Claim for Paid Family Leave Benefits

Paid Family Leave (PFL) provides benefits to eligible workers who have 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 to participate in a qualifying event as a result of your spouse, registered domestic partner, parent, or child's military deployment to a foreign country.

Please read instruction and information pages (A through F) before completing the enclosed forms.

For faster processing, apply using SDI Online at edd.ca.gov/SDI_Online instead of this form.

Do **not** complete this form if you are insured by a Voluntary Plan. Ask your employer for those forms.

If you cannot complete this form due to a disability, or if you are an authorized representative filing for benefits on behalf of an incapacitated or deceased customer, call 1-877-238-4373.

How to Complete This Form

- Use black ink only.
- Type or write clearly within the boxes provided.
- Enter your Social Security number on all pages of the claim form including attachments.
- Do not fax the form.

Mail the completed form to the EDD in the envelope provided. Submit your claim no earlier than the first day your family leave begins but no later than 41 days after your family leave begins.

1. Complete **all** items on the enclosed "Part A – Statement of Claimant" and **sign box A25.** For box A8, the United States Postal Service will not deliver mail to a private mailbox unless it is preceded by the initials "PMB."
2. For bonding, also complete "Part B – Bonding Certification" and enclose a copy of one of the documents listed in box B10. Do **not** complete Part B if you are filing to care for a family member.
3. For care:
   a. Have the care recipient complete and sign "Part C – Statement of Care Recipient." If the care recipient is a minor or incapacitated, an authorized representative may complete this part.
   b. Have the treating physician/practitioner complete and sign "Part D – Physician/Practitioner's Certification." Certification may be made by a licensed physician or practitioner authorized to certify to a patient's disability or serious health condition (California Unemployment Insurance Code, or CUIC, section 2708).

   If the care recipient is under the care of an accredited religious practitioner, obtain a *Practitioner's Certification for Paid Family Leave (PFL) Benefits* (DE 2502F) by calling 1-877-238-4373. **Rubber stamped signatures are not accepted.**
4. For participating in a qualifying event, also complete "Part E – Military Assist Certification" and enclose a copy of one of the documents listed in Box E10.
5. Decide the date you want your claim to begin. See "Your Benefit Amounts" on page B for information.
6. Place the completed, signed forms in the envelope provided. Claims are generally processed within 14 days after we receive a completed claim.
   - For bonding, a claim is complete when parts A and B, and supporting documents are received.
   - For care, a claim is complete when parts A, C, and D are received.
   - For military assist, a claim is complete when Parts A, E and supporting documentation are received.
7. Keep these instructions and information pages (A through F) for future reference.

Note: You may lose or delay benefits if your claim is late, has errors or missing information.

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/or alternate formats need to be made by calling 1-866-490-8879 (voice). TTY users, please call the California Relay Service at 711.

Basic Eligibility Paid Family Leave benefits can be paid only after you meet all of the following requirements:

- You must be unable to do your regular or customary work due to the need to provide care, to bond with a new child, or to participate in a qualifying event.
- You must be employed or actively looking for work at the time your family leave begins.
- If working, you must have lost wages because you were caring for a seriously ill family member, bonding with a new child, or participating in a qualifying event.
- You must have earned at least $300 from which State Disability Insurance (SDI) deductions were withheld during a previous period. (See "Your Benefit Amounts" in the next column.)
- You must complete and mail a claim form within 41 days after the first day your family leave begins or you may lose benefits.

In addition, the following requirements must be met only if your PFL claim is to care for a seriously ill family member:

- The care recipient must be your child, parent, spouse, registered domestic partner, grandparent, grandchild, sibling, or parent-in-law.
- The care recipient must be under the continuing treatment or supervision of a licensed physician/practitioner or accredited religious practitioner while you are receiving benefits.
- The care recipient's physician/practitioner must complete the certification that he/she requires care. If the care recipient is under the care of a religious practitioner, request a *Practitioner's Certification for Paid Family Leave (PFL) Benefits* (DE 2502F) from the PFL office. Certification by a religious practitioner is acceptable only if the practitioner has been accredited by the EDD.

The following requirements must also be met only if your PFL claim is to bond with a new child:

- Your leave must take place within 12 months of the birth, adoption, or foster care placement of the child.
- The new child must be either your or your registered domestic partner's biological child, adopted child, or foster child.

The following requirements must also be met only if your PFL claim is to assist a military family member:

- Provide proof of covered active duty or call to covered active duty documentation of the family member.
- Provide the qualifying event for leave and any supporting documentation. For example, taking the leave to make financial or child care arrangements, or to attend an event sponsored by the military. A document supporting the reason for leave may be required.

