EDD Employment
Development
Department
State of California

NOTICE OF ELECTION TO MAKE VOLUNTARY PLAN APPLICABLE TO ALL EMPLOYEES

1. California Employer Identification Number: _____ (the eight-digit number assigned when the employer registered with the Employment Development Department [EDD]).

2. Employer's legal name: _____

3. Employer's address: _____

    City, State, ZIP Code: _____

4. Pursuant to California Unemployment Insurance Code, Section 3257, the undersigned hereby gives notice of election to make the voluntary plan applicable to all eligible employees except those who reject the plan.

5. On _____ there was a total of _____ eligible employees in employment of whom
    (DATE)
    _____ consented in writing or by electronic mail, at the employee's option if electronic means were available. (At least 85% of the eligible employees must have consented.) The plan will cover all eligible

    employees except those who reject it in writing or by electronic mail on and after _____.
    (DATE)

6. As required by California Unemployment Insurance Code, Section 3257, a notice has been posted on the premises for all eligible employees. The notice was also circulated on or before _____
    for the attention of all employees who have not previously consented to the plan. (DATE)

7. After the date on which the plan is applicable to all employees, all new eligible employees will be furnished a written statement setting forth the essential features of the plan along with a written notice specifying their right to consent to or to reject the plan.

8. The consent records and the rejection records will be maintained for inspection by EDD for a period of not less than four (4) years, or shorter period of time as approved by EDD.

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

If the Elector is an Employee Group

If the Elector is the Employer

BY _____

BY _____
(OWNER, PARTNER, OR OFFICER IF A CORPORATION)

TITLE _____

TITLE _____

DATE _____

DATE _____

Disability Insurance Voluntary Plan Group – P.O. Box 826880, MIC 29-VP – Sacramento CA 94280-0001