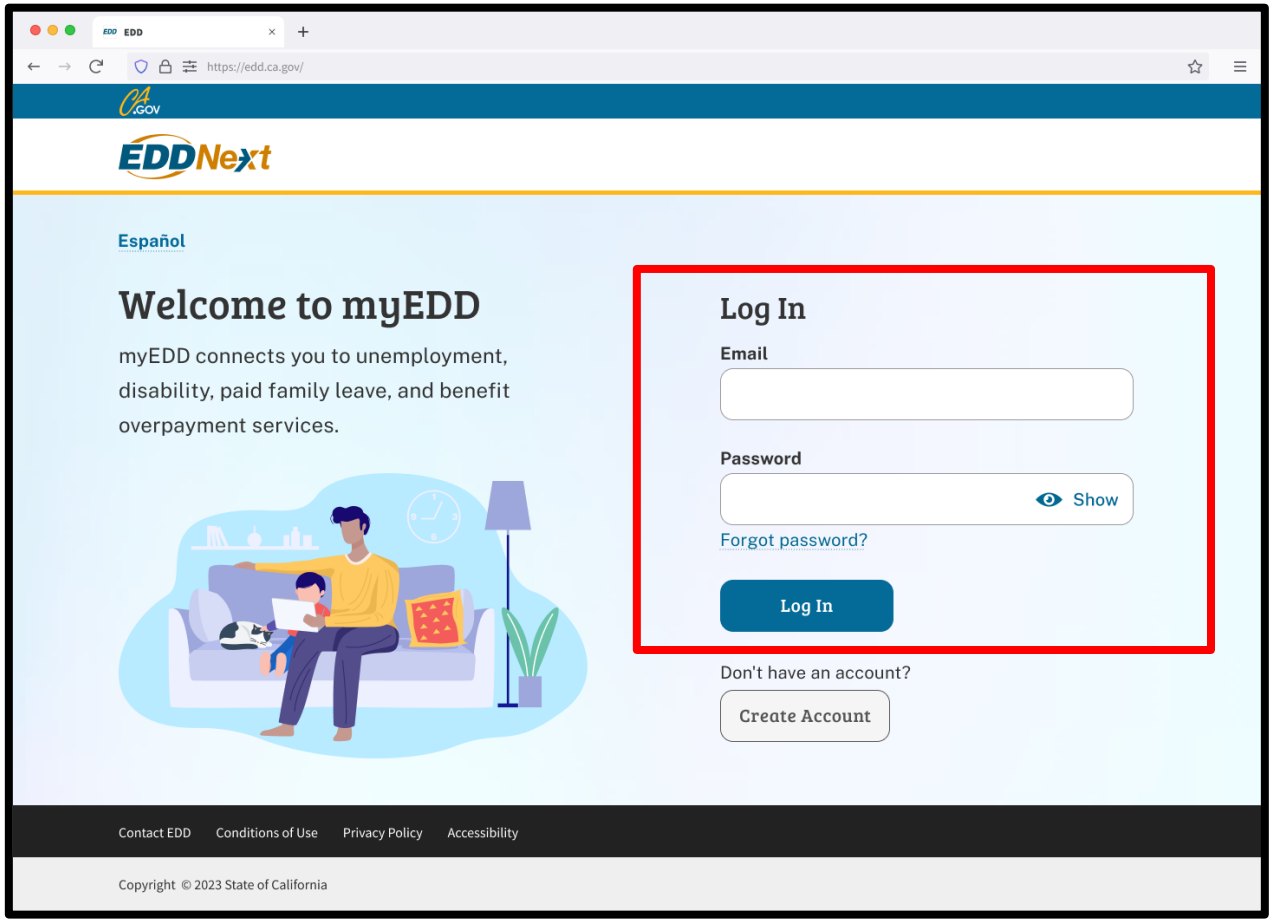
Employment Development Department
State of California

File a Bonding Claim

New Mothers (without a pregnancy-related disability claim), Fathers, and Foster or Adoptive Parents

Learn more about how new mothers (without a pregnancy-related disability claim), fathers, and foster care or adoptive parents file for bonding benefits.

Get Started

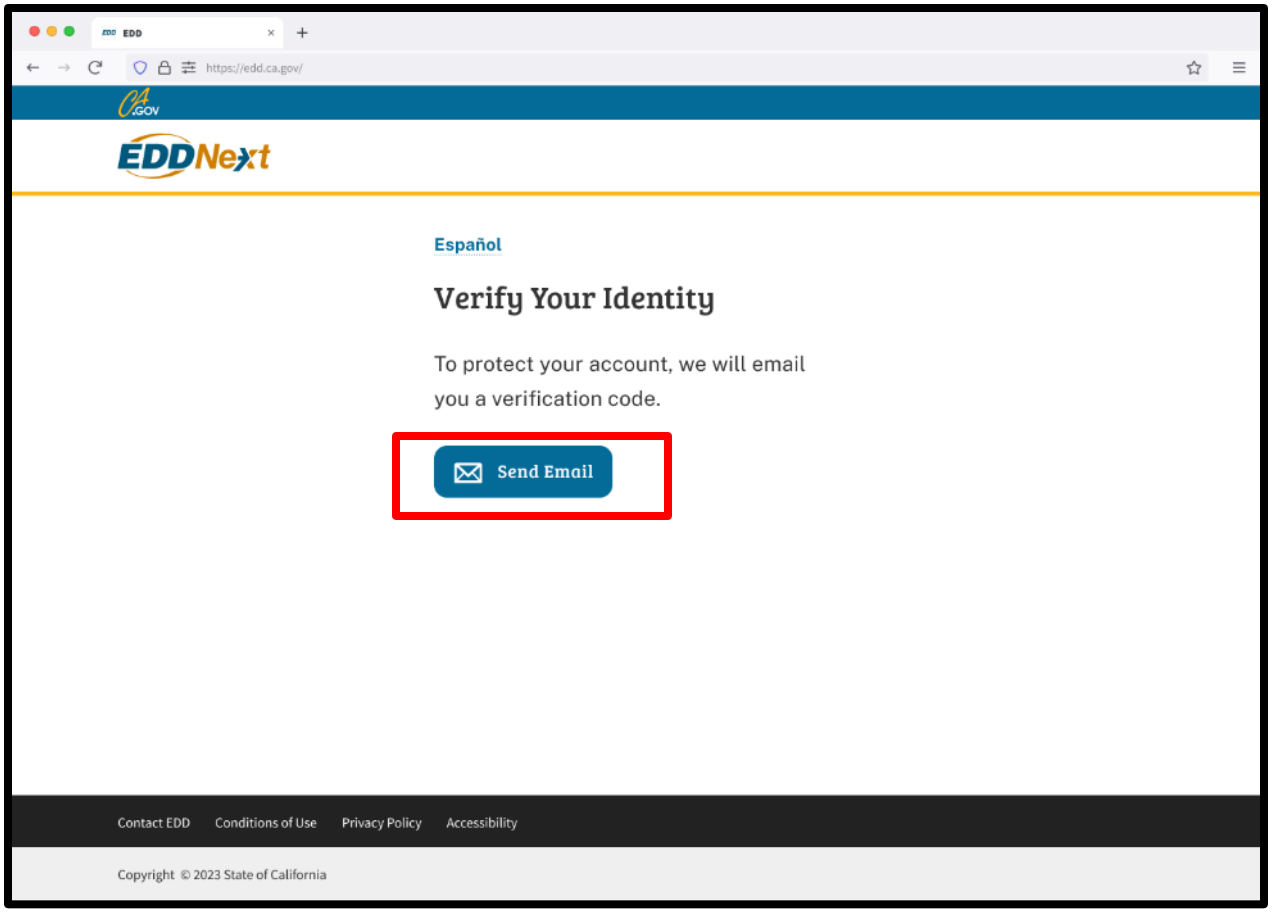


Note

For Spanish, select **Español**.

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

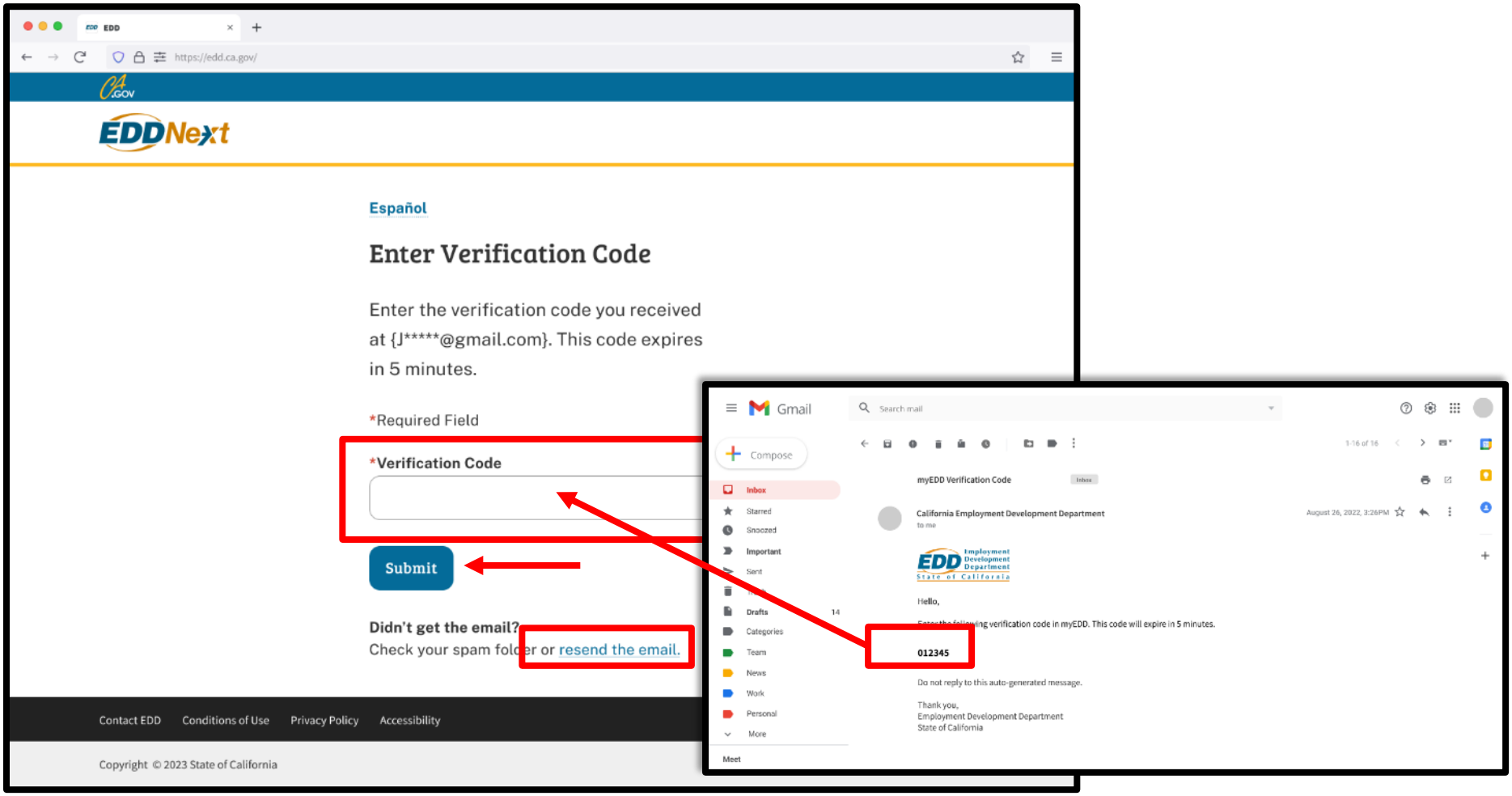
1. Visit myEDD.
2. Enter the email and password used to create your myEDD account.
3. Select **Log In**.



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.

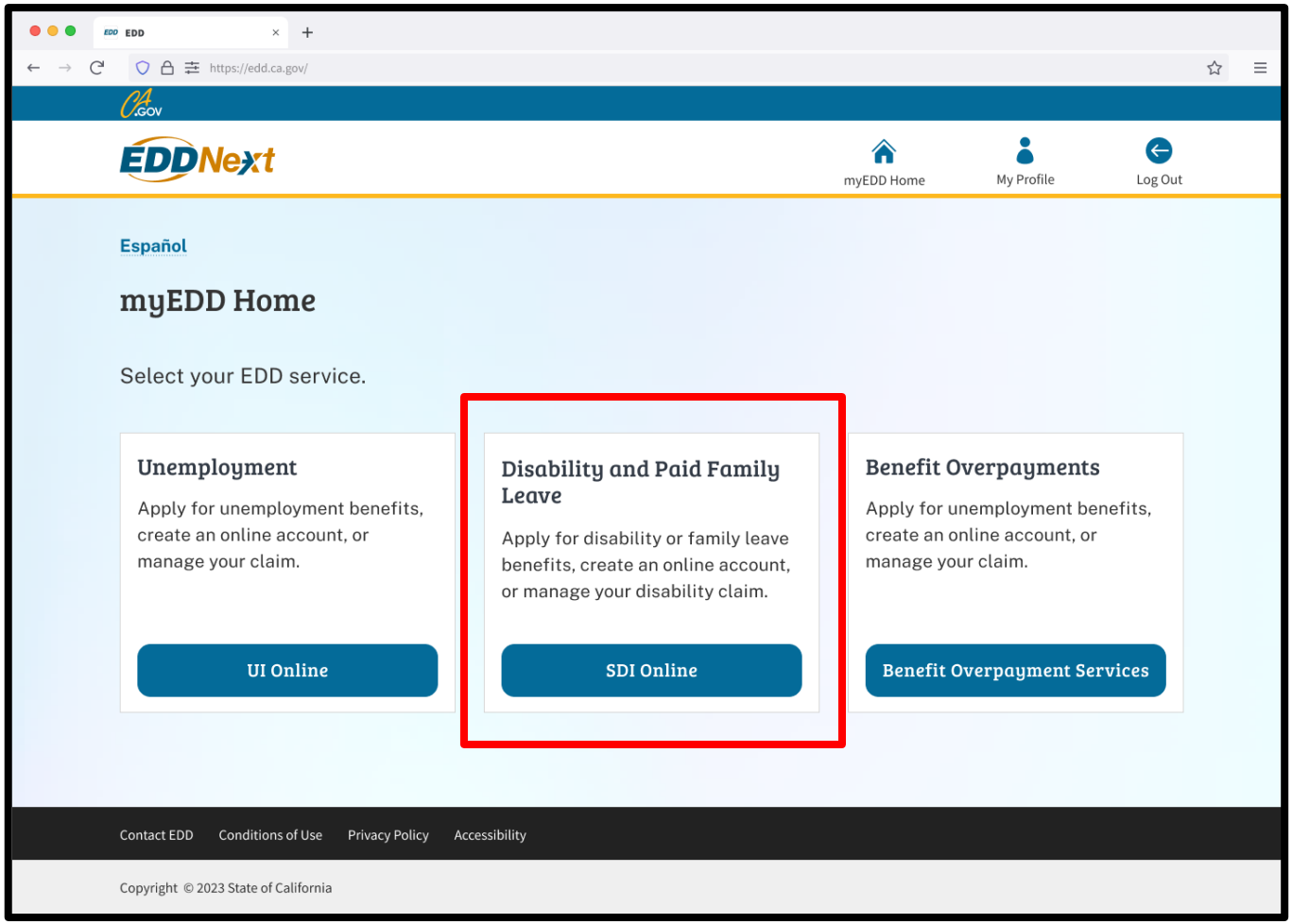
Select **Send Email.**

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.

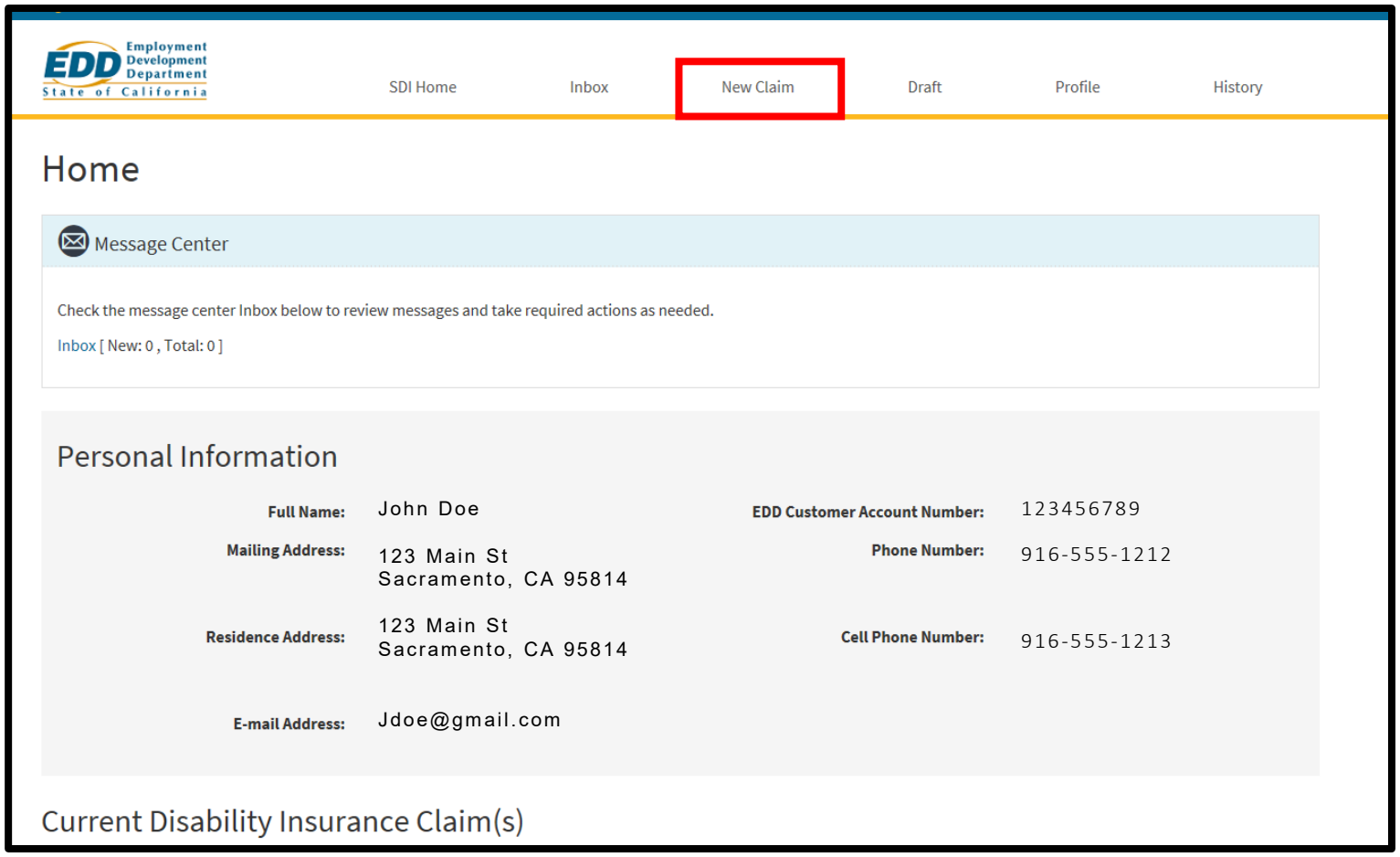
- Enter your verification code and select **Submit**.
- Select **resend the email** if you do not get a code.



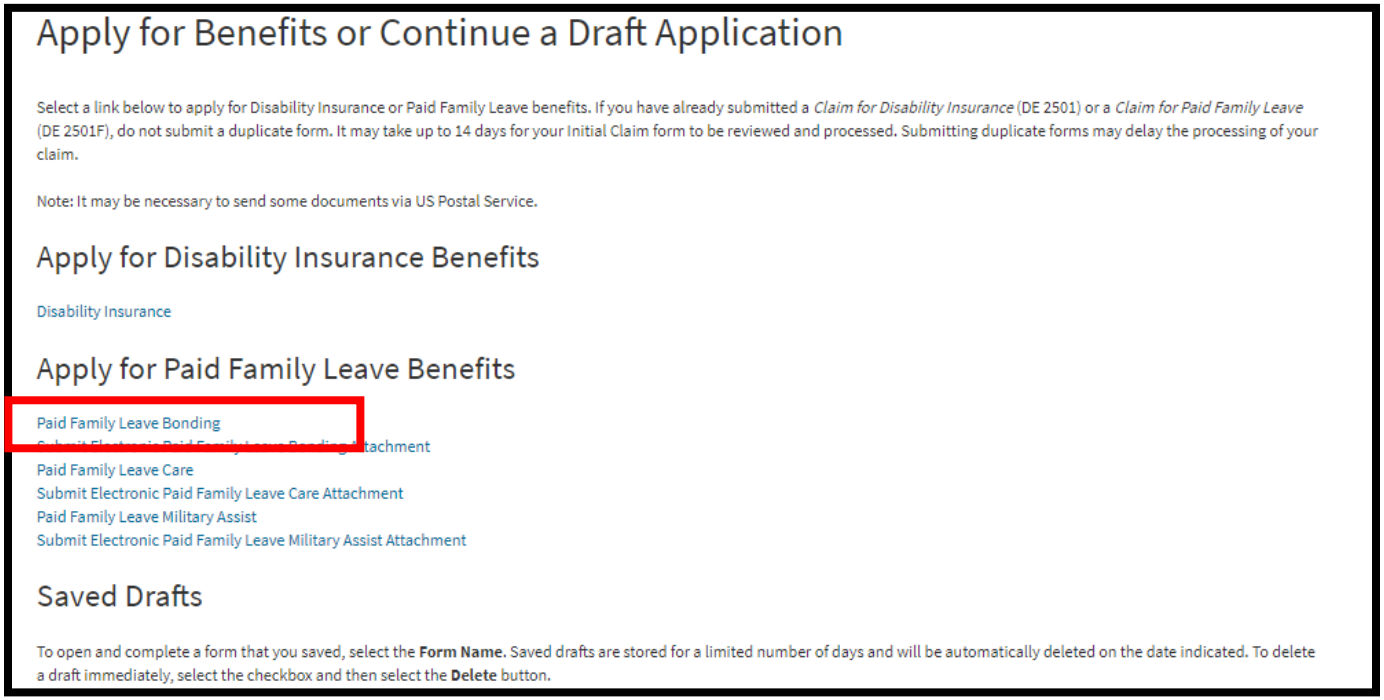
Note

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

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



Select **New Claim** from the main menu.



To apply for bonding benefits, select **Paid Family Leave Bonding** under Apply for Paid Family Leave Benefits.

If you are unsure which application to complete, review Types of Claims.

Note

Submit your claim no earlier than the first day your family leave begins, but no later than 41 days after your family leave begins, or you may lose benefits.

Important

If you already submitted a claim, do not submit another claim. It may take up to 14 days for your claim to be reviewed and processed.

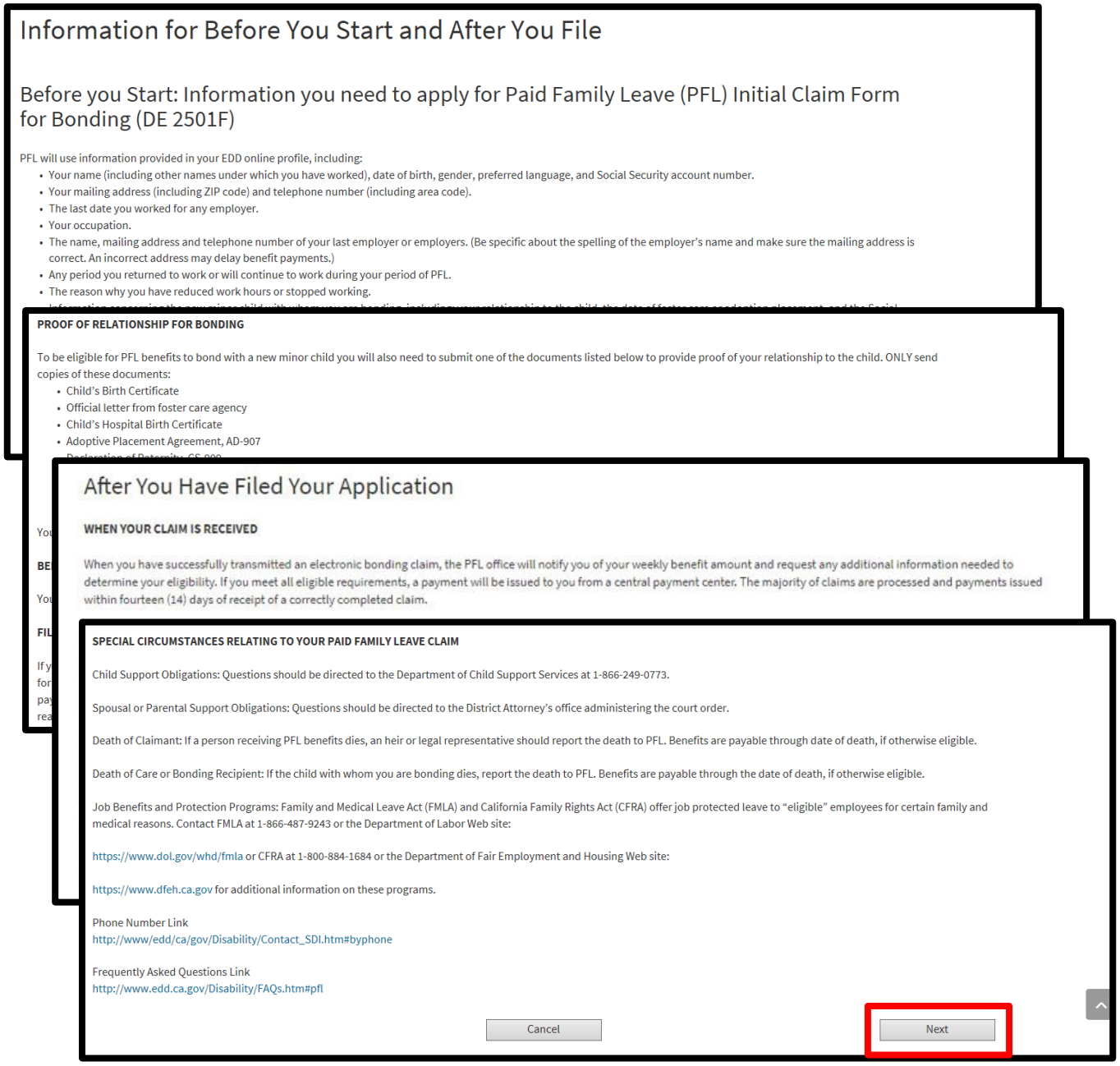
You must answer the prescreening questions:

- If you are a new mother applying for bonding benefits and **did not** file a pregnancy-related disability claim, select **Yes** for the first question and **No** for the second question.
- If you are a new father, or an adoptive, or foster parent applying for bonding benefits, select **No** for both questions.

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

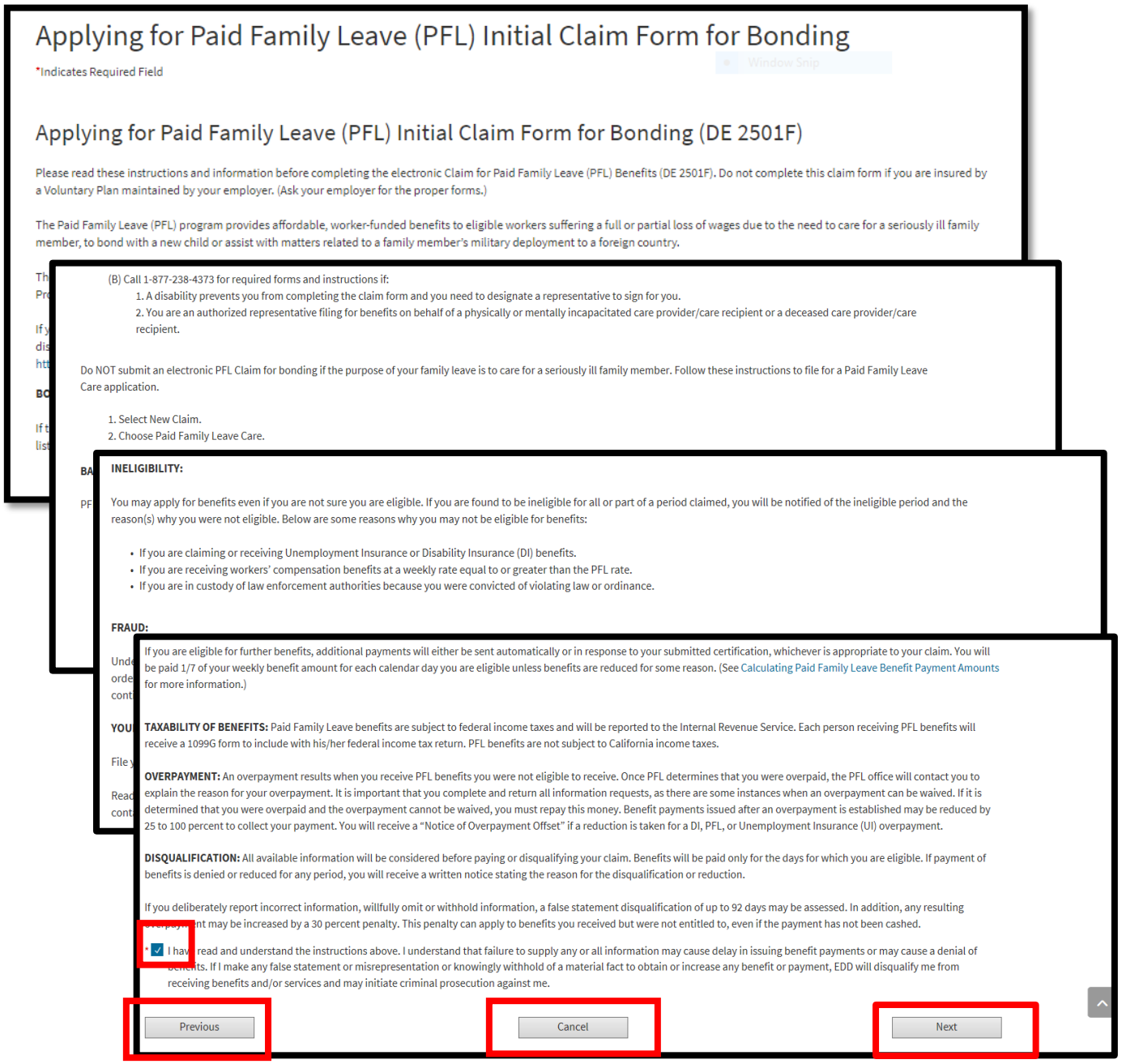
Note

Selecting **Cancel** will cancel the claim and return you to your homepage.



Review the Information for Before You Start and After You File. It has important information you need to file a bonding claim.

Select **Next**.



Continue to review the information on the next screen. It has more information about filing a bonding claim.

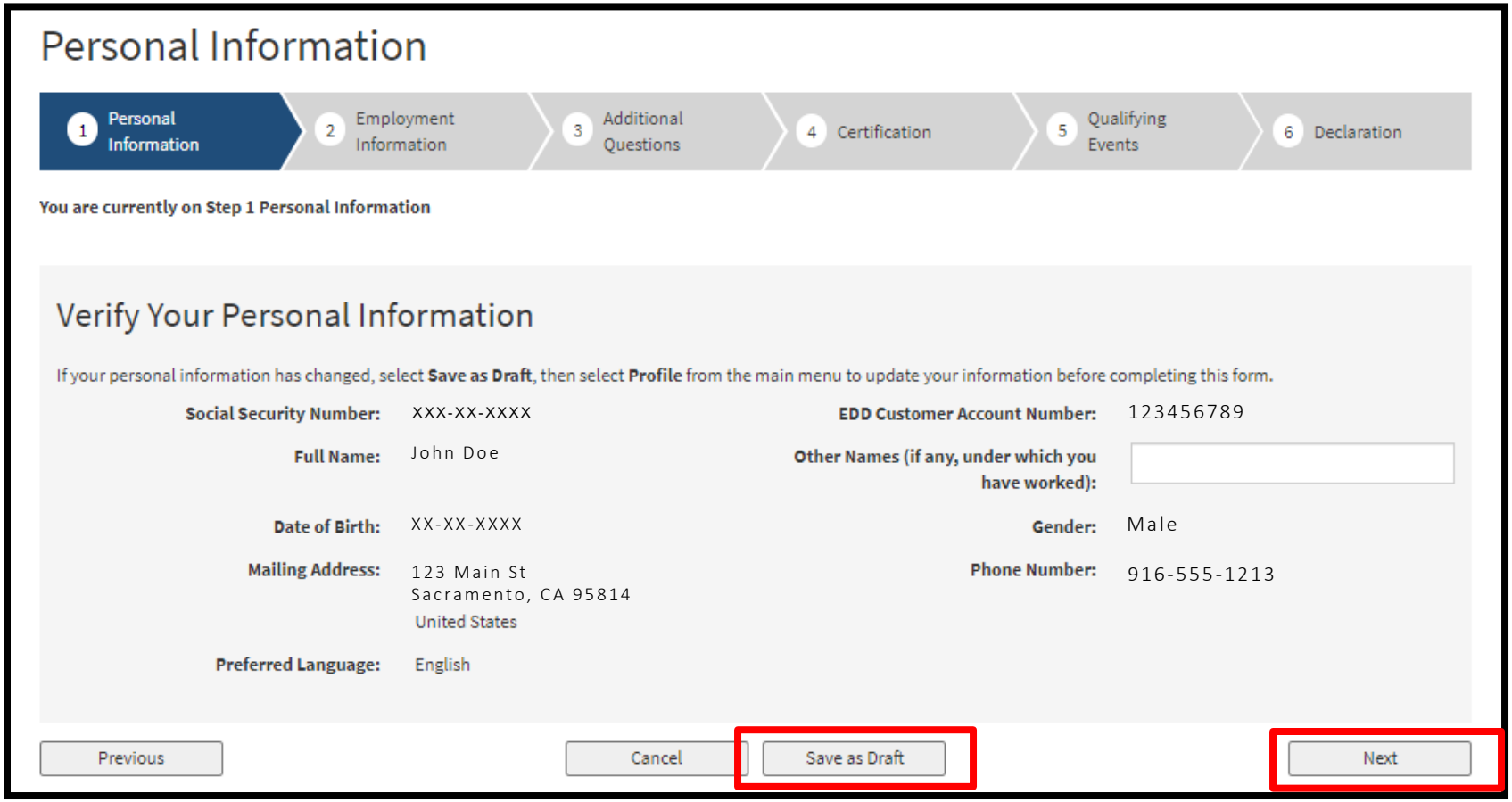
Select the box to agree to the terms.

Select **Next** to proceed.

Note

Select **Cancel** at any time to cancel your claim.

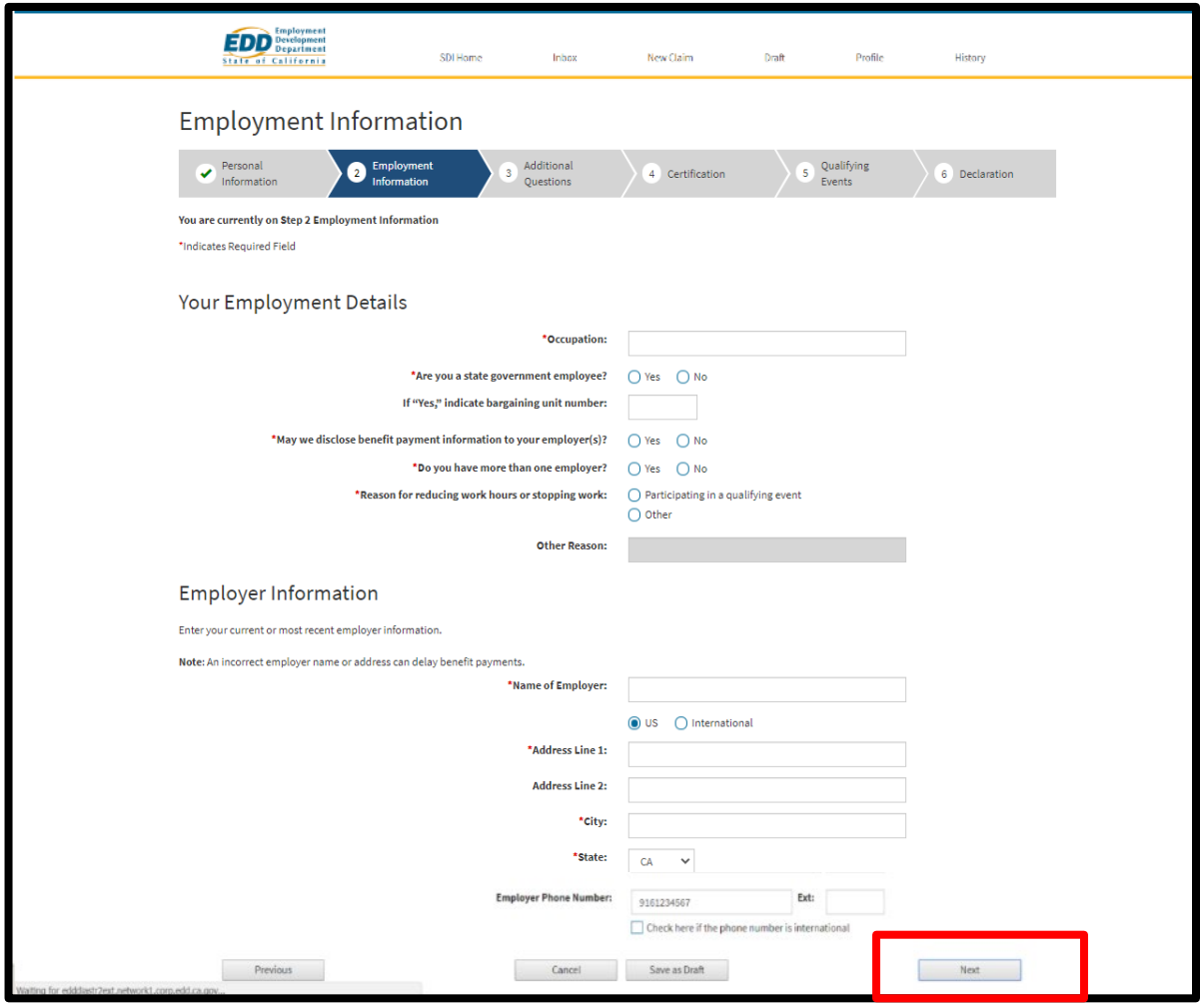
Select **Previous** to return to the previous screen.