Ineligibility You 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 reason. You may not be eligible for PFL benefits if:

- You are claiming or receiving Unemployment Insurance (UI) or Disability Insurance (DI) benefits.
- You are receiving workers' compensation benefits at a weekly rate equal to or greater than the PFL rate.
- You are in jail, prison, or any other facility.

Fraud It is a violation to willfully make a false statement or knowingly conceal a material fact in order to obtain the payment of any benefits.

Such violation is punishable by imprisonment, and/or by a fine not exceeding $20,000, or both. To detect and discourage fraud, the EDD continually monitors claims, vigorously investigates suspicious activity, and will seek restitution and conviction through prosecution (CUIC, sections 1143, 2101, 2116, 2122, and 3305)

Your Responsibilities

- File your claim and other forms completely, accurately, and in a timely manner. If a form is late, include with the form a written explanation of the reason to the form.
- Thoroughly read the instructions on this and all other forms you receive from PFL. If you are not sure what is required, contact the PFL office. Report to PFL in writing, electronically, or by telephone any:
  - change of address or telephone number.
  - return to part-time or full-time work.
  - recovery from your disability.
  - income you receive.
- **Include your name and Social Security number on all correspondence.**

Your Rights Information about your claim will be kept confidential, except for the purposes allowed by law. You have the right to inspect any personal records maintained about you by the EDD and to request that your records be corrected if you believe they are not accurate, relevant, timely, or complete (California Civil Code, sections 1798.34 and 1798.35). 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; records of active criminal, civil, or administrative investigations (Civil Code, section 1798.40). Additionally, the EDD will not disclose or provide copies of care recipients' medical information to care providers. If you are denied access to records which you believe you have a right to inspect or if your request to amend your records is refused, you may file an appeal with the PFL office. You may request a copy of your file by calling the telephone number shown on your *Notice of Computation* (DE 429D).

You also have the right to appeal any disqualification, overpayment, or penalty. Specific instructions on how to appeal will be provided on any appealable document you receive.

Your Benefit Amounts Your claim begins on the date your family leave began. The EDD calculates your weekly benefit amount using your base period. The date your family leave began determines your base period. You may not change the beginning date of your claim or adjust your base period after you have established a valid claim.

This base period covers 12 months and is divided into four consecutive quarters. Your base period includes wages subject to SDI tax that you were paid approximately 5 to 18 months before your PFL claim begins. Your base period does not include wages being paid at the time family leave begins. For a PFL claim to be valid, you must have earned at least $300 in wages in the base period. Using the following, you may determine the base period.

- If your claim begins in January, February, or March, your base period is the 12 months ending last September 30.
- If your claim begins in April, May, or June, your base period is the 12 months ending last December 31.
- If your claim begins in July, August, or September, your base period is the 12 months ending last March 31.
- If your claim begins in October, November, or December, your base period is the 12 months ending last June 30.

The quarter of your base period in which you were paid the highest wages determines your **weekly benefit amount**. For more information about your benefit amount visit **edd.ca.gov/Disability/Calculating_PFL_Benefit_Payment_Amounts.htm**.

Contact the PFL office to inquire about benefits and to provide additional information if your situation fits any of these circumstances:

- If you do not have sufficient base period wages, you may be able to apply by using a later beginning date.
- If you do not have enough base period wages and you were actively seeking work for 60 days or more in any quarter of the base period, you may be able to substitute wages paid in prior quarters.
- If during your base period you served in the military, received workers' compensation benefits, or did not work because of a labor dispute.

How Benefits are Paid When your claim is received, the PFL office will notify you of your weekly benefit amount and request any additional information needed to determine your eligibility. If you are eligible to receive benefits, payments are issued through the Money Network debit card. You do not have to accept the debit card, but the debit card is the fastest and most secure way to receive your benefits. **Select your preferred payment method in field A16.**

You have an option to receive your benefit payments by check. The majority of claims are processed and payments issued within 14 days of receipt of a correctly completed claim.

Payments will be issued automatically. 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 "Benefit Reductions" below.

Benefit Reductions Under certain circumstances, you may not be eligible for benefits for a period of your claim or you may be entitled only to partial benefits. The EDD will determine whether or not benefits must be reduced. The types of income shown in the following list should be reported to the EDD even though they may not always affect your benefits. Failure to report your income could result in an overpayment, penalties, and/or a false statement disqualification.

- Sick leave pay
- Vacation pay
- Self-employment income
- Military pay
- Commissions
- Wages, including modified duty wages
- Residuals
- Bonuses
- Workers' compensation benefits
- Holiday pay
- Paid time off
- Part-time work income

In addition, your benefits may be reduced because of a prior unemployment, disability, or Paid Family Leave overpayment or for delinquent court-ordered support payments.

