

SDI ONLINE TUTORIAL File a Paid Family Leave Claim

Last Updated: May 2025

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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 pregnancyrelated disability claim, or a new father, or a foster or adoptive parent, refer to <u>File a Bonding Claim for New</u> <u>Mothers (without a pregnancy-related disability claim),</u> <u>Fathers, and Foster or Adoptive Parents</u>.



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		For Spanish, select
Español		
Welcome to myEDD myEDD connects you to unemployment, disability, paid family leave, and benefit overpayment services.	Log In Email Password Porgot password?	
Contact EDD Conditions of Use Privacy Policy Accessibility Copyright © 2023 State of California	Don't have an account? Create Account	

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

- 1. Visit <u>myEDD</u>.
- 2. Enter the email and password used to create your myEDD account.
- 3. Select Log In.

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EDDNext	
Español	
Verify Your Identity	
To protect your account, we will email you a verification code.	
Send Email	
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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.



From the myEDD homepage, select SDI Online.

Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History				
Home										
Message Center										
Check the message center Inbox below to review messages and take required actions as needed. Inbox [New: 0, Total: 0]										
Personal Information										
Full Name:	Jane Doe		EDD Customer A	ccount Number:	123456789					
Mailing Address:	123 Main St Sacramento, C	A 95814		Phone Number:	916-555-1212					
Residence Address:	123 Main St Sacramento, C	A 95814	Cell	Phone Number:	916-555-1213					
E-mail Address:	Jdoe@gmail.co	om								
Current Disability Insura	nce Claim(s)									

Select Inbox from the main menu or the Message Center.

Cieov	Arr Home Log Out						
Employment Development Department State of California SD	II Home	Inbox	New Claim	1	Draft	Profile	History
Message Center *Indicates Required Field							
Inbox							
Select a link in the Subject column to view your messa	age.						
Note: You may receive some documents by mail.							
Subject	Sent Date	Due Date	Туре	Viewed	Claimant Name	Date of Birth	Action
2501FP Paid Family Leave New Mother	07-01-2021	None	Notification	Yes	JANE DOE	01-25-1999	Delete
DE 4290, Notice of Computation	07-01-2021	None	Notification	Yes	JANE DOE	01-25-1999	Delete

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

Contact EDD

Conditions of Use

Privacy Policy

Back to Top

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

EDD Employment Development Department State of California		SDI Home	Inbox	New Claim	Draft	Profile	History			
Inbox										
Message	Subject: Due Date:	DE 2501FP, Paid	Family Leave Ne	ew Mother	Sent Date:	07-01-2021				
	Message: Link to Form:	2501FP Paid Family L	eave New Mother		Claim ID:	DI-2000-000-022				
Supporting D Important Information fo Important Information fo Explanation of Notice of 0	Supporting Documentation Important Information for Disability Insurance (DI) Claimants (DE 2515P) Important Information for Paid Family Leave (PFL) Claimants (DE 2515PF) Explanation of Notice of Computation (DE 4290)									
Back to Top Contact	EDD Conditions	of Use Privacy Policy	Delete Accessibility	à						

A Home

Log Out

Forms Available to Submit Online

Claim Information					
Claimant Name:	Jane Doe	Claim ID	DI-1000-XXX->	<xx< th=""><th></th></xx<>	
Expected Return to Work Date:	03-05-2018	Claim Effective Date	e: 02-15-2018		
Forms Available to Subm	it				
Below is a list of forms available to submit electr be processed.	ronically. If you have received a form in the mail, return it by the due	date listed on the form	n. Please allow 5-7 busines	ss days for you	ir form to
If you have already submitted or mailed any of t	he forms listed below, do not submit a duplicate form. Submitting du	plicate forms may del	ay the processing of your	claim.	
Note: "The DE 2587 Notice-Automatic Payment"	will only apply to your Disability Insurance claim and should not be	used if you are curren	tly receiving Paid Family L	eave benefits.	
Note: It may be necessary to send some docume Paid Family Leave Bonding	ents via US Postal Service.				
Saved Drafts					
To open and complete a form that you saved, se draft immediately, select the checkbox and then	lect the Form Name. Saved drafts are stored for a limited number of select the Delete button.	days and will be auton	natically deleted on the da	ate indicated.	To delete a
Form Name		Saved Date	Drafts will be saved un	til	Select
2500A Cert for Continued Benefits		06-29-2018	07-29-2018		
				Dele	te

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.

(,Gov				🟫 Home			Log Out
Employment Development Department State of California	SDI Home	Inbox	New C	Claim	Draft	Profile	History
Prescreening Question	ons						
Prescreening Questions							
*Are yo	ou a mother bonding with	your newborn?	◯ Yes	◯ No			
*Did you receive California State Disability Ins	surance benefits for your	pregnancy with this newborn?	⊖ Yes	◯ No			
		Car	ncel				Next
Back to Top Contact EDD Conditions of U	Jse Privacy Policy	Accessibility					

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**.



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Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History	

Information for Before You Start and After You File

Before you Start: Information you need to submit a *Claim for Paid Family Leave (PFL) Benefits – New Mother* (DE 2501FP)

When your pregnancy-related disability claim ends, we have identified critical items you should have immediately available when you select to file your DE 2501 FP.

- The last date you worked for any employer.
- Whether you returned to work for any period or will continue to work during your period of paid family leave.
- Information concerning the newborn with whom you are bonding, including: name, date of birth, and gender.
- Information as to whether you are receiving, or expect to receive any payment from your former employer (Failure to report your income could result in an overpayment, penalties, and a false statement disqualification)
- Whether you have claimed or plan to claim workers' compensation benefits for any portion of the period covered by this claim.
- Whether you were you in custody of law enforcement authorities because you were convicted of a violation of law or ordinance at any time during your family leave.
- The date you want your DE 2501FP to begin if other than the day your Disability Insurance benefits ended.

After You Have Filed Your Application

WHEN YOUR CLAIM IS SUCCESSFULLY SUBMITTED

The PFL office will notify you of your weekly benefit amount and request any additional information needed to determine your eligibility. If you meet all requirements, a payment will be issued to you. The majority of claims are processed and payments issued within 14 days of receipt of a correctly completed claim.

Note: It may be necessary to send some documents via US Postal Service. This includes Paid Family Leave (PFL) payments and PFL claim-related forms.

YOUR RIGHTS

Information about your claim will be kept confidential, except for the purposes allowed by law. California Civil Code, section 1798.34, gives you the right to inspect any personal records maintained about you by EDD. Section 1798.35 permits you to request that the record be corrected if you believe it is not accurate, relevant, timely, or complete. Certain types of information that would generally be considered personal are exempt from disclosure to you: medical or psychological records where knowledge of the contents might be harmful to the subject (Civil Code, section 1798.40); records of active criminal, civil or administrative investigations (Civil Code, section 1798.40).

If you are denied access to records which you believe you have a right to inspect or if you request to amend your records is refused, you may file an appeal with the PFL office. You may

SPECIAL CIRCUMSTANCE RELATING TO YOUR PAID FAMILY LEAVE CLAIM

Child Support Obligations. Questions should be directed to the Department of Child Support Services at 1-866-249-0773.

Spousal or Parental Support Obligations. Questions should be directed to the District Attorney's office administering the court order.

Death of Claimant. If a person receiving PFL benefits dies, an heir or legal representative should report the death to PFL. Benefits are payable through date of death, if otherwise eligible.

Death of Care or Bonding Recipient. If the child with whom you are bonding dies, report the death to PFL. Benefits are payable through the date of death, if otherwise eligible.

Job Benefits and Protection Programs. Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) offer job protected leave to "eligible" employees for certain family and medical reasons. Contact FMLA at 866-487-9243 or the Department of Labor Web site: https://www.dol.gov/whd/fmla or CFRA at 800-884-1684 or the Department of Fair Employment and Housing Web site: https://www.dol.gov/whd/fmla or CFRA at 800-884-1684 or the Department of Fair Employment and Housing Web site: https://www.dol.gov/whd/fmla or CFRA at 800-884-1684 or the Department of Fair Employment and Housing Web site: https://www.dol.gov/whd/fmla or CFRA at 800-884-1684 or the Department of Fair Employment and Housing Web site: https://www.dol.gov/whd/fmla or CFRA at 800-884-1684 or the Department of Fair Employment and Housing Web site: https://www.dol.gov/whd/fmla or CFRA at 800-884-1684 or the Department of Fair Employment and Housing Web site: https://www.dol.gov/whd/fmla or CFRA at 800-884-1684 or the Department of Fair Employment and Housing Web site: https://www.dol.gov/whd/fmla or CFRA at 800-884-1684 or the Department of Fair Employment and Housing Web site: https://www.dol.gov/whd/fmla or CFRA at 800-884-1684 or the Department of Fair Employment and Housing Web site: https://www.dol.gov/whd/fmla or CFRA at 800-884-1684 or the Department of Fair Employment and Housing Web site: https://www.dol.gov/whd/fmla or CFRA at 800-884-1684 or the Department of Fair Employment and Housing Web site: https://www.dol.gov/whd/fmla or CFRA at 800-884-1684 or the Department of Fair Employment and Housing Web site: https://www.dol.gov/whd/fmla or CFRA at 800-884-1684 or the Department of Fair Employment and Housing Web site: https://www.dol.gov/whd/fmla or CFRA at 800-884-1684 or the Department of Fair Employment and Housing Web site: https://www.dol.gov/whd/fmla or CFRA at 800-884-1684 or the Department of Fair Employment and Housing Web site: https://www.dol.gov/whd/fmla or CFRA at 800-884-1684 or the Department of Fair Employment and Ho

Cancel

Phone Number Link https://www.edd.ca.gov/Disability/Contact_SDI.htm#byphone

Frequently Asked Questions Link https://www.edd.ca.gov/Disability/FAQs.htm#pfl 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.