The system automatically fills certain portions of the claim form.

Make sure the information is correct. If your personal information has changed, select **Save as Draft** and update your SDI Online profile.

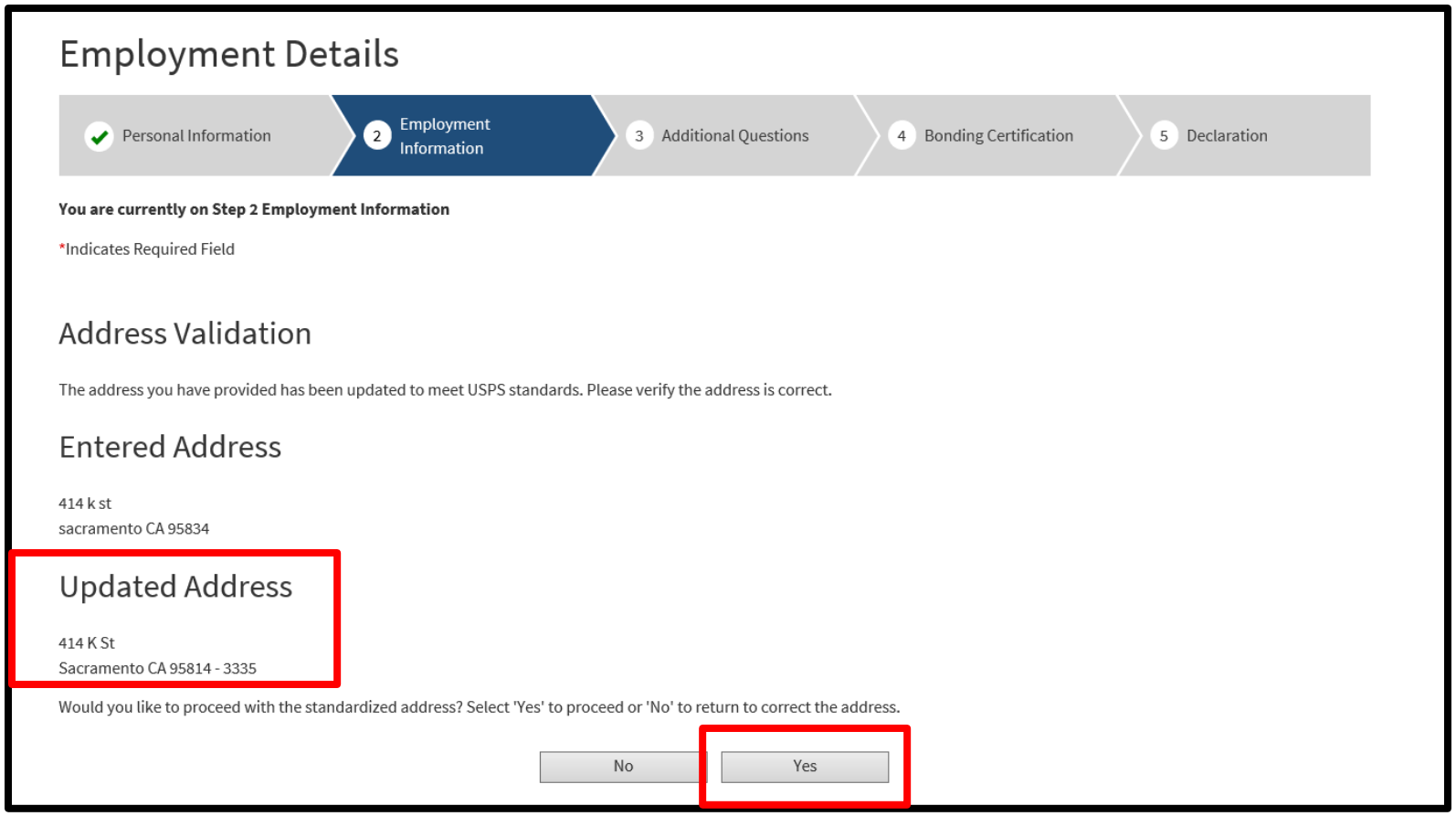
Select **Next** to continue.



On the Employment Information screen add your current employer's business name, phone number, and mailing address as shown on your W-2 or paystub. Ask your employer if you are unsure what address to enter.

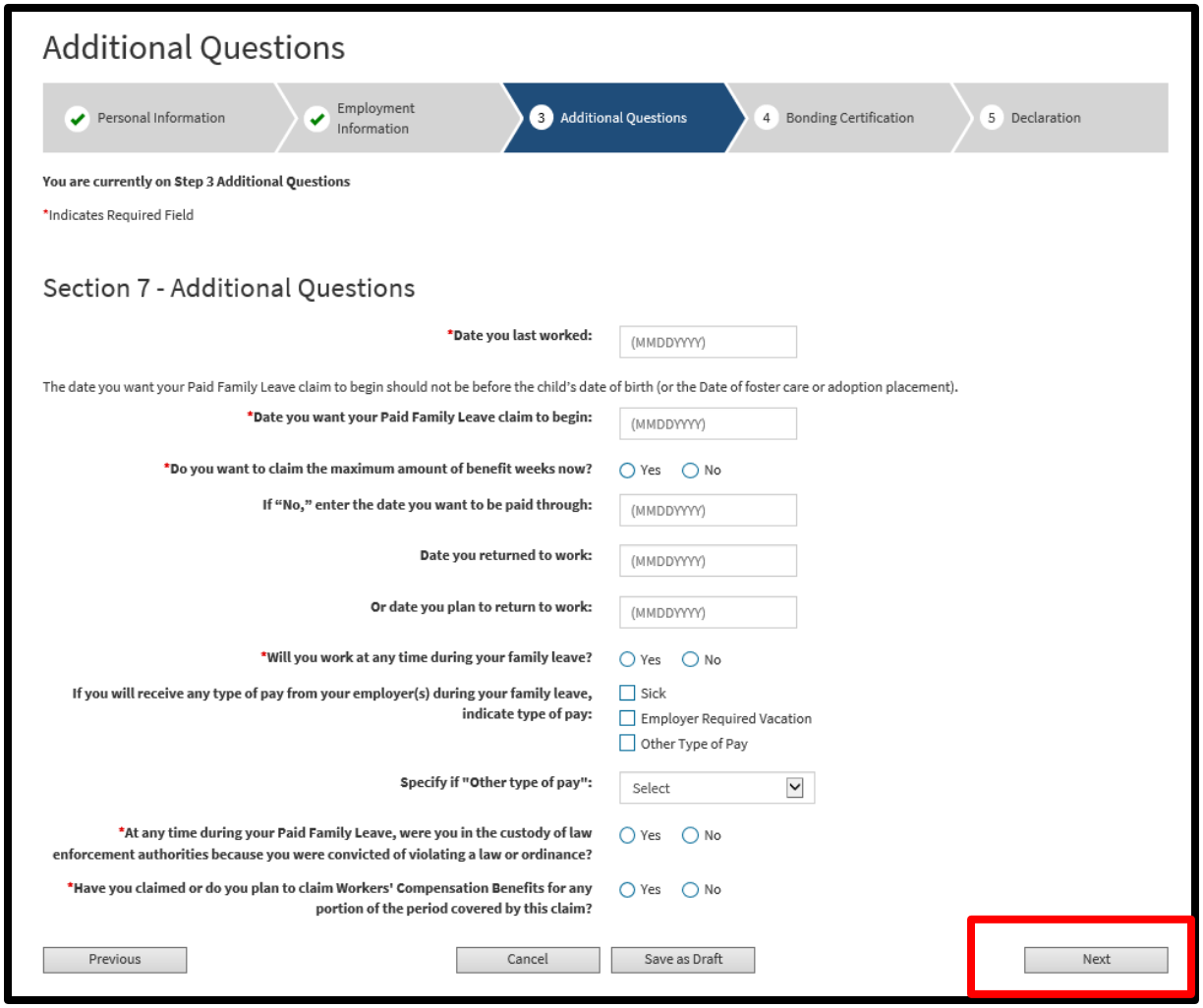
You must complete the fields marked with a red asterisk (*).

Select **Next** to continue.



The system may adjust the employer address to follow USPS standards.

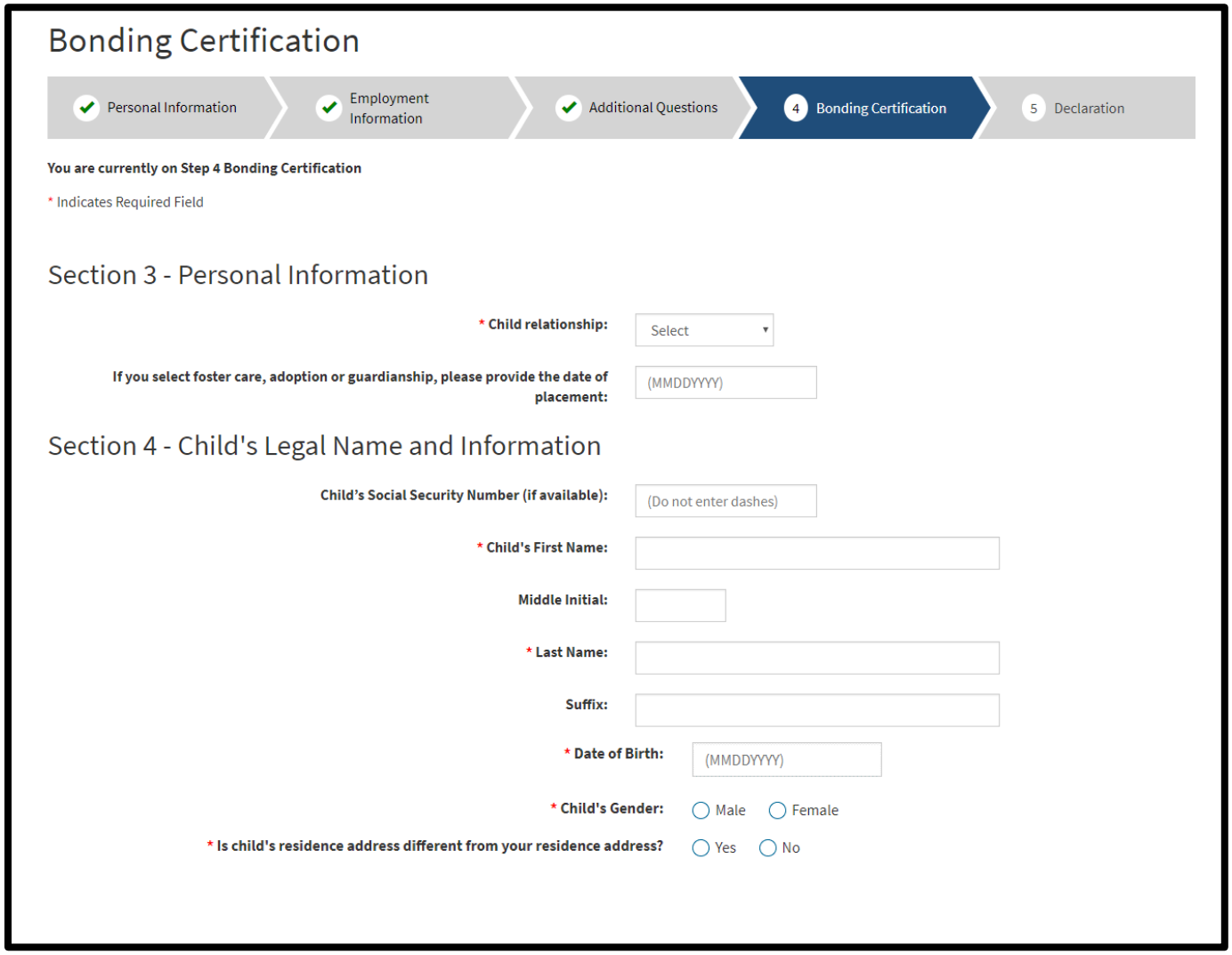
- Select **Yes** to confirm the updated address is correct.
- Select **No** to go back to the previous screen and re-enter the address.



Complete Section 7 - Additional Questions and confirm the dates are correct to avoid a delay or incorrect payment of benefits.

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

Select **Next** to continue.



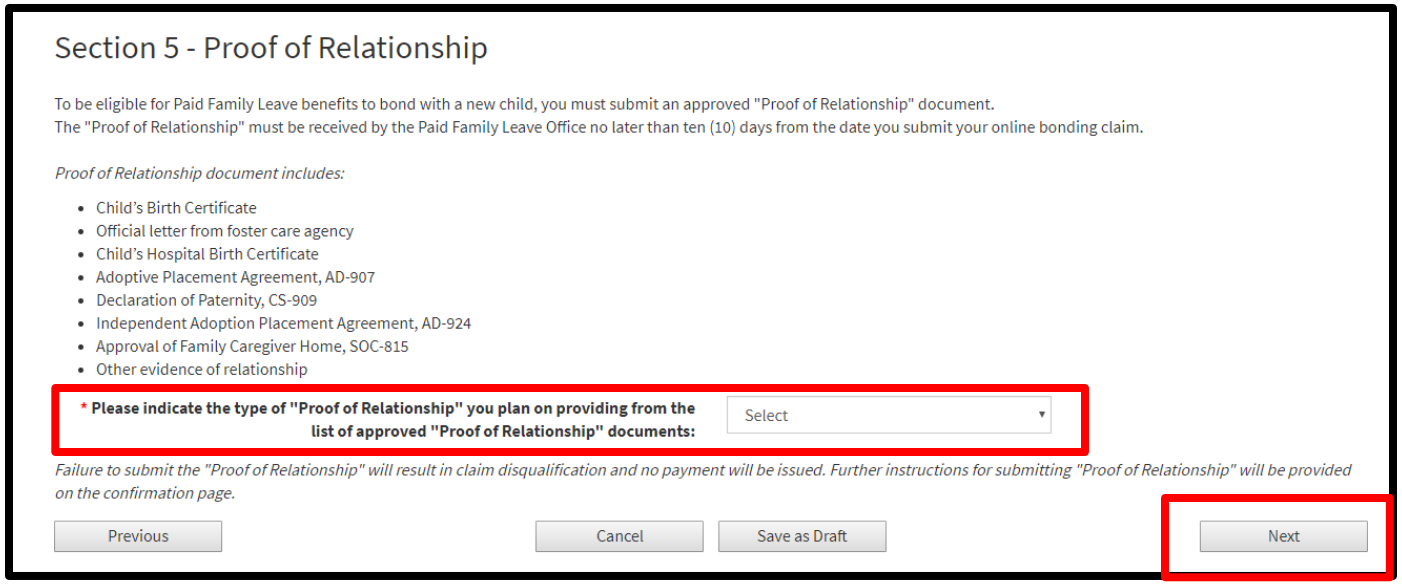
In the Section 3 - Personal Information, select your relationship to the child you are bonding.

Complete Section 4 - Child's Legal Name and Information with the child's information.

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

Note

If the child's legal residence is different than yours, select **Yes** to enter the child's legal address on another screen.



To be eligible for bonding benefits, you must provide an approved Proof of Relationship document after you submit your claim. Upload or mail one of the accepted documents within 10 days from the date you send us your online bonding claim.

Select the type of Proof of Relationship document you plan on giving us after completing the online claim.

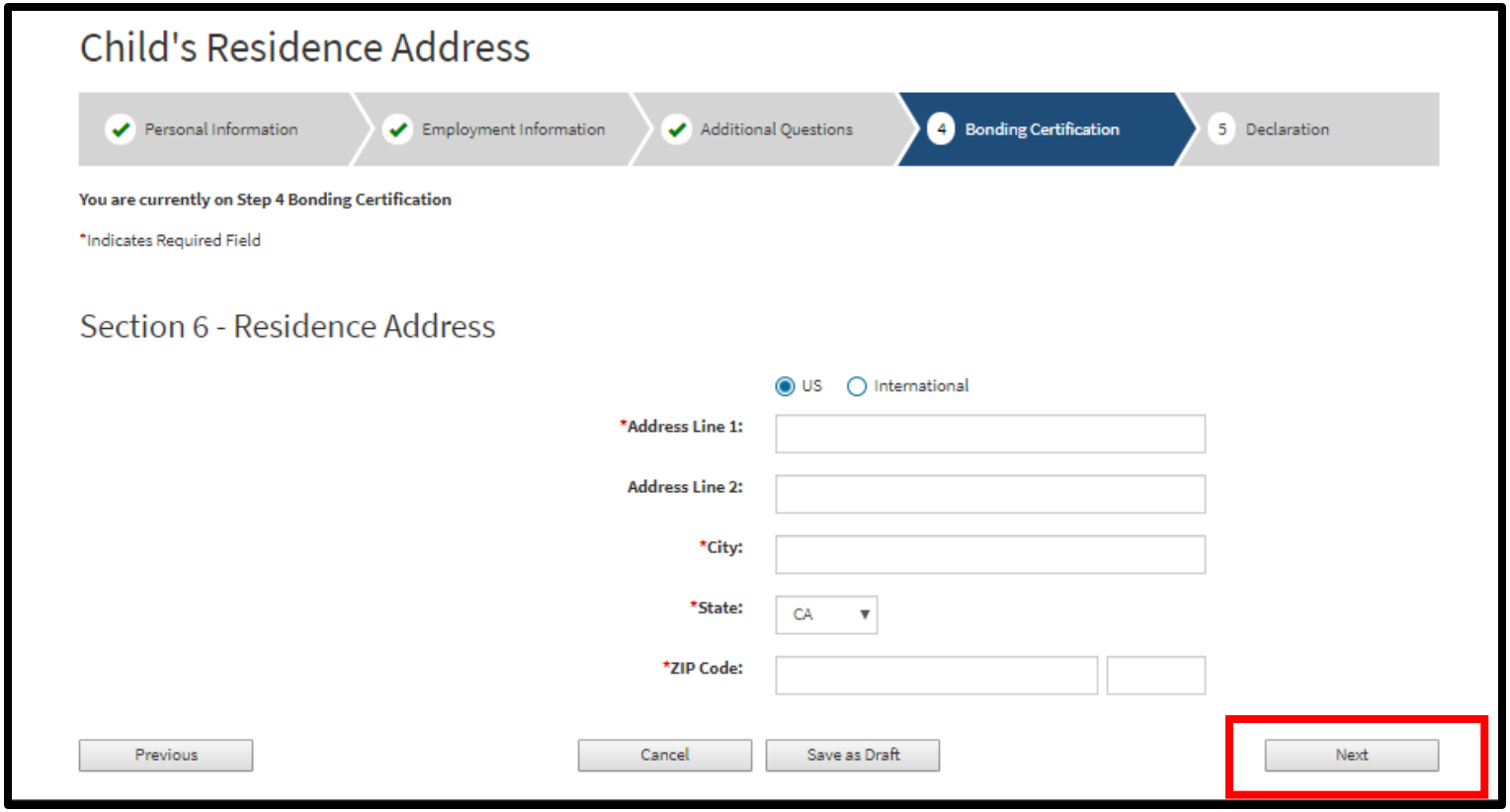
Instructions to upload or mail your proof of relationship documents are available on the Confirmation screen.

Select **Next** to continue.

Note

The accepted "Proof of Relationship" document options are:

- Child's birth certificate
- Official letter from foster care agency
- Child's hospital birth certificate
- Adoptive Placement Agreement, AD-907
- Declaration of Paternity, CS-909
- Independent Adoption Placement Agreement, AD-924
- Approval of Family Caregiver Home, SOC-815
- Other evidence of relationship

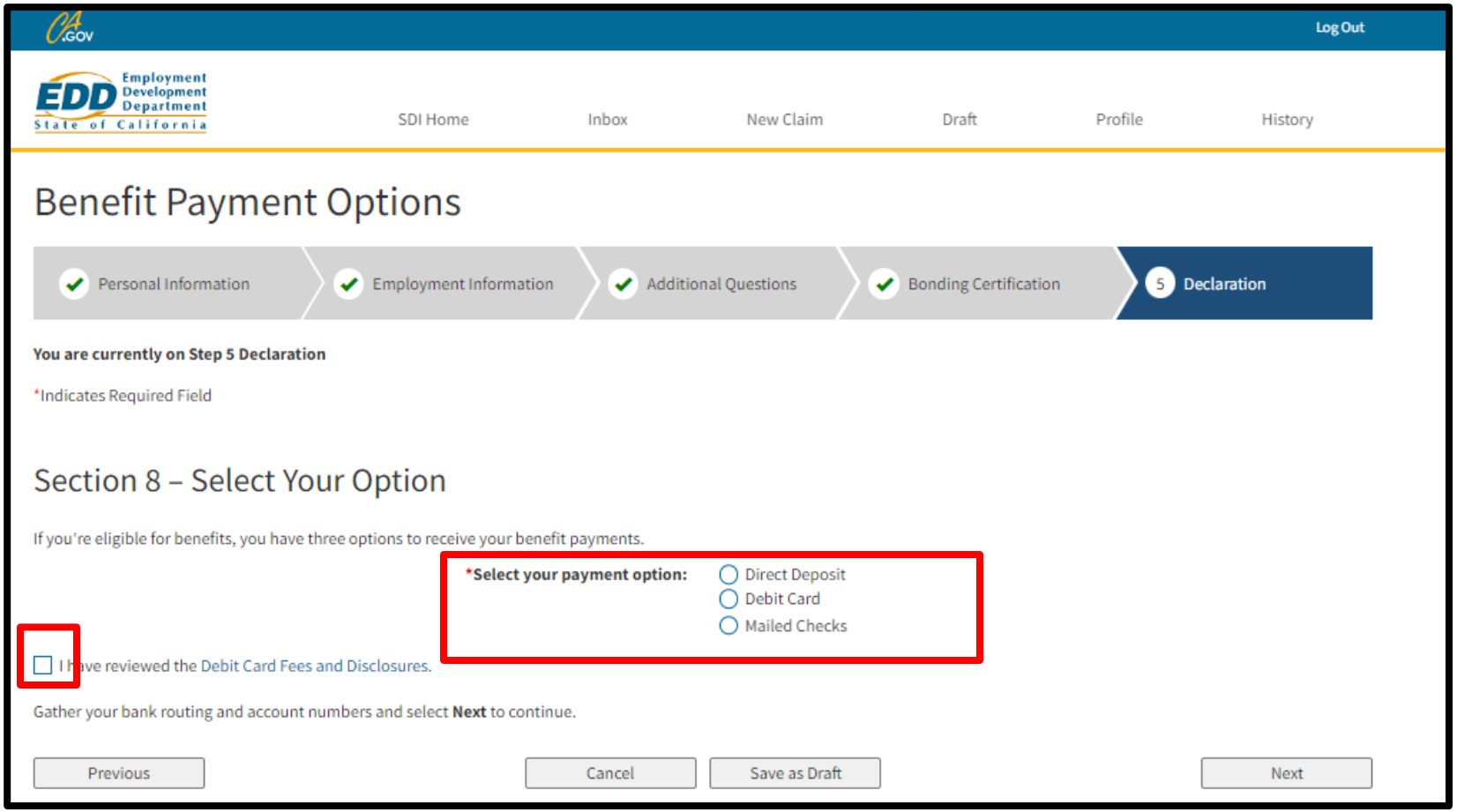


If you selected **Yes** to "Is the child's residence address different from your resident address?" you must enter the child's residential address in Section 6 – Residence Address.

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

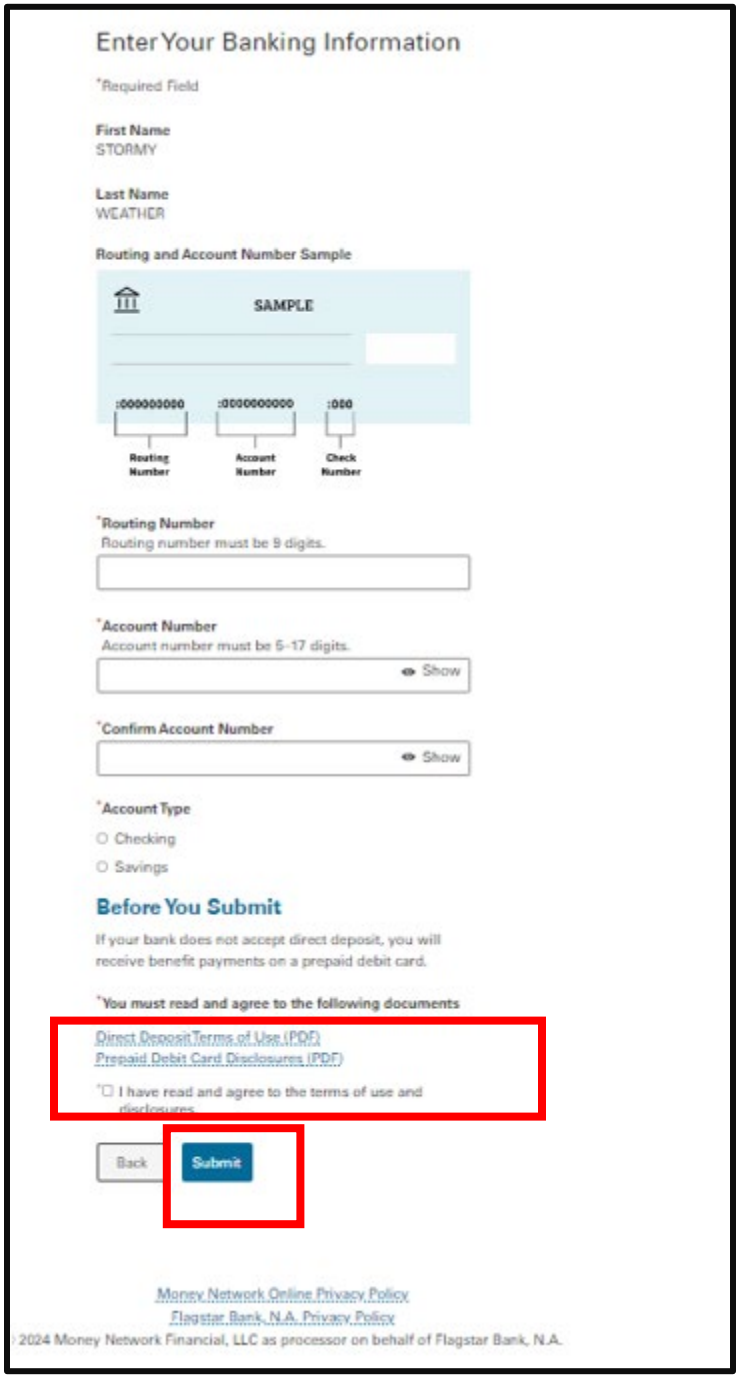
If you selected **No** to the above question, skip to the next page.

Select **Next** to continue.



Complete Section 8 to choose your benefit payment option.

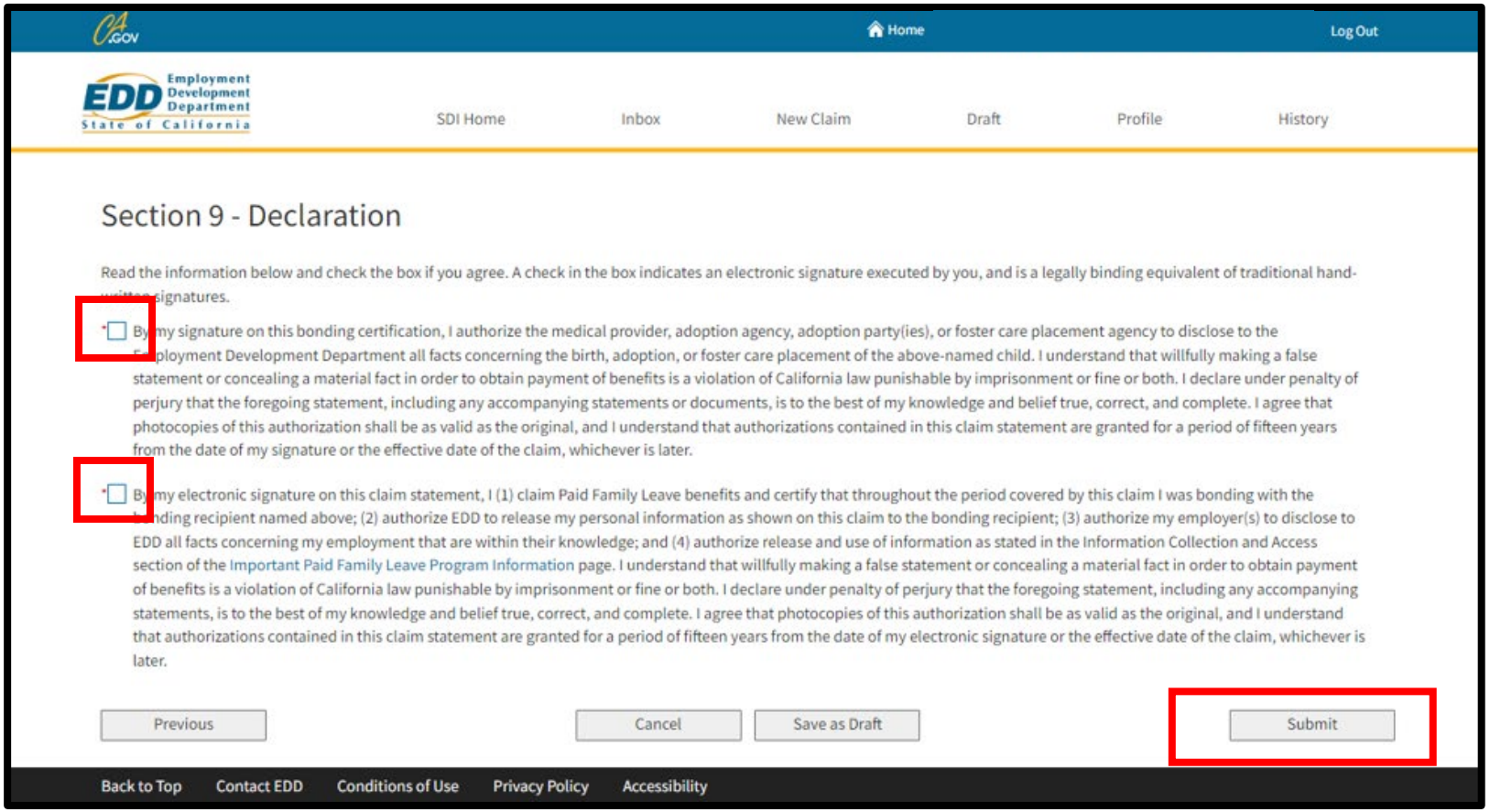
Select the **"I have reviewed..."** box to confirm you have read the disclosures, then select Next.



If you selected Direct Deposit, you will be asked to provide your banking information.

You must select and open the “terms of use” documents and disclosures before you can submit your information.

Select Submit to continue.

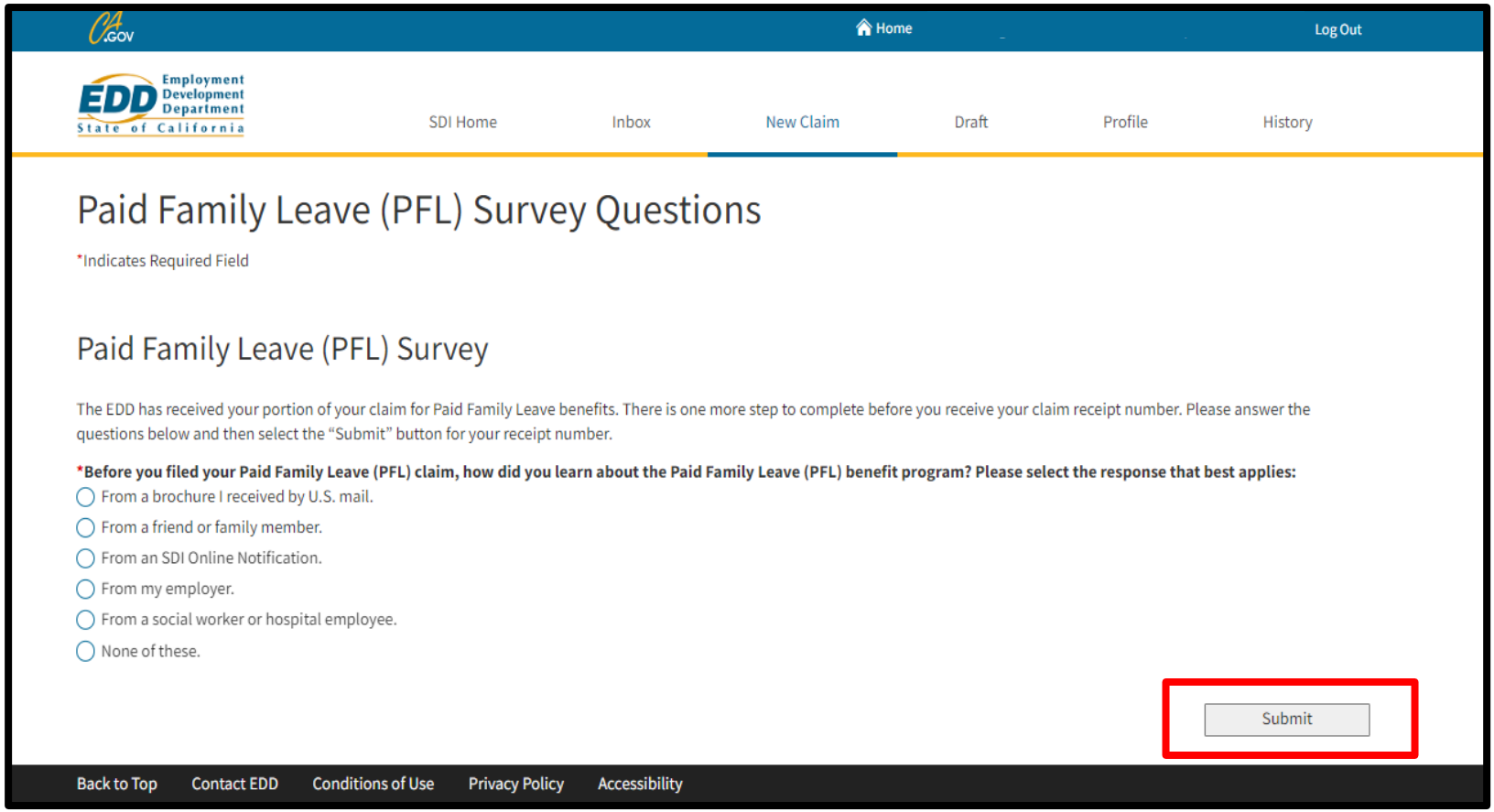


Select both check boxes to authorize an electronic signature and the release of your information.