Benefit Interruption and Termination You will see "Notice of Exhaustion of Paid Family Leave Benefits" on the *Electronic Benefit Payment (EBP) Notification* (DE 2500E) when:

- You have been paid to the date the care recipient no longer requires care, as estimated by the care recipient's physician/practitioner. If the care recipient still requires care, complete and sign the PFL Claimant's Certification portion and ask the care recipient's physician/practitioner to complete and mail the *Physician/Practitioner's Supplementary Certificate* (DE 2525XFA).
- The care recipient has recovered. If you return to work and the care recipient again requires care, immediately submit a new claim form and report the dates you worked.

A *Notice of Exhaustion of Paid Family Leave Benefits* (DE 2525AF) will be issued when records show you have been paid the maximum amount of PFL benefits.

Taxability of Benefits PFL 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. For 1099G inquiries, please call 1-800-795-0193.

Overpayment An overpayment results when you receive PFL benefit payments you were not eligible to receive. Once the EDD 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. Payments issued after an overpayment is established may be reduced by 25 to 100 percent to collect your overpayment. You will receive a *Notice of Overpayment Offset* (DE 826), if your weekly benefit amount is reduced due to a DI, PFL, or UI overpayment.

Disqualification All available information will be considered before issuing a benefit payment or disqualifying your claim.

Benefits will be paid only for the days you are eligible. If payment of benefits is denied or reduced, you will receive a written notice stating the reason for the disqualification.

If you deliberately report incorrect information or if you willfully omit or withhold information, false statement disqualifications of up to 92 days will be assessed. This can apply if you receive a payment that you know includes days you should not be paid, such as days after you returned to work. In addition, any overpayment will be increased by a 30 percent penalty.

Special Circumstances

- For pregnancy, mothers who are receiving DI benefits for a pregnancy-related disability and have delivered their child may be eligible for PFL benefits to bond with their new child. A *Claim for Paid Family Leave (PFL) Benefits - New Mother* (DE 2501FP) will automatically be sent to these new mothers at the end of their pregnancy-related DI claims.
- For child support obligations, contact the District Attorney's office administering the court order.
- For spousal or parental support obligations, questions should be directed to the District Attorney's office administering the court order.
- If a person receiving PFL benefits dies, an heir or legal representative should report the death to PFL. Benefits are payable through the date of death, if otherwise eligible.
- If the person for whom you are caring for or the child with whom you are bonding with dies, report the death to PFL at 1-877-238-4373. Benefits are payable through the date of death, if otherwise eligible.
- For job benefits and protection programs, the 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. For more information about FMLA, call 1-866-487-9293 or visit **dol.gov/whd/fmla**. For more information on CFRA, call 1-800-884-1684 or visit **dfeh.ca.gov**.

PREPAID DEBIT CARD DISCLOSURES

Money Network State Government Disbursement Program Short Form

You do not have to accept this benefits card. Ask about other ways to receive your benefits.			
Monthly fee **$0**	Per purchase **$0**	ATM withdrawal **$0** in-network **$1.00** out-of-network	Cash reload **N/A**
ATM balance inquiry (in-network or out-of-network)			$0
Customer service			$0 per call
Inactivity			$0
We charge 5 other types of fees. Here are two of them:			
ATM Withdrawal Int.			$1.00
Priority Shipping			$8.00
No overdraft/credit feature Your funds are eligible for FDIC insurance. For general information about prepaid accounts, visit *cfpb.gov/prepaid*. Find details and conditions for all fees and services in the Cardholder Agreement.			

Money Network State Government Disbursement Program. The Mastercard Card is issued by My Banking Direct, a service of Flagstar N.A., Member FDIC, pursuant to a license from Mastercard U.S.A. Inc. Incorporated. Card is serviced by Money Network Financial, LLC

List of all fees (Long Form) for the Money Network® State Government Disbursement Program

All Fees	Program Fees	Details
Monthly Usage		
Account Opening and Card Receipt	$0.00	No fee for Account Opening and initial Card.
Monthly Maintenance Fee	$0.00	We do not assess a monthly maintenance fee.
Add Money		
Payer Deposit	$0.00	Funds are loaded only by your Payer.
Spend Money		
Signature Debit Transactions	$0.00	Select “Credit” or sign at point-of-sale (POS). International Service Assessment or Cross Border Assessment may also apply to International Transactions.
PIN Debit Transactions	$0.00	Select “Debit” and enter PIN at POS; cash back option at participating merchants. International Service Assessment or Cross Border Assessment may also apply to International Transactions.
Get Cash or Send Cash		
ATM Withdrawal Fee or ATM Decline Fee | In-Network	$0.00	Withdrawal or Decline from ATM that is a part of our network. To find in-network ATMs, use the locator on our Mobile App (data rates may apply) or on our Website, or call Customer Service.
ATM Withdrawal Fee| Out-of-Network	$1.00	This is our fee. You will receive two (2) free withdrawals after each deposit made to your account. You may also be charged a fee by the ATM operator, even if you do not complete a transaction. “Out-of-Network” means ATMs that are not in-network ATMs. To find in-network ATMs, use the locator on our Mobile App (data rates may apply) or on our Website, or call Customer Service.
ATM Decline Fee | Out-of-Network	$0.00	We do not charge a fee for this service. You may be charged a fee by the ATM operator.
Bank Teller Over the Counter Cash Withdrawal	$1.00	At banks displaying the card association logo on your Card’s front side. This is our fee. You will receive one (1) free per deposit made to your account. International Service Assessment or Cross Border Assessment may also apply to International Transactions.