Next

(🏫 Нол	ne Benefit Programs (Online	Log Out				
Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History				
Applying for Clain	Applying for Claim for Paid Family Leave (PFL) Benefits - New Mother *Indicates Required Field									
Applying for Claim fo Read the information below and check the written ignatures. • I have read and understand the instru- benefits. If I make any false statemen receiving benefits and/or services and	r Paid Family Le ne box if you agree. A check in t uctions above. I understand th nt or misrepresentation or kno id may initiate criminal prosec	ave (PFL) B the box indicates an el nat failure to supply an wingly withhold of a n ution against me.	enefits - New N ectronic signature executed y or all information may can naterial fact to obtain or inc	Mother I by you, and is a lega use delay in issuing b rease any benefit or p	ally binding equivalent c benefit checks or may ca payment, EDD will disqu	of traditional hand- iuse a denial ualify me from				
Previous		Ca	ancel			Next				
Back to Top Contact EDD Condi	tions of Use Privacy Policy	Accessibility								

Select the box to authorize an electronic signature.

Select Next.

Initial Questions	5									
1 Initial Questions	2 DI Clair	n Information	3 Claim Information	4	Declaration					
You are currently on Step 1 Initial Qr * Indicates Required Field	lestions									
Section 1 - Contac	Information									
Claimant	Name: Jane Doe		EDD Customer Account	Number: 1234567	89					
Mailing Ac	dress: 123 Main S Sacramento	t , CA 95814	Phone	Number: 916-555	-1212					
If your personal information has changed, select Save as Draft. To update your personal information before completing this form, select Profile. Submission of the Claim for Paid Family Leave (PFL) Benefits – New Mother, DE2501FP, is available Monday – Saturday, 6 a.m. to 6 p.m. and Sunday, 6 a.m. to 5:30 p.m.										
Is this address different from the	e address where you received y your Disabi	our last payment for OYes lity Insurance claim?	🔿 No							
* Have	ou stopped claiming Disability	Insurance benefits?	◯ No							
Previous		Cancel Sa	ve as Draft		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.

DI Claim Informatio	n								
Initial Questions	2 DI Claim Information	3 Claim Information	4 Declaration						
You are currently on Step 2 DI Claim Information									
Section 2 - DI Claim Information									
Social Security Number:	xxx-xx-xxxx	* Disability Insurance Claim Effective Date:	(MMDDYYYY)						
* Final Date of Disability Insurance Benefits:	(MMDDYYYY)								
Do not submit this form unless you have stopped claiming Disability Insurance benefits and you are ready to claim PFL benefits to bond with your baby/babies.									
Previous	Cancel	Save as Draft	Next						

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.

Paid Family Leav	e Claim Information		
Initial Questions	DI Claim Information	3 Claim Information	(4) Declaration
You are currently on Step 3 Claim Info *Indicates Required Field	prmation		
Section 3 - Baby Info	ormation		
If you had a multiple birth, provide info	rmation for only one baby.		
	*Baby's First Name:		
	Baby's Middle Initial:		
	Baby's Last Name:		
	Baby's Suffix:		
	"Baby's Date of Birth:	(MMDDYYY)	1
	"Baby's Gender:	Male Female	
Section 4 - Paid Fam	ilv Leave Claim Information		
		auglification of boas fits from an	and the supervised
Any overlapping period between bisabl	*Last Day Worked:	(MMDDYYYY)	e or the programs.
*Do you want your Paid Family Leave	e claim to begin on the day after you stop claiming disability insurance benefits?	O Yes O No	
If "No," enter the dat	e you want your Paid Family Leave claim to begin:	(MMDDYYYY)	
*Do you want to cl	laim the maximum amount of benefit weeks now?	O Yes O No	
If	"No," enter the date you want to be paid through:	(MMDDYYYY)	
Section 5 - Employe	erInformation		
ecciente Employe	Will you work at any time during your family leave?	O Yes O No	
	If "Yes," enter the date you returned to work:		
*Will you continue to receive wag	es from your employer(s) during the period you are claiming Paid Family Leave benefits?	O Yes O No	
	If "Yes," indicate type of pay	Select	•
	Beginning Payment Date:	(MMDDYYYY)	
	Ending Payment Date:	(MMDDYYYY)	
	*Do you have more than one employer?	O Yes O No	
*Have you filed or do you	u intend to file for workers' compensation benefits?	O Yes O No	
Previous	Cancel	Save as Draft	Next

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.

(Å.						Log Out
Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History
Benefit Payment O	ptions					
Initial Questions	DI Claim Informat	tion	Claim Information		4 Declaration	
You are currently on Step 4 Declaration *Indicates Required Field						
Section 6 – Select Your	Option					
If you're eligible for benefits, you have three o	options to receive your bene	fit payments.				
	*Select you	r payment option:	 Direct Deposit Debit Card Mailed Checks 			
I have reviewed the Debit Card Fees and D)isclosures.					
Gather your bank routing and account numbe	ers and select Next to contir	iue.				
Previous		Cancel	Save as Draft			Next

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.

Section 7 - Declaration	
Read the information below and check the box if you agree. A check in the box indicates an electronic signature executed by you, and is a legally binding equivaler written signatures. • If y my electronic signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was be bonding recipient named above; (2) authorize EDD to release my personal information as shown on this claim to the bonding recipient; (3) authorize my empleted and below that are within their knowledge; and (4) authorize release and use of information as stated in the Information Colle section of the Important Paid Family Leave Program Information page. I understand that willfully making a false statement or concealing a material fact in or 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, includ 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 origin that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my electronic signature or the effective date of is later.	ent of traditional hand- bonding with the ployer(s) to disclose to ection and Access rder to obtain payment ding any accompanying nal, and I understand if the claim, whichever
Previous Cancel Save as Draft	Submit

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.

<i>Cl</i> cov			🏠 Ho	me		Log Out	
Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History	
Paid Family Leave	(PFL) Surve	ey Questi	ons				
Paid Family Leave (PFL	.) Survey laim for Paid Family Leave	benefits. There is one	more step to complete befo	ore you receive your cla	im receipt number. Ple	ase answer the	
questions below and then select the "Subm *Before you filed your Paid Family Leave	it" button for your receipt (PFL) claim, how did you	number. learn about the Paid	Family Leave (PFL) benefi	t program? Please sel	ect the response that I	pest applies:	
 From a brochure I received by U.S. mail. From a friend or family member. 							
From an SDI Online Notification. From my employer							
From a social worker or hospital employ	ee.						
None of these.					_		
					[Submit	
Back to Top Contact EDD Condition	ns of Use Privacy Polic	y Accessibility					

Complete the survey and select **Submit**.

	(,Gov			🏠 Home			Log Out
S	Employment Development Department tate of California	SDI Home	Inbox	New Claim	Draft	Profile	History
(Confirmation						
Pr Fa M qu	rint this page for your records. If a printer is unav amily Leave (PFL) – New Mother (DE 2501FP) app ost claims are processed and a decision is made uestions you may call 1-877-238-4373.	ailable at this time, record lication. You will not be abl within two weeks of the da	the Form Receipt Num e to access your confir ite the claim was subm	ber below. The Form Receip mation page and Form Rece itted. If you have not receiv	ot Number is required eipt Number after this red anything from PFL	to retrieve a copy of the window is closed. within 10 days or if you	<i>Claim for Paid</i> have any
	Confirmation Informatio	n					
	Claimant Name:	Jane Doe		Social Secur	rity Number: XXX	<-XX-XXXX	
	You requested to have your PFL claim begin on this date. If this field is blank, your PFL claim will begin on the day after you stop claiming Disability Insurance benefits:			Rece	ipt Number: R10	000000032192	
V	Varning						
Yo	ou will receive a paper version of the <i>Claim for Pa</i> ubmitted online.	id Family Leave (PFL) – Ne	<i>w Mother</i> (DE 2501FP) i	n the mail. Do NOT return t	he paper form for the	benefit period you just s	successfully
B	ack to Top Contact EDD Conditions of U	se Privacy Policy	Accessibility				

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.