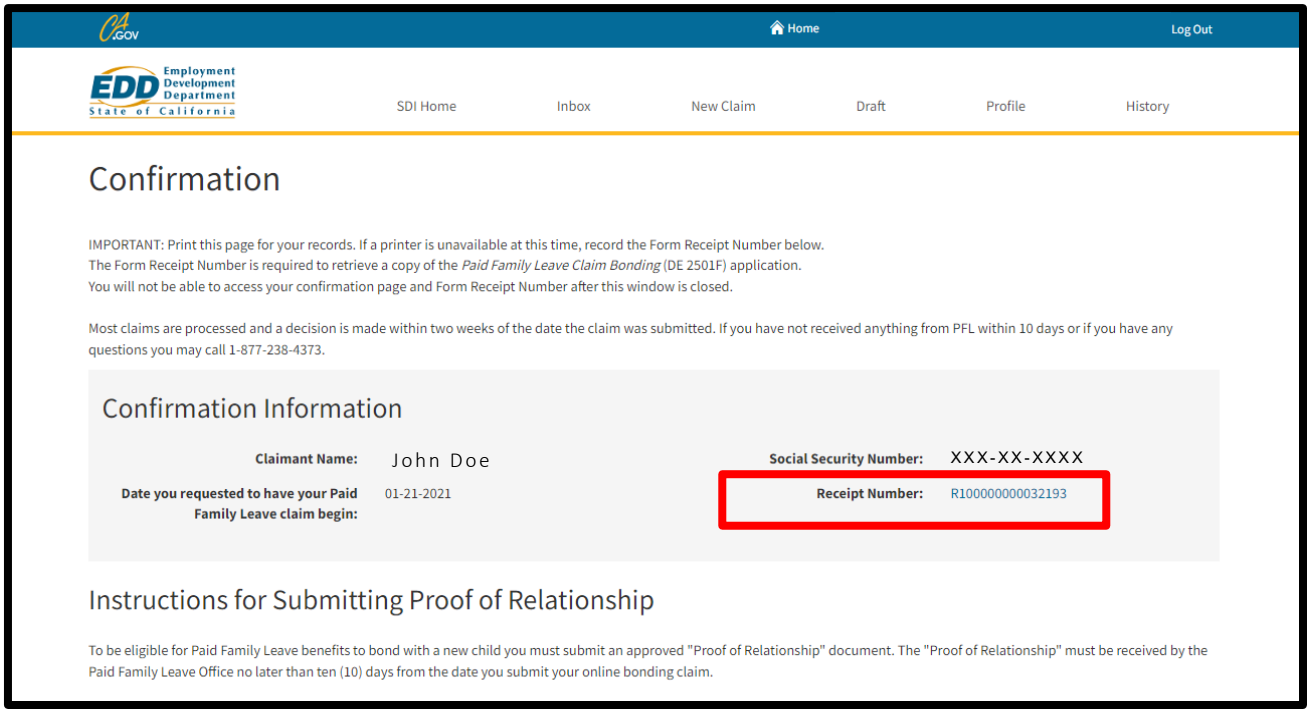
You must complete the fields marked with a red asterisk (*).

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

Select **Submit** to send your online claim to us.



Complete the survey and select **Submit** to proceed to the next step.



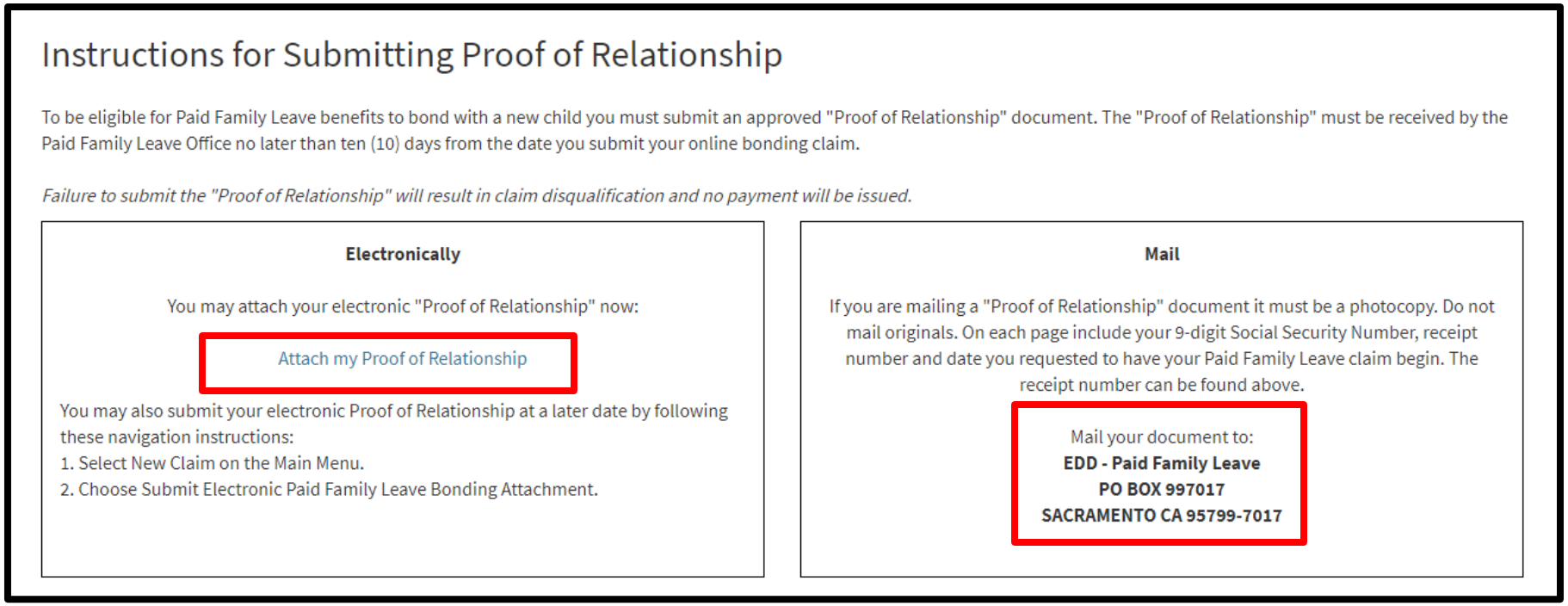
We assign your claim a Receipt Number on the Confirmation screen.

Note

Save the Receipt Number. You need this number to upload your supporting documentation to the correct online claim.

Important

Your claim is not complete. The Confirmation screen provides instructions to upload the other documentation for your bonding claim.



To complete your bonding claim, you must submit your Proof of Relationship online or by mail.

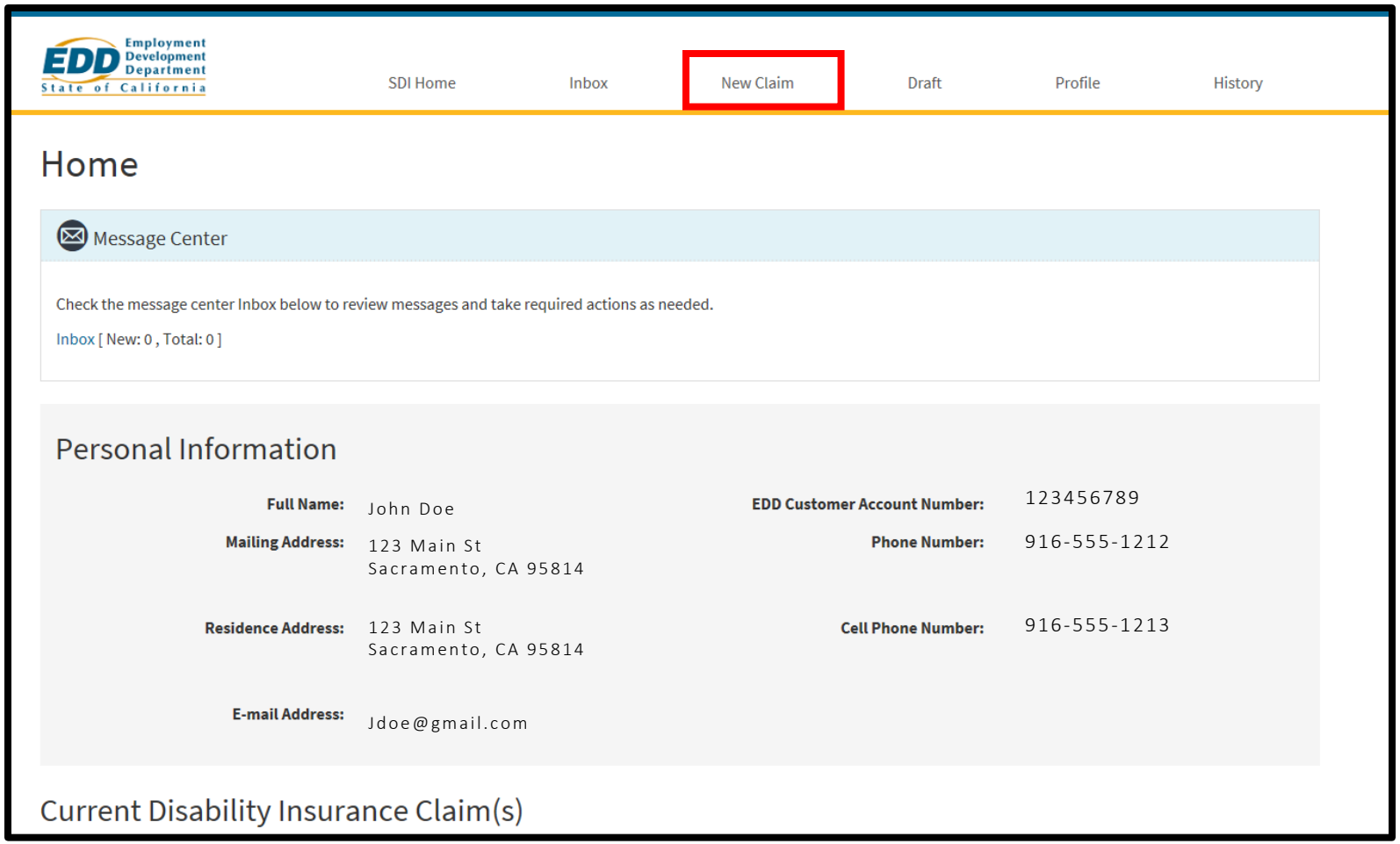
- To submit it online, select **Attach my Proof of Relationship** and follow the instructions. Review Submit Supporting Bonding Claim Documents for instructions.
- To submit by mail, send copies of your proof of relationship documents to the address on the screen. Do not mail originals. On each page include your nine-digit Social Security number, Receipt Number, and your requested claim start date.

Employment Development Department
State of California

Submit Supporting Bonding Claim Documents

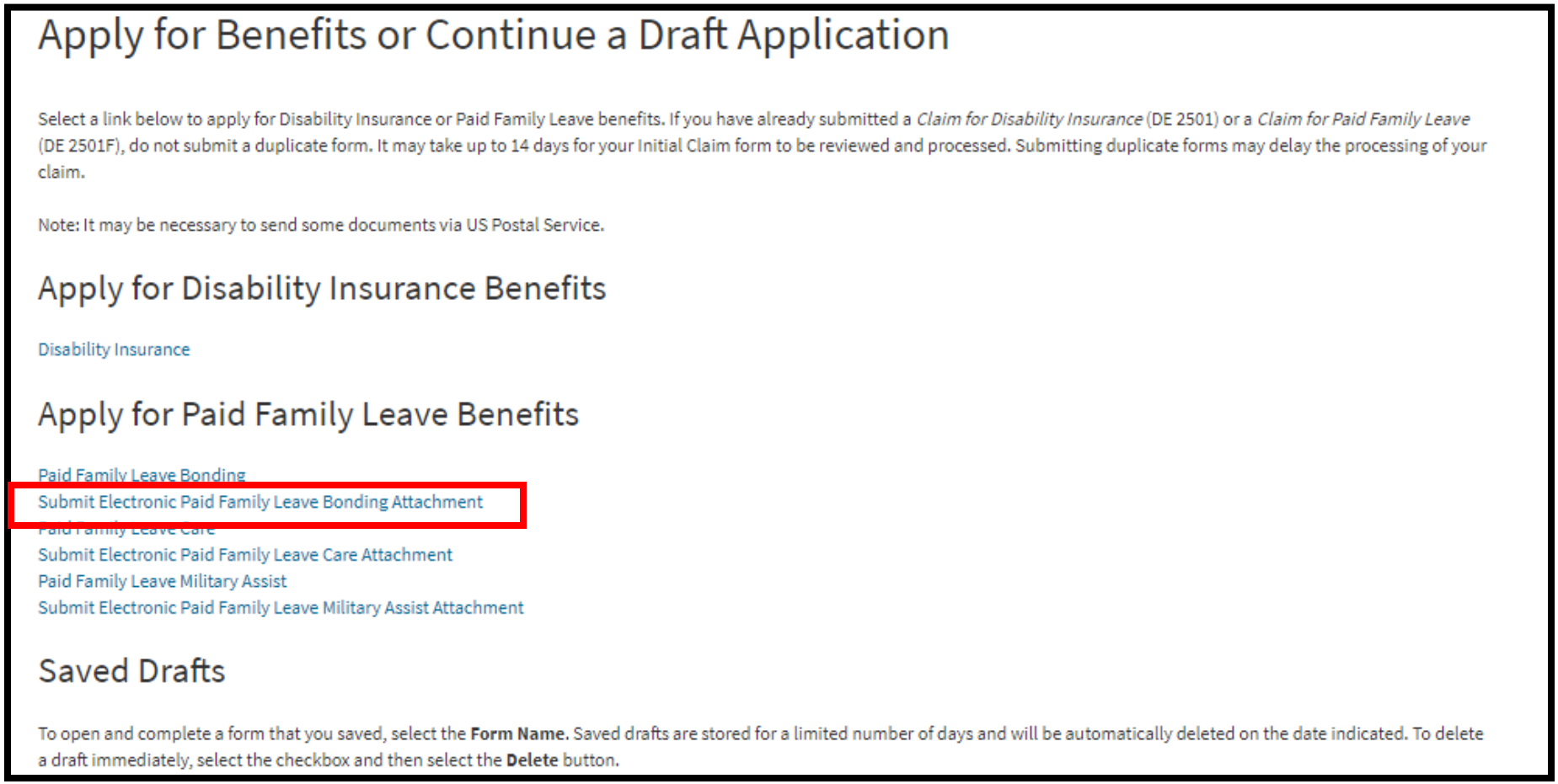
Learn more about how to submit your proof of relationship documents to complete your claim for bonding benefits.

Get Started

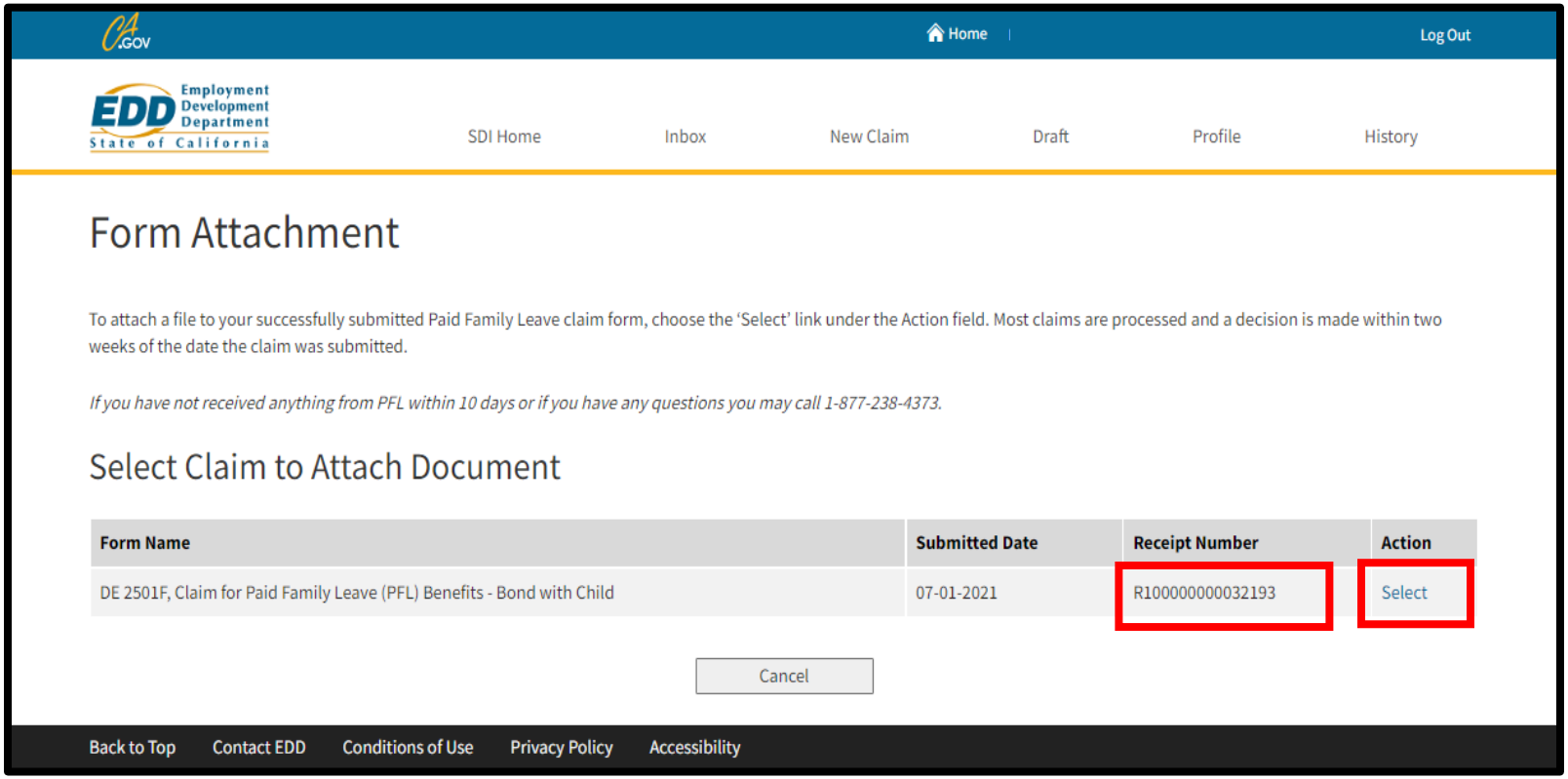


To submit your Proof of Relationship document or if you need to submit more than one document (e.g., birth certificates for twins or to resubmit a document):

- Select **New Claim** from the main menu.

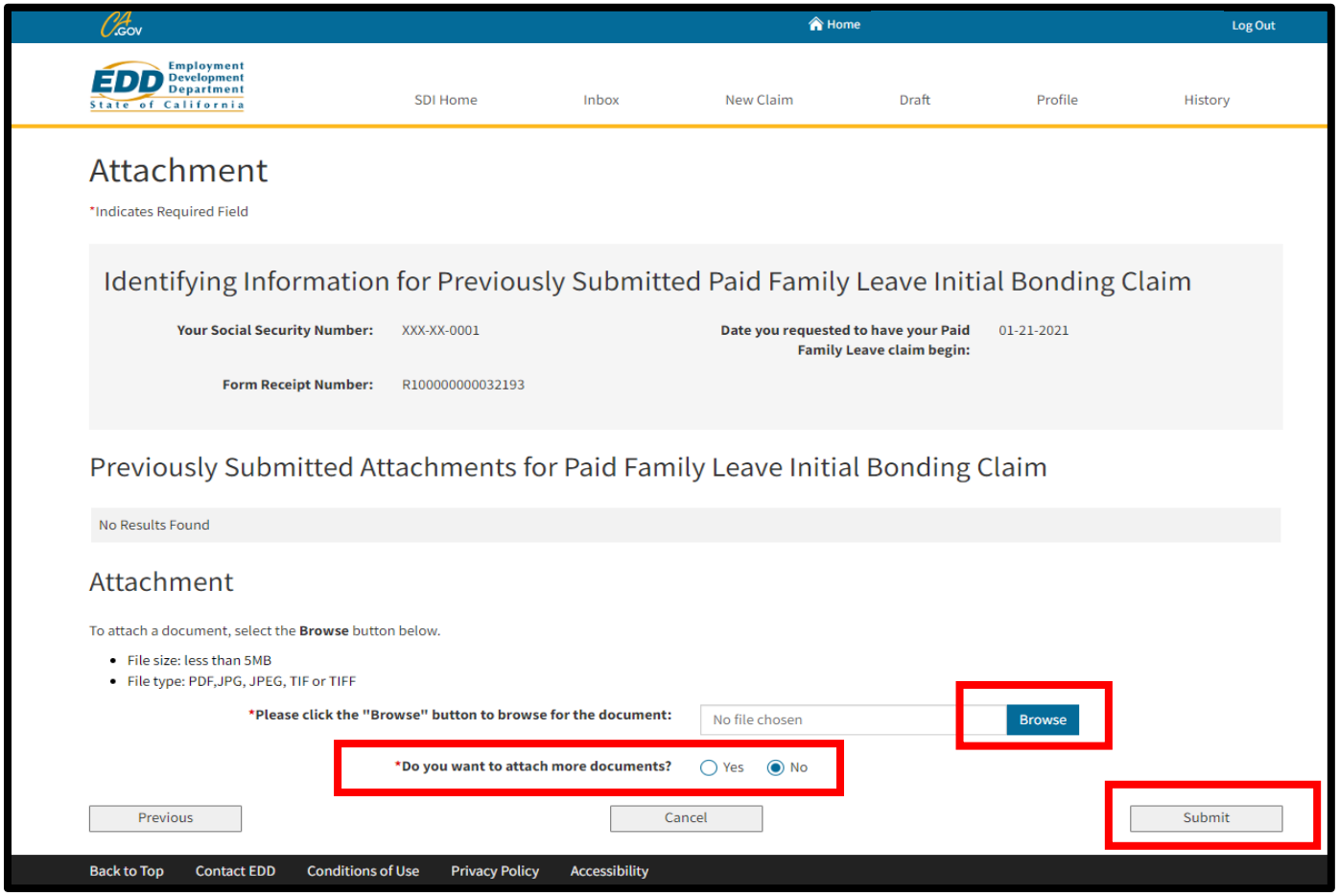


Select **Submit Electronic Paid Family Leave Bonding Attachment** under Apply for Paid Family Leave Benefits.



Make sure the Receipt Number matches the number you got when you submitted the online claim.

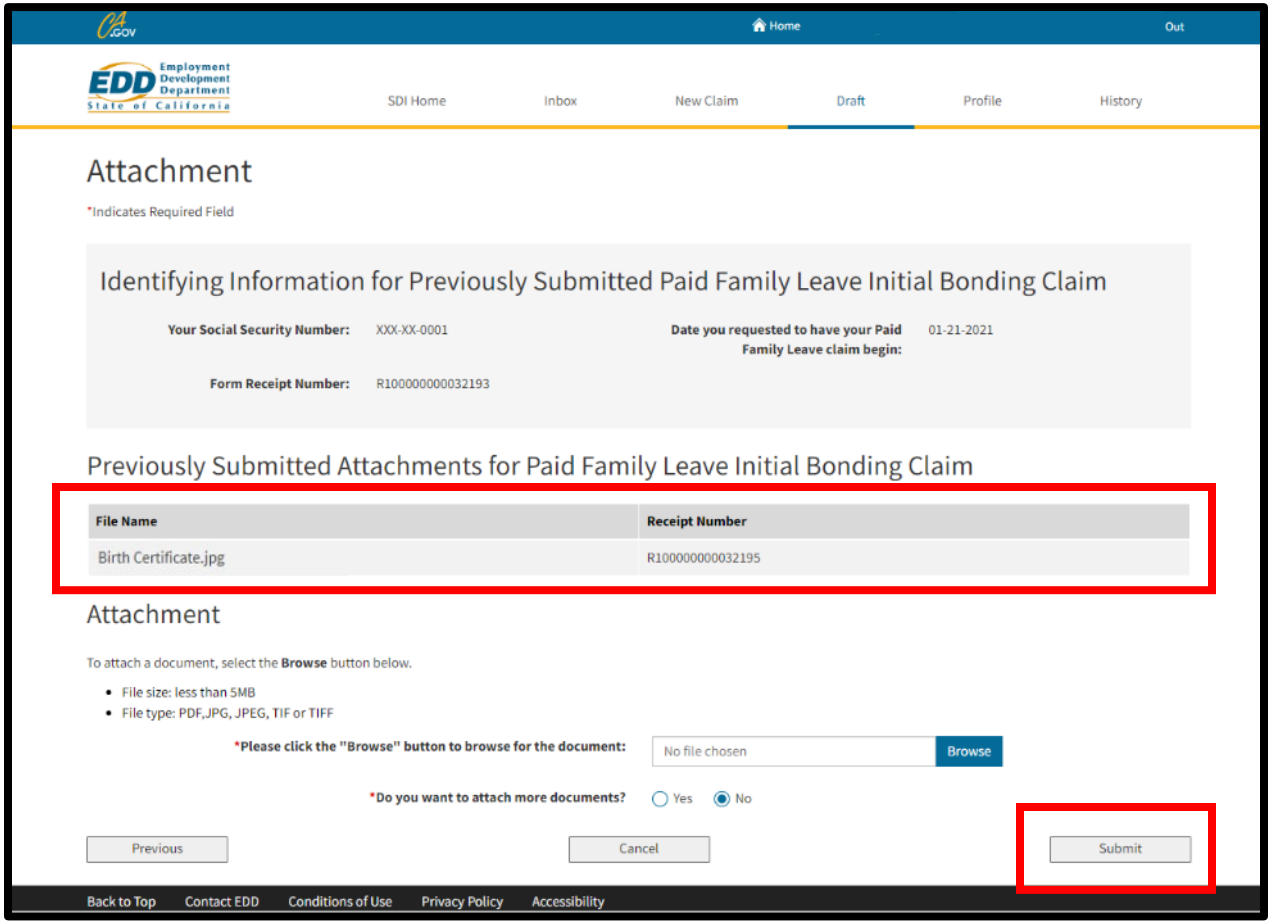
If it matches your claim, choose **Select** from the Action column to attach a document to your claim.



To upload a document, select **Browse**.

To upload more than one document, select **Yes** and then select **Browse**. After uploading one document, the system sends you back to the Attachment screen to continue uploading documents.

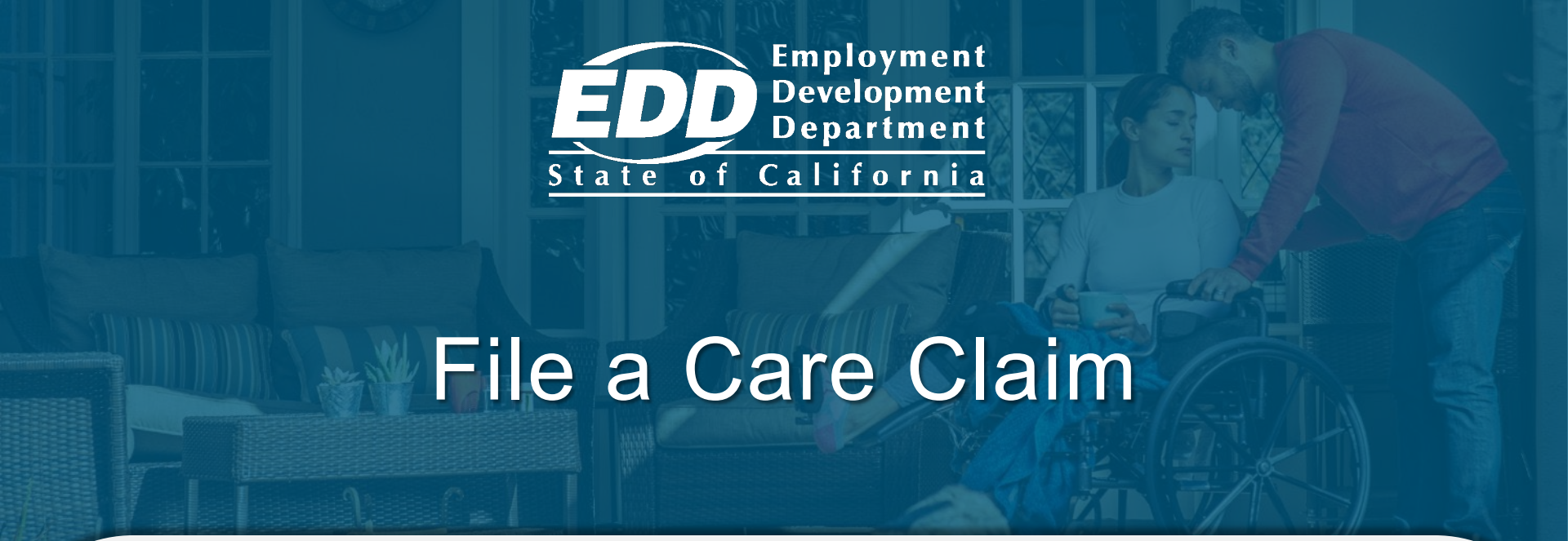
When you are done uploading, select **No** and then **Submit.**



The Attachment screen confirms that the attachment was uploaded.

Save the **Receipt Number** for future reference. Select **Submit**.

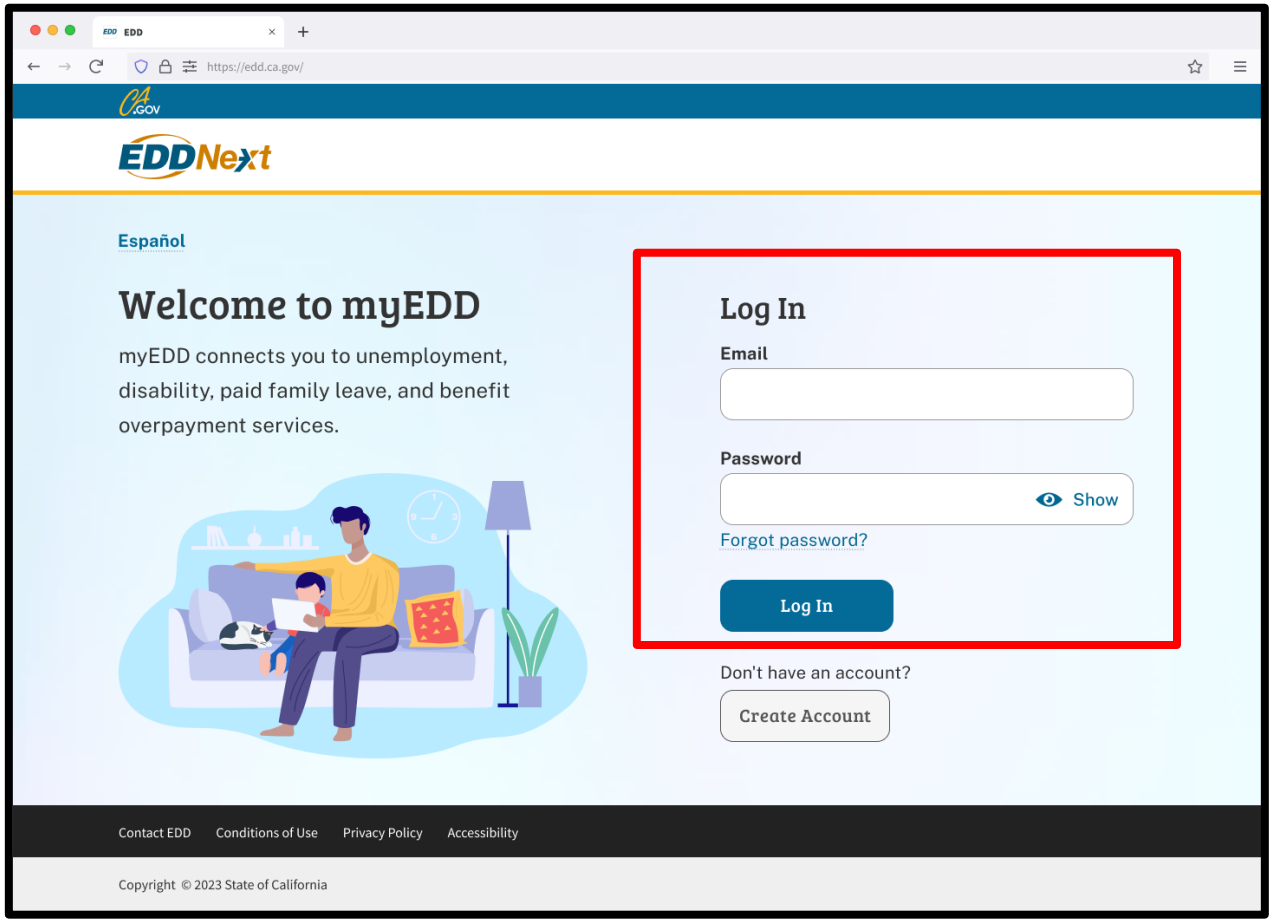
Your bonding claim is now complete. It can take up to 14 days to process your claim.



File a Care Claim

Learn more about how individuals providing care to a seriously ill or injured family member apply for care benefits.

Get Started

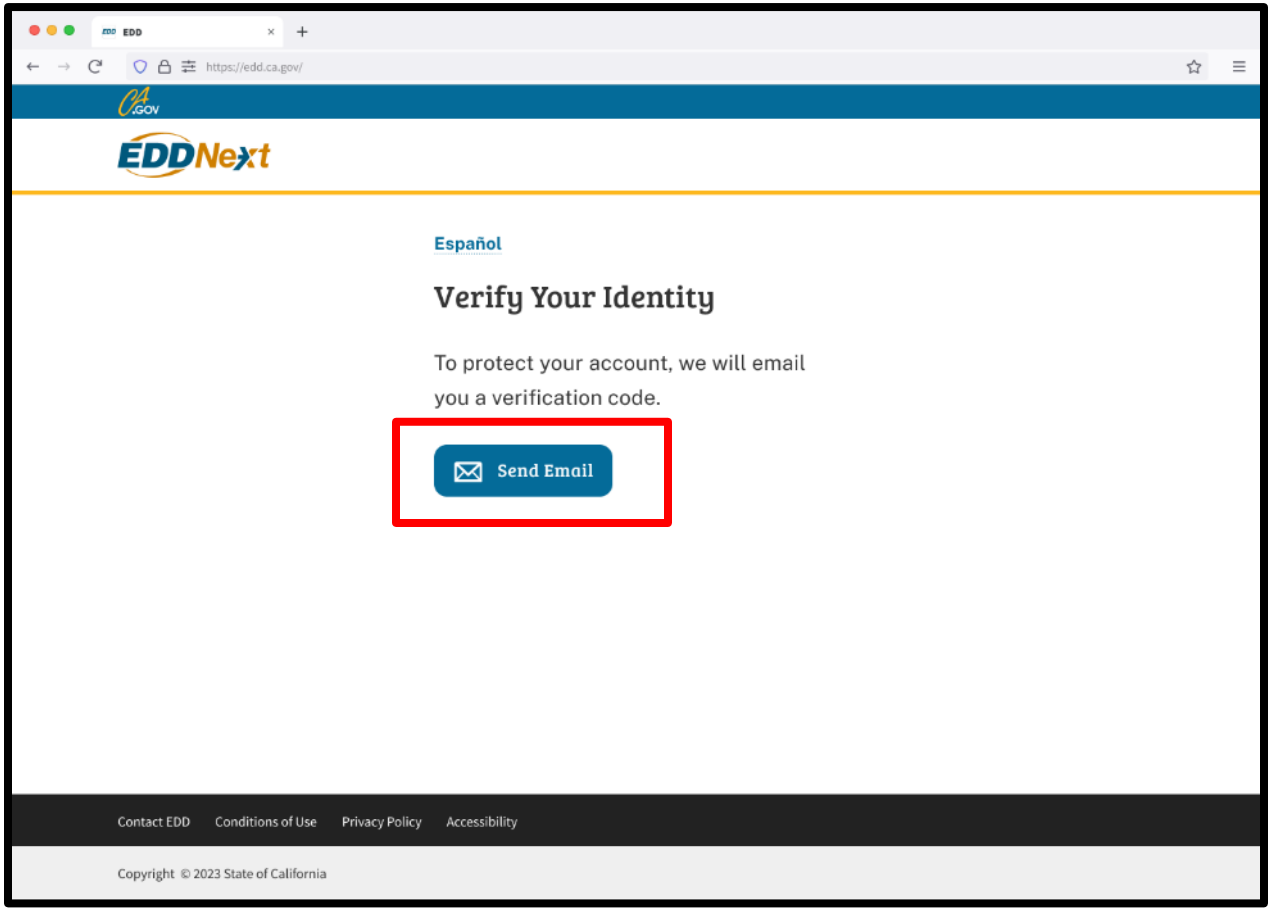


Note

For Spanish, select **Español**.