List of all fees (Long Form) for the Money Network® State Government Disbursement Program
(continued)

All Fees	Program Fees	Details
Transfer to Customer Bank Fee	$0.00	Domestic ACH transactions are subject to additional terms that are disclosed when transaction is initiated.
International ACH Withdrawal Fee	$0.00 plus 0% of the exchange rate	This transaction allows you to transfer funds via ACH to an international bank account. We charge transfer fees consisting of a flat fee of up to $7.00 plus a mark-up on the exchange rate of up to 3.5%. The transfer fees may be less depending on the amount transferred and market conditions. Applicable transfer taxes will also be charged. The exact amount of transfer fees and transfer taxes charged by us will be disclosed to you before you complete the transaction. Your transaction is subject to an exchange rate conversion, and may be subject to additional fees and taxes from 3rd parties. Recipient's financial institution may also charge fees and taxes. We do not monitor exchange rates or fees established by 3rd parties, and these amounts are subject to change. These transactions are subject to additional terms that are disclosed when a transaction is initiated. See Website for more information. You may call Customer Service for assistance.
Information		
Monthly Paper Statement	$0.00	You may also obtain Account activity without a fee via Mobile App (data rates may apply), our Website, or by contacting Customer Service.
Customer Service	$0.00	24/7 toll free Account access, including account balance inquiries.
ATM Balance Inquiry Fee | In-Network	$0.00	To find in-network ATMs, use the locator on our Mobile App (data rates may apply) or at our Website, or call Customer Service.
ATM Balance Inquiry Fee | Out-of-Network	$0.00	This is our fee. You may also be charged a fee by the ATM operator, even if you do not complete a transaction.
Using Your Card Outside the U.S. (International Transactions)		
ATM Withdrawal INT Fee (Non-U.S.)	$1.00	This is our fee. You may also be charged a fee by the ATM operator, even if you do not complete a transaction. Currency Conversion Assessment Fee, International Service Assessment, and/or Cross Border Assessment may also apply to these transactions.
ATM Decline INT Fee (Non-U.S.)	$0.00	
ATM Balance Inquiry INT Fee (Non-U.S.)	$0.00	
Mastercard International Service Assessment	2.0%	This fee applies if a transaction is initiated in a currency other than U.S. dollars and a currency conversion rate applies. Fee is assessed as a percentage of the U.S. dollar amount of each International Transaction made with your Card. See the section labeled "International Transactions" in your Cardholder Agreement for additional information. If this fee applies to your transaction, it will be included in the transaction amount on your statement.
Mastercard Cross Border Assessment	0.0%	This fee applies if a transaction is initiated in U.S. dollars by a merchant with a non-U.S. country code. Fee is assessed as a percentage of the U.S. dollar amount of each International Transaction made with your Card. See the section labeled "International Transactions" in your Cardholder Agreement for additional information. If this fee applies to your transaction, it will be included in the transaction amount on your statement.
Other		
Reissuance of Lost/ Stolen Card	$0.00	Reissued Card shipped via U.S. mail 7-10 business days after order placed. One replacement Card provided at no charge each calendar year.
Priority Shipping Fee	$8.00	Additional fee to ship replacement Card 4-7 business days after order placed. Reissuance of Card Fee also applies.

Additional Disclosures

Your funds are eligible for deposit insurance up to the applicable limits by the Federal Deposit Insurance Corporation ("FDIC"). Your funds will be held at My Banking Direct, a service of New York Community Bank, an FDIC-insured institution. Once there, your funds are insured up to $250,000 by the FDIC in the event New York Community Bank fails, if specific deposit insurance requirements are met and your card is registered. See fdic.gov/deposit/deposits/prepaid.html for details.

No overdraft/credit feature.

Contact Customer Service by calling 1-800-684-7051, by mail at 2900 Westside Parkway, Alpharetta, GA 30004, or visit our Website at *moneynetwork.com/EDD*.

For general information about prepaid accounts, visit *cfpb.gov/prepaid*.

If you have a complaint about a prepaid account, call the Consumer Financial Protection Bureau at 1-855-411-2372 or visit cfpb.gov/complaint.

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FEDERAL PRIVACY ACT.

