Employment Development Department
State of California

APPLICATION FOR APPROVAL OF VOLUNTARY PLAN SELF-INSURED DISABILITY BENEFITS

1. Requested effective date of Voluntary Plan (VP) _____

2. California Employer Account Number _____
   The eight-digit number that the Employment Development Department (EDD) assigned to the employer when the employer registered with the Department.

3. Employer's legal name: _____

4. If this employer is doing business in the State of California under any other business name(s) besides the one identified above, list the doing business as (dba) or commercial nickname(s) (provide a separate list if necessary): _____

   _____

5. Employer's headquarters address:

   _____
   Street City State ZIP Code

6. Describe the employer's business (i.e., type of product manufactured or service provided):

   _____

   _____

7. VP will be administered by:

   ☐ Third Party Administrator (TPA)

   ☐ Self-Administered by employer

COMPLIANCE FORMS AND INFORMATION

Complete the required forms listed below:

8. ***Voluntary Plan Third Party Administrator Authorization*** **(DE 2520BV-A).** See Attachment A. This form is required when designating a TPA and authorizing the TPA to contact the EDD on behalf of the employer. Without this completed authorization form, the EDD will not communicate with the TPA in regards to the employer's VP which will prevent the TPA from administering the VP.

9. ***Voluntary Plan Third Party Administrator Administrative Changes*** **(DE 2520BV-B).** See Attachment B. This form is required to identify TPA personnel and their duties in administering the VP. The completion of this form will ensure that the EDD has the appropriate contact information when communicating with the TPA about important VP material. The EDD is required to obtain this information for record keeping purposes.

10. ***Voluntary Plan Employer Administrative Changes*** **(DE 2520BV-C).** See Attachment C. This form is required to identify and maintain the employer's current address and the personnel tasked with administering the VP. The contact information provided will be used by the EDD in communicating with the employer, and releasing crucial, time-sensitive plan information to the correct mailing address and/or personnel.

PLAN PROVISIONS

11. Will the VP be made available to employees in all establishments of the employer in California? Yes ☐ No ☐

    If yes, (a) provide a list of the locations that will be covered; if no (b) provide a list of the locations that will not be covered. The list should include the business name, physical address, and provide the number of eligible employees at each location. If there is more than one establishment, the list should be broken down by business names and alphabetized by city.

12. Are part-time employees (employed for only part of the usual working day or week) eligible for coverage? Yes ☐ No ☐

13. Are short-term employees (employed with the expectation that employment will not exceed two weeks) eligible for coverage? Yes ☐ No ☐

14. The contribution required of employees selecting enrollment in the VP will be:
    _____% of the first $ _____ of taxable wages paid in this calendar year, or
    (other) _____.

ENROLLMENT INFORMATION

15. Total number of employees eligible to be covered by the plan:

    _____ as of _____.
    Number Date

16. Total number of employees who have consented, in writing or by email, at the employee's option to be covered by the VP:

    _____ as of _____.
    Number Date

17. The enrollment was conducted between _____ and _____.
    Date Date

SECURITY DEPOSIT

18. Check the type of security deposit that will be filed to secure the VP:

- ☐ *Guarantee Bond* (DE 2544V)
- ☐ Letter of Credit
- ☐ Cash
- ☐ Bearer Bond(s)

NOTE: Do not send the security deposit with this application. Instructions for sending the security deposit will be provided to the party identified in question 7 upon approval of the plan.

19. Estimated State Disability Insurance (SDI) taxable wages projected to be paid over the 12-month period following your requested VP effective date:

Estimated SDI taxable wages: $_____.

NOTE: (1) The estimated SDI taxable wages are used to determine the amount of deposit required using the following formula:

Estimated Annual Taxable Wages x .5 x SDI Contribution Tax Rate = Amount of Security Deposit; and

(2) The minimum required deposit is $1,000 (uneven dollar amounts will be rounded up to the next $100).

REQUIRED DOCUMENTS

Items 8 through 10 and 21 through 25 must be filed with this application:

	Attached		
	Y	N	N/A
20. Completed ***Voluntary Plan Third Party Administrator Authorization*** **(DE 2520BV-A)** (See Attachment A, if applicable).	☐	☐	☐
21. Completed ***Voluntary Plan Third Party Administrator Administrative Changes*** **(DE 2520BV-B)** (See Attachment B, if applicable).	☐	☐	☐
22. Completed ***Voluntary Plan Employer Administrative Changes*** **(DE 2520BV-C)** (See Attachment C).	☐	☐	☐
23. Two separate lists for the VP covered and non-covered locations in California (See question 11).	☐	☐	☐
24. The Plan Text fully describing the provisions of the VP.	☐	☐	☐
25. Copies of all enrollment literature which were distributed to the employees to secure their consent for the VP.	☐	☐	☐

CERTIFICATION

By signing below:

A. I am submitting an application of a VP for approval under the California Unemployment Insurance Code (*hereinafter identified as "Code"*) and Title 22 of the California Code of Regulations (*hereinafter identified as "Regulations"*).

B. I agree to operate the VP in conformity with the Code and Regulations and in accordance with the provisions of the Plan Text provided to the EDD Voluntary Plan Group (VPG).

C. I understand and agree that approval of the plan is contingent upon the deposit of security as required under the Code and Regulations, and further agree that such security may be held or disposed of in accordance with the provisions of the Code and Regulations. I agree to send the security within 30 days upon notification by the EDD VPG.

D. I agree to pay any assessments which are levied in conformity with the Code and Regulations.

E. I certify that all eligible employees were given the opportunity to elect or reject coverage under the plan and that a majority of the eligible employees consented, in writing, to coverage under the VPG.

F. I agree to offer the VP to all eligible new employees, and will maintain available for inspection by the EDD representatives, the signed consent documents of all employees.

G. I certify that the VP will be in effect for not less than one year that no reduction in VP disability benefits or increase in employee contributions for the VP coverage will be made while the VP is in effect without the approval of the EDD.

H. I certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true and correct.

Complete this side if the VP is proposed by the employer.

By _____
(Must be signed by Owner, Partner, or Officer if a Corporation)

_____
Print Name and Title

Date _____

Complete this side if the VP is proposed by employee group.

By _____
Authorized Representative

_____
Print Name and Title

The employer consents to the proposed VP and agrees to make employee deductions, if any.

By _____
(Must be signed by Owner, Partner, or Officer if a Corporation)

_____
Print Name and Title

Date _____