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

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



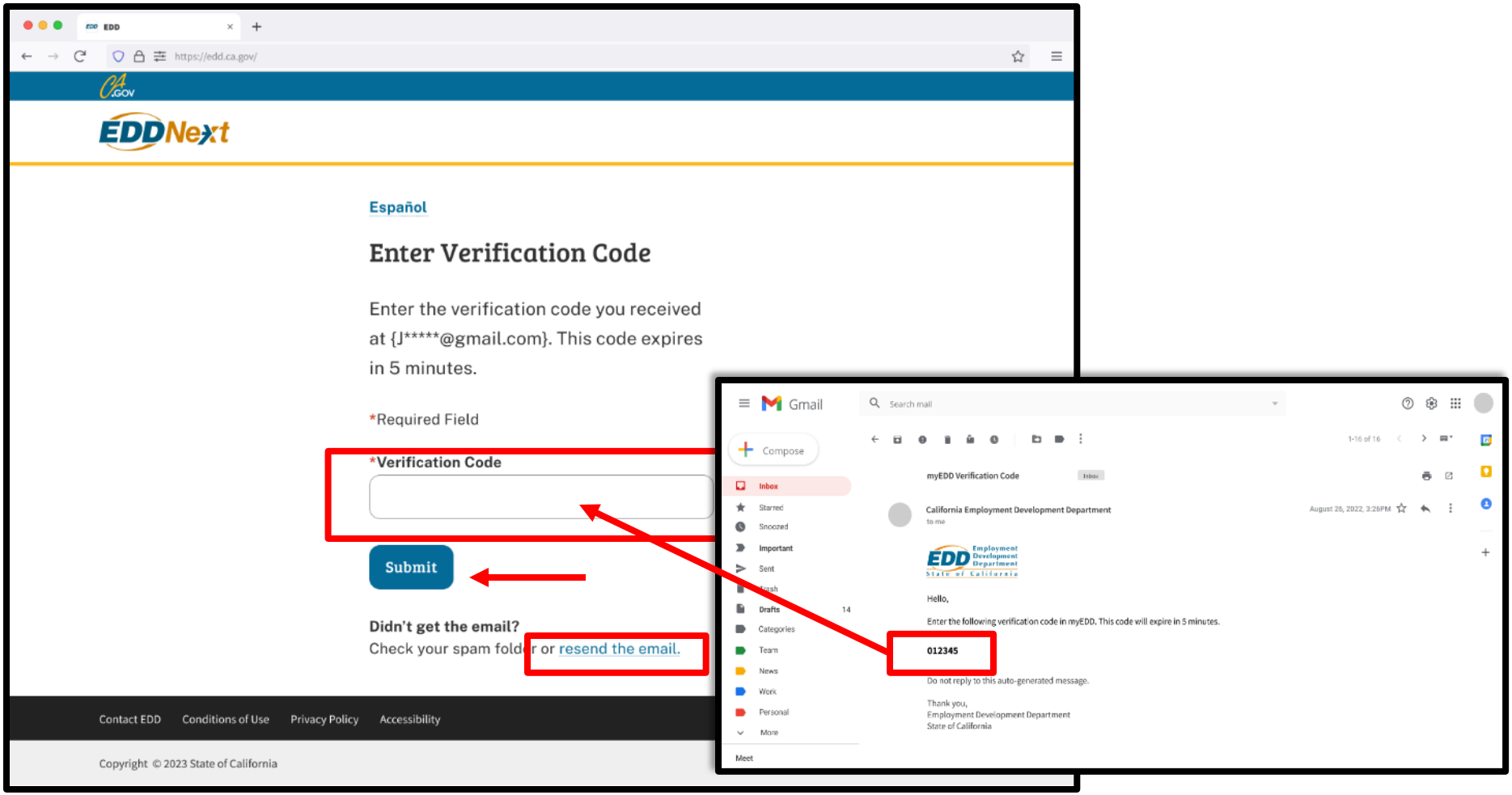
Note

You can verify your identity through email even if your preferred verification option is text or voice.

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.

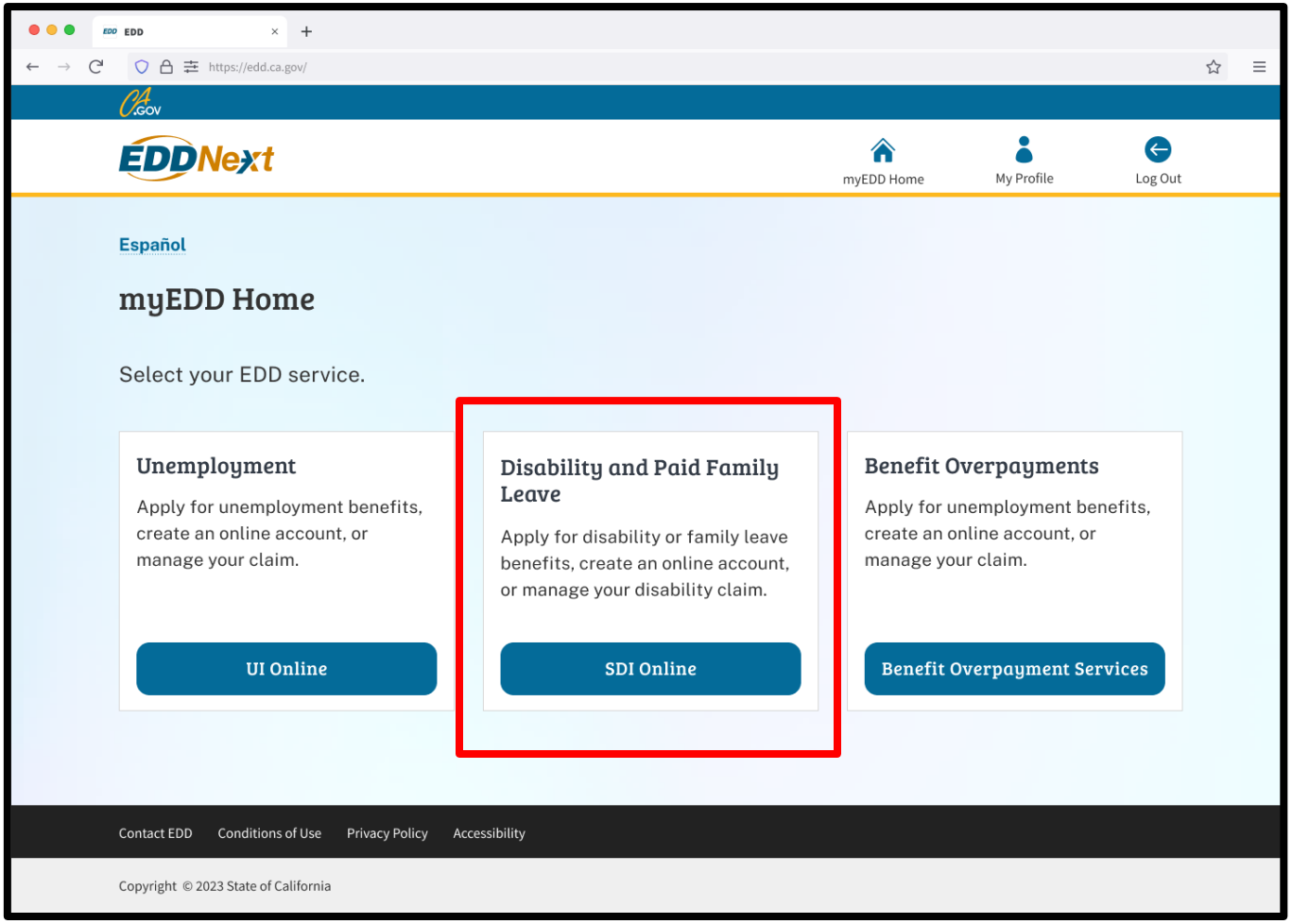
Select **Send Email**.

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.

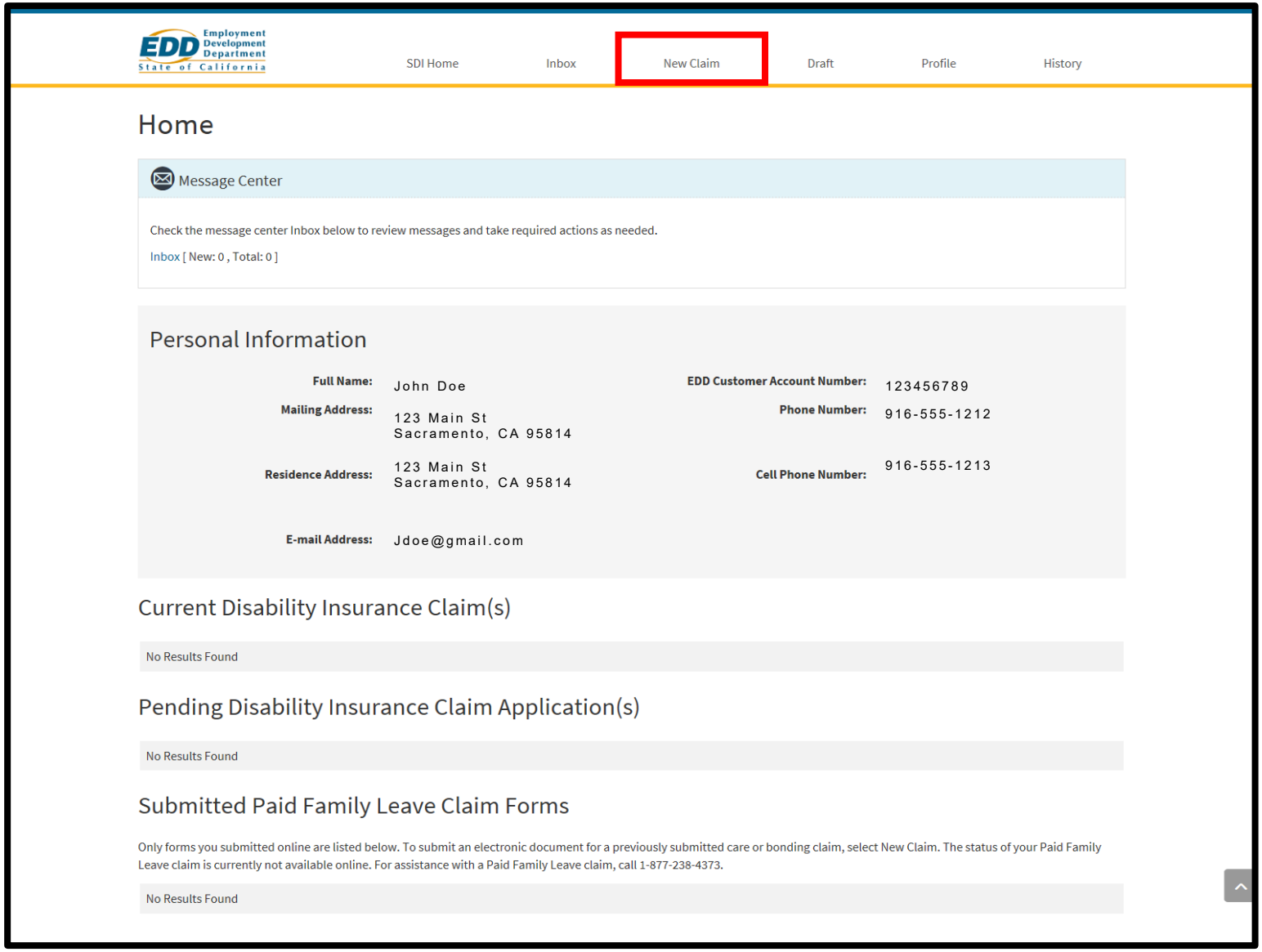
- Enter your verification code and select **Submit**.
- Select **resend the email** if you do not get a code.



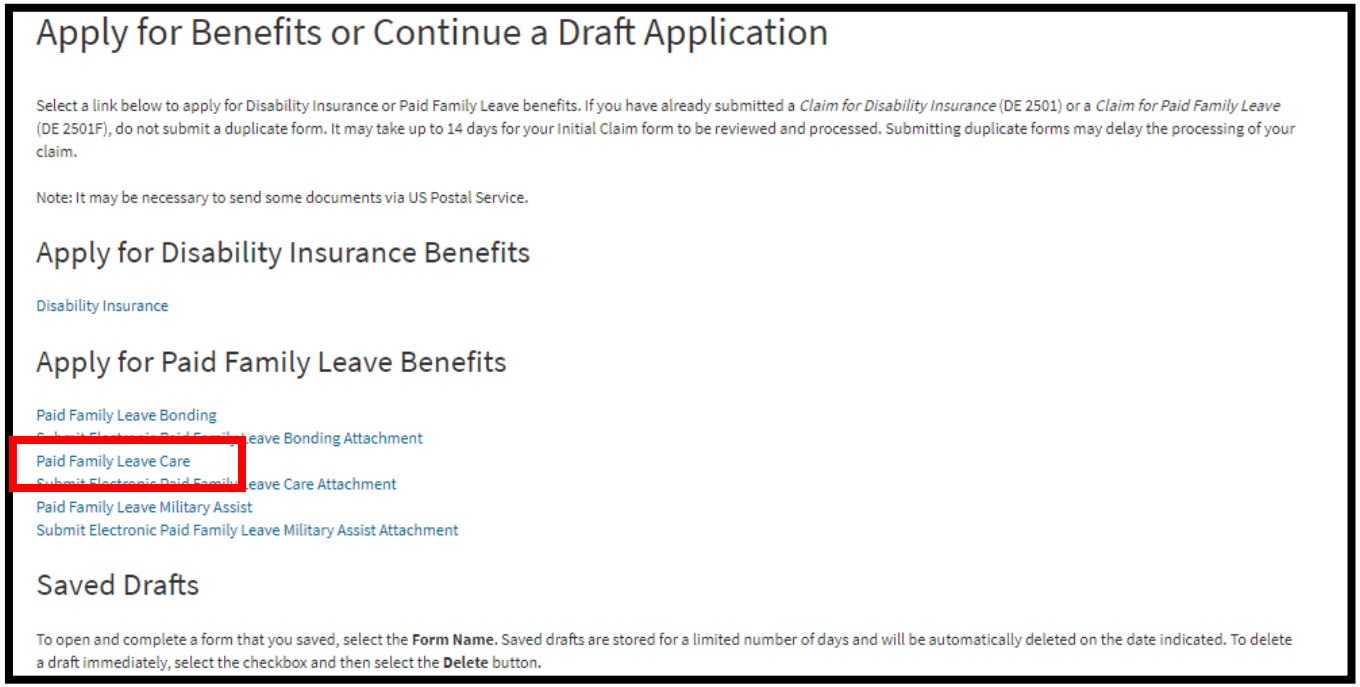
Note

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

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



Select **New Claim** from the main menu.



To apply for care benefits, select **Paid Family Leave Care** under Apply for Paid Family Leave Benefits.

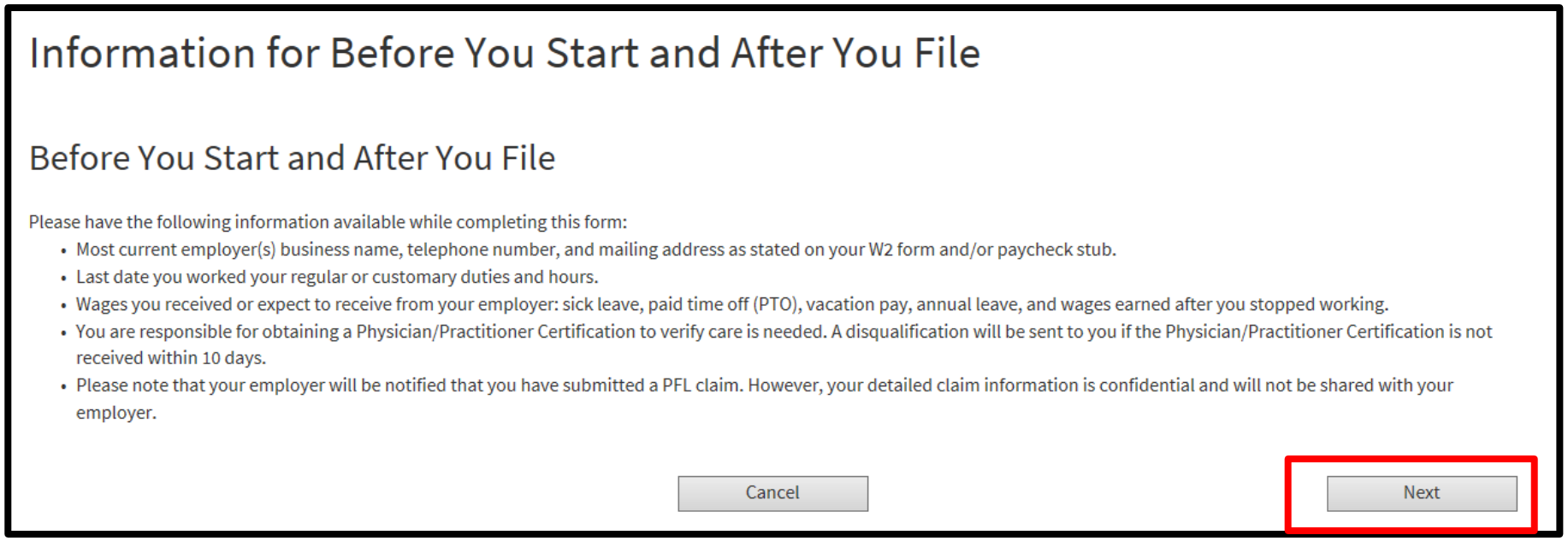
If you are unsure which application to complete, review Types of Claims.

Note

Submit your claim no earlier than the first day your family leave begins, but no later than 41 days after your family leave begins, or you may lose benefits.

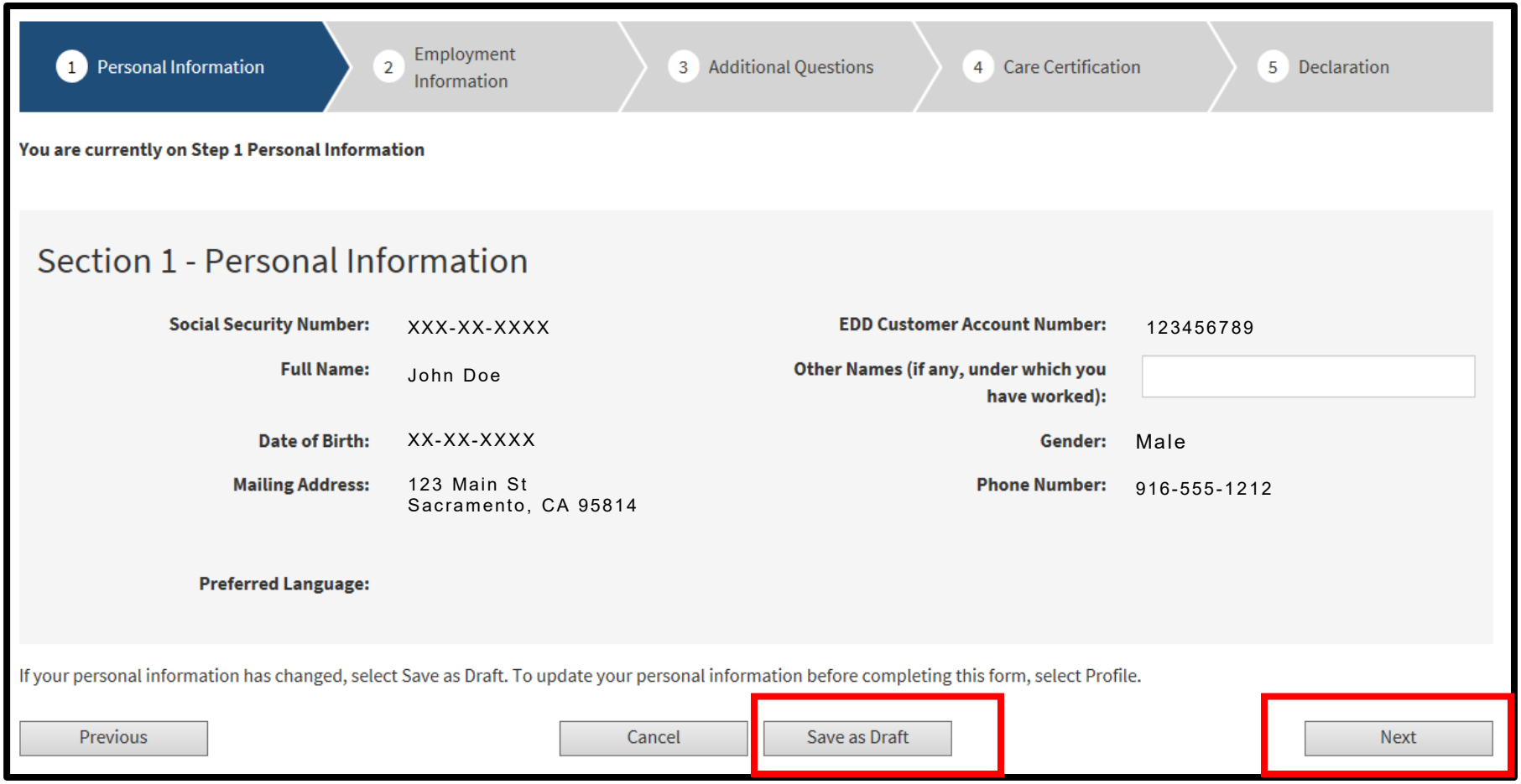
Important

If you already submitted a claim, do not submit another claim. It may take up to 14 days for your claim to be reviewed and processed.



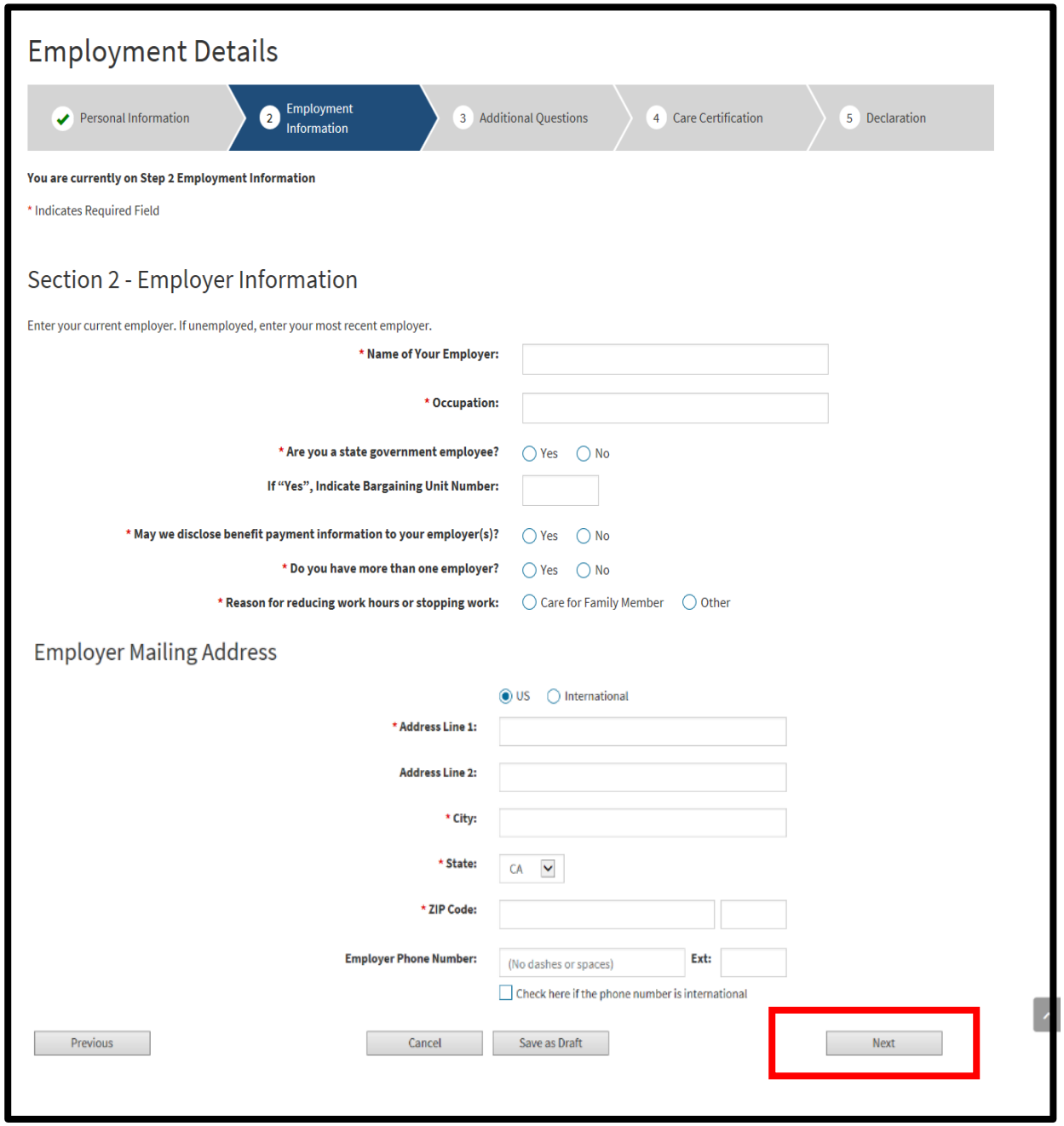
Review the Information for Before You Start and After You File. It has important information you need to file a care claim.

Select **Next.**



The system automatically fills certain portions of the claim form.

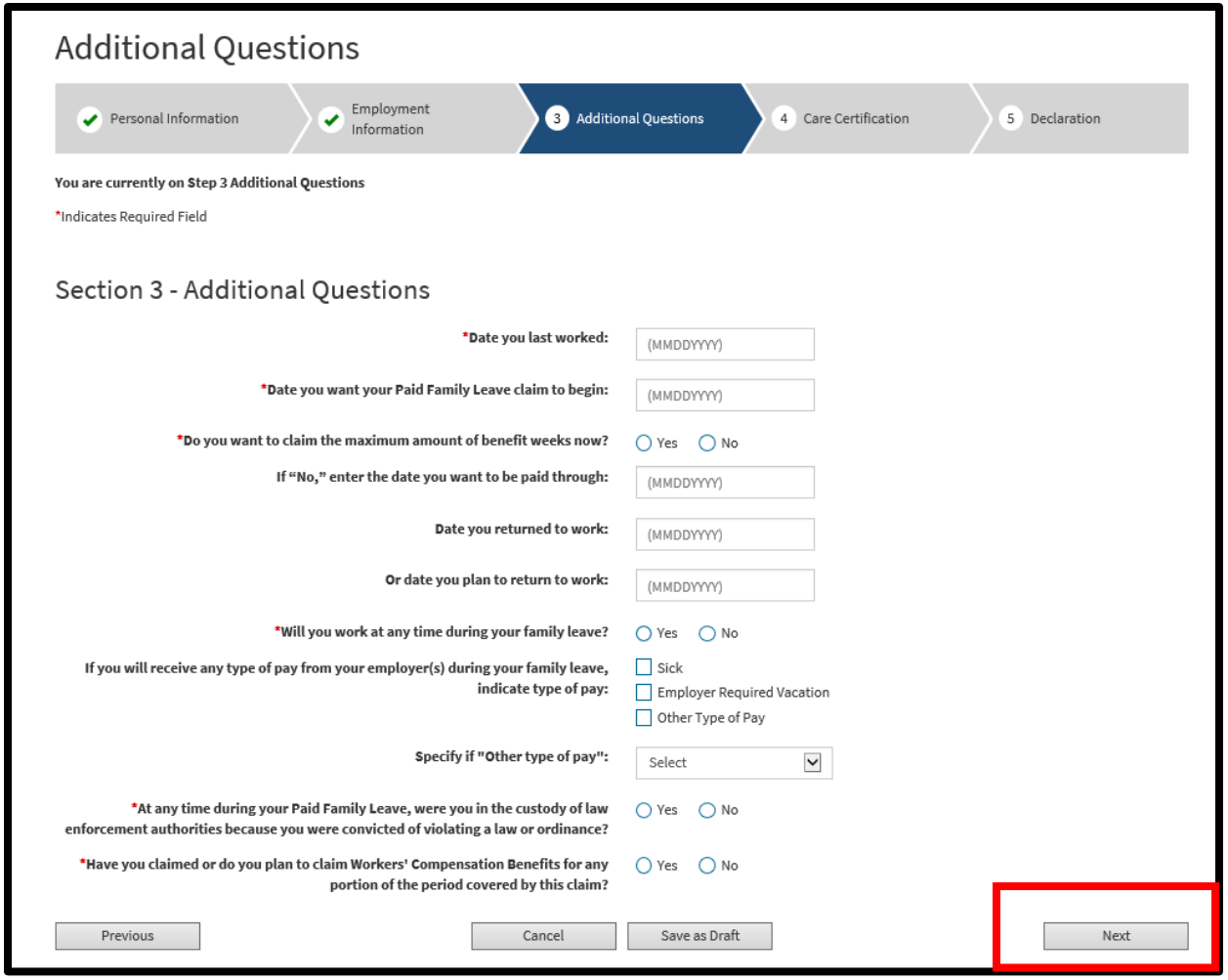
- Make sure the information is correct. If your personal information has changed, select **Save as Draft** and update your SDI Online profile.
- Select **Next** to continue.



Complete Section 2 - Employer Information with your current employer's business name, phone number, and mailing address as shown on your W-2 or paystub. If you're unsure what address to enter, ask your employer.

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

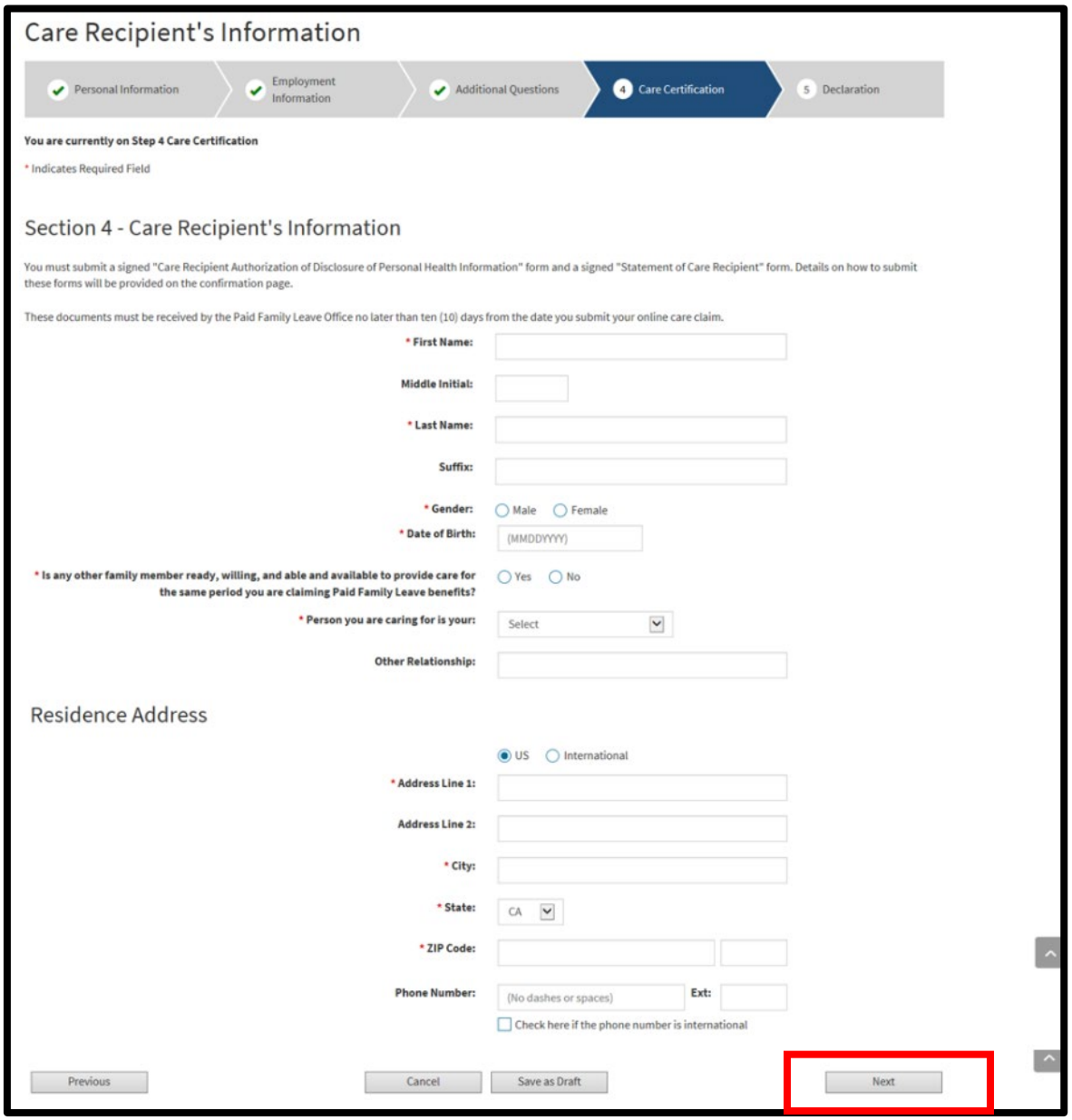
Select **Next** to continue.



Complete Section 3 - Additional Questions and confirm all dates are correct to avoid a delay or incorrect payment of benefits.

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

Select **Next**.

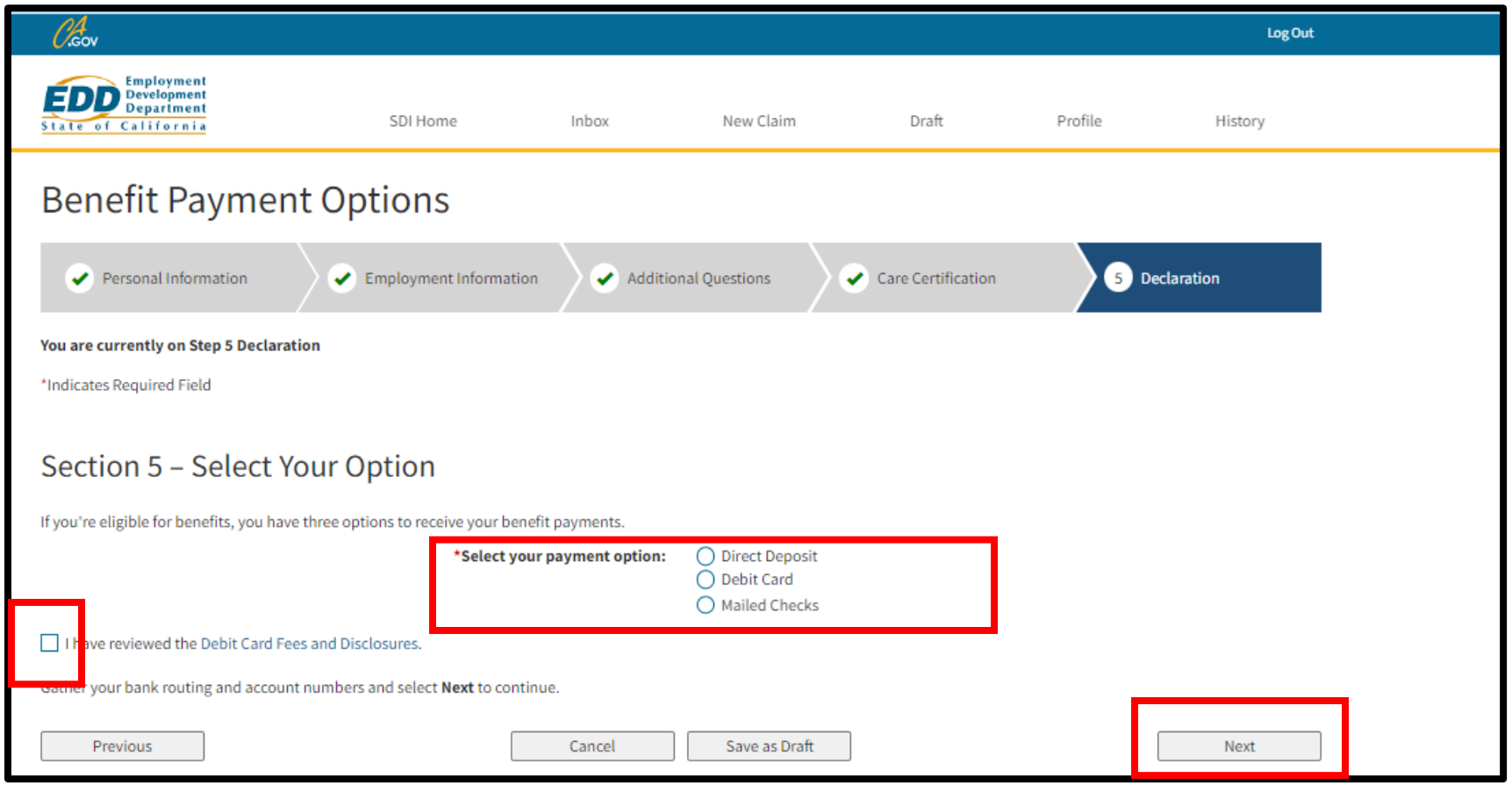


Complete Section 4 - Care Recipient's Information and Residence Address with information about the person you are caring for.

Details on how to submit a signed Statement of Care Recipient form are available on the Confirmation screen.