The EDD requires disclosure of Social Security numbers to comply with California Unemployment Insurance Code, sections 1253 and 2627; with California Code of Regulations, Title 22, sections 1085, 1088, and 1326; with Code of Federal Regulations, Title 20, Part 604; and with U.S. Code, Title 8, sections 1621, 1641, and 1642.

INFORMATION COLLECTION AND ACCESS.

State law requires the following information to be provided when collecting information from individuals:

Agency Name:	**Title of Official Responsible for Information Maintenance:**
Employment Development Department (EDD)	Manager, EDD Paid Family Leave Office

Local Contact Person:	**Contact Information:**
Manager, EDD Paid Family Leave Office	You may contact Paid Family Leave by calling 1-877-238-4373. A list of Paid Family Leave local office locations can be found by visiting **edd.ca.gov/disability/Contact_DI.htm**. The address and phone number of Paid Family Leave will also appear on the *Notice of Computation* (DE 429D) issued at the time your benefit determination is made.

Maintenance of the information is authorized by:

California Unemployment Insurance Code, sections 2601 through 3306.

California Code of Regulations, Title 22, sections 2706-2, 2706-3, and 2708-1.

Consequences of not providing all or any part of the requested information:

- Failure to supply any or all information may cause delay in issuing benefit payments or may cause you to be denied benefits to which you are entitled.
- If you willfully make a false statement or representation or knowingly withhold a material fact to obtain or increase any benefit or payment, the EDD will disqualify you from receiving benefits and/or services and may initiate criminal prosecution against you.

Principal purpose(s) for which the information is to be used:

- To determine eligibility for Paid Family Leave benefits.
- To be summarized and published in statistical form for the use and information of government agencies and the public. (Neither your name and identification nor the name and identification of the care, bonding or military assist recipient will appear in publications.)
- To be used to locate persons who are being sought for failure to provide child or spousal support.
- To be used by other governmental agencies to determine eligibility for public social services under the provisions of California Welfare and Institutions Code, Division 9.
- To be used by the EDD to carry out its responsibilities under the California Unemployment Insurance Code.
- To be exchanged pursuant to California Unemployment Insurance Code, section 322, and California Civil Code, section 1798.24, with other governmental departments and agencies, both federal and state, which are concerned with any of the following:
  - (1) Administration of an Unemployment Insurance program.
  - (2) Collection of taxes which may be used to finance Unemployment Insurance or State Disability Insurance.
  - (3) Relief of unemployed or destitute individuals.
  - (4) Investigation of labor law violations or allegations of unlawful employment discrimination.
  - (5) The hearing of workers' compensation appeals.
  - (6) Whenever necessary to permit a state agency to carry out its mandated responsibilities where the use to which the information will be put is compatible with the purpose for which it was gathered.
  - (7) When mandated by state or federal law. Disclosures under California Unemployment Insurance Code, section 322, will be made only in those instances in which it furthers the administration of the programs mandated by that Code.
- Pursuant to California Unemployment Insurance Code, sections 1095 and 2714, information may be revealed to the extent necessary for the administration of public social services or to the Director of Social Services or his/her representatives.
- Information shall be disclosed to authorized agencies in accordance with California Unemployment Insurance Code, sections 1095 and 2714.

SAMPLE, this page for reference only

Employment Development Department
State of California

Claim for Paid Family Leave (PFL) Benefits

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

A1. YOUR SOCIAL SECURITY NO.: 000-00-0000

A2. YOUR DATE OF BIRTH (MM DD YYYY): 01/01/1900

A3. LANGUAGE YOU PREFER TO USE: ENGLISH [X] ESPAÑOL [ ] OTHER (PRINT BELOW)

A4. YOUR LEGAL NAME: FIRST NAME: SAMPLE; MI: ; LAST NAME: CLAIMANT

A5. YOUR GENDER: MALE [X] FEMALE [ ]

A6. YOUR TELEPHONE NUMBER: 999-023-6789

A7. OTHER LAST NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED:

A8. YOUR MAILING ADDRESS (TO RECEIVE MAIL AT A PRIVATE MAIL BOX—NOT A US POSTAL SERVICE BOX—YOU MUST SHOW THE NUMBER IN THE "PMB#" SPACE.): 123 ANY STREET

PMB# (IF APPLICABLE):

CITY: ANYTOWN; STATE/PROV.: CA; ZIP OR POSTAL CODE: 12345; COUNTRY (IF NOT U.S.A.):