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.



	☆ ≡	
Ciev		Note
EDDNext		For Spanish, select
Español		Español.
Welcome to myEDD myEDD connects you to unemployment, disability, paid family leave, and benefit overpayment services.	Log In Email Password Password Forgot password? Log In Don't have an account?	
Contact EDD Conditions of Use Privacy Policy Accessibility Copyright © 2023 State of California		

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

- 1. Visit <u>myEDD</u>.
- 2. Enter the email and password used to create your myEDD account.
- 3. Select Log In.

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<i>Ol</i> isov			
EDDNext			
	Español		
	Verify Your Identity		
	To protect your account, we will email		
	you a verification code.		
	Send Email		
Contact EDD Conditions of Use Privacy P	olicy Accessibility		
Copyright © 2023 State of California			

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.



From the myEDD homepage, select SDI Online.

Note

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

Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History
Home						
Message Center						
Check the message center Inbox below to rev Inbox [New: 0 , Total: 0]	view messages and take requir	ed actions as nee	eded.			
Personal Information						
Full Name:	John Doe		EDD Custom	er Account Number:	123456789	
Mailing Address:	123 Main St Sacramento, CA s	95814		Phone Number:	916-555-1212	
Residence Address:	123 Main St Sacramento, CA S	95814		Cell Phone Number:	916-555-1213	
E-mail Address:	Jdoe@gmail.com					
Current Disability Insura	nce Claim(s)					

Select New Claim from the main menu.

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

Note: It may be necessary to send some documents via US Postal Service.

Apply for Disability Insurance Benefits

Disability Insurance

Apply for Paid Family Leave Benefits

Paid Family Leave Bonding

and Reading tachment

Paid Family Leave Care Submit Electronic Paid Family Leave Care Attachment Paid Family Leave Military Assist Submit Electronic Paid Family Leave Military Assist Attachment

Saved Drafts

To open and complete a form that you saved, select the Form Name. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the Delete button.

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 <u>Types of</u> <u>Claims</u>.

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.

Prescreening Questions * Indicates Required Field	
Prescreening Questions	
* Are you a mother bonding with your newborn?	◯ Yes ◯ No
* Did you receive California State Disability Insurance benefits for your pregnancy with this newborn?	◯ Yes ◯ No
Са	Next

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 (*).



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

Information for Before You Start and After You File

Before you Start: Information you need to apply for Paid Family Leave (PFL) Initial Claim Form for Bonding (DE 2501F)

PFL will use information provided in your EDD online profile, including:

- Your name (including other names under which you have worked), date of birth, gender, preferred language, and Social Security account number.
- Your mailing address (including ZIP code) and telephone number (including area code).
- The last date you worked for any employer.
- Your occupation.
- The name, mailing address and telephone number of your last employer or employers. (Be specific about the spelling of the employer's name and make sure the mailing address is correct. An incorrect address may delay benefit payments.)
- Any period you returned to work or will continue to work during your period of PFL.
- The reason why you have reduced work hours or stopped working.

PROOF OF RELATIONSHIP FOR BONDING

To be eligible for PFL benefits to bond with a new minor child you will also need to submit one of the documents listed below to provide proof of your relationship to the child. ONLY send copies of these documents:

- Child's Birth Certificate
- Official letter from foster care agency
- Child's Hospital Birth Certificate
- Adoptive Placement Agreement, AD-907

After You Have Filed Your Application

WHEN YOUR CLAIM IS RECEIVED

When you have successfully transmitted an electronic bonding claim, the PFL office will notify you of your weekly benefit amount and request any additional information needed to determine your eligibility. If you meet all eligible requirements, a payment will be issued to you from a central payment center. The majority of claims are processed and payments issued within fourteen (14) days of receipt of a correctly completed claim.

SPECIAL CIRCUMSTANCES RELATING TO YOUR PAID FAMILY LEAVE CLAIM

Child Support Obligations: Questions should be directed to the Department of Child Support Services at 1-866-249-0773.

Spousal or Parental Support Obligations: Questions should be directed to the District Attorney's office administering the court order.

Death of Claimant: If a person receiving PFL benefits dies, an heir or legal representative should report the death to PFL. Benefits are payable through date of death, if otherwise eligible.

Death of Care or Bonding Recipient: If the child with whom you are bonding dies, report the death to PFL. Benefits are payable through the date of death, if otherwise eligible.

Job Benefits and Protection Programs: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) offer job protected leave to "eligible" employees for certain family and medical reasons. Contact FMLA at 1-866-487-9243 or the Department of Labor Web site:

https://www.dol.gov/whd/fmla or CFRA at 1-800-884-1684 or the Department of Fair Employment and Housing Web site:

https://www.dfeh.ca.gov for additional information on these programs.

Phone Number Link http://www/edd/ca/gov/Disability/Contact_SDI.htm#byphone

Frequently Asked Questions Link http://www.edd.ca.gov/Disability/FAQs.htm#pfl

Cancel

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

Select Next.

Next

Applying for Paid Family Leave (PFL) Initial Claim Form for Bonding

*Indicates Required Field

Pn

Applying for Paid Family Leave (PFL) Initial Claim Form for Bonding (DE 2501F)

Please read these instructions and information before completing the electronic Claim for Paid Family Leave (PFL) Benefits (DE 2501F). Do not complete this claim form if you are insured by a Voluntary Plan maintained by your employer. (Ask your employer for the proper forms.)

The Paid Family Leave (PFL) program provides affordable, worker-funded benefits to eligible workers suffering a full or partial loss of wages due to the need to care for a seriously ill family member, to bond with a new child or assist with matters related to a family member's military deployment to a foreign country.

(B)	 Call 1-877-238-4373 for required forms and instructions if: A disability prevents you from completing the claim form and you need to designate a representative to sign for you. You are an authorized representative filing for benefits on behalf of a physically or mentally incapacitated care provider/care recipient or a deceased care provider/care recipient.
Do NOT : Care app	submit an electronic PFL Claim for bonding if the purpose of your family leave is to care for a seriously ill family member. Follow these instructions to file for a Paid Family Leave ilication.
1.	Select New Claim. Choose Paid Family Leave Care.
BA IN	IELIGIBILITY:
PF Yo	ou may apply for benefits even if you are not sure you are eligible. If you are found to be ineligible for all or part of a period claimed, you will be notified of the ineligible period and the ason(s) why you were not eligible. Below are some reasons why you may not be eligible for benefits:
	 If you are claiming or receiving Unemployment Insurance or Disability Insurance (DI) benefits. If you are receiving workers' compensation benefits at a weekly rate equal to or greater than the PFL rate. If you are in custody of law enforcement authorities because you were convicted of violating law or ordinance.
F	RAUD:
Ui or cc	If you are eligible for further benefits, additional payments will either be sent automatically or in response to your submitted certification, whichever is appropriate to your claim. You will be paid 1/7 of your weekly benefit amount for each calendar day you are eligible unless benefits are reduced for some reason. (See Calculating Paid Family Leave Benefit Payment Amounts for more information.)
Y	TAXABILITY OF BENEFITS: Paid Family Leave benefits are subject to federal income taxes and will be reported to the Internal Revenue Service. Each person receiving PFL benefits will receive a 1099G form to include with his/her federal income tax return. PFL benefits are not subject to California income taxes.
Fi	VerRPAYMENT: An overpayment results when you receive PFL benefits you were not eligible to receive. Once PFL determines that you were overpaid, the PFL office will contact you to explain the reason for your overpayment. It is important that you complete and return all information requests, as there are some instances when an overpayment can be waived. If it is determined that you were overpaid and the overpayment cannot be waived, you must repay this money. Benefit payments issued after an overpayment is established may be reduced by 25 to 100 percent to collect your payment. You will receive a "Notice of Overpayment Offset" if a reduction is taken for a DI, PFL, or Unemployment Insurance (UI) overpayment.
	DISQUALIFICATION: All available information will be considered before paying or disqualifying your claim. Benefits will be paid only for the days for which you are eligible. If payment of benefits is denied or reduced for any period, you will receive a written notice stating the reason for the disqualification or reduction.
	If you deliberately report incorrect information, willfully omit or withhold information, a false statement disqualification of up to 92 days may be assessed. In addition, any resulting
	• 🗹 I hav read and understand the instructions above. I understand that failure to supply any or all information may cause delay in issuing benefit payments or may cause a denial of occurs. If I make any false statement or misrepresentation or knowingly withhold of a material fact to obtain or increase any benefit or payment, EDD will disqualify me from receiving benefits and/or services and may initiate criminal prosecution against me.
	Previous Cancel 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.