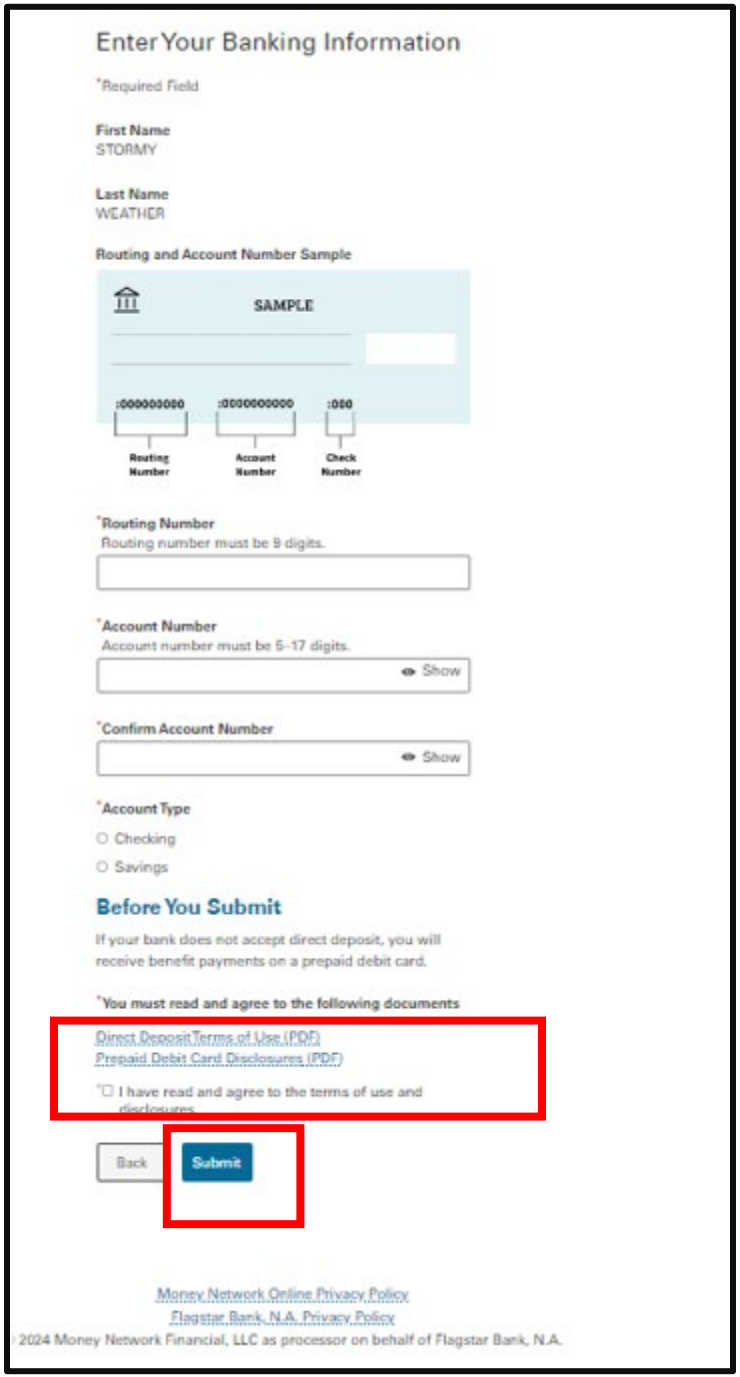
You must complete the fields marked with a red asterisk (*).

Select **Next**.



Complete Section 5 to choose your benefit payment option.

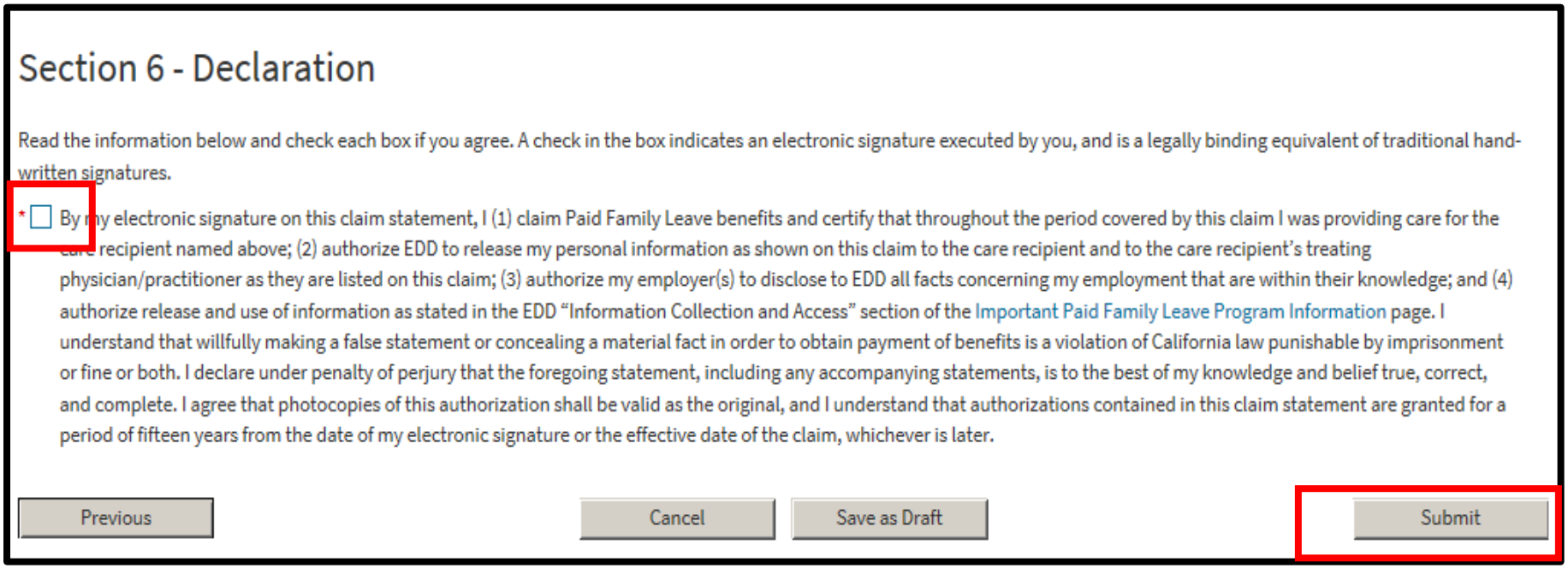
Select the **"I have reviewed..."** box to confirm you have read the disclosures, then select Next.



If you selected Direct Deposit, you will be asked to provide your banking information.

You must select and open the “terms of use” documents and disclosures before you can submit your information.

Select Submit to continue.



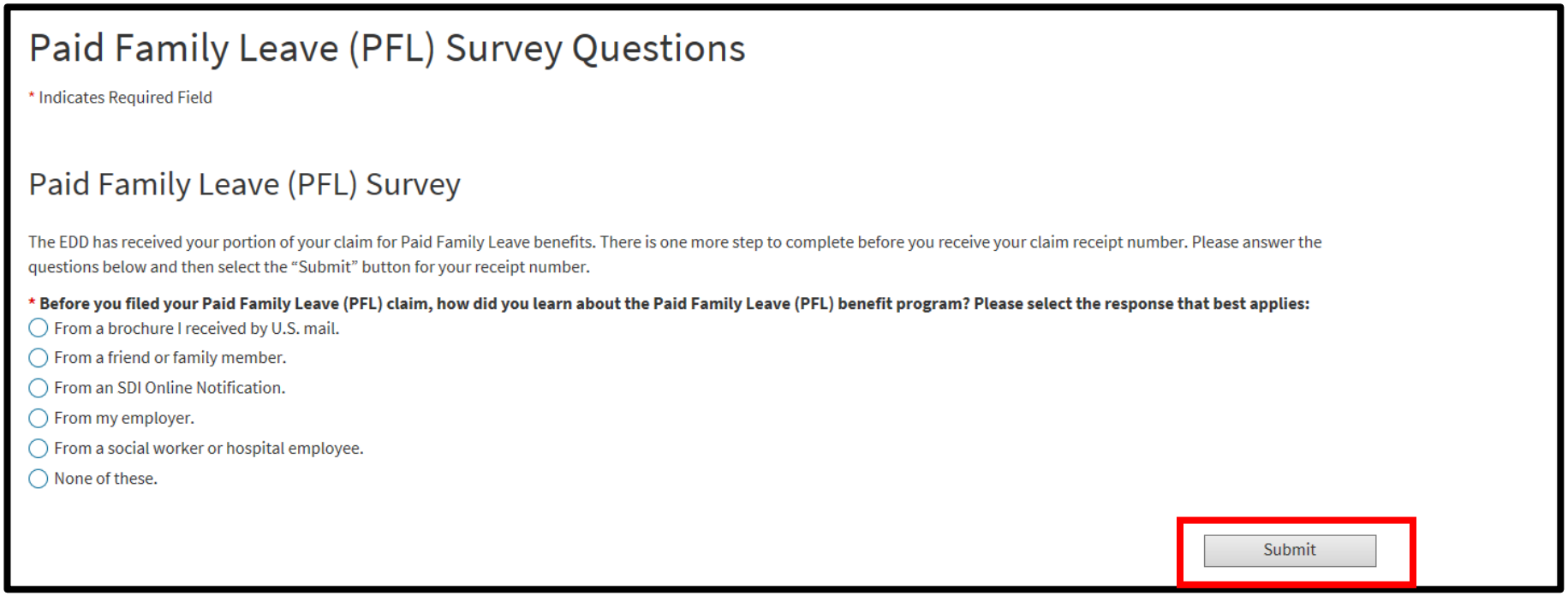
In Section 6 – Declaration, select the box to authorize an electronic signature. You must select this box to complete your claim.

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

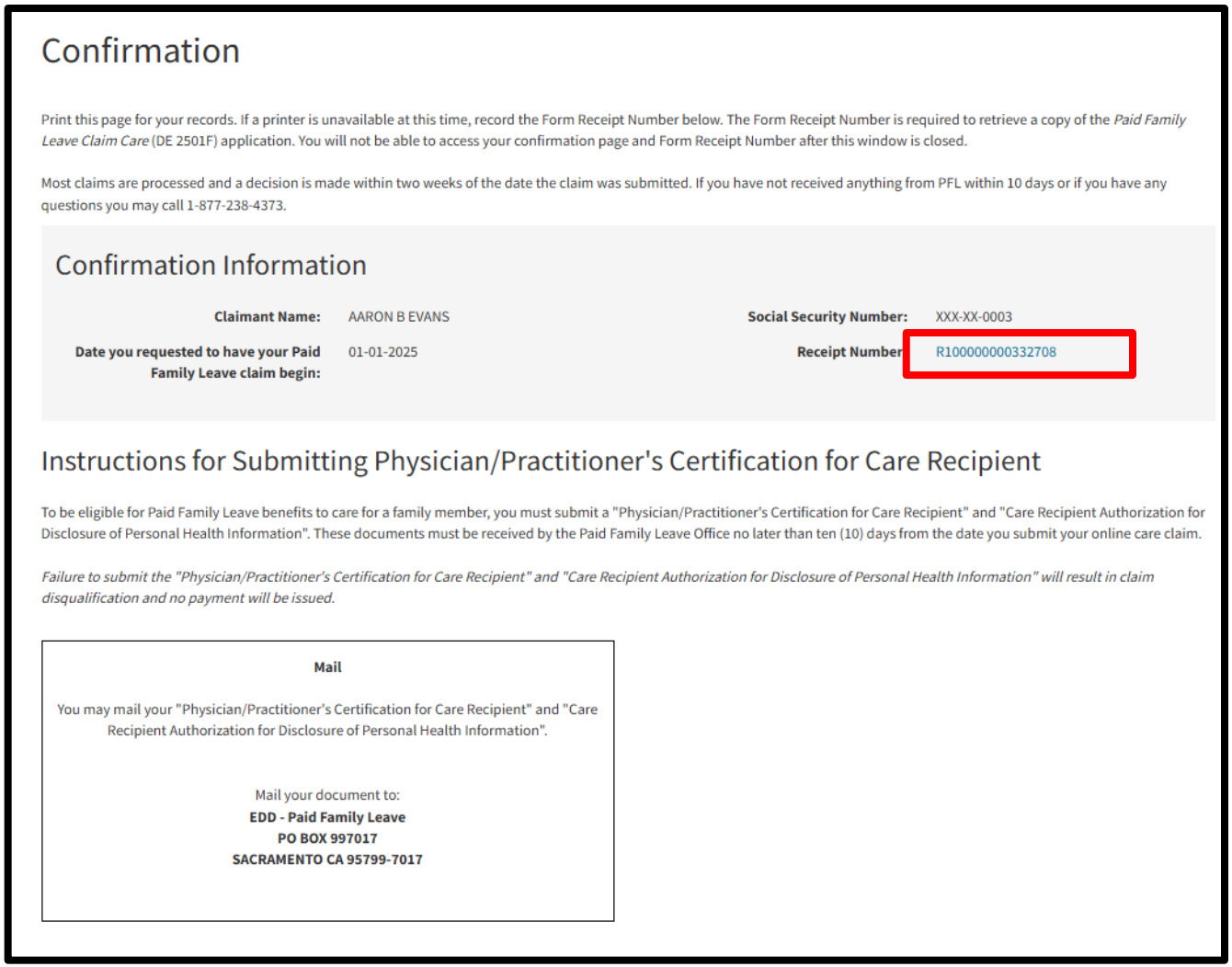
Select **Submit** to send the online portion of your claim to us.

Important

Your claim is not complete. The Confirmation screen provides instructions to submit the Statement of Care Recipient and the Physician's/Practitioner's Certification sections of the *Claim for Paid Family Leave (PFL) Care Benefits* (DE 2501FC).



Complete the survey and select **Submit**.



Confirmation

Print this page for your records. If a printer is unavailable at this time, record the Form Receipt Number below. The Form Receipt Number is required to retrieve a copy of the *Paid Family Leave Claim Care* (DE 2501F) application. You will not be able to access your confirmation page and Form Receipt Number after this window is closed.

Most claims are processed and a decision is made within two weeks of the date the claim was submitted. If you have not received anything from PFL within 10 days or if you have any questions you may call 1-877-238-4373.

Confirmation Information

Claimant Name: AARON B EVANS

Social Security Number: XXX-XX-0003

Date you requested to have your Paid Family Leave claim begin: 01-01-2025

Receipt Number R100000000332708

Instructions for Submitting Physician/Practitioner's Certification for Care Recipient

To be eligible for Paid Family Leave benefits to care for a family member, you must submit a "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information". These documents must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online care claim.

Failure to submit the "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information" will result in claim disqualification and no payment will be issued.

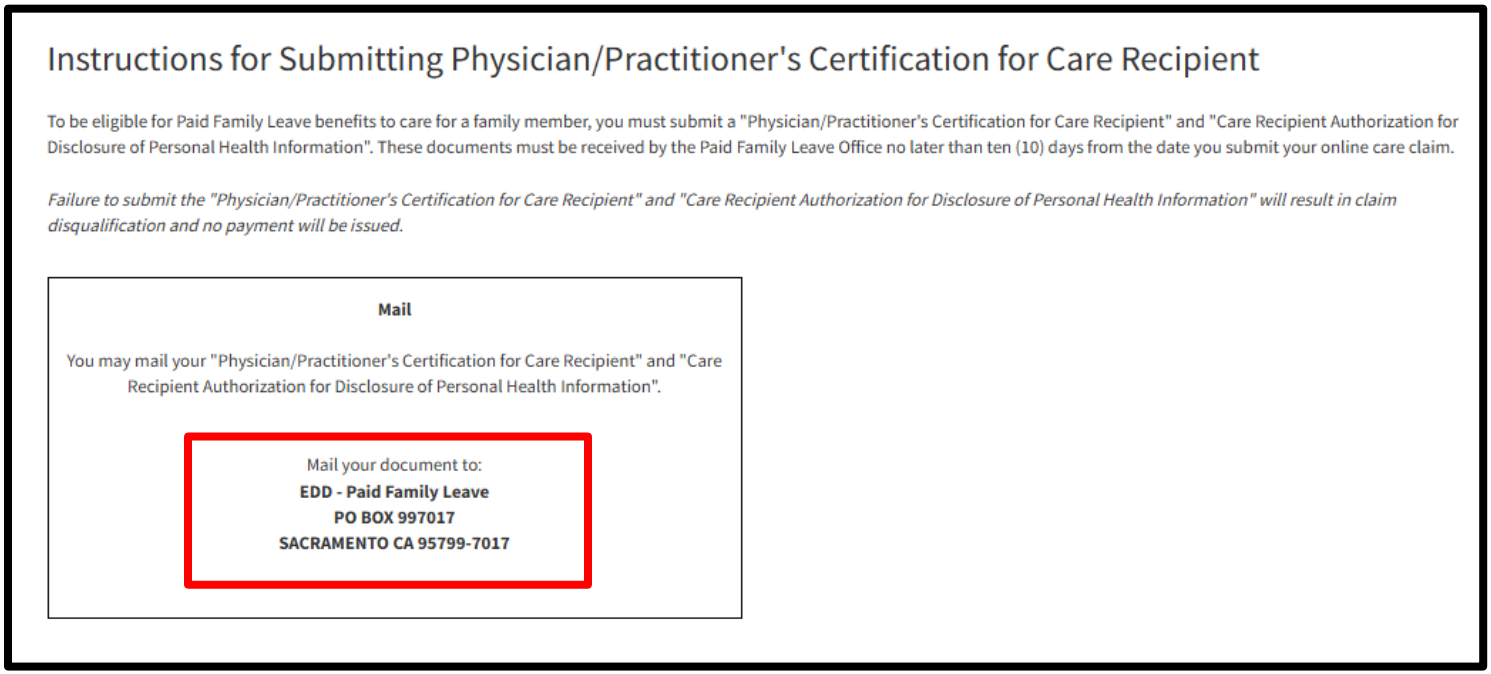
Mail

You may mail your "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information".

Mail your document to:
EDD - Paid Family Leave
PO BOX 997017
SACRAMENTO CA 95799-7017

We assign your claim a **Receipt Number** on the Confirmation screen.

Save the **Receipt Number** for future reference**.** You need this number to upload the supporting documentation to the correct online claim.



Instructions for Submitting Physician/Practitioner's Certification for Care Recipient

To be eligible for Paid Family Leave benefits to care for a family member, you must submit a "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information". These documents must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online care claim.

Failure to submit the "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information" will result in claim disqualification and no payment will be issued.

Mail

You may mail your "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information".

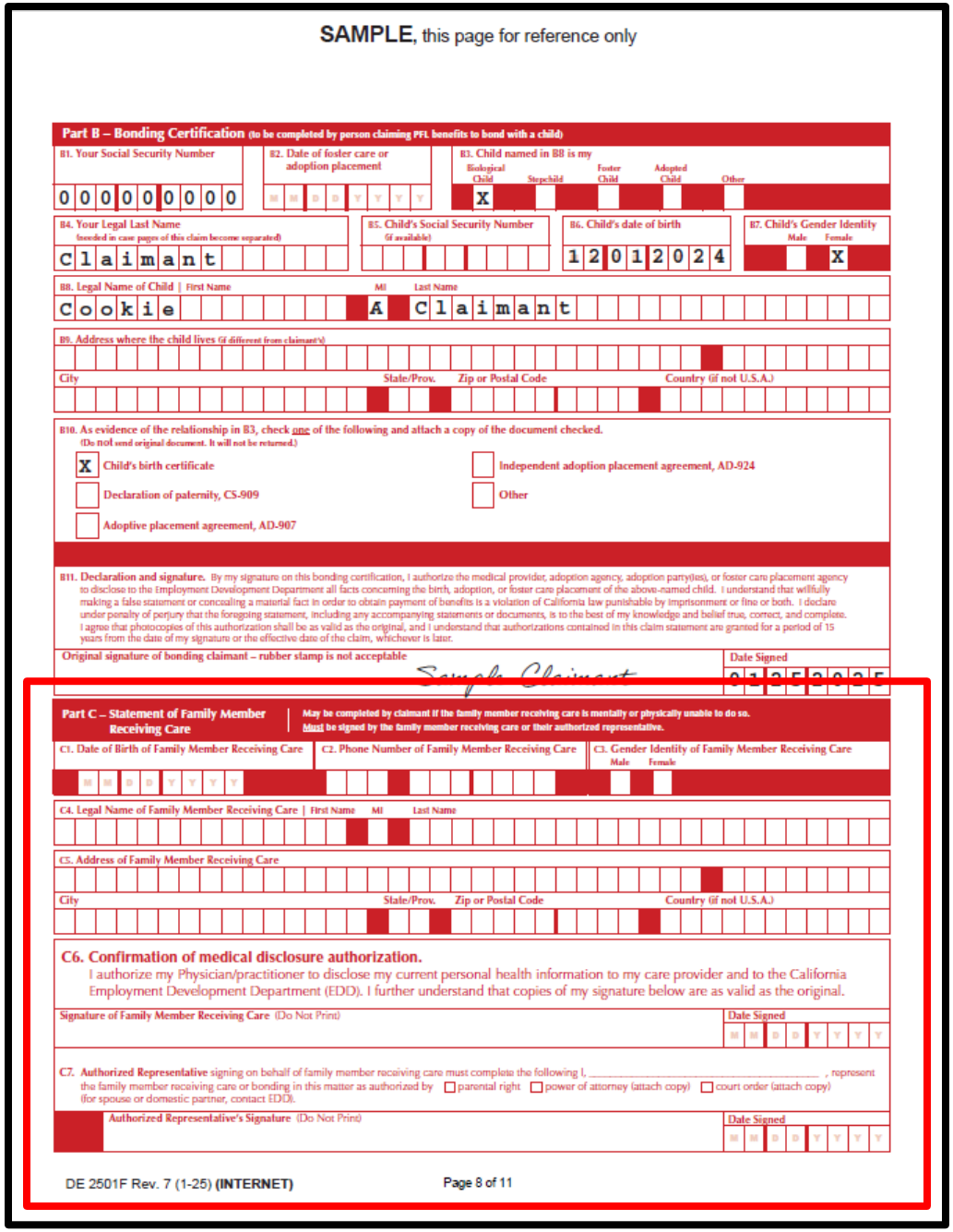
Mail your document to:
EDD - Paid Family Leave
PO BOX 997017
SACRAMENTO CA 95799-7017

You must order an *Application for Paid Family Leave Benefits* (DE 2501F) form. It is your responsibility to make sure Part C and Part D of this form are completed and signed by all parties and sent to us within 10 days.

- Mail the completed, signed form to the address on the screen.

Note

You can order the DE 2501F in English or DE 2501F/S in Spanish from Online Forms and Publications.



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 statement, including any accompanying statements or documents, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of 15 years from the date of my signature or the effective date of the claim, whichever is later.

Original signature of bonding claimant – rubber stamp is not acceptable: Sample Claimant | Date Signed: 01252025

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

C1. Date of Birth of Family Member Receiving Care: 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).

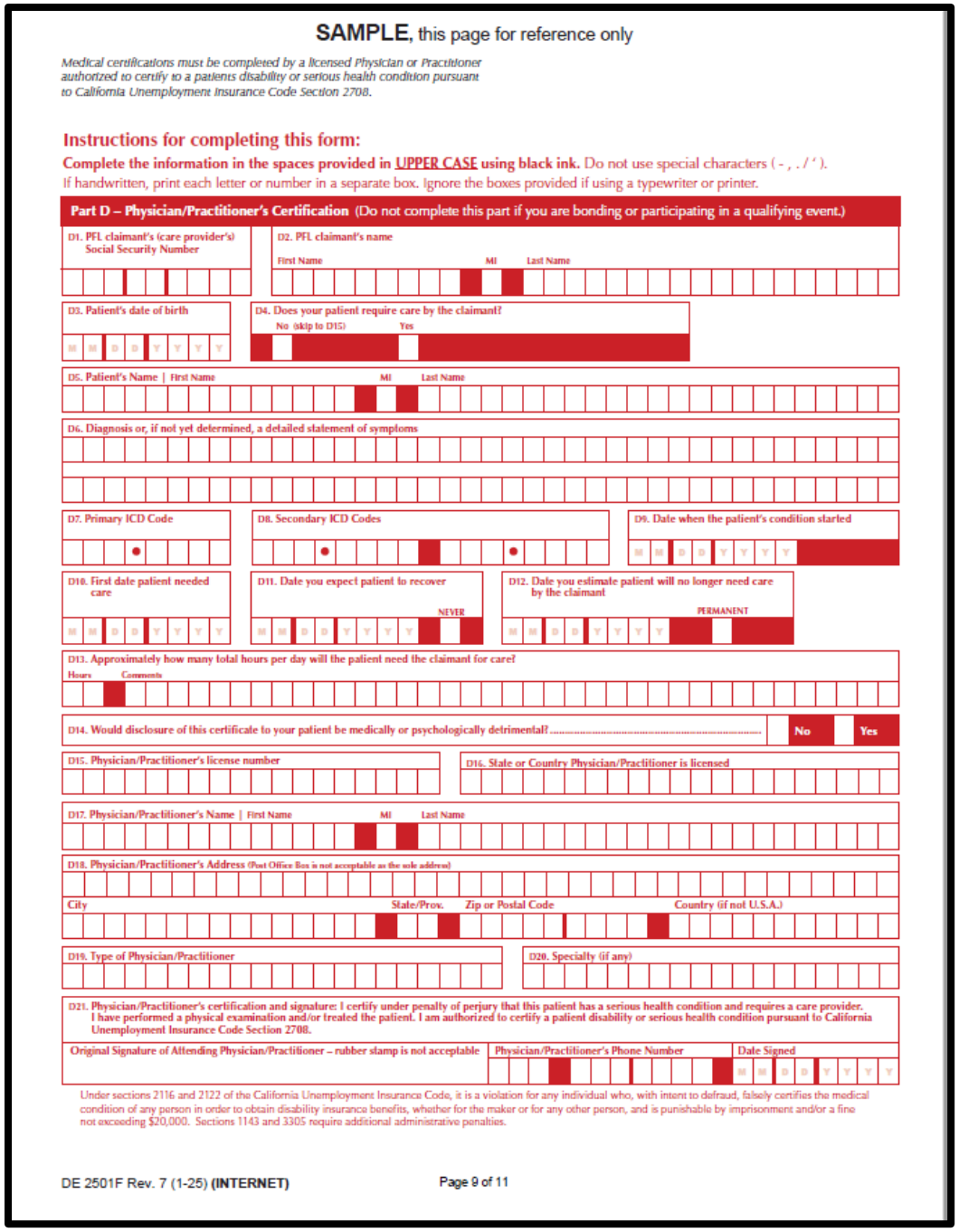
Authorized Representative's Signature (Do Not Print) | Date Signed: MM DD YYYY

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

Application for Paid Family Leave Benefits (DE 2501F)

Page 8 is the Statement of Care Recipient, Part C.

- Make sure you answer all questions in Part C.
- The care recipient or their authorized representative must sign and date the bottom of this page.



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

Application for Paid Family Leave Benefits (DE 2501F), cont'd

Page 9 is the Physician/Practitioner's Certification, Part D.

- The care recipient's physician/practitioner must complete all relevant information including ICD codes.
- Get a signature from the care recipient's physician/practitioner before you mail the form.

Note

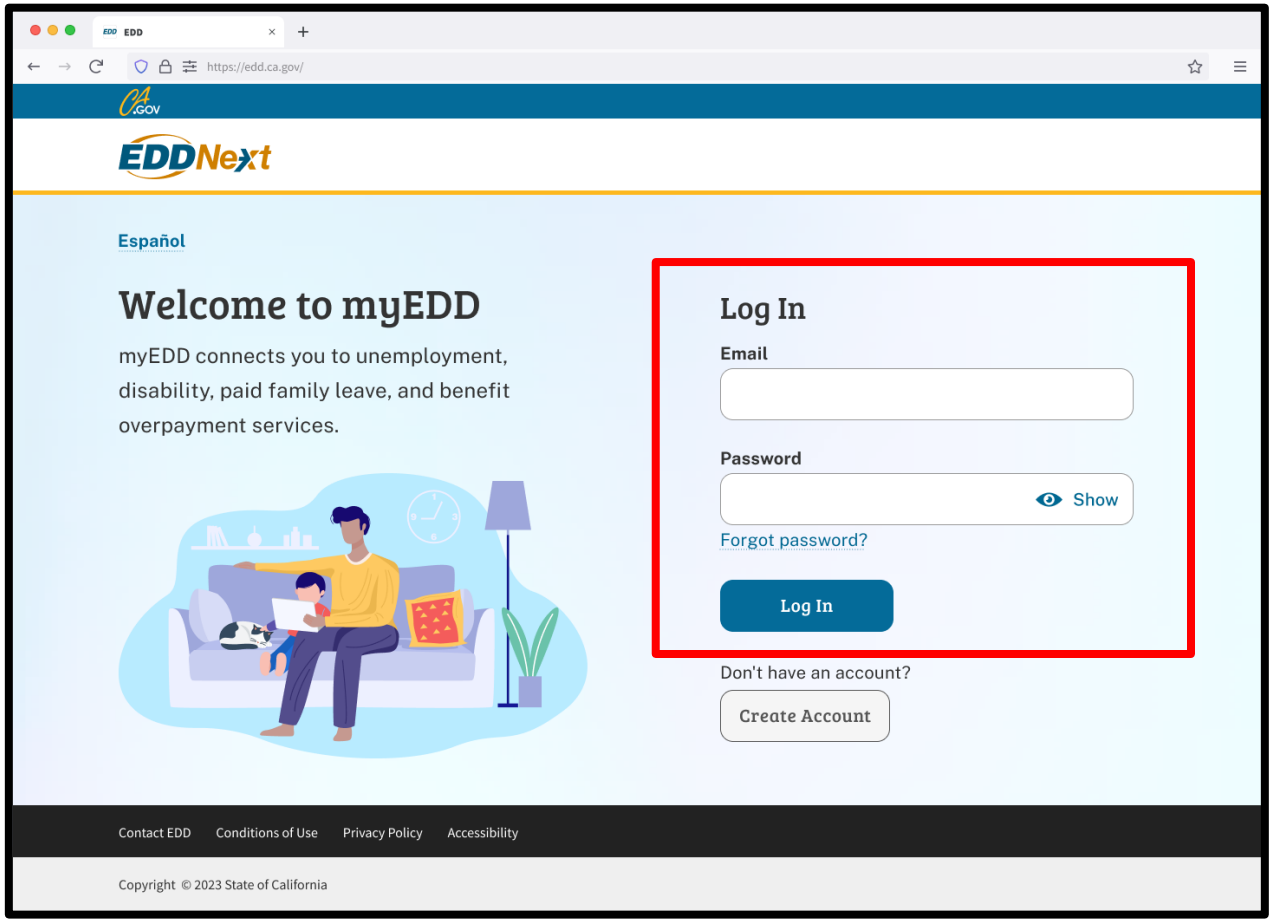
You may also give your **Receipt Number** to your care recipient's physician/practitioner to submit the medical certificate using SDI Online. Ask the physician/practitioner about how they submit a claim. Some submit them differently than others.

Employment Development Department
State of California

File a Military Assist Claim

For individuals participating in a qualifying event because of a family member's military deployment to a foreign country.

Get Started

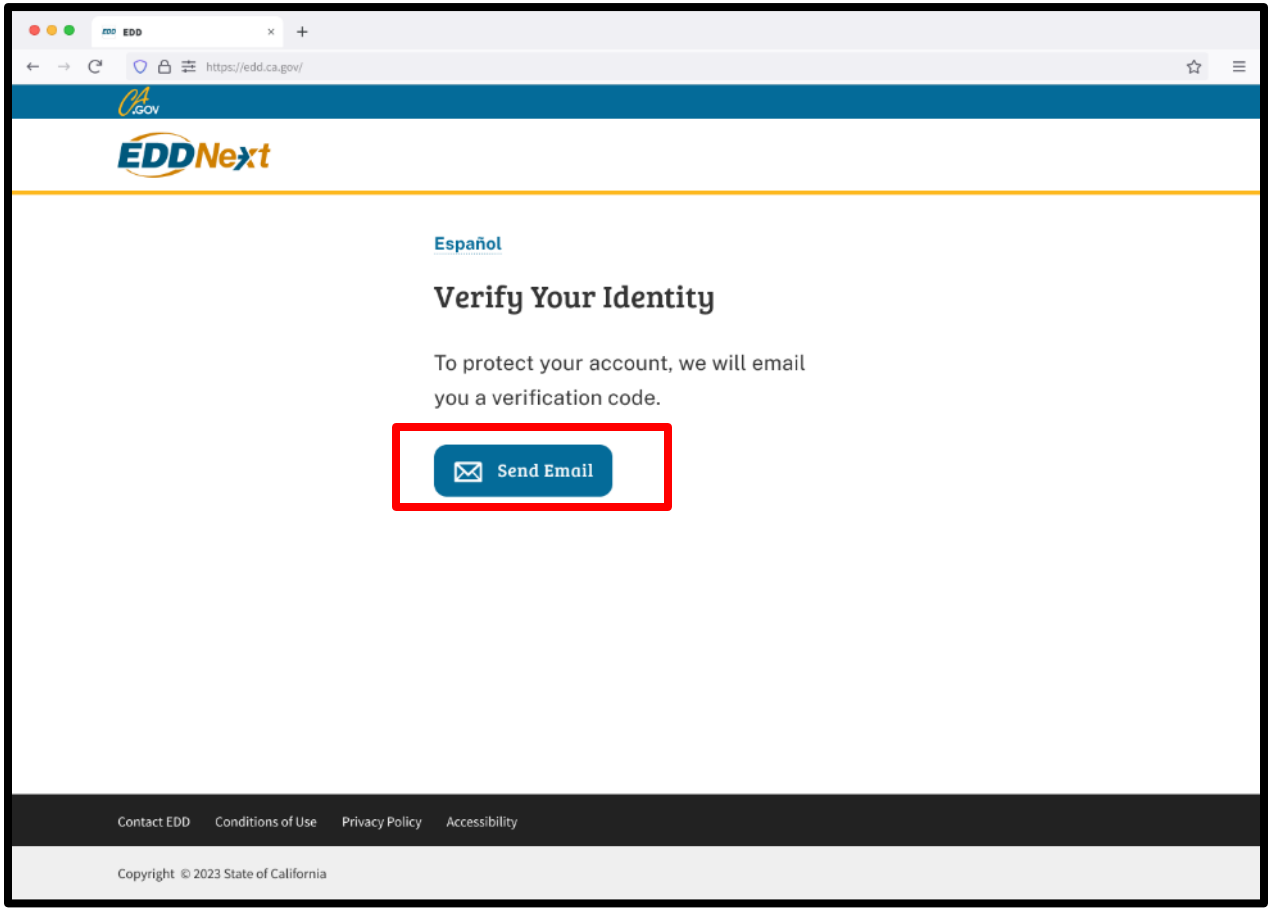


Note

For Spanish, select **Español**.