A9. NAME OF YOUR EMPLOYER: ROADRUNNER PASTRIES

MAILING ADDRESS: 647 ARMISTICE WAY

CITY: ANYWHERE; STATE/PROV.: CA; ZIP OR POSTAL CODE: 66222; EMPLOYER'S PHONE NUMBER: 499-311-1111

A10. DATE YOU LAST WORKED (MM DD YYYY): 12/01/2015

A11. DATE YOU WANT YOUR PFL CLAIM TO BEGIN (MM DD YYYY): 12/16/2015

A12. DATE YOU RETURNED OR WILL RETURN TO WORK (MM DD YYYY): 01/27/2016

A13. DID YOU WORK OR WILL YOU CONTINUE TO WORK DURING YOUR FAMILY LEAVE PERIOD? NO [X] YES [ ]

A14. WHY DID YOU OR WILL YOU REDUCE YOUR WORK HOURS OR STOP WORKING? CARE FOR FAMILY MEMBER [ ] BOND WITH CHILD [X] MILITARY ASSIST [ ] OTHER (EXPLAIN):

A15. WHAT IS YOUR OCCUPATION? PASTRY CHEF

A16. SELECT YOUR PREFERRED PAYMENT METHOD: [ ] EDD DEBIT CARD℠ [ ] CHECK

A17. LEGAL NAME OF CARE, BONDING, OR MILITARY ASSIST RECIPIENT (FIRST / MIDDLE INITIAL / LAST): COOKIE A CLAIMANT

A18. THE ABOVE-NAMED CARE, BONDING, OR MILITARY ASSIST RECIPIENT IS YOUR: CHILD [X] SPOUSE [ ] REGISTERED DOMESTIC PARTNER [ ] PARENT [ ] PARENT IN-LAW [ ] GRAND PARENT [ ] GRAND CHILD [ ] SIBLING [ ] OTHER (EXPLAIN):

A19. IS ANY OTHER FAMILY MEMBER READY, WILLING, AND ABLE AND AVAILABLE TO PROVIDE CARE FOR THE SAME PERIOD YOU ARE CLAIMING PFL BENEFITS? NO [X] YES [ ]

A20. HAVE YOU CLAIMED OR DO YOU PLAN TO CLAIM WORKERS' COMPENSATION BENEFITS FOR ANY PORTION OF THE PERIOD COVERED BY THIS CLAIM? NO [X] YES [ ]

A21. DO YOU HAVE MORE THAN ONE EMPLOYER? NO [X] YES [ ]

A22. IF YOUR EMPLOYER(S) CONTINUED OR WILL CONTINUE TO PAY YOU DURING YOUR FAMILY LEAVE, INDICATE TYPE OF PAY: SICK [ ] VACATION [ ] OTHER (EXPLAIN):

A23. MAY WE DISCLOSE BENEFIT PAYMENT INFORMATION TO YOUR EMPLOYER(S)? NO [ ] YES [X]

A24. AT ANY TIME DURING YOUR PFL LEAVE, WERE YOU IN THE CUSTODY OF LAW ENFORCEMENT AUTHORITIES BECAUSE YOU WERE CONVICTED OF VIOLATING A LAW OR ORDINANCE? NO [X] YES [ ]

A25. Declaration and Signature. By my 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, bonding with, or participating in a qualifying event with the recipient named above (2) authorize EDD to release my personal information as shown on this claim to the care recipient's treating physician as they are respectively listed in Part C and Part D of this claim (3) authorize my employer(s) to disclose EDD all facts concerning my employment that are within their knowledge and (4) authorize release and use of information as stated in the Information Collection and Access portion of this form. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement including any accompanying statements is to the best of my knowledge and belief true correct and complete. I agree that photocopies of this authorization shall be as valid as the original and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.

Claimant's Signature (DO NOT PRINT): Sample Claimant

If signature is made by mark (X), please place mark here.*

Date Signed (MM DD YYYY): 12/16/2015

*If your signature is made by mark (X), it must be attested by two witnesses with their addresses

1st Witness Signature and Address

2nd Witness Signature and Address

PART B – BONDING CERTIFICATION (TO BE COMPLETED BY PERSON CLAIMING PFL BENEFITS TO BOND WITH A CHILD)

B1. YOUR SOCIAL SECURITY NUMBER
000-00-0000

B2. DATE OF FOSTER CARE OR ADOPTION PLACEMENT (M M D D Y Y Y Y)

B3. CHILD NAMED IN B8 IS MY
BIOLOGICAL CHILD: X | STEPCHILD | FOSTER CHILD | ADOPTED CHILD | OTHER

B4. YOUR LEGAL LAST NAME (NEEDED IN CASE PAGES OF THIS CLAIM BECOME SEPARATED)
CLAIMANT

B5. CHILD'S SOCIAL SECURITY NUMBER (IF AVAILABLE)

B6. CHILD'S DATE OF BIRTH (M M D D Y Y Y Y)
12012015

B7. CHILD'S GENDER
MALE | FEMALE: X

B8. LEGAL NAME OF CHILD (FIRST | MIDDLE INITIAL | LAST)
COOKIE | A | CLAIMANT

B9. CHILD'S RESIDENCE ADDRESS (IF DIFFERENT FROM CLAIMANT'S)

CITY | STATE/PROV. | ZIP OR POSTAL CODE | COUNTRY (IF NOT U.S.A.)