Personal Information	on					
1 Personal Information 2 Empl Inform	oyment mation	Additional Questions	4 Certification	5 Qui	alifying ents	6 Declaration
You are currently on Step 1 Personal Informa	ntion					
Verify Your Personal Inf	ormation	then select Profile from the r	main menu to undate your inforr	nation before (completing this for	n.
Social Security Number	xxx-xx-xxxx	enerisedeer Forde nom ener	EDD Customer Accou	nt Number:	123456789	
social security number.			EDD Customer Accou		123430703	
Full Name:	John Doe		Other Names (if any, unde ha	r which you ve worked):		
Date of Birth:	XX-XX-XXXX			Gender:	Male	
Mailing Address:	123 Main St Sacramento, United States	CA 95814	Pho	ne Number:	916-555-121	3
Preferred Language:	English					
Previous		Cancel	Save as Draft			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.

Declopment Declopment State of California SDI Home Inbox	New Claim Draft Profile	History
Employment Information		
Personal Personal Additional Additional Additional Questions	4 Certification 5 Qualifying Events	6 Declaration
You are currently on Step 2 Employment Information "Indicates Required Field		
Your Employment Details		
*Occupation:		
*Are you a state government employee?	Ves No	
If "Yes," indicate bargaining unit number:		
*May we disclose benefit payment information to your employer(s)?	Ves No	
*Do you have more than one employer?	🔿 Yes 💫 No	
*Reason for reducing work hours or stopping work:	 Participating in a qualifying event Other 	
Other Reason:		
Employer Information		
Enter your current or most recent employer information.		
Note: An incorrect employer name or address can delay benefit payments.		
*Name of Employer:		
	US O International	
*Address Line 1:		
Address Line 2:		
*City:		
"State:	CA 🗸	
Employer Phone Number:	9161234567 Ext:	
Previous Cancel Cancel	Save as Draft	Next

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.

Employment Details					
Personal Information	2 Employment Information	3 Additional Questions	4 Bonding Certification	5 Declaration	
You are currently on Step 2 Employment Information					
*Indicates Required Field					
Address Validation					
The address you have provided has been updated to meet USPS standards. Please verify the address is correct.					
Entered Address					
414 k st sacramento CA 95834					
Updated Address					
414 K St Sacramento CA 95814 - 3335					
Would you like to proceed with the standardized address? Select 'Yes' to proceed or 'No' to return to correct the address.					
		No Yes			

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.

Additional Questions					
Personal Information Personal Information Additio	nal Questions 4 Bonding Certification 5 Declaration				
You are currently on Step 3 Additional Questions *Indicates Required Field					
Section 7 - Additional Questions					
*Date you last worked:	(MMDDYYYY)				
The date you want your Paid Family Leave claim to begin should not be before the child's date of birth (or the Date of foster care or adoption placement).					
*Date you want your Paid Family Leave claim to begin:	(MMDDYYYY)				
*Do you want to claim the maximum amount of benefit weeks now?	◯ Yes ◯ No				
If "No ₂ " enter the date you want to be paid through:	(MMDDYYYY)				
Date you returned to work:	(MMDDYYYY)				
Or date you plan to return to work:	(MMDDYYYY)				
*Will you work at any time during your family leave?	◯ Yes ◯ No				
If you will receive any type of pay from your employer(s) during your family leave, indicate type of pay:	Sick Employer Required Vacation Other Type of Pay				
Specify if "Other type of pay":	Select				
*At any time during your Paid Family Leave, were you in the custody of law enforcement authorities because you were convicted of violating a law or ordinance?	🔿 Yes 🚫 No				
*Have you claimed or do you plan to claim Workers' Compensation Benefits for any portion of the period covered by this claim?	O Yes O No				
Previous	Save as Draft Next				

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.
Bonding Certification	
Personal Information Employment Information Addition	nal Questions 4 Bonding Certification 5 Declaration
You are currently on Step 4 Bonding Certification * Indicates Required Field	
Section 3 - Personal Information	
* Child relationship:	Select •
If you select foster care, adoption or guardianship, please provide the date of placement:	(MMDDYYYY)
Section 4 - Child's Legal Name and Information	
Child's Social Security Number (if available):	(Do not enter dashes)
* Child's First Name:	
Middle Initial:	
* Last Name:	
Suffix:	
* Date of B	irth: (MMDDYYYY)
* Child's Gen	der: O Male O Female
* Is child's residence address different from your residence addr	ress? Yes No

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.

Section 5 - Proof of Relationship	
To be eligible for Paid Family Leave benefits to bond with a new child, you must submit an approved "Proof of Relationship" document. The "Proof of Relationship" must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online bonding claim.	Т
Proof of Relationship document includes: 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	R 0 •
* Please indicate the type of "Proof of Relationship" you plan on providing from the list of approved "Proof of Relationship" documents:	•
Failure to submit the "Proof of Relationship" will result in claim disqualification and no payment will be issued. Further instructions for submitting "Proof of Relationship" will be provided on the confirmation page. Previous Cancel Save as Draft	

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

Child's Residence Address	
Personal Information Personal Information Addition	al Questions 4 Bonding Certification 5 Declaration
You are currently on Step 4 Bonding Certification *Indicates Required Field	
Section 6 - Residence Address	
	● US O International
*Address Line 1:	
Address Line 2:	
*City:	
*State:	CA 🔻
*ZIP Code:	
Previous Cancel	Save as Draft Next

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.

<i>Cl</i> .gov						Log Out		
Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History		
Benefit Paymen	t Options							
Personal Information	Employment Information	Addition	al Questions	Bonding Certificatio	n 5 De	claration		
You are currently on Step 5 Declarati	ion							
*Indicates Required Field								
Section 8 – Select Your Option								
	*Select your	payment option:	O Direct Deposi	t				
			O Mailed Check	s				
I have reviewed the Debit Card Fee	s and Disclosures.							
Gather your bank routing and account	numbers and select Next to continu	.e.						
Previous		Cancel	Save as Draft		ĺ	Next		

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.

Cheon			🏫 Hom	e		Log Out
Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History
	•					
Section 9 - Declarat	lion					
Read the information below and cheo	ck the box if you agree. A check	in the box indicates a	n electronic signature execute	ed by you, and is a leg	ally binding equivalent	of traditional hand-
By my signature on this bonding Fulployment Development Depa statement or concealing a mater perjury that the foregoing staten photocopies of this authorization from the date of my signature or	certification, I authorize the m intment all facts concerning the ial fact in order to obtain paym nent, including any accompany n shall be as valid as the origina the effective date of the claim,	edical provider, adopt e birth, adoption, or fo- ent of benefits is a vio ving statements or doc al, and I understand th , whichever is later.	ion agency, adoption party(ie ster care placement of the ab lation of California law punisl uments, is to the best of my k lat authorizations contained i	s), or foster care place ove-named child. I un nable by imprisonmer nowledge and belief in n this claim statemen	ement agency to disclor iderstand that willfully in nt or fine or both. I decli- true, correct, and comp it are granted for a peric	se to the making a false are under penalty of lete. I agree that vd of fifteen years
* By my electronic signature on the	is claim statement, I (1) claim P ; (2) authorize EDD to release m	Paid Family Leave bene ny personal informatio	fits and certify that througho n as shown on this claim to th	ut the period covered the bonding recipient; rmation as stated in t	d by this claim I was bon (3) authorize my emplo	iding with the yer(s) to disclose to on and Access
section of the Important Paid Fai of benefits is a violation of Califo statements, is to the best of my k that authorizations contained in	mily Leave Program Informatio rnia law punishable by imprise mowledge and belief true, corr this claim statement are grant	on page. I understand to onment or fine or both rect, and complete. I ag ed for a period of fiftee	hat willfully making a false str . I declare under penalty of pe gree that photocopies of this a en years from the date of my e	atement or concealing rjury that the foregoi authorization shall be lectronic signature or	g a material fact in orde ing statement, including as valid as the original, r the effective date of th	r to obtain payment g any accompanying , and I understand le claim, whichever is
later.						n na haran karan daga k
Previous		Cancel	Save as Draft			Submit

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.

Cicov			🏫 Hon	ne _		Log Out			
Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History			
Paid Family Leave (*Indicates Required Field	(PFL) Surve	ey Questio	ons						
Paid Family Leave (PFL) The EDD has received your portion of your cla questions below and then select the "Submit	Paid Family Leave (PFL) Survey The EDD has received your portion of your claim for Paid Family Leave benefits. There is one more step to complete before you receive your claim receipt number. Please answer the								
 *Before you filed your Paid Family Leave (F From a brochure I received by U.S. mail. From a friend or family member. From an SDI Online Notification. From my employer. From a social worker or hospital employee. None of these. 	FL) claim, how did you l e.	earn about the Paid Fa	amily Leave (PFL) benefit	program? Please sel	ect the response that l	best applies:			
Back to Top Contact FDD <u>Conditions</u>	of Use Privacy Policy	y Accessibility				Submit			

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.

Instructions for Submitting Proof of Relationship

To be eligible for Paid Family Leave benefits to bond with a new child you must submit an approved "Proof of Relationship" document. The "Proof of Relationship" must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online bonding claim.

Failure to submit the "Proof of Relationship" will result in claim disqualification and no payment will be issued.



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 <u>Submit Supporting Bonding Claim Documents</u> 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.



Submit Supporting Bonding Claim Documents

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



Employment Development State of California	SDI Home	Inbox	New Claim	Draft	Profile	History
Home						
🖾 Message Center						
Check the message center Inbox below to re Inbox [New: 0 , Total: 0]	eview messages and take req	uired actions as nee	ded.			
Personal Information						
Full Name:	John Doe		EDD Custom	er Account Number:	123456789	
Mailing Address:	123 Main St Sacramento, CA 95	814		Phone Number:	916-555-1212	
Residence Address:	123 Main St Sacramento, CA 95	814		Cell Phone Number:	916-555-1213	
E-mail Address:	Jdoe@gmail.com					
Current Disability Insura	ance Claim(s)					

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.

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

Note: It may be necessary to send some documents via US Postal Service.

Apply for Disability Insurance Benefits

Disability Insurance

Apply for Paid Family Leave Benefits

Paid Family Leave Bonding Submit Electronic Paid Family Leave Bonding Attachment Faid Family Leave Care Submit Electronic Paid Family Leave Care Attachment Paid Family Leave Military Assist Submit Electronic Paid Family Leave Military Assist Attachment

Saved Drafts

To open and complete a form that you saved, select the Form Name. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the Delete button.

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

0.cov			🏠 Hor	ne I		Log Out
Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History
Form Attachment						
To attach a file to your successfully submitte weeks of the date the claim was submitted.	ed Paid Family Leave claim	form, choose the 'Selec	t' link under the Action fiel	ld. Most claims are p	processed and a decision is m	ade within two
If you have not received anything from PFL	within 10 days or if you hav	e any questions you ma	ay call 1-877-238-4373.			
Select Claim to Attach	Document					
Form Name			Submit	ted Date	Receipt Number	Action
DE 2501F, Claim for Paid Family Leave (PFL	.) Benefits - Bond with Chil	d	07-01-2	021	R10000000032193	Select
		Ca	ncel			
Back to Top Contact EDD Condition	ns of Use Privacy Polic	y Accessibility				

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.

<i>Cl</i> eov			🏠 Hoi	me		Log Out
Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History
Attachment *Indicates Required Field						
Identifying Information	for Previously	y Submitte	ed Paid Family	/ Leave Initia	al Bonding	Claim
Your Social Security Number: Form Receipt Number:	XXX-XX-0001 R10000000032193		Date you requester Family	d to have your Paid Leave claim begin:	01-21-2021	
Previously Submitted At	tachments for	Paid Fami	ily Leave Initia	al Bonding C	laim	
Attachment						
To attach a document, select the Browse butto File size: less than 5MB File type: PDF,JPG, JPEG, TIF or TIFF 	n below.			_		
*Please click the "Br	*Do you want to attach t	for the document:	No file chosen		Browse	
Previous	you mane to attach	Ca	ncel		[Submit
Back to Top Contact EDD Conditions o	f Use Privacy Policy	Accessibility			-	

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.

<i>Clicov</i>			🏫 Home	-		Out	
Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History	
Attachment *Indicates Required Field							
Identifying Information Your Social Security Number: Form Receipt Number:	for Previously XXX-XX-0001 R10000000032193	Submitted	Paid Family Date you requested t Family Le	Leave Initi to have your Paid save claim begin:	al Bonding C	laim	
Previously Submitted At File Name Birth Certificate.jpg	tachments for	Paid Family	/ Leave Initial Receipt Number	Bonding	Claim		1
Attachment To attach a document, select the Browse butto • File size: less than 5MB • File type: PDF,JPG, JPEG, TIF or TIFF • Please click the "Br	n below. owse" button to browse for *Do you want to attach me	r the document: ore documents?	No file chosen Yes No		Browse		-
Previous Back to Top Contact EDD Conditions c	f Use Privacy Policy	Cance	el		[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.



	A =	Noto
	ω =	Note
EDDNext		For Spanish, selec
Español		Español.
<text><text></text></text>	Log In Email Password Password Forgot password? Log In Don't have an account? Create Account	
Contact EDD Conditions of Use Privacy Policy Accessibility		
Copyright © 2023 State of California		

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

- 1. Visit <u>myEDD</u>.
- 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.



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

Note

Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History
Home						
🖾 Message Center						
Check the message center Inbox below to rev Inbox [New: 0 , Total: 0]	view messages and take requin	ed actions as ne	eded.			
Personal Information						
Full Name:	John Doe		EDD Customer	Account Number:	123456789	
Mailing Address:	123 Main St Sacramento, CA 95	814		Phone Number:	916-555-1212	
Residence Address:	123 Main St Sacramento, CA 95	814	Ce	ell Phone Number:	916-555-1213	
E-mail Address:	Jdoe@gmail.com					
Current Disability Insura	nce Claim(s)					
No Results Found						
Pending Disability Insura	ance Claim Appl	ication(s	5)			
No Results Found						
Submitted Paid Family L	eave Claim Forr.	ns				
Only forms you submitted online are listed belo Leave claim is currently not available online. Fo	ow. To submit an electronic do or assistance with a Paid Family	cument for a pre / Leave claim, ca	eviously submitted care or all 1-877-238-4373.	bonding claim, selec	t New Claim. The status of	your Paid Family
No Results Found						

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

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

Note: It may be necessary to send some documents via US Postal Service.

Apply for Disability Insurance Benefits

Disability Insurance

Apply for Paid Family Leave Benefits

Paid Family Leave Bonding

Genilyi eave Bonding Attachment

Paid Family Leave Care Submit Electronic Paid Family, eave Care Attachment

Paid Family Leave Military Assist Submit Electronic Paid Family Leave Military Assist Attachment

Saved Drafts

To open and complete a form that you saved, select the Form Name. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the Delete button.

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 <u>Types of</u> <u>Claims</u>.

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.

Information for Before You Start and After You File

Before You Start and After You File

Please have the following information available while completing this form:

- Most current employer(s) business name, telephone number, and mailing address as stated on your W2 form and/or paycheck stub.
- · Last date you worked your regular or customary duties and hours.
- · Wages you received or expect to receive from your employer: sick leave, paid time off (PTO), vacation pay, annual leave, and wages earned after you stopped working.
- You are responsible for obtaining a Physician/Practitioner Certification to verify care is needed. A disqualification will be sent to you if the Physician/Practitioner Certification is not received within 10 days.
- Please note that your employer will be notified that you have submitted a PFL claim. However, your detailed claim information is confidential and will not be shared with your employer.

Cancel

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

Select Next.

Next

1 Personal Information 2	Employment Information	3 Additional Questions	4 Care Certificatio	on	5 Declaration
You are currently on Step 1 Personal Informa	tion				
Section 1 - Personal Info	ormation				
Social Security Number:	XXX-XX-XXXX	EDD Cus	tomer Account Number:	123456789	
Full Name:	John Doe	Other Names	(if any, under which you have worked):		
Date of Birth:	XX-XX-XXXX		Gender:	Male	
Mailing Address:	123 Main St Sacramento, CA 958	4	Phone Number:	916-555-1212	
Preferred Language:					
If your personal information has changed, selec	t Save as Draft. To update yo	Ir personal information before comp	leting this form, select Profi	le.	
Previous		Cancel Save as Draft	t		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.

Employment Details	
Personal Information 2 Employment Information 3 Ad	ditional Questions 4 Care Certification 5 Declaration
You are currently on Step 2 Employment Information * Indicates Required Field	
Section 2 - Employer Information	
Enter your current employer. If unemployed, enter your most recent employer. * Name of Your Employee * Occupation	r:
* Are you a state government employee If "Yes", Indicate Bargaining Unit Numbe	? Ves No
* May we disclose benefit payment information to your employer(s) * Do you have more than one employer * Reason for reducing work hours or stopping work	Yes No Yes No Care for Family Member Other
Employer Mailing Address	
* Address Line 1:	US International
Address Line 2:	
* State:	CA V
* ZIP Code:	
Employer Phone Number:	(No dashes or spaces) Ext: Check here if the phone number is international
Previous Cancel	Save as Draft Next

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.

Additional Questions		
Personal Information Personal Information Addition	nal Questions 4 Care Certification	5 Declaration
You are currently on Step 3 Additional Questions Indicates Required Field		
Section 3 - Additional Questions		
*Date you last worked:	(MMDDYYYY)	
*Date you want your Paid Family Leave claim to begin:	(MMDDYYYY)	
*Do you want to claim the maximum amount of benefit weeks now?	🔿 Yes 🔵 No	
If "No," enter the date you want to be paid through:	(MMDDYYYY)	
Date you returned to work:	(MMDDYYYY)	
Or date you plan to return to work:	(MMDDYYYY)	
*Will you work at any time during your family leave?	🔿 Yes 🔵 No	
If you will receive any type of pay from your employer(s) during your family leave, indicate type of pay:	Sick Employer Required Vacation Other Type of Pay	
Specify if "Other type of pay":	Select 💌	
*At any time during your Paid Family Leave, were you in the custody of law enforcement authorities because you were convicted of violating a law or ordinance?	🔿 Yes 🔵 No	
*Have you claimed or do you plan to claim Workers' Compensation Benefits for any portion of the period covered by this claim?	O Yes O No	
Previous Cancel	Save as Draft	Next

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.

Care Recipient's Information	
Personal Information Personal Information Additi	ional Questions Care Certification S Declaration
You are currently on Step 4 Care Certification Indicates Required Field	
Section 4 - Care Recipient's Information	
You must submit a signed "Care Recipient Authorization of Disclosure of Personal Health Infor these forms will be provided on the confirmation page.	mation" form and a signed "Statement of Care Recipient" form. Details on how to submit
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.
* First Name:	
Middle Initial:	
* Last Name:	
Suffix:	
* Gender:	Male Female
* Date of Birth:	(MMDDYYYY)
* Is any other family member ready, willing, and able and available to provide care for the same period you are claiming Paid Family Leave benefits?	Ves No
* Person you are caring for is your:	Select
Other Relationship:	
Residence Address	
	US International
* Address Line 1:	
Address Line 3:	
WALESS FILE 1	
* City:	
* State:	CA 💌
* ZIP Code:	
Phone Number:	(No dashes or spaces) Ext:
	Check here if the phone number is international
Previous Cancel	Save as Draft 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.

<i>O.</i> Gov						Log Out	
Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History	
Benefit Payment O	ptions						
Personal Information	Employment Information	Additiona	l Questions	Care Certification	5 Dec	claration	
You are currently on Step 5 Declaration *Indicates Required Field							
Section 5 – Select Your (Option						
If you're eligible for benefits, you have three o	ptions to receive your benefit	payments.					
_	*Select your p	payment option:	 Direct Deposi Debit Card Mailed Check 	5			
I have reviewed the Debit Card Fees and Di	isclosures.						
Gather your bank routing and account numbe	ers and select Next to continue	2.			_		-
Previous		Cancel	Save as Draft		[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.

Section	6 -	Dec	laration

Read the information below and check each box if you agree. A check in the box indicates an electronic signature executed by you, and is a legally binding equivalent of traditional handwritten signatures.

By my electronic signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was providing care for the care recipient named above; (2) authorize EDD to release my personal information as shown on this claim to the care recipient and to the care recipient's treating physician/practitioner as they are listed on this claim; (3) authorize my employer(s) to disclose to EDD all facts concerning my employment that are within their knowledge; and (4) authorize release and use of information as stated in the EDD "Information Collection and Access" section of the Important Paid Family Leave Program Information page. 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 valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my electronic signature or the effective date of the claim, whichever is later.



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).

Paid Family Leave (PFL) Survey Questions

* Indicates Required Field

Paid Family Leave (PFL) Survey

The EDD has received your portion of your claim for Paid Family Leave benefits. There is one more step to complete before you receive your claim receipt number. Please answer the questions below and then select the "Submit" button for your receipt number.

* Before you filed your Paid Family Leave (PFL) claim, how did you learn about the Paid Family Leave (PFL) benefit program? Please select the response that best applies:

From a brochure I received by U.S. mail.

From a friend or family member.

From an SDI Online Notification.

From my employer.

From a social worker or hospital employee.

○ None of these.

Submit

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	on		
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	R10000000332708
Instructions for Submitti	ng Physician/Practitior	ner's Certification for Care	Recipient
To be eligible for Paid Family Leave benefits to c Disclosure of Personal Health Information". The Failure to submit the "Physician/Practitioner's C disqualification and no payment will be issued.	are for a family member, you must submit a se documents must be received by the Paid f Certification for Care Recipient" and "Care Re	"Physician/Practitioner's Certification for Care Re Family Leave Office no later than ten (10) days fror Accipient Authorization for Disclosure of Personal H	cipient" and "Care Recipient Authorization for m the date you submit your online care claim. dealth Information" will result in claim
Mai You may mail your "Physician/Practitioner's (Recipient Authorization for Disclosure	l Certification for Care Recipient" and "Care e of Personal Health Information".		
Mail your doc EDD - Paid Far PO BOX 9 SACRAMENTO C/	ument to: mily Leave 97017 A 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/Practition	ner's Certification for Care Recipient
To be eligible for Paid Family Leave benefits to care for a family member, you must submit a Disclosure of Personal Health Information". These documents must be received by the Paid	"Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for 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 Re disqualification and no payment will be issued.	cipient Authorization for Disclosure of Personal Health Information" will result in claim
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.



	S	AMPLE,	this page	e for refere	ence on	у					
art B – Bonding Certification	D (to be comoleted by	person claiming PF	L benefits to be	and with a child)							
Your Social Security Number	82. Date of fos	ler care or	B3. Ch	ild named in B8	is my						
	auopuon p	accinent	Chile	eal d Stepchild	Child	Child	01	her			
Your Legal Last Name		BS. Child's S	incial Security	Number	R6. Child's d	ate of birth		87 Chile	l's Gende	er Identij	fw.
thereded in case pages of this claim become	reparated)	Gf availabl	a)		1 2 0	1 2 0	24		Male F	emale	•7
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ookie		AC	lai	m a n t	t						
Address where the child lives G diff	ferent from claimant's)										
Ļ I I I I I I I		State/Pro	ov. Zipor	Postal Code		Cou	ntry (if no	(U.S.A.)			
1. As evidence of the relationship in	B3, check one of the	e following and att	ach a copy of	the document of	checked.						
X Child's birth certificate	a an alternet,		Г	Independent	adoption plac	ement agree	ement, AD	-924			
Declaration of paternity, CS-	909			Other							
Adoptive placement agreeme	ent, AD-907										
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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 <u>UPPER CASE</u> 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.

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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.



File a Military Assist Claim

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


● ● ● ● ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■	☆ =	Note For Spanish, select Español .
<section-header></section-header>	Log In Email Password Password Forgot password? Log In Don't have an account? Create Account	
Contact EDD Conditions of Use Privacy Policy Accessibility Copyright © 2023 State of California		

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

- 1. Visit <u>myEDD</u>.
- 2. Enter the email and password used to create your myEDD account.
- 3. Select Log In.

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EDDNext		
Español		
Verify Your Identity		
To protect your account, we will email you a verification code.		
Send Email		
Contact EDD Conditions of Use Privacy Policy Accessibility		
Copyright © 2023 State of California		

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.



From the myEDD homepage, select SDI Online.

Note

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

Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History
Home						
🞯 Message Center						
Check the message center Inbox below to revi Inbox [New: 0 , Total: 0]	iew messages and take r	required actions as	needed.			
Personal Information						
Full Name:	John Doe		EDD Customer Ac	count Number:	123456789	
Mailing Address:	123 Main St Sacramento,	CA 95814	,	Phone Number:	916-555-1212	
Residence Address:	123 Main St Sacramento,	CA 95814	Cell F	Phone Number:	916-555-1213	
E-mail Address:	Jdoe@gmail.c	com				
Current Disability Insura	nce Claim(s)					
No Results Found						
Pending Disability Insura	ince Claim A	pplication	(s)			
No Results Found						
Submitted Paid Family L	eave Claim F	orms				
Only forms you submitted online are listed below Leave claim is currently not available online. For	w. To submit an electror rassistance with a Paid I	nic document for a p Family Leave claim,	previously submitted care or bor , call 1-877-238-4373.	nding claim, selec	t New Claim. The status of yo	ur Paid Family
No Results Found						

Select New Claim from the main menu.

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

Note: It may be necessary to send some documents via US Postal Service.

Apply for Disability Insurance Benefits

Disability Insurance

Apply for Paid Family Leave Benefits

Paid Family Leave Bonding Submit Electronic Paid Family Leave Bonding Attachment Paid Family Leave Care Submit Electronic Faid Family Leave Care Attachment Paid Family Leave Military Assist Submit Electronic Paid Family Leave Military Assist Attachment

Saved Drafts

To open and complete a form that you saved, select the Form Name. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the Delete button.

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

If unsure which application to complete, review the <u>Types of Claims</u>.



Military A	eld	tructions		Con insti	
Requirements					
Your Responsi	bilities			a m	
You must:				You	
Read these Include you File your cla Report in w • You c • You c • You c • You c • The n If you are not sure Basic Eligib You must:	Ineligibility You must not be: Claiming or receiving Ur Receiving Workers' Com In custody of law enforc You can apply for benefits eve why. Disqualification The PFL office will consider all	employment insurance (UI) or Disability insurance (DI) benefits. pensation benefits at a weekly rate equal to or greater than the PFL benefit rate. ament authorities because you were convicted of a crime. If you are not sure you are eligible. If you are ineligible for all or part of a period claimed, the EDD will notify you of the ineligib available information before disqualifying your claim. If the PFL office denies your claim, you will receive a written notice stati	e period and the reason(s) g the reason(s) why.	agre cont cont	
 Have a fam notification Have had o Be employe Have earne Have subm Be the spou Certify the r 	Do not deliberately report inc percent penalty. The penalty Benefits Benefit Amount Carefully decide the date you paid one-seventh of your wee start date of your claim can in How Benefits Are P After your claim is processed, requirements, a payment will continued benefits. If paymer Note: The majority of claims - Taxability of Benefit PFL benefits are subject to fee PFL benefits are not subject to Overpayment If you receive PFL benefits yo waived. Otherwise, you must from 25 to 100 percent until t Fraud	Reporting incorrect or incomplete information to collect or increase your benefits violates the California Unemployment in S20,000, or both. The EDD actively prosecutes fraud, and claimants who are caught will face criminal prosecution to the fu Your Rights Confidentiality Information about your claim will be kept confidential, except for the purposes allowed by law. The EDD will not disclose of Inspection You have the right to inspect any of your personal records maintained by the EDD, except for: • Medical or psychological records where knowledge of the contents might be harmful to the subject. • Medical or psychological records where knowledge of the contents might be harmful to the subject. • Medical or psychological records where knowledge of the contents might be harmful to the subject. • Medical or psychological records where knowledge of the contents might be harmful to the subject. • Medical or psychological records where knowledge of the contents might be harmful to the subject. • Medical or psychological records where knowledge of the contents might be harmful to the subject. • Medical or psychological records where knowledge of the contents might be harmful to the subject. • Medical or psychological records if you personal records. If the EDD denies you access, you can mail a request to review the of Employment Development Department Information Security Office, MIC 33 PO Box 328800 Sacramento, CA 94280-0001 Appeal You have the right to appeal any overpayment, penalty, or disqualification. Instructions on how to appeal will be provided Agree Before Continuing * I understand these instructions for submitting military assist claim, If I don't provide complete and accurate information	surance Code and is punishable t est extent of the law.	y imprisonment, a fine up to nation to medical providers. request to review the denial to: receive.	
		report incorrect or incomplete information to allect or increase my benefits, the EDD will disqualify my claim and I co	n face criminal prosecution.		
		Previous		Next	

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

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

1 Personal Information 2 Emplo	yment ation Additional Questions	4 Certification 5 Qual	ifying ts
You are currently on Step 1 Personal Informa	tion		
Section 1 - Personal Inf	ormation		
Social Security Number:	XXX-XX-XXXX	EDD Customer Account Number:	123456789
Full Name:	John Doe	Other Names (if any, under which you have worked):	
Date of Birth:	XX-XX-XXXX	Gender:	Male
Mailing Address:	123 Main St Sacramento, CA 95814	Phone Number:	916-555-1212
Preferred Language:			
If your personal information has changed, selec	t Save as Draft. To update your personal infor	mation before completing this form, select Profi	le.
Previous	Cancel	Save as Draft	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.

Employment Details	
Personal 2 Employment 3 Additional Questions	4 Certification 5 Qualifying Events 6 Declaration
You are currently on Step 2 Employment Information	
* Indicates Required Field	
Section 2 - Employer Information	
Enter your current employer. If unemployed, enter your most recent employer.	
* Name of Your Employer:	
* Occupation:	
* Are you a state government employee:	V Yes V No
* May we disclose benefit payment information to your employer(s)?	Yes No
* Do you have more than one employer?	○ Yes ○ No
* Reason for reducing work hours or stopping work	Care for Family Member Other
Employer Mailing Address	
	● US 🔿 International
* Address Line 1:	
Address Line 2:	
* City:	
* States	
June	CA 🗹
* ZIP Code:	
Employer Phone Number:	(No dashes or spaces) Ext:
	Check here if the phone number is international
Previous Cancel	Save as Draft Next

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.

Additional Questions	
Personal Information Information Additional Questions	4 Certification 5 Qualifying Events 6 Declaration
You are currently on Step 3 Additional Questions	
*Indicates Required Field	
Paid Family Leave Information	
*Date you last worked:	(MMDDYYYY)
The date you want your Paid Family Leave (PFL) benefits to begin cannot be before the date the	military member was notified of covered active duty status.
*Date you want your PFL claim to begin:	(MMDDYYYY)
*Do you want to claim the maximum amount of benefit weeks now?	○ Yes ○ No
If "No," enter the date you want to be paid through:	(MMDDYYYY)
Date you returned to work:	(MMDDYYYY)
Or date you plan to return to work:	(MMDDYYYY)
*Did you or will you work at any time during your family leave period?	O Yes O No
If you have or will receive any type of pay from your employer(s) during your family	Sick
leave period, select the type of pay:	Employer Required Vacation
	Other Type of Pay
If "Other Type of Pay ₃ " specify the type:	Select 🗸
*Have you claimed or do you plan to claim Workers' Compensation during your family leave period?	O Yes O No
*At any time during your Paid Family Leave, were you in the custody of law enforcement authorities because you were convicted of violating a law or ordinance?	○ Yes ○ No
Previous	Save as Draft 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.

Military Assist Certification		
Personal Employment Additional Information	Certification	on
You are currently on Step 4 Certification		
*Indicates Required Field		
Your Information		
*The Military Member is your:	Select 🗸	
If "Other," please specify:		
Military Member's Information		
*Military Member's First Name:		
Military Member's Middle Initial:		
*Military Member's Last Name:		
Military Member's Suffix:		
*Military Member's Date of Birth:	(MMDDYYYY)	
"Military Member's Gender:	Male Female	
*Last four digits of Military Member's Social Security Number:		
*Date Military Member was notified of covered active duty status:	(MMDDYYYY)	
*Covered active duty start date:	(MMDDYYYY)	
Covered active duty end date (if known):	(MMDDYYYY)	
Military Member's Mailing Address		
	US International	
Address Line 1:		
Address Line 2:		
"State:		
*ZIP Code:		
Supporting Military Documentation		
After you file this claim, you must submit an approved supporting military document to receive	PFL benefits.	
"\$elect the type of military document you will submit:	Covered active duty orders Letter of impending call or order to covered active duty Documentation approving rest and recuperation leave	
Instructions for submitting a supporting military document will be provided on the Confirmati	on page.	
Previous Cancel	Save as Draft N	ext

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.

Qualifying E	vents				
Personal Information	Employment Information	Additional Questions	Certification	S Qualifying Events	6 Declaration
You are currently on Step 5	Qualifying Events				
*Indicates Required Field					
Add Event					
Enter a qualifying event. If yo	ou are requesting PFL benefits for m	ultiple events, enter each eve	nt separately. You can add up to	eight events.	shild
	**114	n o your qualitying evenu	Provide an ange constant Provide arrange care for Attend counseling Make financial/legal arrar Assist the military memb Attend a military event Represent the military me Address issues due to the Other	e to the initiary member's parer ngements er during rest and recuperat ember at federal, state, or lo emilitary member's death	inn leave cal agencies
		If "Other," please specify:			
		*Event Start Date:	(MMDDYYYY)]	
		*Event End Date:	(MMDDYYYY)		
Event Details					
Provide the following inform	ation related to the qualifying event	•			
Provide the following monit	actor related to the qualitying even	Name or Organization:			
			US O International		
		Address Line 1:			
		Address Line 2:			
		City:			
		State:	CA 🗸		
		ZIP Code:			
		*Bhone Number		Eveta	
		Phone Number:	(No dashes or spaces)	number is international	
		Email Address:	Greek here it the priorier	namoerna meenacional	
	••				
	*Descri	ibe your qualifying event:	(Max characters is 255)		
					h
ou can add more events on th	he next page.				
Previous		Cancel	Save as Draft		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.

List of Qualifying Events					
Personal Information Employment Information	Additional Questions	Certification	5 Qualifying Events	6 Decl	aration
You are currently on Step 5 Qualifying Events *Indicates Required Field					
Your Events					
Select Add to enter another qualifying event. If you are finished	adding events, select Next to c	ontinue.			
Qualifying Event	Name or Or	ganization	Event Start Date	Event End Date	Action
Provide/arrange care for the military member's parent	Mother Jon	es	MM-DD-YYYY	MM-DD-YYYY	Delete
Previous	Cancel Ad	d Save a	is Draft		Next

To add more than one event:

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

0. Gov						Log Out
Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History
Benefit Paym	ent Options					
Personal Information	Employment Information	Additional Questions	Certification	Qua Eve	lifying nts	6 Declaration
You are currently on Step 6 De	claration					
*Indicates Required Field						
Select Your Option						
	*Sele	ct your payment option:	O Direct Deposit			
_			O Mailed Checks			
I have reviewed the Debit Card Fees and Disclosures.						
Gather your bank routing and a	ccount numbers and select Next to	continue.				
Previous		Cancel	Save as Draft			Next

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.

Digital	Signature
Digital	Signature

Read the following information and check the box if you agree. Note: A check in the box is a digital signature executed by you and is the legally binding equivalent to a traditional handwritten signature. * By my signature on this Military Assist Certification and claim statement, I: Claim Paid Family Leave benefits and certify that, throughout the period covered by this claim, I was assisting a military member during a qualifying event. Authorize the EDD to release my personal information as shown on this claim to the military member I am assisting. Authorize my employer(s) to disclose all facts concerning my employment that are within their knowledge to the EDD. Authorize the release and use of information as stated in the Information Collection and Access section on the Claim for Paid Family Leave (PFL) Benefits (DE 2501F). 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. 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. Agree that photocopies of this authorization shall be as valid as the original. 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. Previous Cancel Save as Draft Submit

Next, select the box to acknowledge your digital signature.

Select Submit to continue.

Paid Family Leave (PFL) Survey Questions

* Indicates Required Field

Paid Family Leave (PFL) Survey

The EDD has received your portion of your claim for Paid Family Leave benefits. There is one more step to complete before you receive your claim receipt number. Please answer the questions below and then select the "Submit" button for your receipt number.

* Before you filed your Paid Family Leave (PFL) claim, how did you learn about the Paid Family Leave (PFL) benefit program? Please select the response that best applies:

- From a brochure I received by U.S. mail.
- O From a friend or family member.
- O From an SDI Online Notification.
- O From my employer.
- From a social worker or hospital employee.
- None of these.

Complete the survey and select Submit.

Submit

Confirmation

You have successfully submitted your PFL claim. Allow two weeks for it to be processed. If you have any questions, call 1-877-238-4373.



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.

Important Next Steps

Failure to submit your supporting document will result in disqualification, and you will not receive payment. You must send it within 10 business days electronically or by mail.



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 <u>Submit Supporting Military Assist Claim Documents</u> 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.



Submit Supporting Military Assist Claim Documents

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



Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History
Home						
🖾 Message Center						
Check the message center Inbox below to revio Inbox [New: 0 , Total: 0]	ew messages and take r	equired actions as nee	ded.			
Personal Information						
Full Name:	John Doe		EDD Custom	er Account Number:	123456789	
Mailing Address:	123 Main St Sacramento,	CA 95814		Phone Number:	916-555-1212	
Residence Address:	123 Main St Sacramento,	CA 95814		Cell Phone Number:	916-555-1213	
E-mail Address:	Jdoe@gmail	.com				
Current Disability Insurar	nce Claim(s)					

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.

Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

Note: It may be necessary to send some documents via US Postal Service.

Apply for Disability Insurance Benefits

Disability Insurance

Apply for Paid Family Leave Benefits

Paid Family Leave Bonding Submit Electronic Paid Family Leave Bonding Attachment Paid Family Leave Care Submit Electronic Paid Family Leave Care Attachment Paid Family Leave Military Assist Submit Electronic Paid Family Leave Military Assist Attachment

Saved Drafts

To open and complete a form that you saved, select the Form Name. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the Delete button.

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

Form Attachment						
Allow two weeks for attachments to be process	ed. If you have any questio	ons, call 1-877-238-4373.				
Select a Claim						
Only claims you have successfully submitted w	ill be listed.					
Form Name			Date Submitte	ed Rece	ipt Number	Action
Claim for Paid Family Leave (PFL) Benefits - N	filitary Assist (DE 2501F)		MM-DD-YYY	Y R100	001000032163	Select

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.

Attach File				Note
*Indicates Required Field				To upload a
Claim Information Social Security Number: XXX-XX-XXXX Receipt Number: R100001000032163	Requested Claim Start Date:	MM-DD-YYYY		document, save the document to your computer of
Current Attachments				phone as a PDF, JPG,
No Results Found				JPEG, TIF,
Select a File				All file sizes
Select Browse to attach a file to your claim. Files must be less than 5MB Allowed file types: PDF, JPG, JPEG, TIF or TIFF 				must be 5MB or less
*Choose a file:	No file chosen	Browse		
*Attach another document?	🔿 Yes 💿 No			
Previous	ancel		Submit	

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**.

Áttachment Confirmation		
Your file has been uploaded and attached to your claim.		
Claim Information Social Security Number: XXX-XX-XXX Receipt Number: R100001000	<x 032163</x 	Requested Claim Start Date: MM-DD-YYYY
Attachments		
File Name	Date Submitted	Attachment Receipt Number
covered active duty orders - provide care.JPG	MM-DD-YYYY	R100001000032167

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.



Complete Paper Claim Forms

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



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 <u>form online</u> to have it mailed to you.
- Visit an <u>SDI Office</u>.
- 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.



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 not send photocopied or faxed forms.

Don't

 Do not mail the paper form if you already filed a claim online.

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

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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.



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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.





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



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El. Your Social Security Number E2. Your Legal Name	
El. Name of military member on covered active duty or impending call to cover	ed active duly slatus: (First Name AE Last Name)
EL Military Member's Dale of EL Military Member's Gender Identity	
TE Military Manhark Mailine Address	
City State/Prox.	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	10. Date military member
	was notified of covered active duty
	W W D D A A A A
E10. Select one of the following and attach the indicated document to support to active duty status	hat the military member is on covered active duty or impending call or order to covered
Covered Active Duty Orders Letter of Impending C Documentation of Military Leave Signed by the Approving Authority i	all or Order to Covered Duty for Military Member's Red and Recuperation
E11. The qualifying event for the PFL claim is for [One or more reasons may be se	elected)
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
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 at	lached!
Yes No None Available	
Note: A complete and sufficient conflictation to support a request for FR laws for less. Documentation may include, a cosp of a matting amountement for Rest and Recuperation leave, an appointment with a third party (i.e., a counside or financial affini. Haven is requested to meas while a third party, the employees and appropriate contact information of the individual or entity with whom you a	due to a qualifying event includes any available written documentation that supports the need informational briefings sponned by the milliary, a document confirming the milliary member's is school official, or staff at a care tacility, or a copy of a bill for services for the handing of legal means provide the supporting documentation of the meaning that includes the name, address are meeting (i.e., either phone number, tax number, or ornali address of the individual or entity).
ESS. Declaration and Signature. By my signature on the military anist conflication, i unit of bandho is a violation of California has purchabile by imposurement or five or book, or documents, is to the base of my inconcludge and billioning, contrast, and complexe, authorizations constanted in this claim statement are granted for a ported of 15 years from the statement and the statement are granted for a ported of 15 years from the statement and statement are granted for a ported of 15 years from the statement and statement are granted for a ported of 15 years from the statement and statement are granted for a ported of 15 years from the statement and statement are granted for a ported of 15 years from the statement and statement are granted for a ported of 15 years from the statement and statement are granted for a ported of 15 years from the statement are statement and statement are granted for a ported of 15 years from the statement are statement and statement and the statement are granted for a ported of 15 years from the statement are statement and the statement are granted for a ported of 15 years from the statement are statement and statement are granted for a ported of 15 years from the statement are granted for a ported of 15 years from the statement are statement and statement are granted for a ported of 15 years from the statement are statement are statement and statement are statement and statement are statement are statement and statement are stat	demand that willfelly making a false assument or conceasing a material fact in order to obtain payment 1 docken under penalty of penginy that the foregoing essement, including any accompanying assuments 1 agene that phenotepine of the advectments hell be an while a the original, and Lundinetand that on 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 V V V
DE 2501F Rev. 7 (1-25) (INTERNET) Pa	age 10 of 11

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.



O	alifyin	z.Even	t for I	eave	– D	cum	entati	on.														
If le	ave is rec	uested	to mee	t with a	third	party,	the emp	ployee n	nust prov	ide suppo	rting doo	umentar	tion of t	he mee	ting th	iat Inc	ludes	the n	ame,	addres	ss, an	d
app Ind as t atte	ropriate ividual or he milita nding an	ontact l entity). y memb	nforma The rea ier's rej sponso	tion of uson fo present red by	the Ir r a me ative i the m	dividu eting o sefore litary o	al or en an Incl a federa or milita	tity with ude: arr: al, state (ry servic	whom y anging for or local a ce organiz	ou are me r child or gency for zations.	seting (i.e parental purpose	t, either care, coi s of obta	the pho unseling ining, a	one nur g, maktr rrangin	nber, f ng fina g or aj	ax nu ncial (opeali	mber or leg ng mi	or en al arr litary	angen servie	idress nents, ce ben	of the acting efits, (e B OF
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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





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.