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

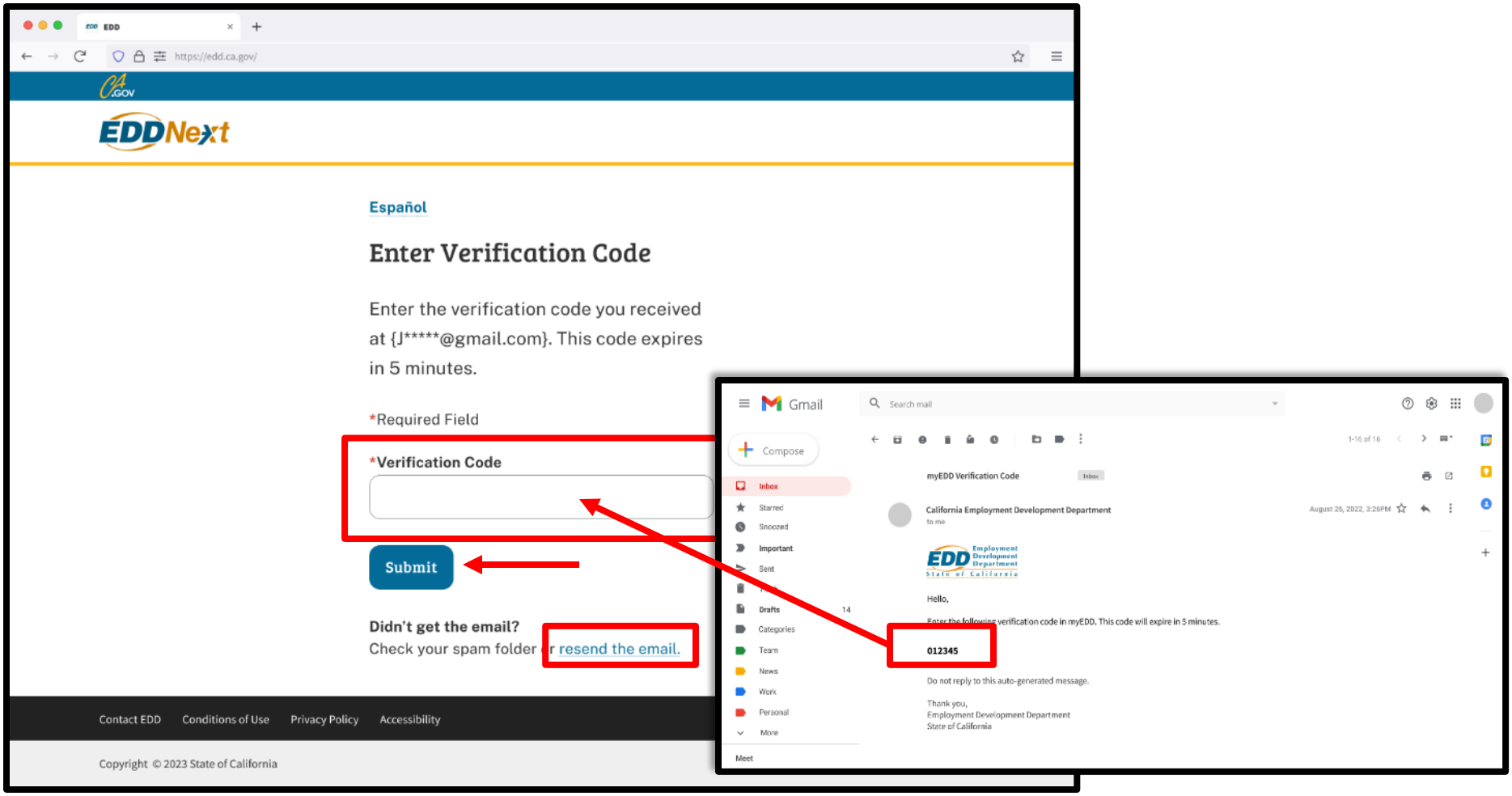
1. Visit myEDD.
2. Enter the email and password used to create your myEDD account.
3. Select **Log In**.



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.

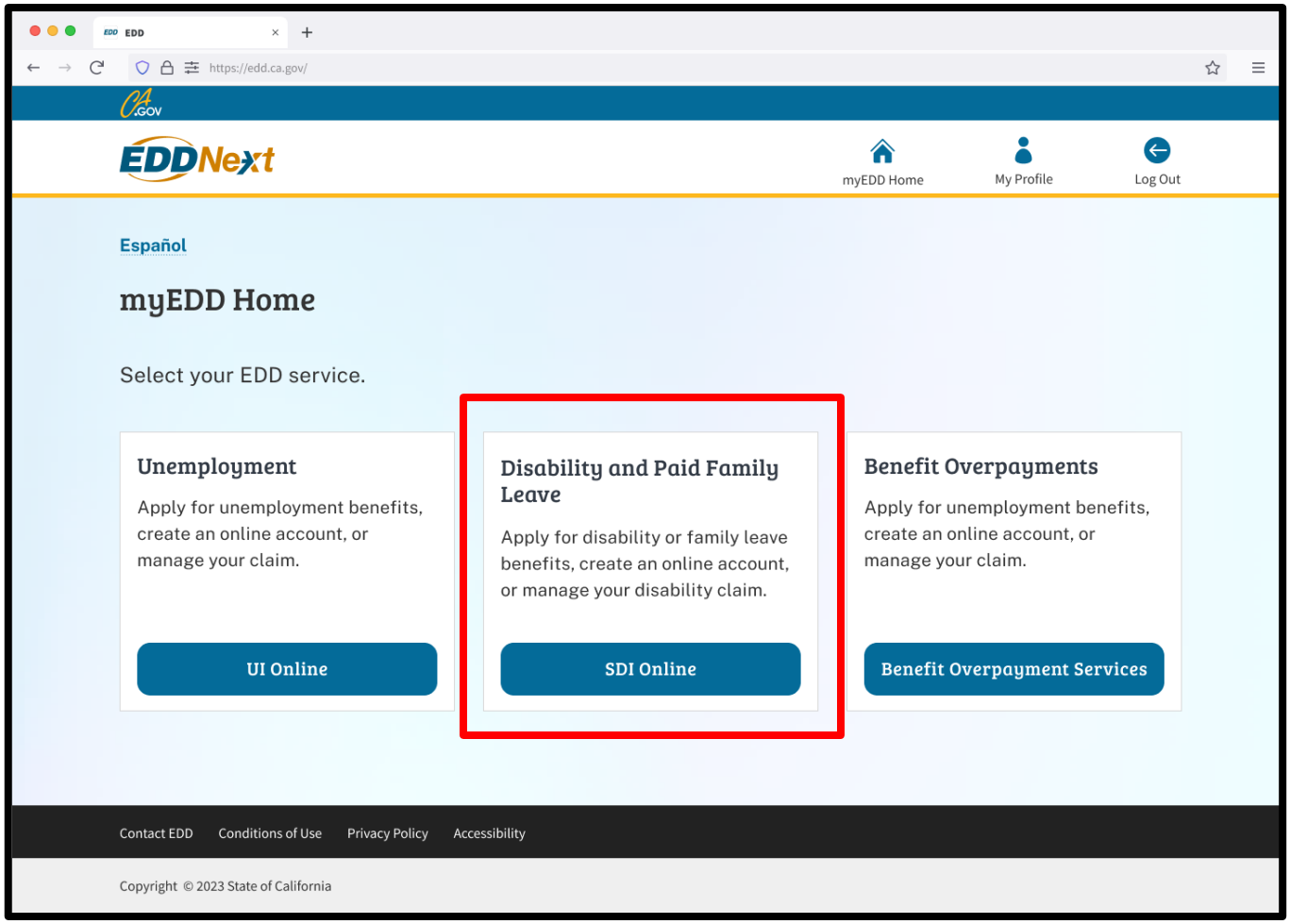
Select **Send Email**.

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.

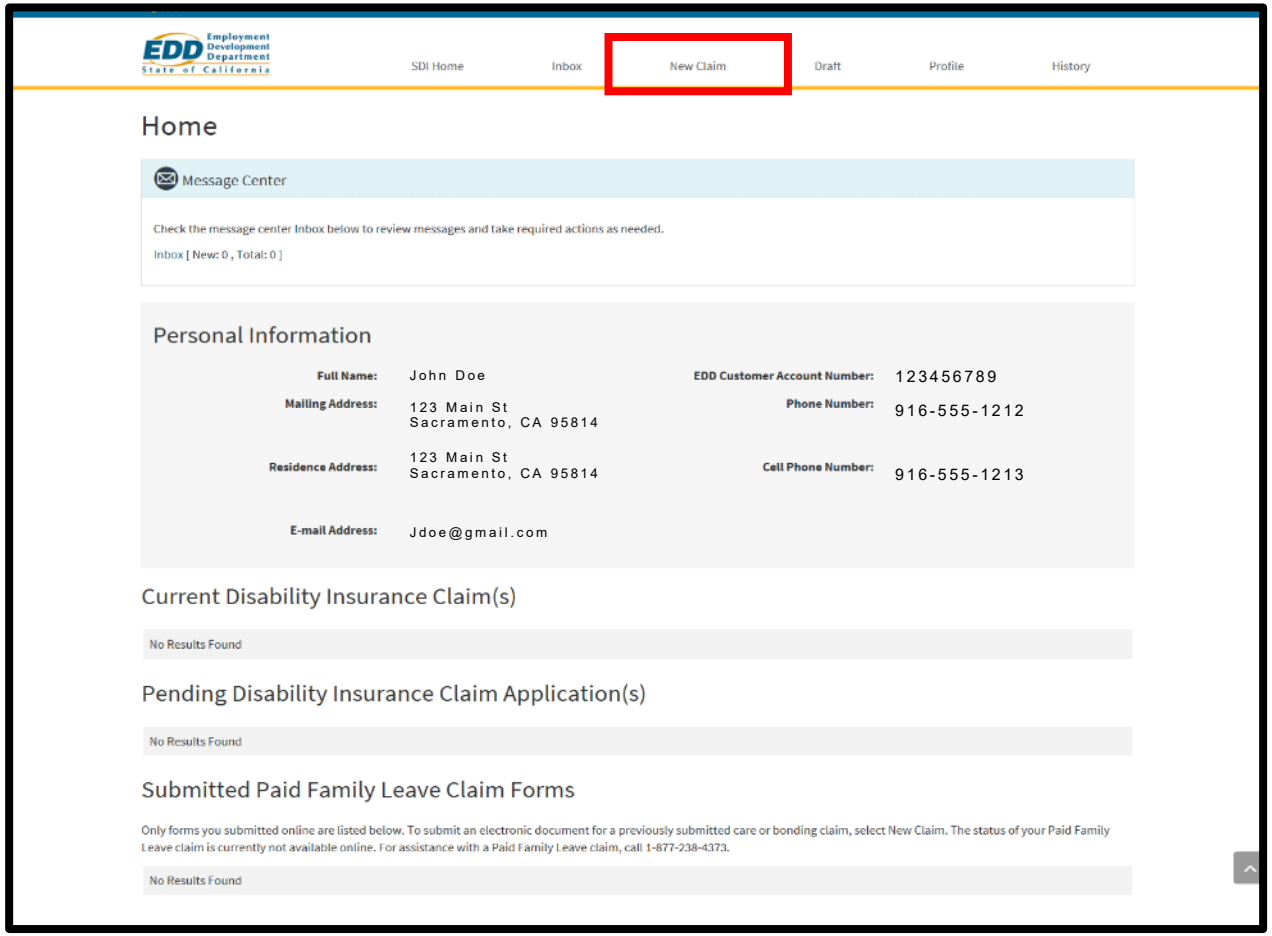
- Enter your verification code and select **Submit**.
- Select **resend the email** if you do not get a code.



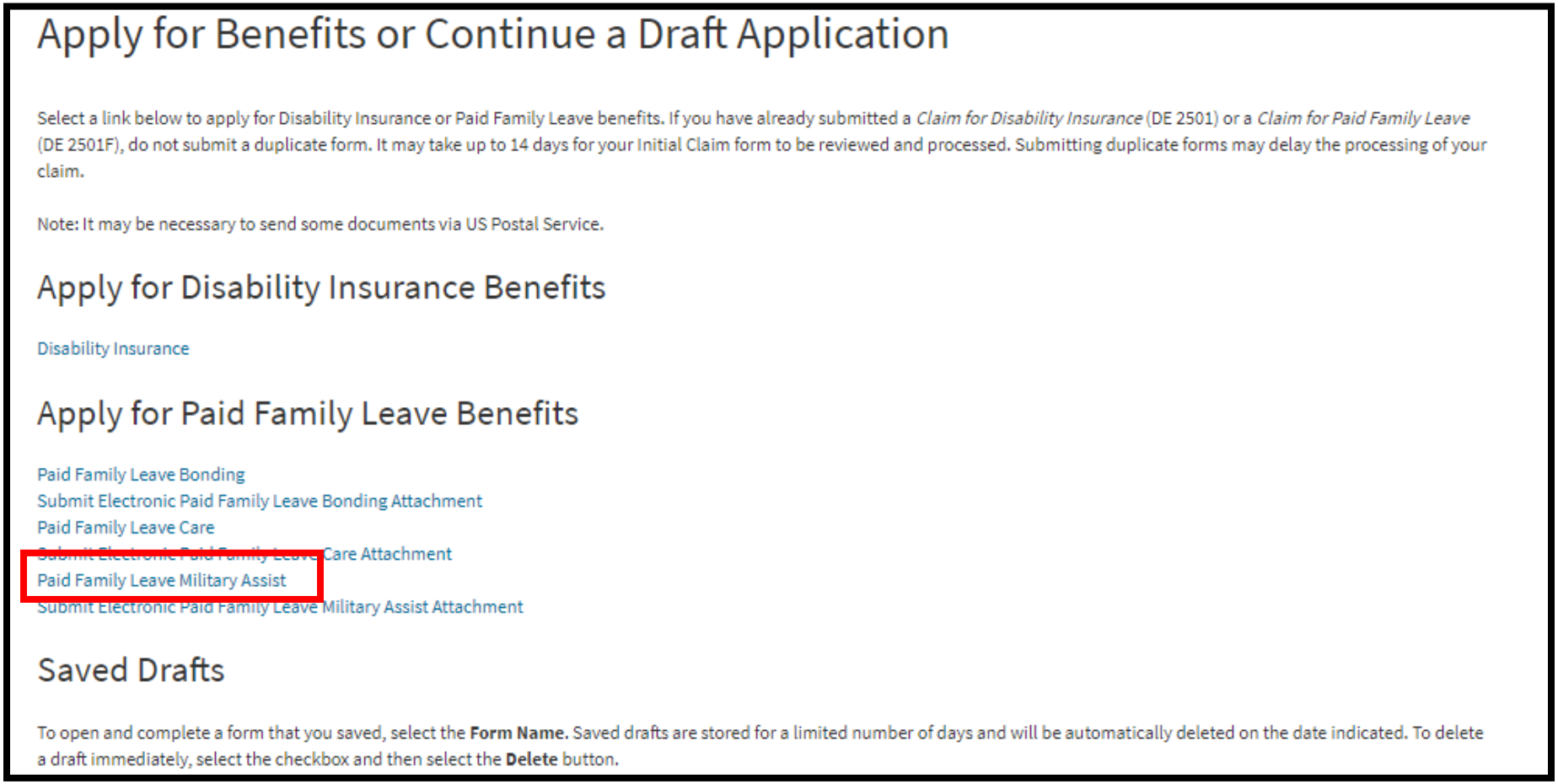
Note

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

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

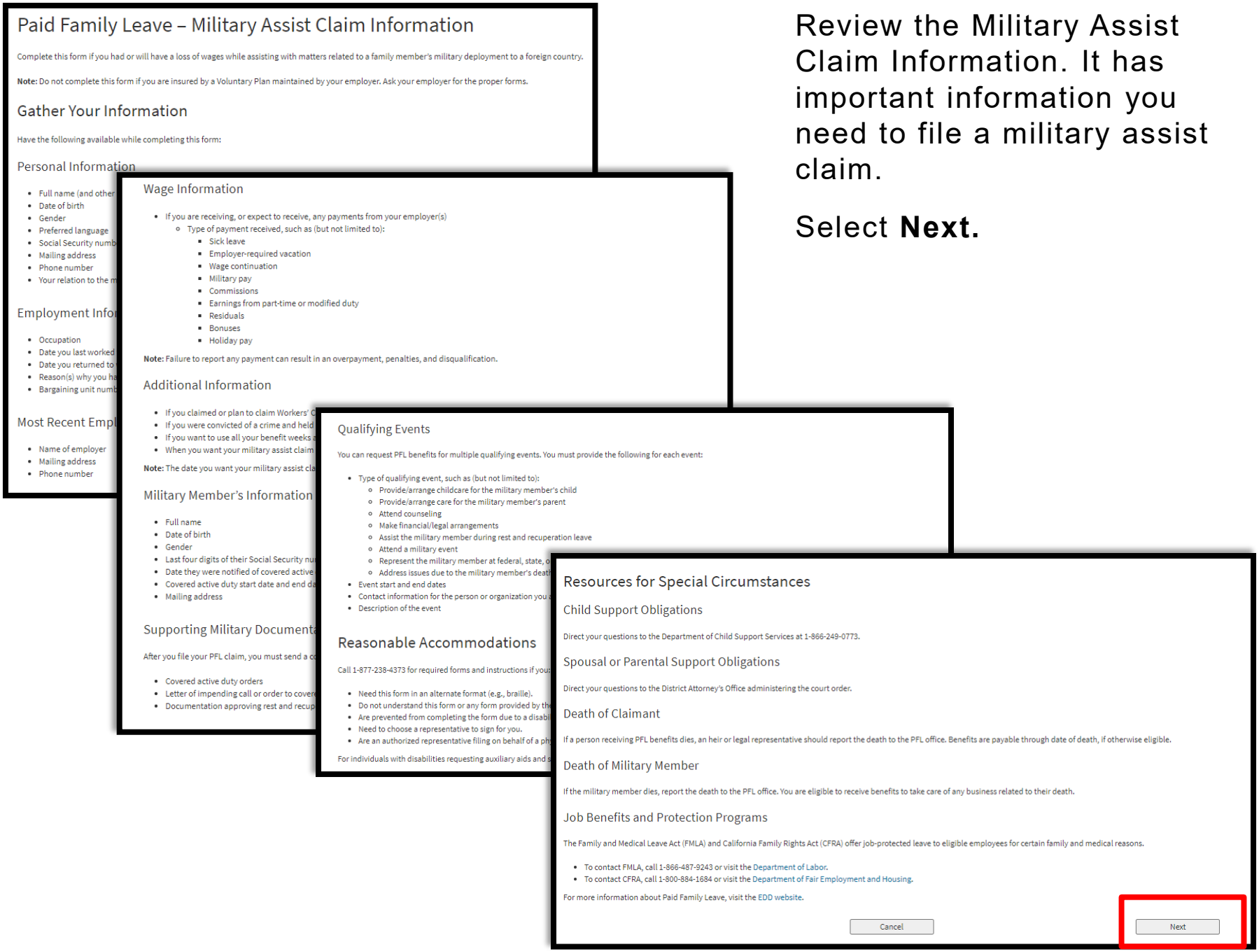


Select **New Claim** from the main menu.



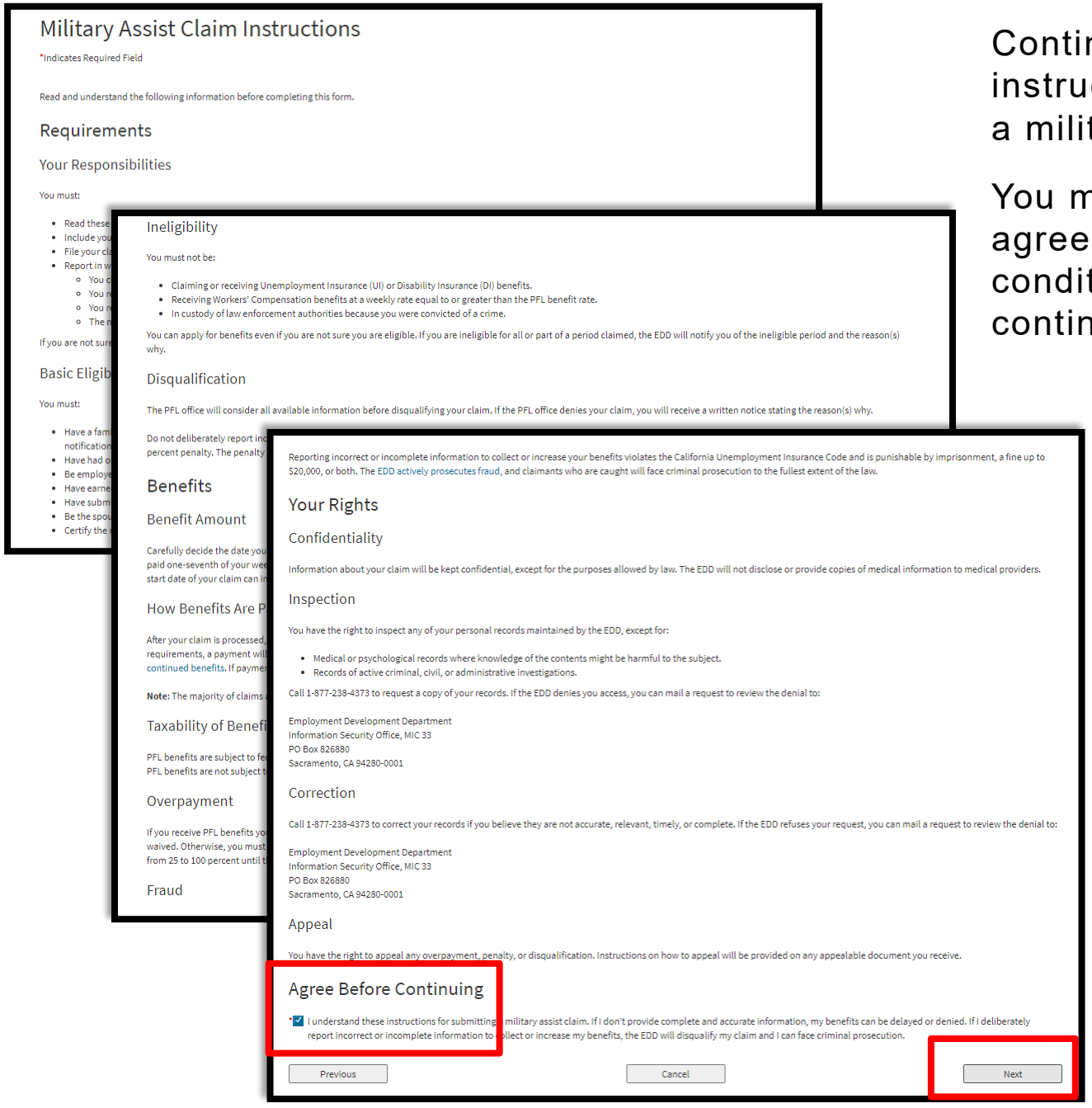
Select **Paid Family Leave Military Assist** under Apply for Paid Family Leave Benefits.

If unsure which application to complete, review the Types of Claims.



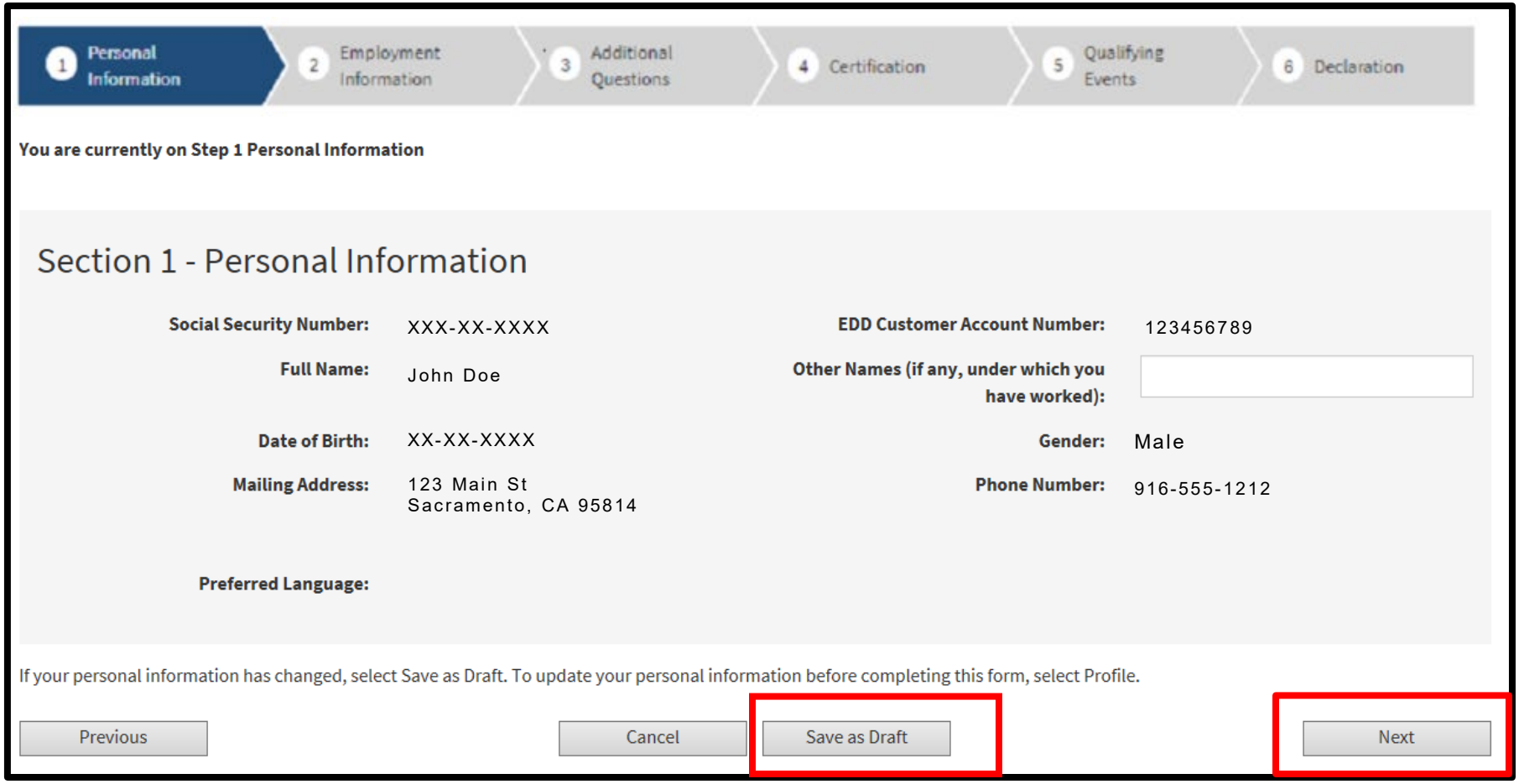
Review the Military Assist Claim Information. It has important information you need to file a military assist claim.

Select **Next.**



Continue to review the instructions on how to file a military assist claim.

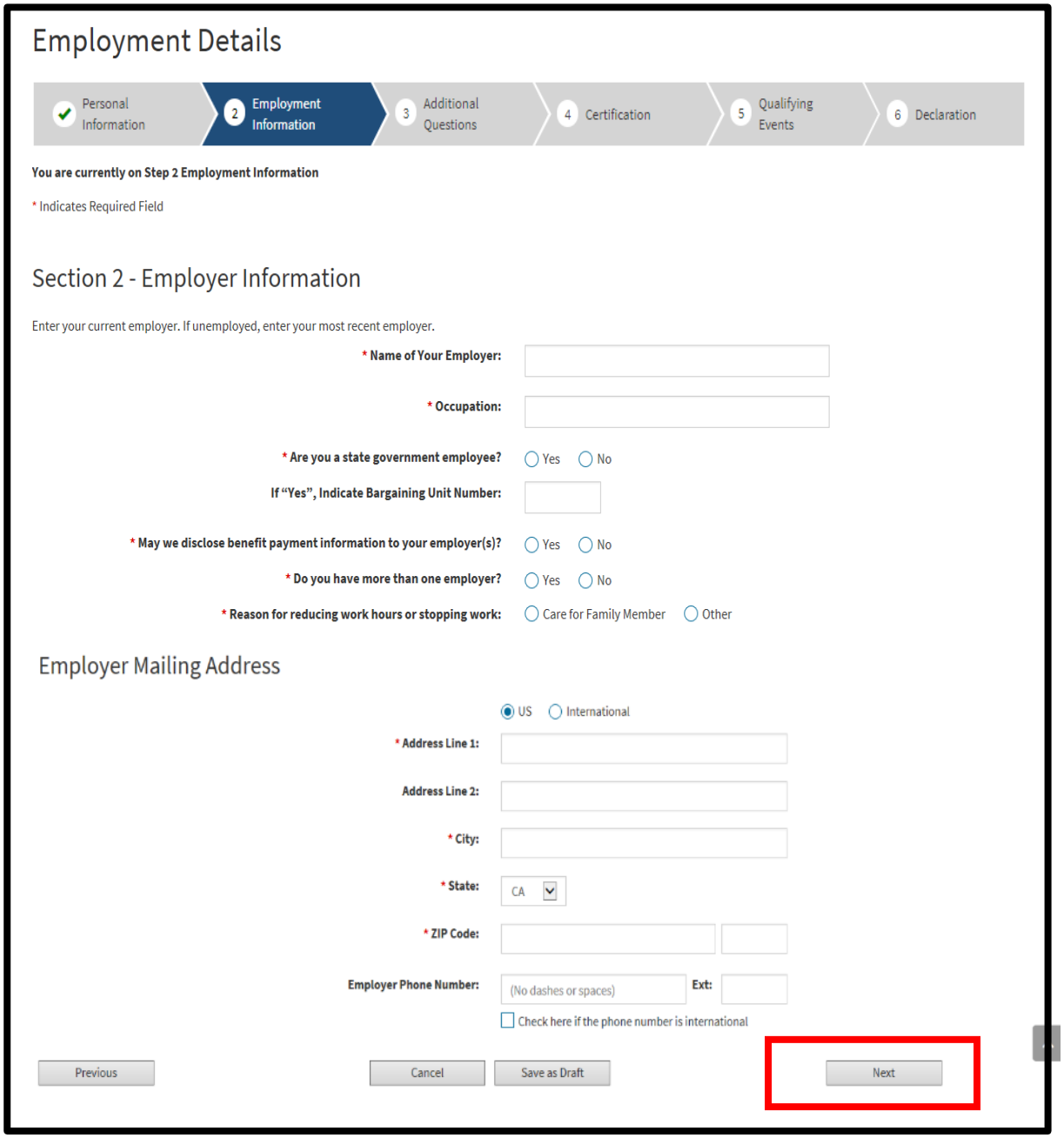
You must check the box to agree to our terms and conditions. Select **Next** to continue.



The system automatically fills certain portions of the claim form.

Make sure the information is correct. If your personal information has changed, select **Save as Draft** and update your SDI Online profile.

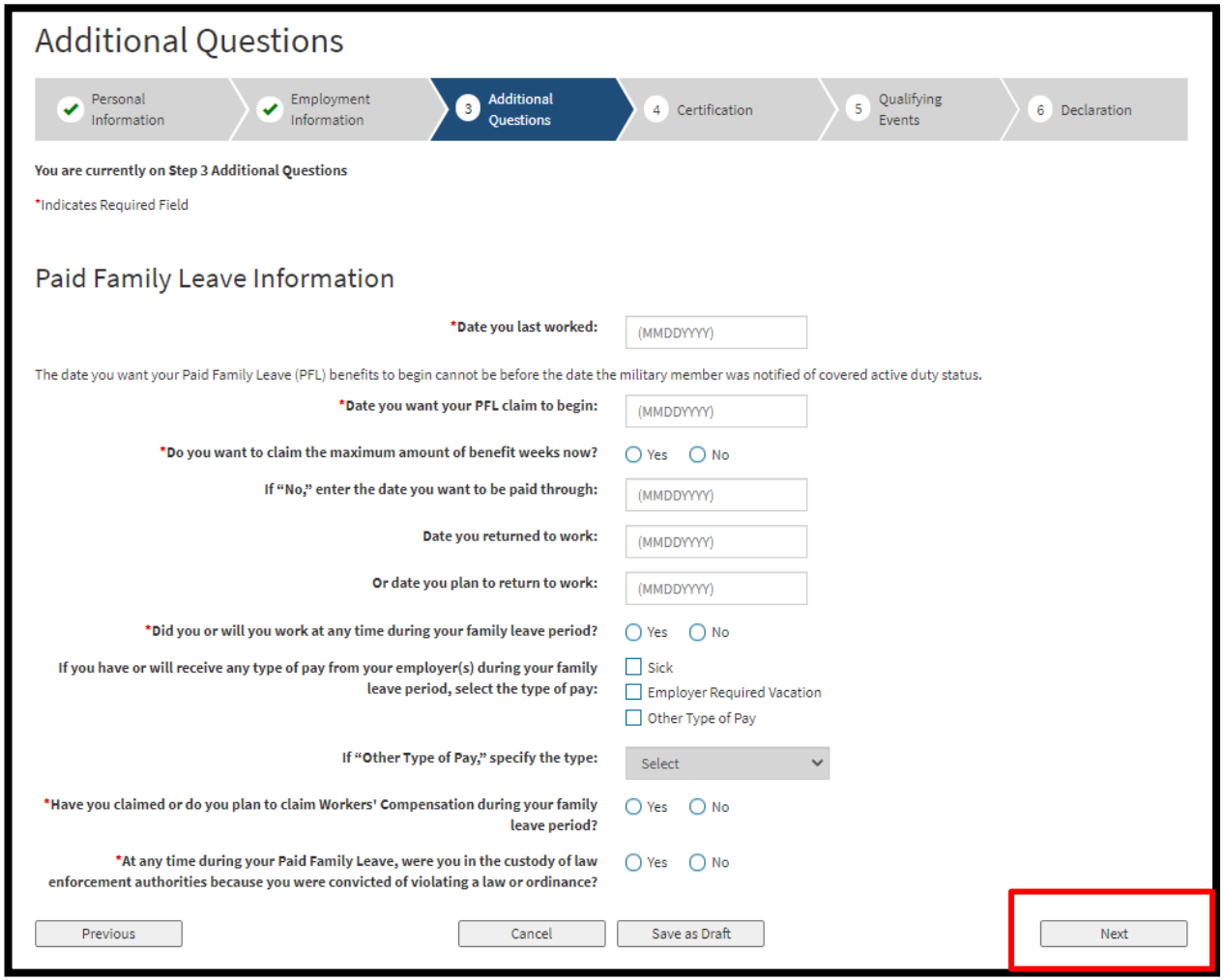
Select **Next** to continue.



Complete Section 2 - Employer Information with your current employer's business name, phone number, and mailing address as shown on your W-2 or paystub. If you are unsure what address to enter, ask your employer.

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

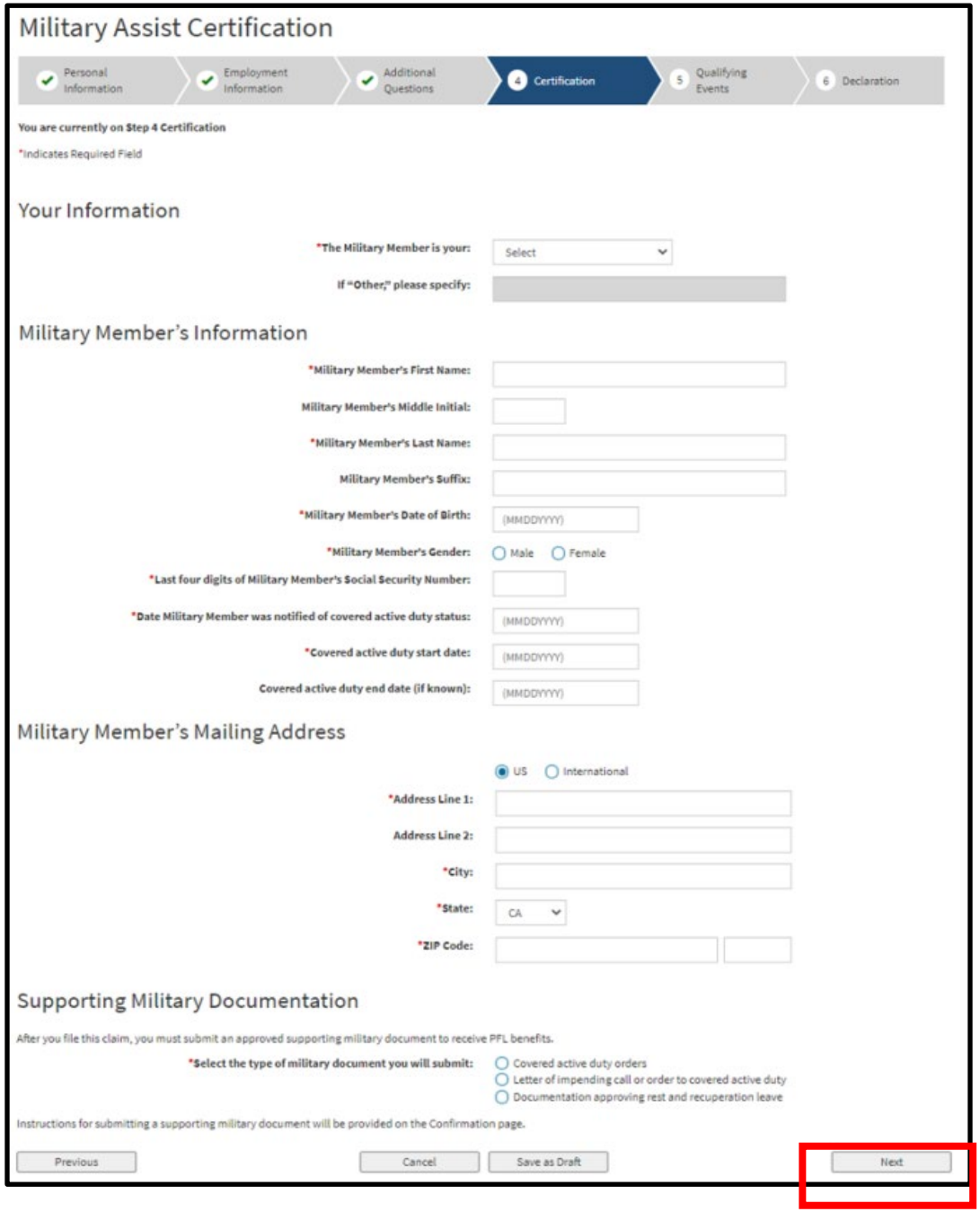
Select **Next**.



Complete the Paid Family Leave Information section and make sure all dates are correct to avoid a delay or incorrect payment of benefits.

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

Select **Next**.



Complete the following sections:

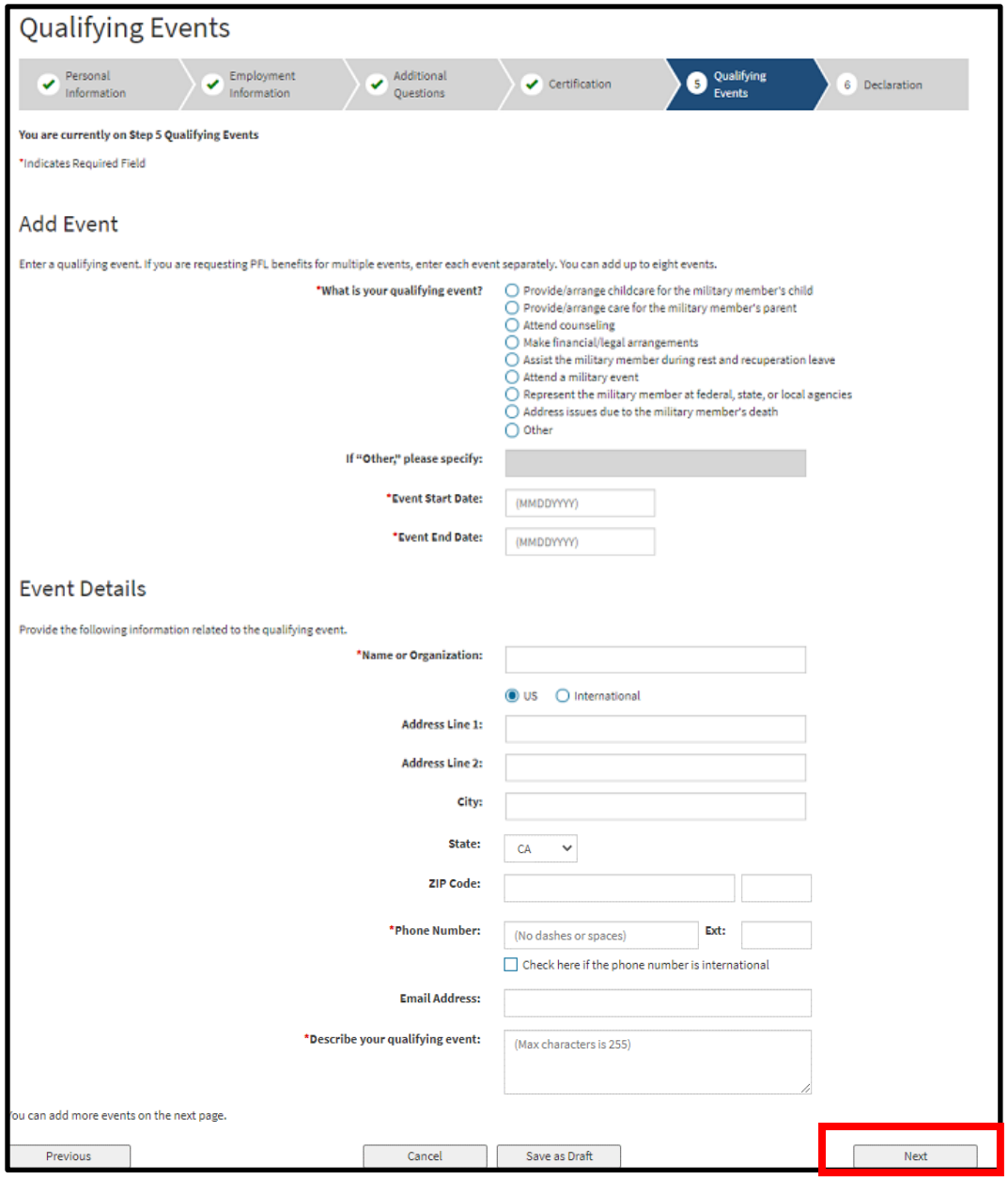
- Your Information
- Military Member's Information
- Military Member's Mailing Address
- Supporting Military Documentation

Make sure the information you enter is about the military member you are assisting.

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

Instructions on how to submit supporting military documentation are available on the Confirmation screen.

Select **Next**.



Complete the following sections:

- Add Event
- Event Details

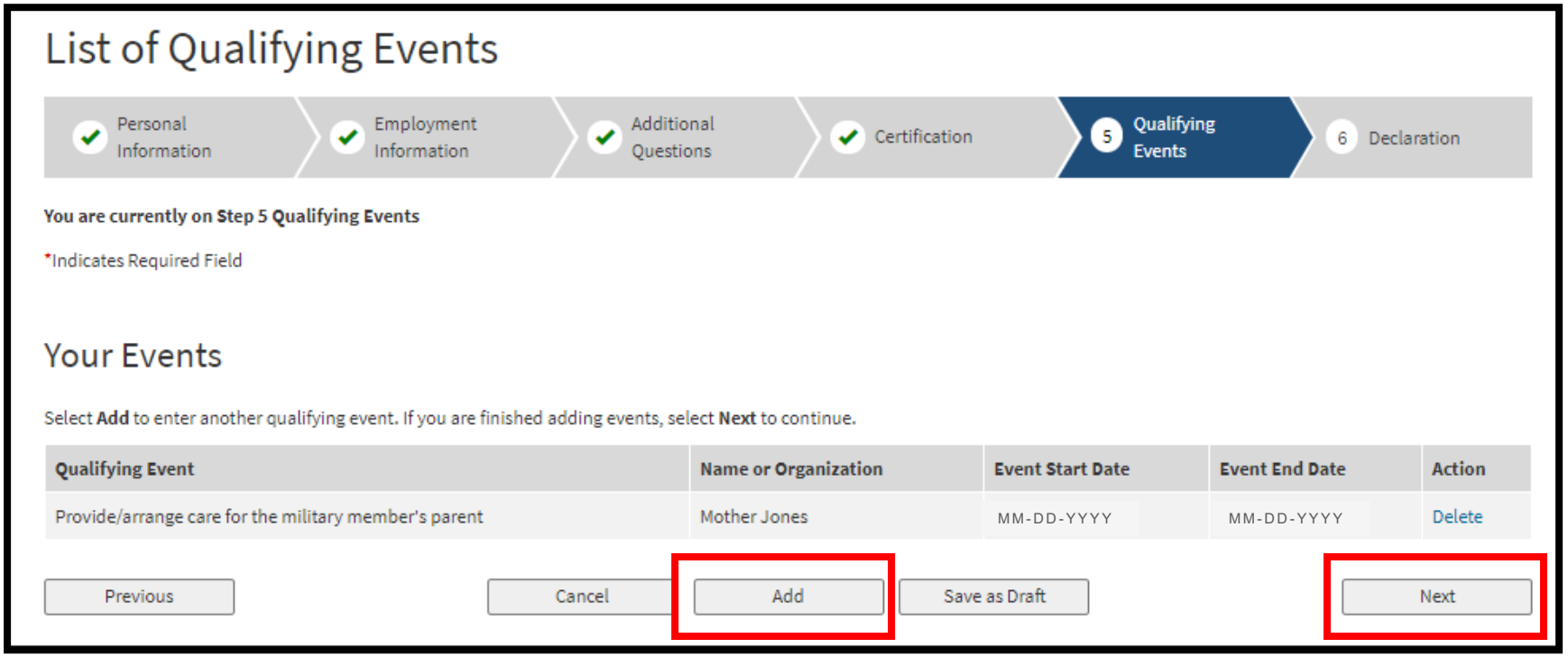
Make sure you enter information about the qualifying event you attend.

If requesting military assist benefits for multiple events:

- Enter each event separately.
- You can add up to eight events.
- Instructions to add additional events are located on the next page.

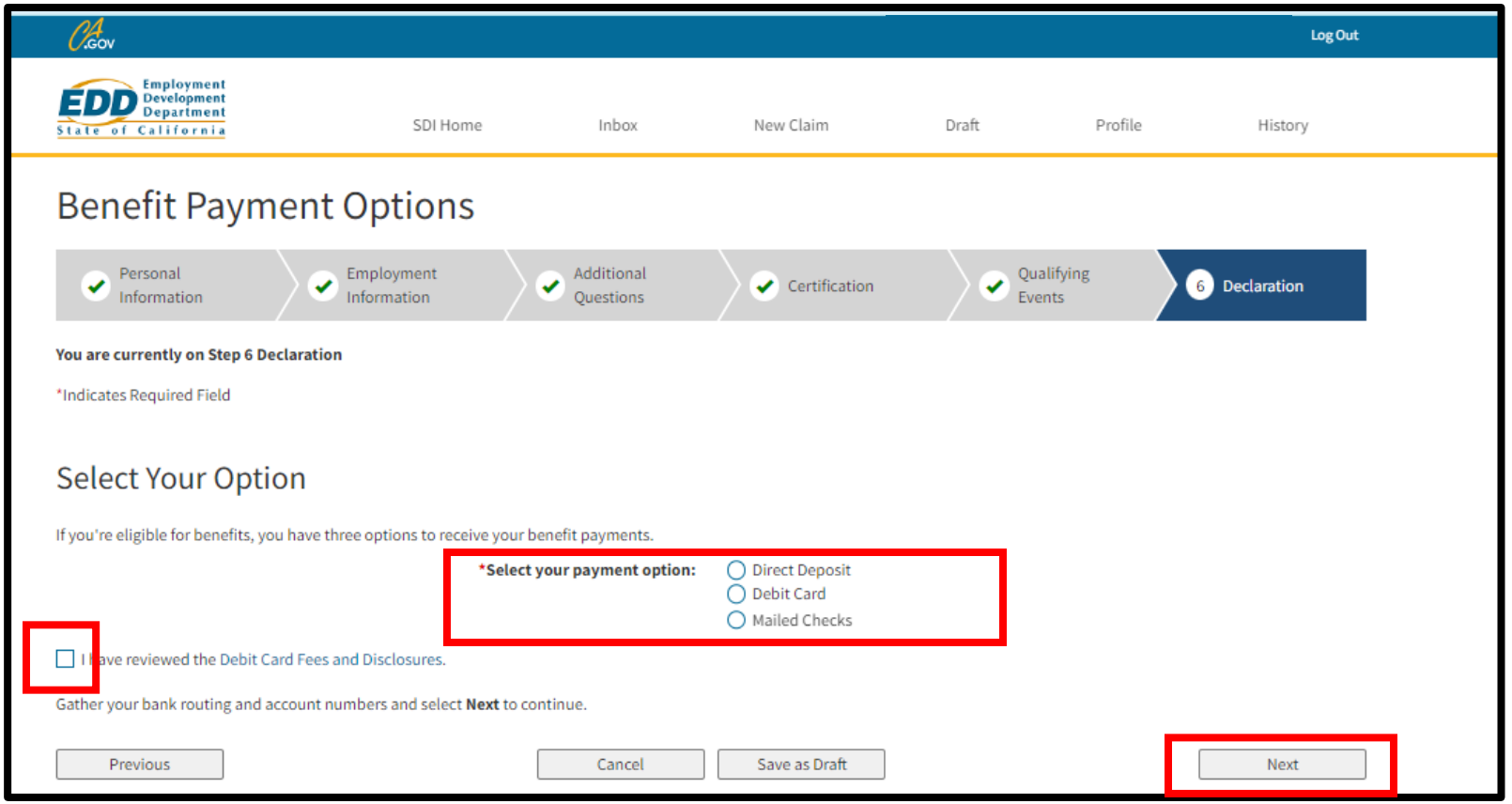
You must complete the fields marked with a red asterisk (*).

Select **Next** to continue.



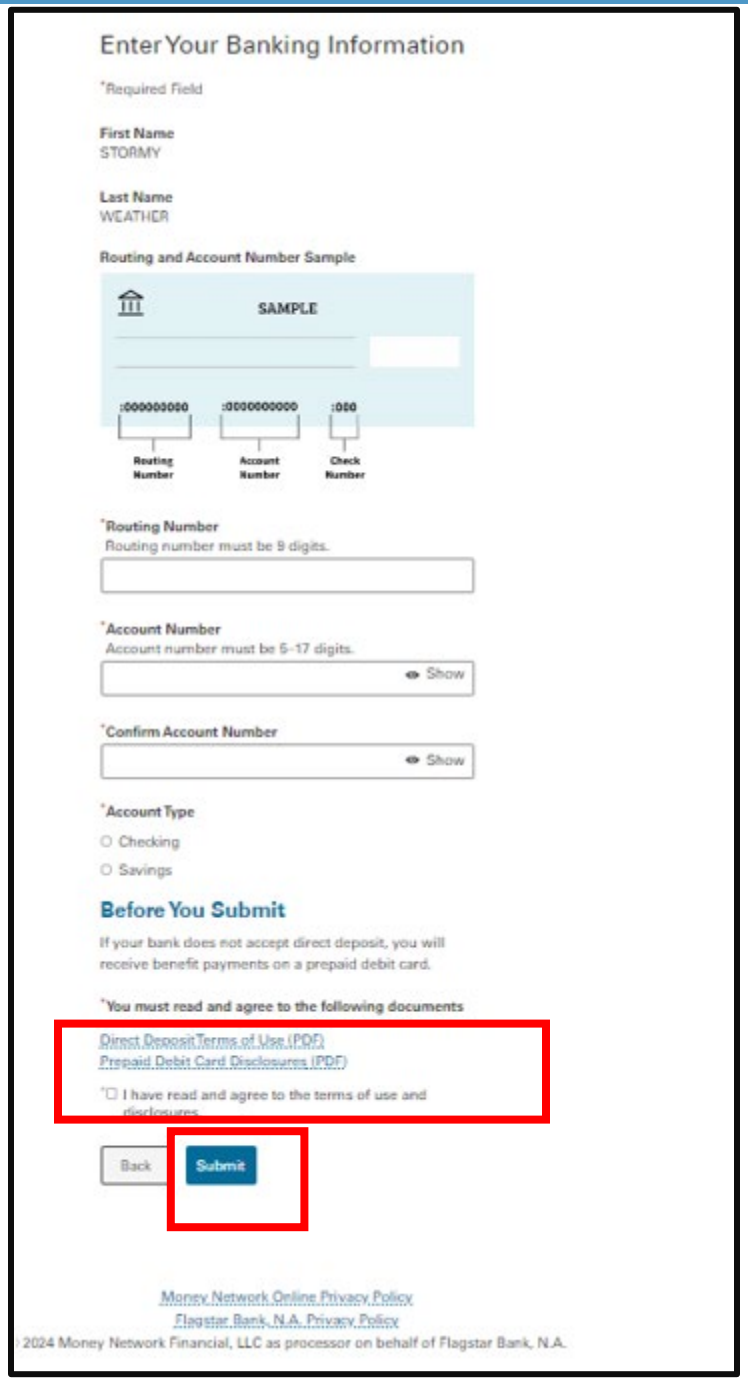
To add more than one event:

- Select **Add** and enter the event information.
- Select **Next** once all events have been added.



On the Benefit Payment Options screen, choose your benefit payment option.

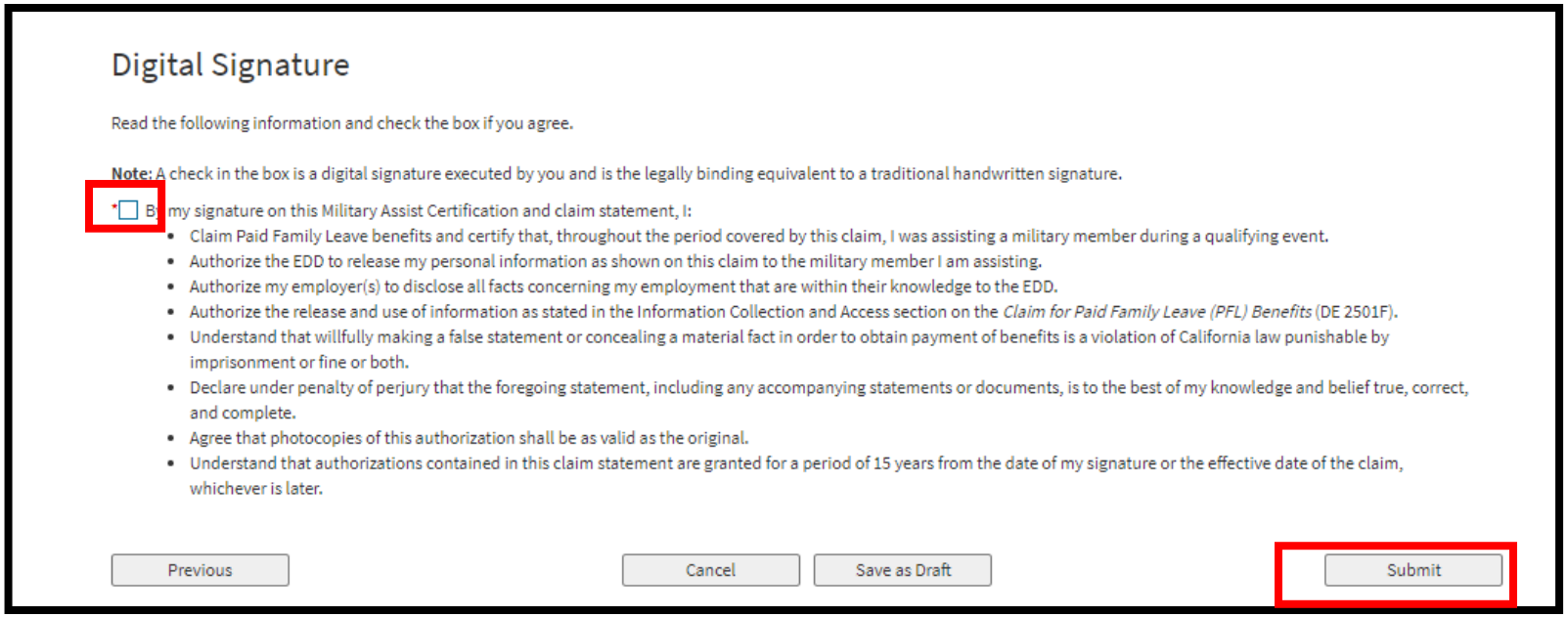
Select the **"I have reviewed..."** box to confirm you have read the disclosures, then select Next.



If you selected Direct Deposit, you will be asked to provide your banking information.

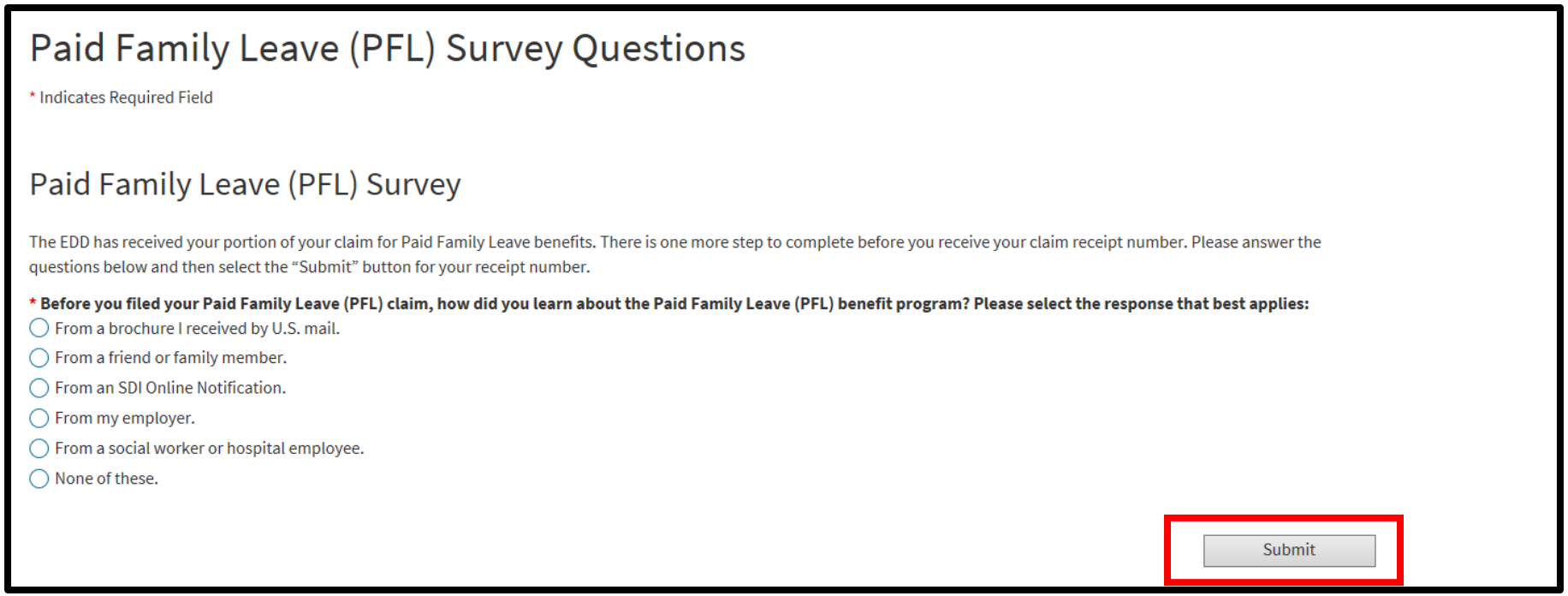
You must select and open the “terms of use” documents and disclosures before you can submit your information.

Select Submit to continue.

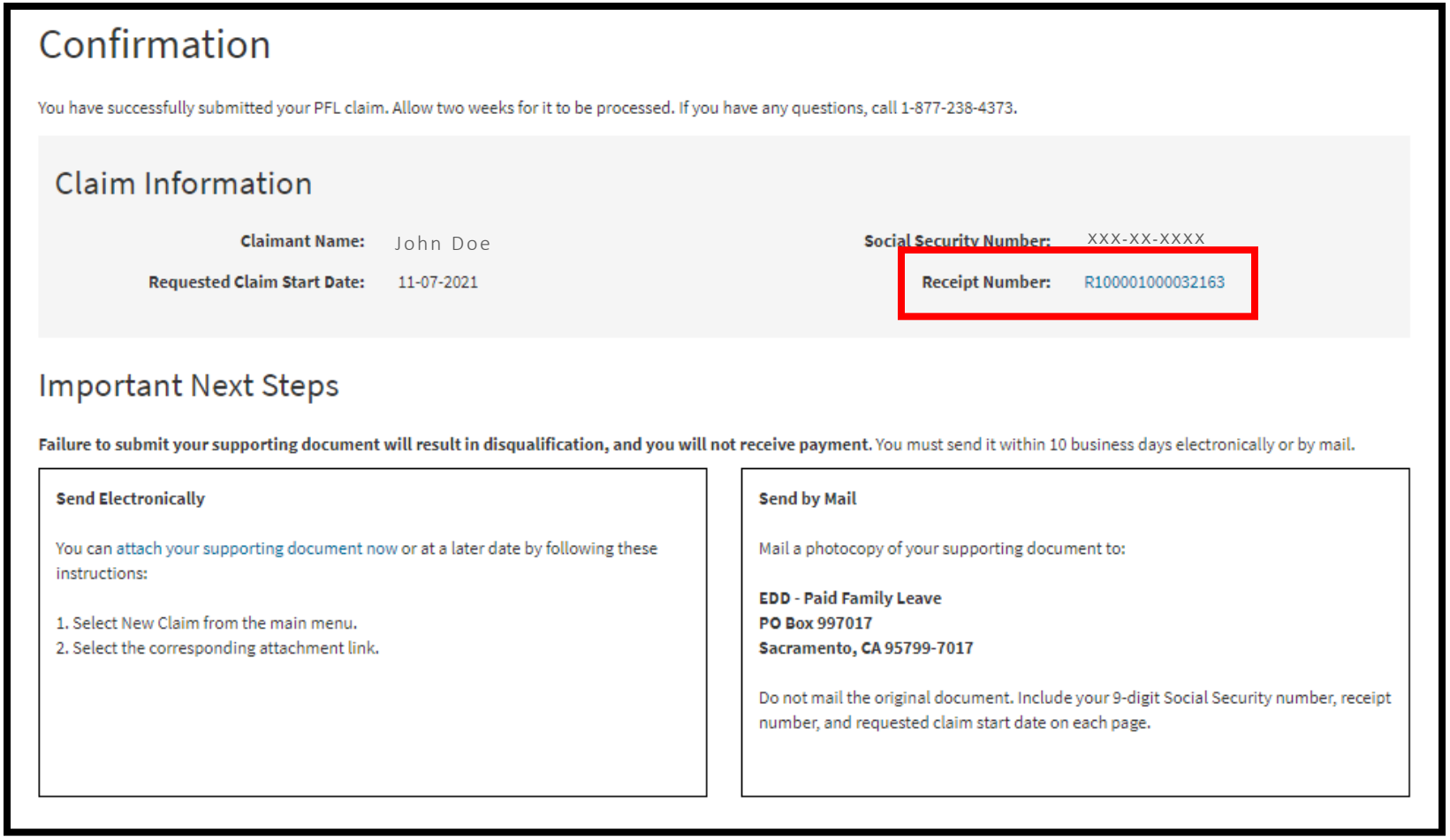


Next, select the box to acknowledge your digital signature.

Select **Submit** to continue.



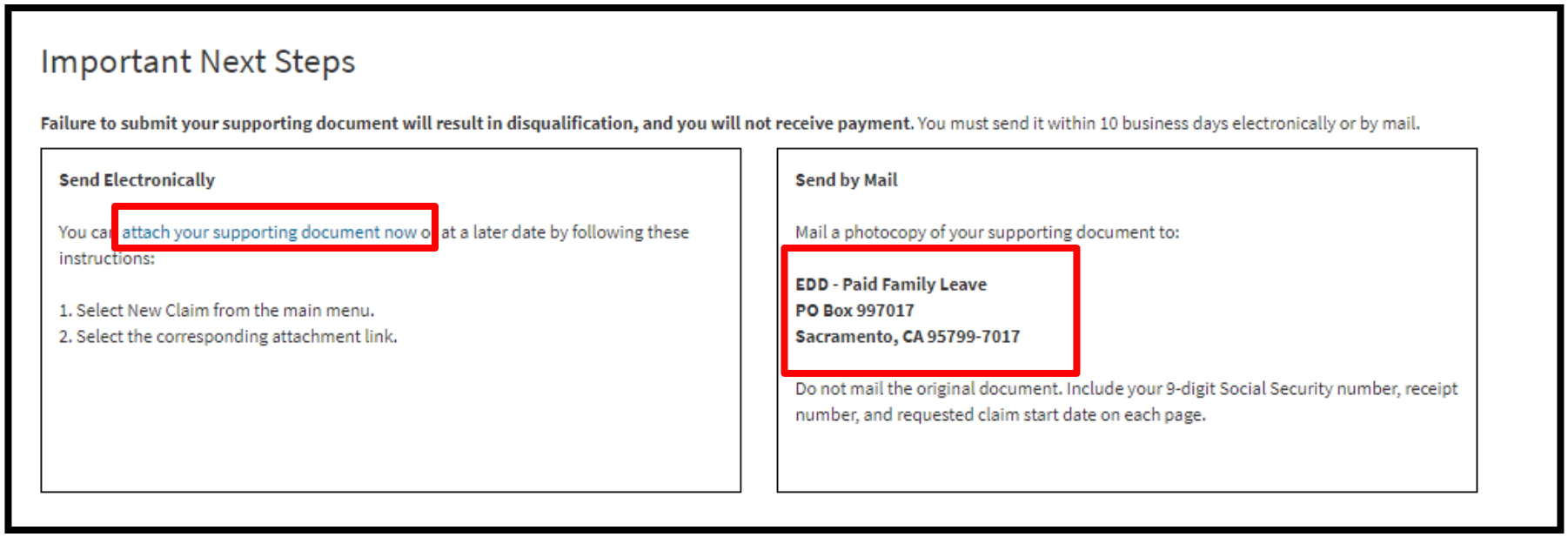
Complete the survey and select **Submit**.



We assign your claim a **Receipt Number** on the Confirmation screen.

Save the **Receipt Number.** You need this number to upload your supporting documentation to the correct online claim.

The Confirmation screen also gives you instructions on how to upload your documentation to your military assist claim.



To complete your military assist claim, you must send us your supporting military documentation and documentation of the qualifying event within 10 days.

To submit your documentation online:

- Select **attach your supporting document now**.
- Use the Submit Supporting Military Assist Claim Documents section of this tutorial for instructions.

To submit your documentation by mail:

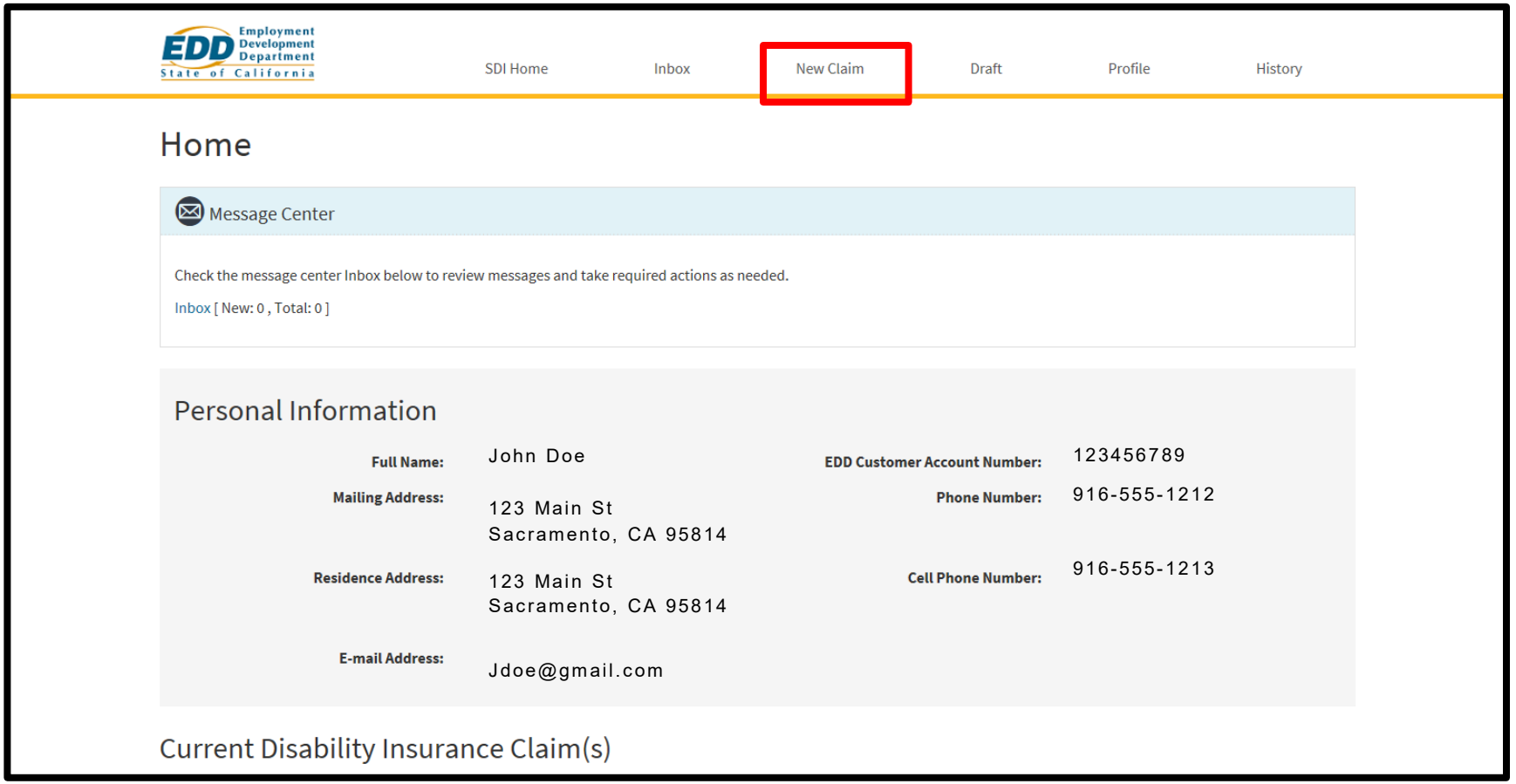
- Send copies of your supporting military documentation and documentation of the qualifying event to the address on the screen.
- Do not mail the original documents. Include your nine-digit Social Security number, Receipt Number, and the date you want your claim to start on each page.

Employment Development Department
State of California

Submit Supporting Military Assist Claim Documents

Learn more about how to submit supporting documents to complete your claim for military assist benefits.

Get Started

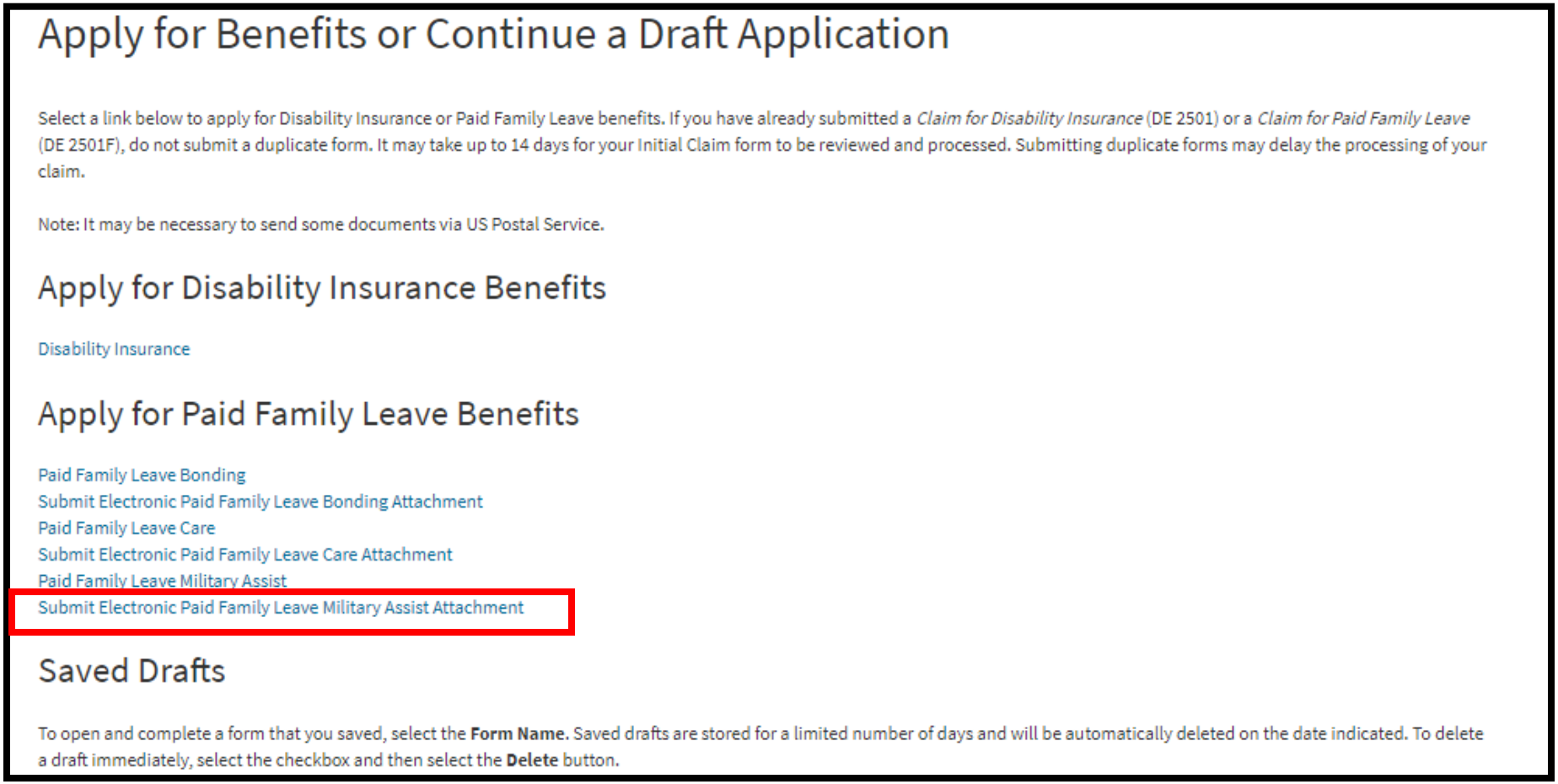


To upload the military documentation and documentation of the qualifying event we need for your online claim:

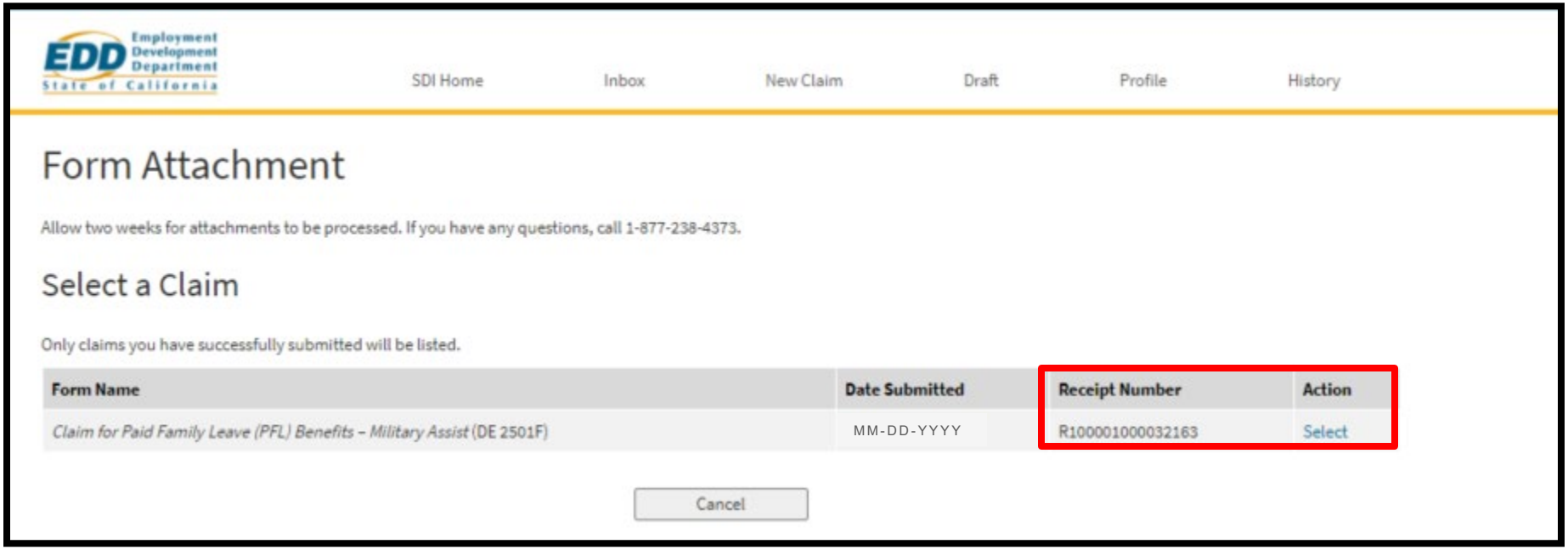
- Return to your homepage.
- Select **New Claim** from the main menu.

Important

You must send us these documents within 10 days from the date you filed your claim.

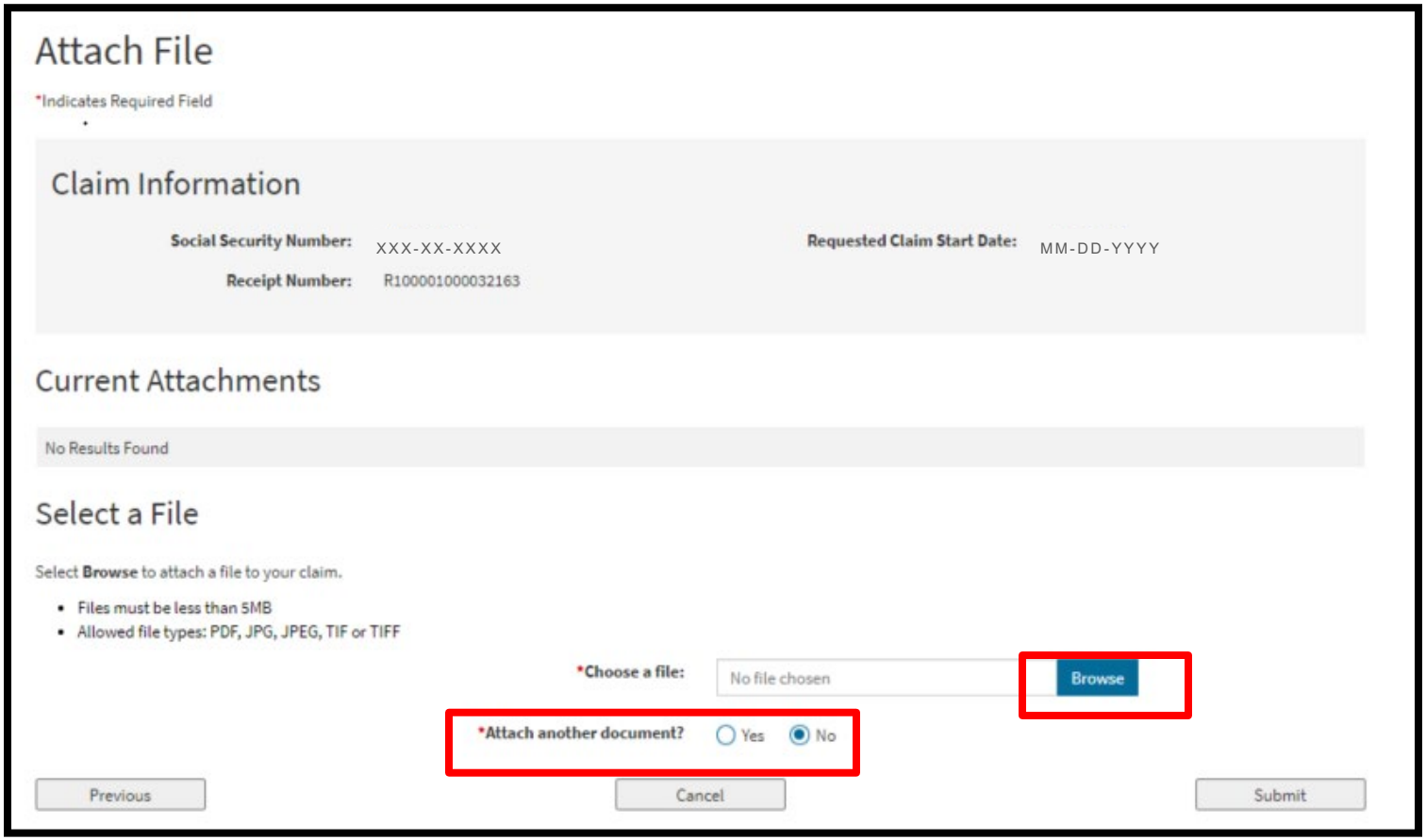


Select **Submit Electronic Paid Family Leave Military Assist Attachment** under Apply for Paid Family Leave Benefits.



Make sure the **Receipt Number** on the screen matches the number you got when you filed the online portion of the claim.

If it matches, choose **Select** from the Action column to attach a document to your claim.



Note

To upload a document, save the document to your computer or phone as a PDF, JPG, JPEG, TIF, or TIFF file. All file sizes must be 5MB or less.

Select **Browse** to upload a document from your computer or phone.

To upload another document, select **Yes** to “Attach another document?” and then select **Submit**. This sends you back to the Attachment screen to continue uploading documents.

When you are done uploading your documents, select **No** to “Attach another document?” and then select **Submit.**

The Attachment Confirmation screen confirms the attachment was submitted.

Save the **Receipt Number** for future reference.

Your military assist claim is complete when you send us the supporting military documentation and documentation of the qualifying event. Allow at least 14 days for the claim to process.

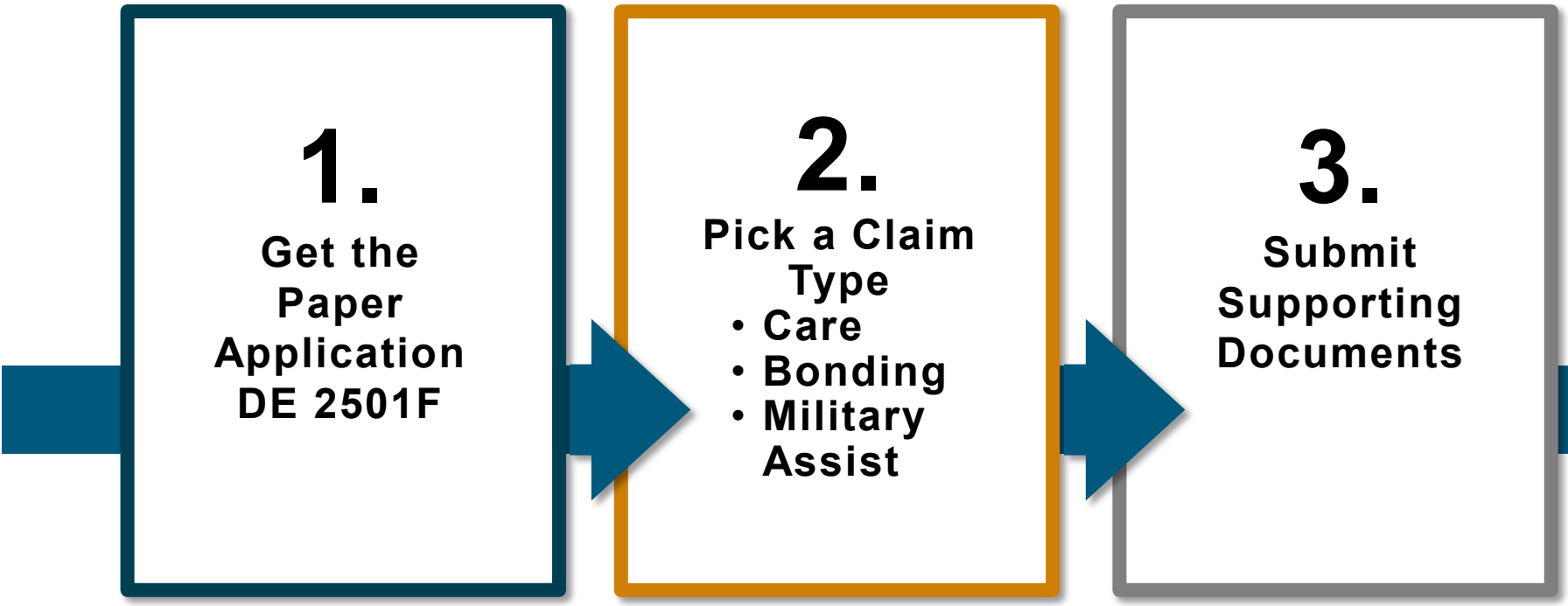
EDD Employment Development Department
State of California

Complete Paper Claim Forms

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

Get Started

How to file a PFL claim



Important

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

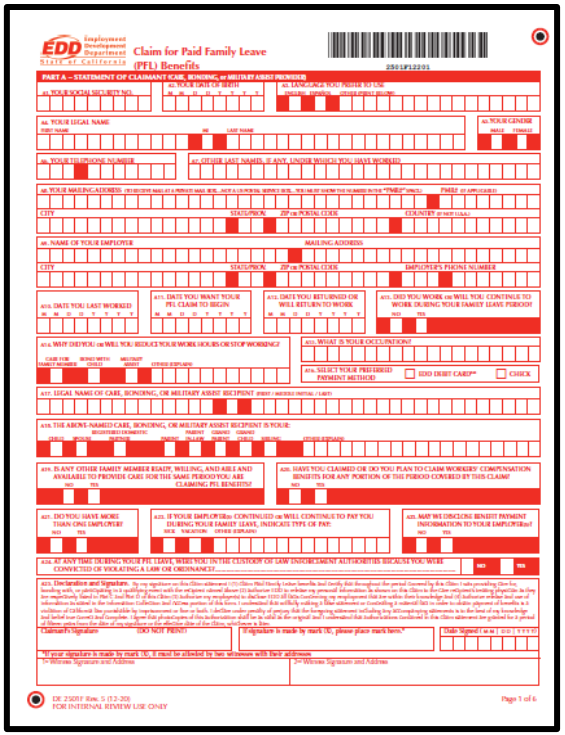
Get the *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F)

- Order a form online to have it mailed to you.
- Visit an SDI Office.
- Call 1-877-238-4373 to request a paper form be mailed to you.
- Get the form from your licensed health professional or employer.

It may take up to 10 days to get 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.


EDD Employment Development Department State of California

Claim for Paid Family Leave (PFL) Benefits

2501F12201

PART A – STATEMENT OF CLAIMANT CARE, BONDING, or MILITARY ASSIST PROVIDER

DE 2501F Rev. 5 (12-20)
FOR INTERNAL REVIEW USE ONLY

Page 1 of 6

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

Complete and review your portion of the DE 2501F form

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

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.

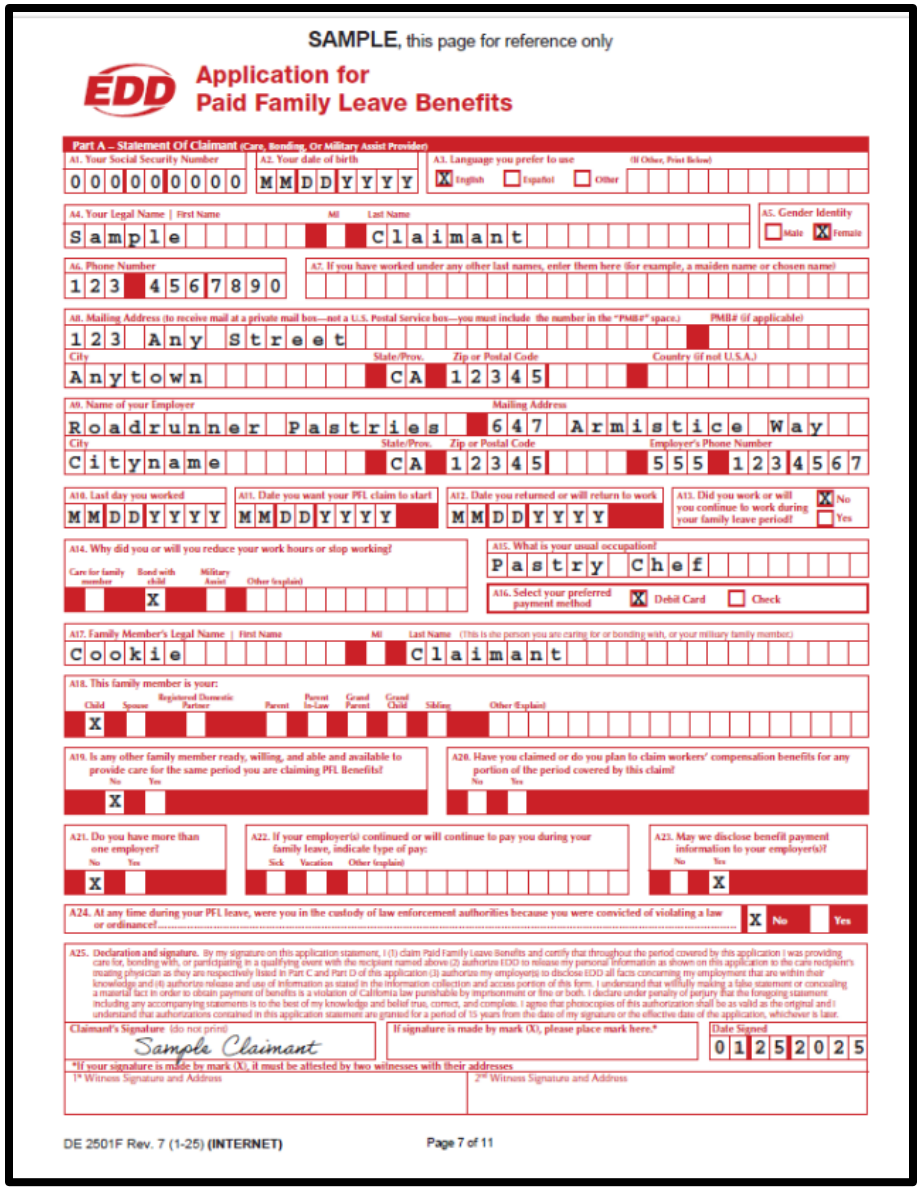
Claim for Paid Family Leave (PFL) Benefits (DE 2501F) - Page 1

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

EDD Application for Paid Family Leave Benefits

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

A1. Your Social Security Number: 000000000
A2. Your date of birth: MM DD YYYY
A3. Language you prefer to use: [X] English [ ] Español [ ] Other
A4. Your Legal Name | First Name: Sample | MI: | Last Name: Claimant
A5. Gender Identity: [ ] Male [X] Female
A6. Phone Number: 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: MM DD YYYY
A11. Date you want your PFL claim to start: MM DD YYYY
A12. Date you returned or will return to work: MM DD YYYY
A13. Did you work or will you continue to work during your family leave period? [X] No [ ] Yes
A14. Why did you or will you reduce your work hours or stop working? Care for family member | 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 2

Part B - Bonding Certification:

- If you are filing a bonding claim, you must complete this section and sign the form.

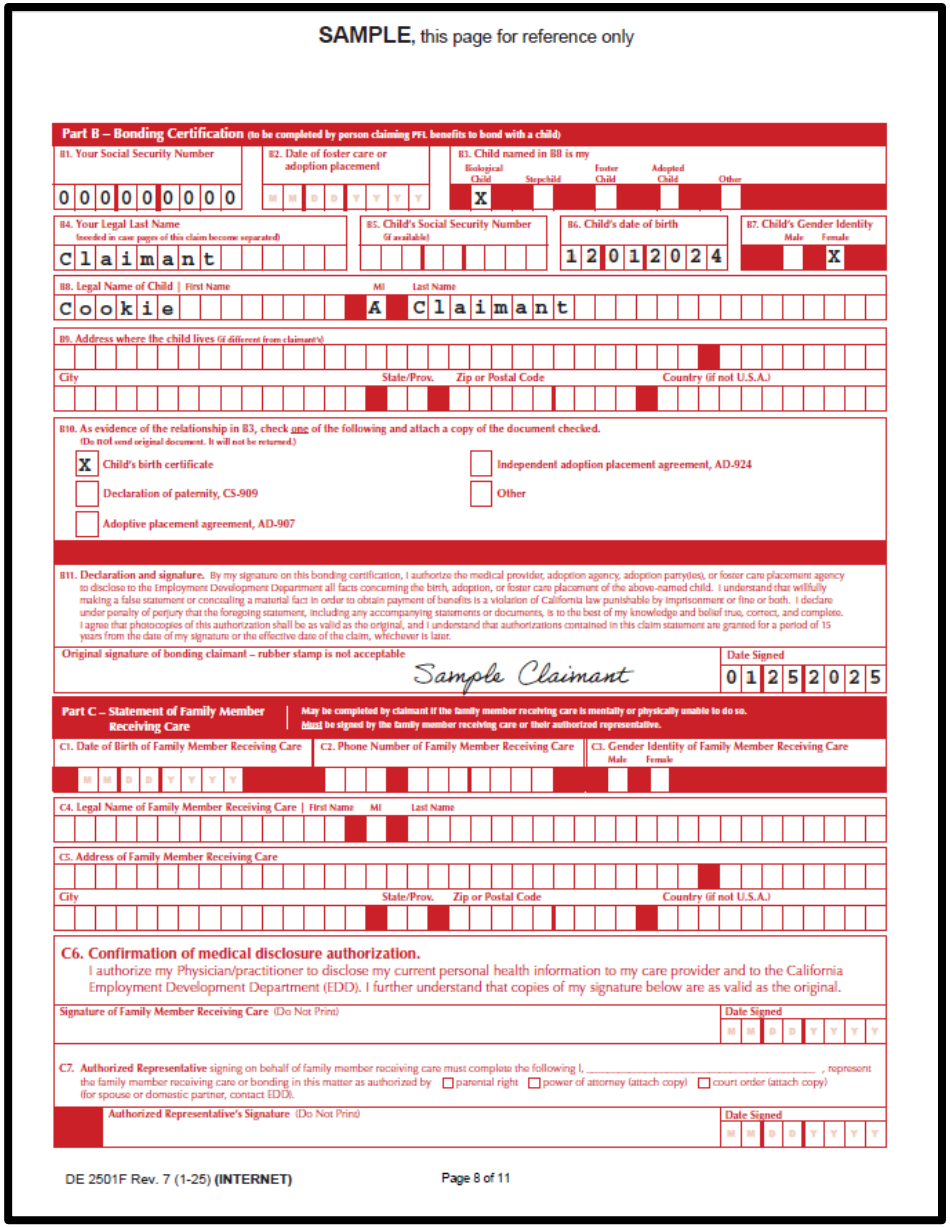
Part C - Statement of Care Recipient:

- 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: 000000000

B2. Date of foster care or adoption placement:

B3. Child named in B8 is my: Biological Child, Stepchild, Foster Child, Adopted Child, Other — X

B4. Your Legal Last Name (needed in case pages of this claim become separated): Claimant

B5. Child's Social Security Number (if available):

B6. Child's date of birth: 12012024

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

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

B9. Address where the child lives (if different from claimant's):

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

B10. As evidence of the relationship in B3, check one of the following and attach a copy of the document checked. (Do NOT send original document. It will not be returned.)

- [X] Child's birth certificate
- [ ] Declaration of paternity, CS-909
- [ ] Adoptive placement agreement, AD-907
- [ ] Independent adoption placement agreement, AD-924
- [ ] Other

B11. Declaration and signature. By my signature on this bonding certification, I authorize the medical provider, adoption agency, adoption party(ies), or foster care placement agency to disclose to the Employment Development Department all facts concerning the birth, adoption, or foster care placement of the above-named child. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements or documents, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of 15 years from the date of my signature or the effective date of the claim, whichever is later.

Original signature of bonding claimant – rubber stamp is not acceptable: Sample Claimant | Date Signed: 01252025

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

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

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

C5. Address of Family Member Receiving Care

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

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

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

C7. Authorized Representative signing on behalf of family member receiving care must complete the following I, _____, represent the family member receiving care or bonding in this matter as authorized by ☐ parental right ☐ power of attorney (attach copy) ☐ court order (attach copy) (for spouse or domestic partner, contact EDD).

Authorized Representative's Signature (Do Not Print) | Date Signed

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

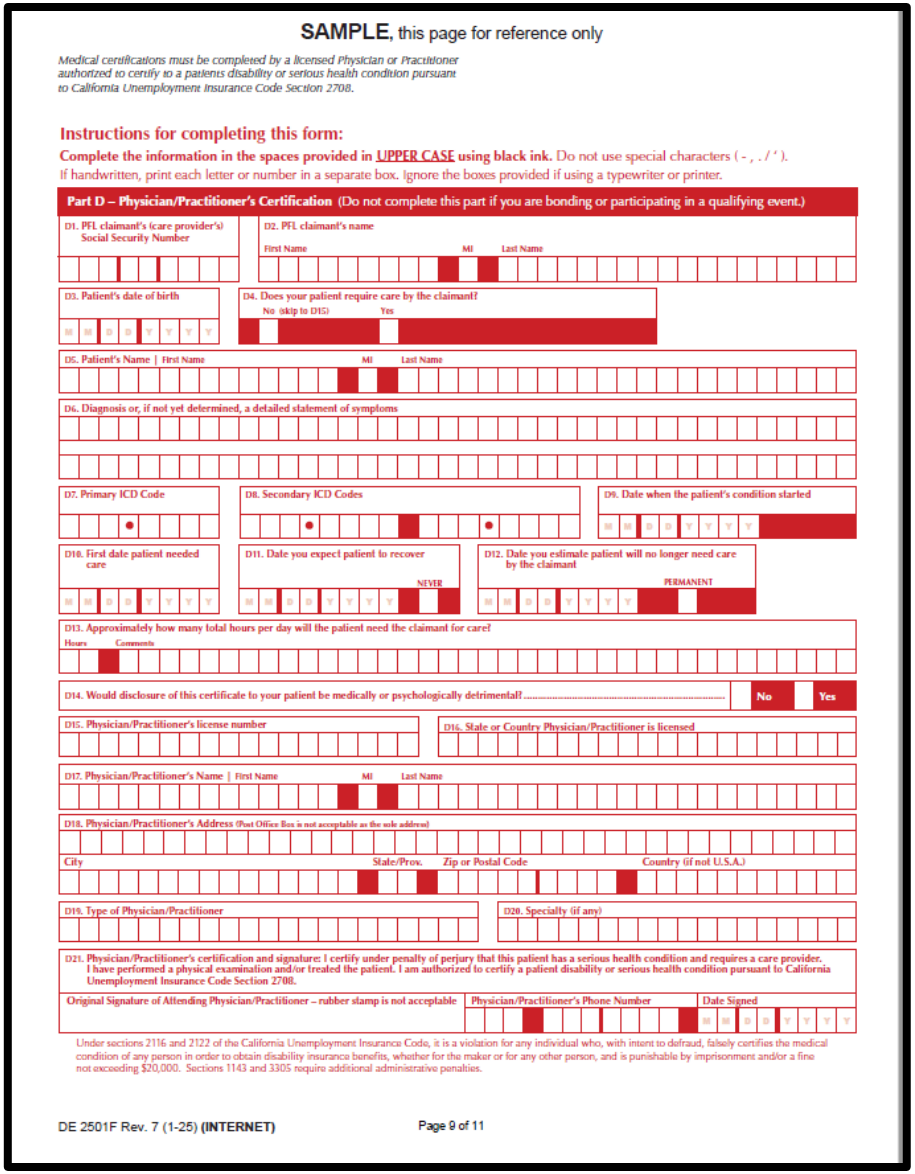
Claim for Paid Family Leave (PFL) Benefits (DE 2501F) - Page 3

Part D - Physician/Practitioner's Certification:

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

Note

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



SAMPLE, this page for reference only

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

Instructions for completing this form:

Complete the information in the spaces provided in UPPER CASE using black ink. Do not use special characters (- , . / ').
If handwritten, print each letter or number in a separate box. Ignore the boxes provided if using a typewriter or printer.

Part D – Physician/Practitioner's Certification (Do not complete this part if you are bonding or participating in a qualifying event.)

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

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

D3. Patient's date of birth (M M D D Y Y Y Y)

D4. Does your patient require care by the claimant? No (skip to D15) Yes

D5. Patient's Name | First Name | MI | Last Name

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

D7. Primary ICD Code

D8. Secondary ICD Codes

D9. Date when the patient's condition started

D10. First date patient needed care

D11. Date you expect patient to recover — NEVER

D12. Date you estimate patient will no longer need care by the claimant — 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

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

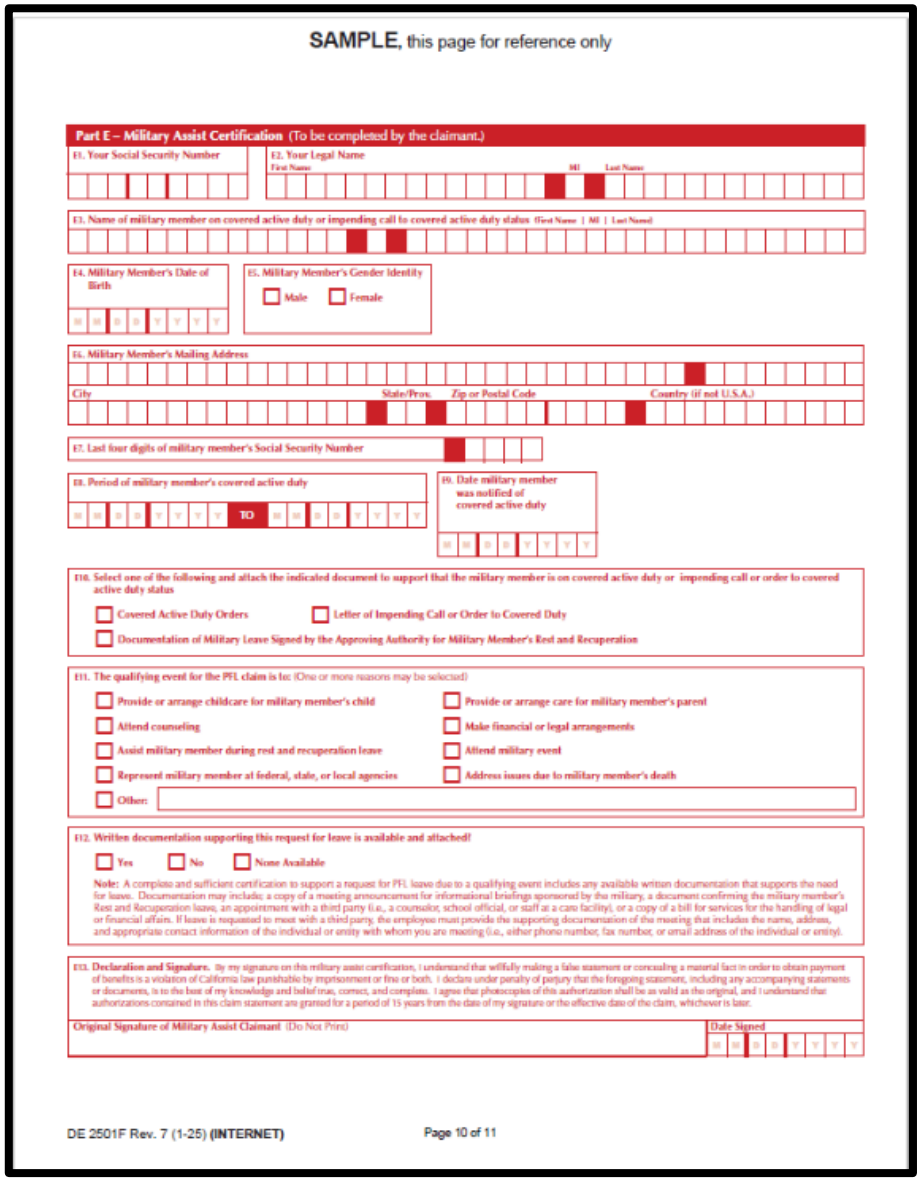
Part E – Military Assist Certification:

You must complete all information under Part E, including:

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

Note

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



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

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

Part E - Qualifying Event for Leave Documentation:

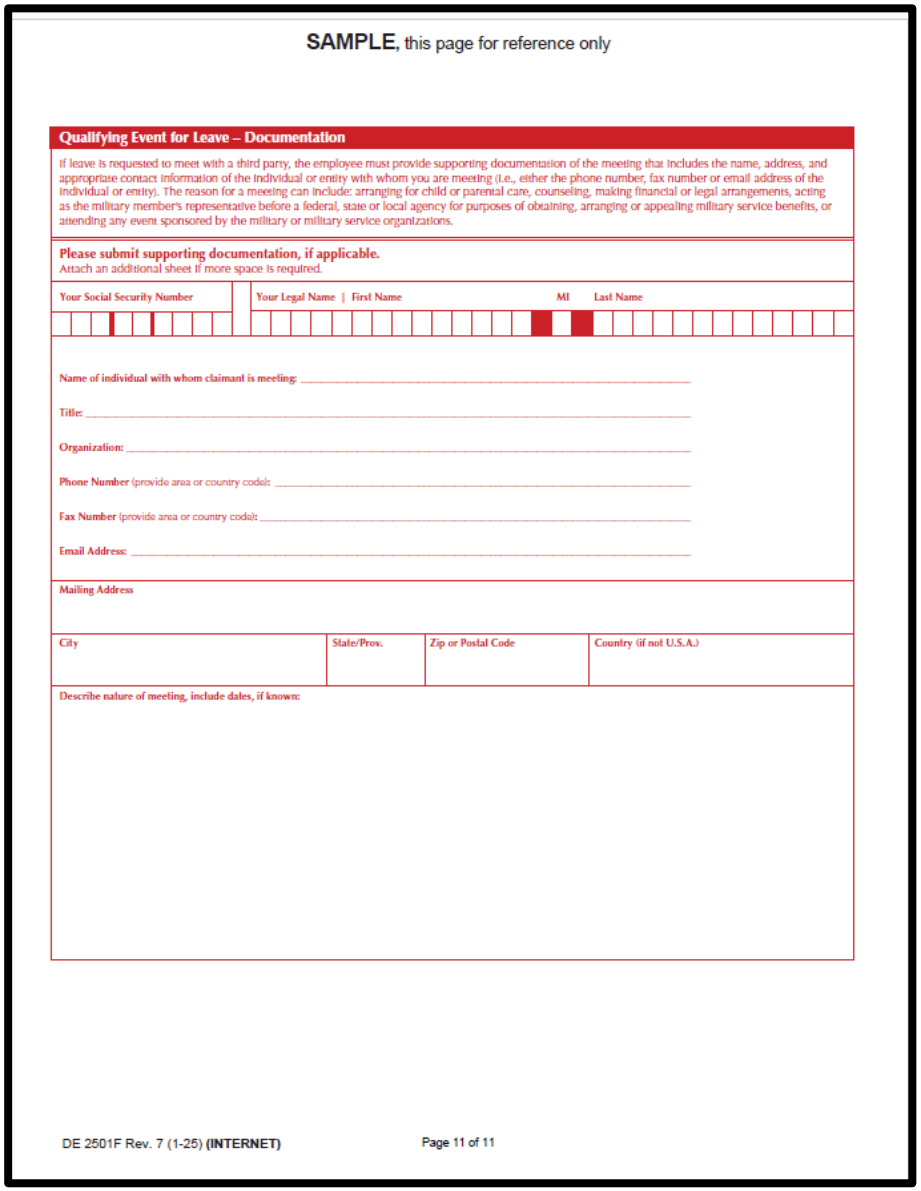
If you're requesting leave to meet with a third party, you must include:

- 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

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

Mail in your completed claim form

Use the pre-addressed envelope to mail to:

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

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

CONTACT US

1-877-238-4373

– Helpful Links –

Order Forms

Schedule a Webinar

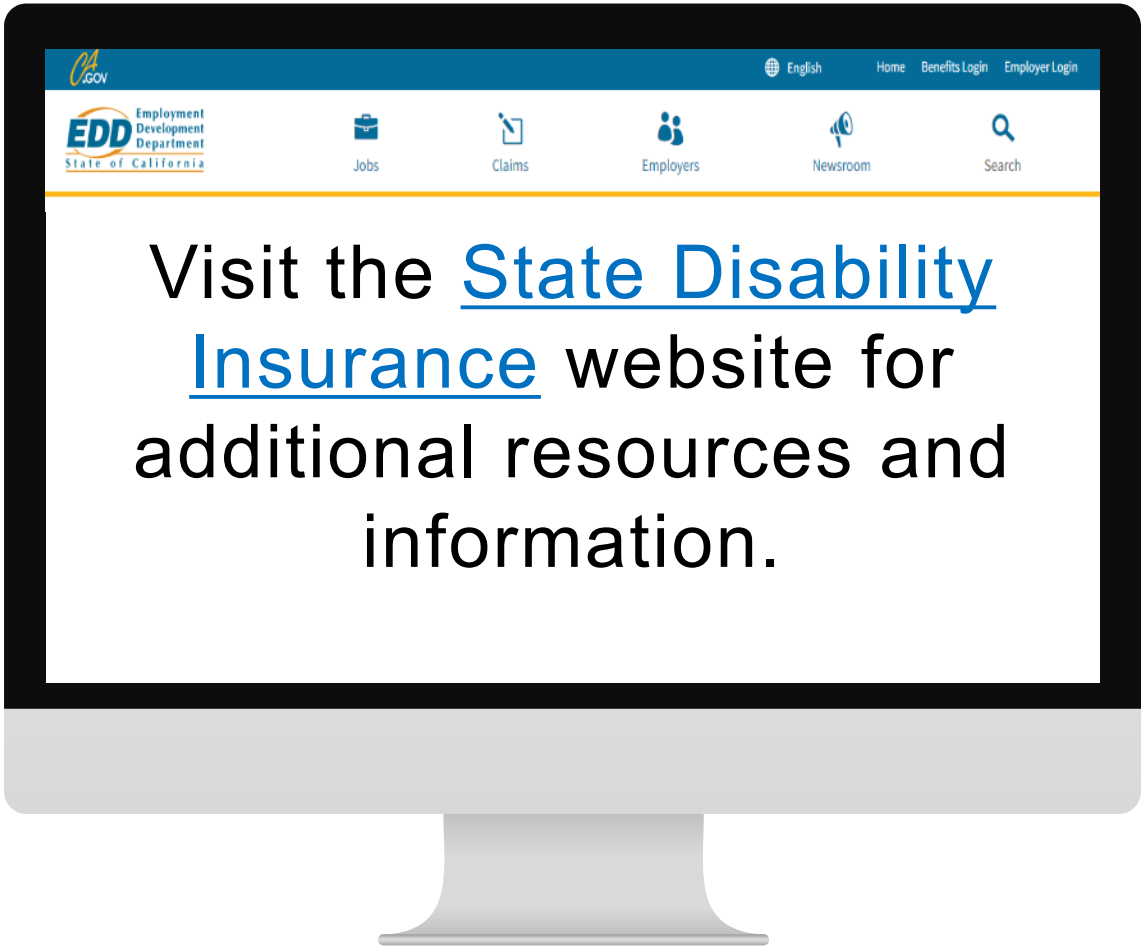
Help Fight Fraud

Contact Us

Accessibility

Language Resources

– Follow us –



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.