B10. AS EVIDENCE OF THE RELATIONSHIP IN B3, CHECK ONE OF THE FOLLOWING AND ATTACH A COPY OF THE DOCUMENT CHECKED.
(DO NOT SEND ORIGINAL DOCUMENT. IT WILL NOT BE RETURNED.)

- [X] CHILD'S BIRTH CERTIFICATE
- [ ] DECLARATION OF PATERNITY, CS-909
- [ ] FOSTER CARE PLACEMENT RECORD, SOC-815
- [ ] ADOPTIVE PLACEMENT AGREEMENT, AD-907
- [ ] INDEPENDENT ADOPTION PLACEMENT AGREEMENT, AD-924
- [ ] OTHER

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

Original Signature of Bonding Claimant – RUBBER STAMP IS NOT ACCEPTABLE
Sample Claimant

Date Signed (M M | D D | Y Y Y Y)
12162015

PART C – STATEMENT OF CARE RECIPIENT

(MAY BE COMPLETED BY CLAIMANT IF CARE RECIPIENT IS MENTALLY OR PHYSICALLY UNABLE TO DO SO. MUST BE SIGNED BY CARE RECIPIENT OR CARE RECIPIENT'S AUTHORIZED REPRESENTATIVE.)

C1. RECIPIENT'S DATE OF BIRTH (M M D D Y Y Y Y)

C2. RECIPIENT'S TELEPHONE NUMBER

C3. RECIPIENT'S GENDER
MALE | FEMALE

C4. LEGAL NAME OF CARE RECIPIENT (FIRST | MIDDLE INITIAL | LAST)

C5. CARE RECIPIENT'S RESIDENCE ADDRESS

CITY | STATE/PROV. | ZIP OR POSTAL CODE | COUNTRY (IF NOT U.S.A.)

C6. CONFIRMATION OF MEDICAL DISCLOSURE AUTHORIZATION. I authorize my physician/practitioner to disclose my current personal health information to my care provider and to the California Employment Development Department (EDD). I further understand that copies of my signature below are as valid as the original.

Care Recipient's Signature (DO NOT PRINT)

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

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

Authorized Representative's Signature (DO NOT PRINT)

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

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

INSTRUCTIONS FOR COMPLETING THIS FORM:

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

PART D – PHYSICIAN/PRACTITIONER'S CERTIFICATION (DO NOT COMPLETE THIS PART IF YOU ARE BONDING OR PARTICIPATING IN A QUALIFYING EVENT.)

D1. PFL CLAIMANT'S (CARE PROVIDER'S) SOCIAL SECURITY NUMBER

D2. PFL CLAIMANT'S NAME (FIRST MIDDLE INITIAL LAST)

D3. **PATIENT'S** DATE OF BIRTH (M M D D Y Y Y Y)

D4. DOES YOUR PATIENT REQUIRE CARE BY THE CLAIMANT? NO (SKIP TO D15) YES

D5. PATIENT'S NAME (FIRST MIDDLE INITIAL LAST)

D6. DIAGNOSIS OR, IF NOT YET DETERMINED, A DETAILED STATEMENT OF SYMPTOMS

D7. PRIMARY ICD CODE

D8. SECONDARY ICD CODES

D9. DATE PATIENT'S CONDITION COMMENCED (M M D D Y Y Y Y)

D10. FIRST DATE CARE NEEDED (M M D D Y Y Y Y)

D11. DATE YOU EXPECT RECOVERY (M M D D Y Y Y Y) NEVER

D12. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CLAIMANT (M M D D Y Y Y Y) PERMANANT

D13. APPROXIMATELY HOW MANY TOTAL HOURS PER DAY WILL PATIENT REQUIRE CLAIMANT?

HOURS COMMENTS

D14. WOULD DISCLOSURE OF THIS CERTIFICATE TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL? ..... NO YES

D15. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER

D16. STATE OR COUNTRY PHYSICIAN/PRACTITIONER IS LICENSED.

D17. PHYSICIAN/PRACTITIONER'S NAME (FIRST MIDDLE INITIAL LAST)

D18. PHYSICIAN/PRACTITIONER'S ADDRESS (POST OFFICE BOX IS NOT ACCEPTABLE AS THE SOLE ADDRESS)

CITY STATE/PROV. ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)

D19. TYPE OF PHYSICIAN/PRACTITIONER

D20. SPECIALTY (IF ANY)

D21. PHYSICIAN/PRACTITIONER'S Certification and Signature: I certify under penalty of perjury that this patient has a serious health condition and requires a care provider. I have performed a physical examination and/or treated the patient. I am authorized to certify a patient disability or serious health condition pursuant to California Unemployment Insurance Code Section 2708.

Original Signature of Attending Physician/Practitioner – RUBBER STAMP IS NOT ACCEPTABLE | PHYSICIAN/PRACTITIONER'S PHONE NO. | Date Signed (M M | D D | Y Y Y Y)

Under sections 2116 and 2122 of the California Unemployment Insurance Code, it is a violation for any individual who, with intent to defraud, falsely certifies the medical condition of any person in order to obtain disability insurance benefits, whether for the maker or for any other person, and is punishable by imprisonment and/or a fine not exceeding $20,000. Sections 1143 and 3305 require additional administrative penalties.

PART E – MILITARY ASSIST CERTIFICATION (TO BE COMPLETED BY THE CLAIMANT)

E1. YOUR SOCIAL SECURITY NUMBER

E2. YOUR LEGAL NAME (FIRST / MIDDLE INITIAL / LAST)

E3. NAME OF MILITARY MEMBER ON COVERED ACTIVE DUTY OR IMPENDING CALL TO COVERED ACTIVE DUTY STATUS (FIRST / MIDDLE INITIAL / LAST)

E4. MILITARY MEMBER'S DATE OF BIRTH
M M D D Y Y Y Y

E5. MILITARY MEMBER'S GENDER
☐ MALE ☐ FEMALE

E6. MILITARY MEMBER'S MAILING ADDRESS

CITY | STATE/PROV. | ZIP OR POSTAL CODE | COUNTRY (IF NOT U.S.A.)

E7. LAST FOUR DIGITS OF MILITARY MEMBER'S SOCIAL SECURITY NUMBER

E8. PERIOD OF MILITARY MEMBER'S COVERED ACTIVE DUTY
M M D D Y Y Y Y TO M M D D Y Y Y Y

E9. DATE MILITARY MEMBER WAS NOTIFIED OF COVERED ACTIVE DUTY
M M D D Y Y Y Y

E10. PLEASE SELECT ONE OF THE FOLLOWING AND ATTACH THE INDICATED DOCUMENT TO SUPPORT THAT THE MILITARY MEMBER IS ON COVERED ACTIVE DUTY OR IMPENDING CALL OR ORDER TO COVERED ACTIVE DUTY STATUS

- ☐ COVERED ACTIVE DUTY ORDERS
- ☐ LETTER OF IMPENDING CALL OR ORDER TO COVERED DUTY
- ☐ DOCUMENTATION OF MILITARY LEAVE SIGNED BY THE APPROVING AUTHORITY FOR MILITARY MEMBER'S REST AND RECUPERATION

E11. THE QUALIFYING EVENT FOR THE PFL CLAIM IS TO: (One or more reasons may be selected)

- ☐ PROVIDE/ARRANGE CHILDCARE FOR MILITARY MEMBER'S CHILD
- ☐ PROVIDE/ARRANGE CARE FOR MILITARY MEMBER'S PARENT
- ☐ ATTEND COUNSELING
- ☐ MAKE FINANCIAL/LEGAL ARRANGEMENTS
- ☐ ASSIST MILITARY MEMBER DURING REST AND RECUPERATION LEAVE
- ☐ ATTEND MILITARY EVENT
- ☐ REPRESENT MILITARY MEMBER AT FEDERAL, STATE, OR LOCAL AGENCIES
- ☐ ADDRESS ISSUES DUE TO MILITARY MEMBER'S DEATH
- ☐ OTHER:

E12. WRITTEN DOCUMENTION SUPPORTING THIS REQUEST FOR LEAVE IS AVAILABLE AND ATTACHED?

☐ YES ☐ NO ☐ NONE AVAILABLE

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

E13. **Declaration and Signature.** By my signature on this military assist certification, I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements or documents, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.

Original Signature of Military Assist Claimant (DO NOT PRINT) | Date Signed (M M | D D | Y Y Y Y)

QUALIFYING EVENT FOR LEAVE - DOCUMENTATION

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

PLEASE SUBMIT SUPPORTING DOCUMENTATION, IF APPLICABLE
(Attach an additional sheet if more space is required)

YOUR SOCIAL SECURITY NUMBER

YOUR LEGAL NAME (FIRST / MIDDLE INITIAL / LAST)

NAME OF INDIVIDUAL WITH WHOM CLAIMANT IS MEETING:_____

TITLE:_____

ORGANIZATION:_____

PHONE NUMBER (provide area or country code):_____

FAX NUMBER (provide area or country code):_____

EMAIL ADDRESS:_____

MAILING ADDRESS

Mailing Address			
City	**State/Prov**	**ZIP or Postal Code**	**Country (if not U.S.A.)**

DESCRIBE NATURE OF MEETING. INCLUDE DATES, IF KNOWN: