

SDI Online Tutorial:

Employer Registration, Access, and Form Submission

SDI Online Overview for Employers

Employers may use SDI Online to:

- Submit a Notice to Employer of Disability Insurance Claim Filed (DE 2503).
- Submit a Disability Insurance Eligibility – Workers' Compensation (DE 2578A).
- Submit an Employer's Statement of Job Duties (DE 2546PE).
- Update contact information.

Employer Representatives may use SDI Online to:

- Complete and submit claim information on behalf of the employer once the representative has created their own separate employer account with a unique login.
- Employers may have an unlimited number of representatives with employer accounts, with each representative using their own unique login.

Note: To enable employers to manage their employer representative accounts, the employer representatives need to provide their username and password information to the employer. Employers should maintain this information in a secure environment, to be used only to deactivate representative accounts.

Requirements to Register an Employer Account

- Employers must be registered and have filed quarterly payroll taxes with the Employment Development Department (EDD).
- Employers must provide their:
 - EDD Employer Account Number.
 - ZIP Code as reported to the EDD when the company registered as an employer.
 - Total subject wages from the most recent Quarterly Contribution Return and Report of Wages (DE 9C).
- To establish an account, an employer's entries in SDI Online must match the EDD's payroll tax records.

Employer Registration

State Disability Insurance

Disability Insurance and Paid Family Leave Benefits

The California State Disability Insurance (SDI) program provides short-term Disability Insurance (DI) and Paid Family Leave (PFL) wage replacement benefits to eligible workers who need time off work. You may be eligible for DI if you are unable to work due to non-work-related illness or injury, pregnancy, or childbirth. You may be eligible for PFL to care for a seriously ill family member or to bond with a new child. To file for benefits, visit [SDI Online](#).

To provide feedback about the SDI information available on the EDD website, take our [SDI Survey](#).

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To create an SDI Online account, visit www.edd.ca.gov/disability.

On the State Disability Insurance overview page, select any **SDI Online** link.

SDI Online

[En español](#)

The Employment Development Department (EDD) automated some key State Disability Insurance (SDI) services to better serve you with your Disability Insurance (DI) and Paid Family Leave (PFL) needs.

SDI Online is convenient and secure. The system reduces claim processing time, provides electronic confirmation of forms submitted online, decreases costs in paper and postage, and includes security safeguards to detect and manage fraud and abuse. A mobile-friendly version, [SDI Online Mobile](#) is available for your smartphone and tablet.

Log In or Register

If you have an existing account, select the appropriate login option. Before using SDI Online or SDI Online Mobile, you must register in SDI Online.

[Log In](#)

[Log into Mobile](#)

[Register](#)

Note: If you are experiencing trouble accessing SDI Online, visit [Troubleshooting Tips for Accessing SDI Online](#).

Disability Insurance Claimants

- [How to File a DI Claim in SDI Online](#)
- [Manage Your Claim with SDI Online](#)
- [Am I Eligible for DI?](#)
- [SDI Online Tutorials](#)
- [SDI Online Tips for Claimants](#)
- [SDI Online FAQs](#)

Paid Family Leave Claimants

- [How to File a PFL Claim in SDI Online](#)
- [Manage Your PFL Claim with SDI Online](#)
- [Am I Eligible for PFL?](#)
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Select the **SDI Online Registration** link to register.

On the **SDI Registration Instructions** page, select **Continue to Employer Registration** and follow the instructions.

Security Check

*Indicates Required Field

Security Check



-  Try Another
-  Vision Impaired
-  Help

This Security Check allows us to:

Ensure Restricted Access to Registration

Automated programs known as "Bots" cannot read distorted text as well as humans. The Security Check helps prevent automated programs from blocking other users from registering for accounts with the EDD.

Provide an Audio Option for Visually Impaired Customers

An audio option allows visually impaired customers to hear a set of eight (8) digits that can be entered instead of the word challenge.

*Please type both words separated by a space below:

You do not have permission to access this website if you are using an automated program.

Next

On the **Security Check** page, type the text displayed and then select **Next**.

Employer: Terms and Conditions

Terms and Conditions

Please read through the entire Terms and Conditions before proceeding. The information you provide may be used to verify your identity with federal and/or state agencies. If "I Do Not Agree" is selected, you will not be able to establish an online account.

These Terms and Conditions, which include the Conditions of Use and Privacy Statements, govern the use of and access to: (i) this website (www.edd.ca.gov/); and (ii) the information on or provided through this website.

If you establish an online account you are responsible for maintaining the confidentiality of your username and password, and you are responsible for all activities which you authorize under your username and password. You agree to: (i) immediately notify the Employment Development Department (EDD) of any unauthorized use of your username and password or any other breach of security; and (ii) log out from your account at the end of each session.

By registering for an online account, you agree to check your account regularly and frequently for messages from the EDD. Please note that e-mails will only be used to send notifications to log in to your account or when you request to reset your username or password. No confidential claim information will be sent via e-mail.

The information submitted by any party will be used by the Employment Development Department to carry out its responsibilities under the California Unemployment Insurance Code, which may include the sharing of the information with other entities as required by law.

These Terms and Conditions may change from time to time and it is your responsibility to check for updates. The last revision date for these Terms and Conditions is February 1, 2012.

I have read and understand all the above information and wish to continue with establishing an account in the State Disability Insurance (SDI) Online.

I Do Not Agree

I Agree

Read the Terms and Conditions and select **I Agree**.

Selecting **I Do Not Agree** prevents an account from being established.

Contact SDI

- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

Employer: Account Verification Information

***Indicates Required Field**

If you already have an account with SDI, [log in here](#).

Personal Information

Please enter your full legal name to register.

*First Name:

Middle Name:
(If you have no middle name, leave blank.)

*Last Name:

Suffix:
(If you have no suffix, leave blank.)

*E-mail Address:

*Re-Type E-mail Address:

*Employer Account Number:
(Do not include dashes.)

*Employer ZIP Code:

*Total Subject Wages from most recent Wage Report:
(Enter dollars and cents. Do not include dashes.)

Next **Cancel**

Complete the **Personal Information** section and select **Next**. Mandatory fields are marked with a red asterisk (*).

Note: An Employer Account Number is 8 digits and should not contain any spaces or dashes. Total Subject Wages from the most recent Wage Report can be found on the Quarterly Contribution Return and Report of Wages (DE 9C). This should be a number with two digits after the decimal—no commas or dollar signs.

Contact SDI

- Online
- By Location
- By Phone
- Telephone Numbers
- Automated Info System

Employer: Setup Security Profile Information**Account Information**

Enter a Username and Password. Do not share your password with anyone.

*Username:
(must be 8 to 15 characters, no special characters)

*Password: (case sensitive)
(must be 8 to 12 characters long, including an uppercase letter, a lowercase letter, a number, and one of the following: ! # \$ % ^ & * () -)

*Re-Type Password: (case sensitive)

*Password Hint: (50 characters maximum, no special characters)

Choose your Security Questions and enter your answer to each question. This will be part of your Account Recovery Options.

*Question 1: Please select your question

*Answer to Question 1: (50 characters maximum, no special characters)

*Question 2: Please select your question

*Answer to Question 2: (50 characters maximum, no special characters)

*Question 3: Please select your question

*Answer to Question 3: (50 characters maximum, no special characters)

*Question 4: Please select your question

*Answer to Question 4: (50 characters maximum, no special characters)

*Choose your Personal Image and enter a Personal Image Caption for it. The image along with your image caption helps you know that you are at a valid EDD site and that it is safe to enter information. [Refresh to get a new set of personal images.](#)



*Personal Image Caption: (50 characters maximum, no special characters)

Next

Cancel

Complete the **Account Information** section by selecting a Username, Password, Personal Image, and Security Questions. Then select **Next**.

Be sure to make note of this information to ensure easy access when using SDI Online.

Contact SDI

- Online
- By Location
- By Phone
- Telephone Numbers
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Employer: Personal Profile Information

***Indicates Required Field**

Mailing Address

All written correspondence from EDD regarding this account will be sent to this address.

Employer Name:

US International

*Address Line 1:

Address Line 2:

*City:

*State:

*ZIP Code:

Phone Number

Employer Phone Number: Ext: Check here if the phone number is international
(No dashes or spaces)

Communication Preferences

Indicate below how you prefer to be notified. Some EDD forms are not available online and will be sent through the US Postal Service.

- *Preferred Communication:
- I prefer to be notified by e-mail.
 - I prefer to be notified by paper mail
 - I do not want to receive notifications. I will be reviewing the items in my message center regularly

Enter the required information, select your preferred method of communication, then select **Submit**.

Contact SDI

Online

By Location

By Phone

Telephone Numbers

Automated Info

System

Account Setup Confirmation

Successful Account Creation Notification

Your account has been created and your EDD Customer Account Number is 0007467204. A notification has been sent to you via e-mail. If you do not receive an email, please check your junk/spam folder. To ensure e-mails from the EDD appear in your inbox, add noreply@edd.ca.gov to your address book.

[Login](#)

Be sure to make a note of your EDD Customer Account Number.

A letter will be mailed to your address to confirm this account has been created.

If you selected electronic communication, a notification will also be sent to you via e-mail.

Select **Login** to access your newly created account.

Access Employer Account

State Disability Insurance

Disability Insurance and Paid Family Leave Benefits

The California State Disability Insurance (SDI) program provides short-term Disability Insurance (DI) and Paid Family Leave (PFL) wage replacement benefits to eligible workers who need time off work. You may be eligible for DI if you are unable to work due to non-work-related illness or injury, pregnancy, or childbirth. You may be eligible for PFL to care for a seriously ill family member or to bond with a new child. To file for benefits, visit [SDI Online](#).

To provide feedback about the SDI information available on the EDD website, take our [SDI Survey](#).

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To access your account, visit www.edd.ca.gov/disability. Select any **SDI Online** link which will direct you to the SDI Online page.

On the **State Disability Insurance (SDI) Online** page, select the **SDI Online Login**.

You will be directed to the **SDI Online Login** page where you will log in using your Username and Password.



Employment Development Department
 State of California
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Language: English ▾

Contact SDI

- Online
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SDI Online Login

***Indicates Required Field**

*Username:

Submit

[Forgot username?](#)
[Register for a new online account](#)

SECURITY REMINDER
 Enter the username you provided during registration. We will ask you for your new password and display your personal image on the next screen.

On the **SDI Online Login** page, enter your Username and select **Submit**.



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Contact SDI

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Confirm Your Personal Image and Log In

***Indicates Required Field**

Verify your personal image and enter your password.

Personal Image: 

Personal Image Caption: hat

Username: seamount2

*Password: (case sensitive)

Log In

[Forgot your personal image?](#)
[Incorrect personal image showing?](#)
[Forgot password?](#)

SECURITY REMINDER
 Recognizing your Personal Image and Personal Image Caption helps you know that you are at a valid EDD web site, and that it is safe to enter your password.

If you do not recognize your personal image, do not enter your password.

Confirm the Personal Image, enter your Password, then select **Log In**.

MAIN MENU

Home
Inbox
Saved Drafts
Manage My Profile

Home

*Indicates Required Field

Message Center

[Inbox](#) [New: 1026, Total: 1031]
[Saved Drafts](#) [Total: 1]

Search

To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by the Receipt Number.

*Search By:

*Employee Last Name:

Search Results

On the **Home** page you may:

- Update your profile information by selecting **Manage My Profile** from the **Main Menu**.
- Complete forms by selecting **Inbox** under the **Message Center** or by using the **Search By** drop down menu and searching by **Claim ID** and entering the **Employee Last Name**. This information is printed on the DE 2503 Notice to Employer.
- Search by Receipt Number and enter Employer Last Name to view the form you have submitted.

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Saved Drafts

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 Delete action.

Form Name	Claimant Name	Saved Date	Saved By	Draft will be saved until	Action
2503 Employer Notice of DI Claim	Jane Doe	10-16-2014		11-15-2014	Delete

Access previously saved drafts by selecting **Saved Drafts** from the **Main Menu** or **Message Center**. This will direct you to the Saved Drafts page which displays a list of forms that were started, but not completed or submitted.

Select the form under the **Form Name** column to view and complete the form.

Select **Delete** under the **Action** column to delete the form.

Note: Drafts are saved in SDI Online for 30 days.

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Utilities

Message Center

Inbox

It is important to read all messages from EDD carefully. Select the subject hyperlink below to view the message.

Claimant Name	Date of Birth	Subject	Sent Date	Due Date	Type	Read?	Action
POPEYE SAILORMAN	09-01-1950	DE 2503, Notice to Employer of SDI Claim Filed	05-16-2014	05-20-2014	Requires Attention	No	Delete
STRAWBERRY SHORTCAKE	07-19-1968	DE 2503, Notice to Employer of SDI Claim Filed	05-12-2014	05-14-2014	Requires Attention	No	Delete
OLIVE OYL	06-20-1957	DE 2503, Notice to Employer of SDI Claim Filed	04-22-2014	04-24-2014	Requires Attention	No	Delete

Selecting **Inbox** under the **Main Menu** or **Message Center** on the **Home** page will direct you to the **Inbox** on the **Message Center** page.

Select the message link under **Subject** that you wish to review, select **Delete** under **Actions** to delete items that you have already read or completed.

Note: You will receive a hard copy DE 2503 and can use the search option to find the claim to complete the form online. If the form was sent electronically, select the **DE 2503, Notice to Employer of SDI Claim Filed** link from the **Subject** column to begin completing the form.

Submit a Notice to Employer of Disability Insurance Claim Filed, DE 2503

Home

*Indicates Required Field

Message Center

[Inbox](#) [New: 0, Total: 0]
[Saved Drafts](#) [Total: 0]

Search

To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by the Receipt Number.

*Search By:
*Employee Last Name:

Search Results

Claim ID	Employee Name	Claim Effective Date	Claim Type	Last 4 Digits of SSN
DI1000022250	Jane Doe	10-01-2014	Disability Insurance	2276

On the **Home** page, select **Claim ID** from the drop down menu and enter **Employee Last Name**. Select **Search**.

Under **Search Results** Select the **Claim ID** link.

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Claim Summary

Claim Summary

Claimant Name: Jane Doe

Claim ID: DI-1000-022-250

Claim Effective Date: 10-01-2014

My Message Center Regarding

[Inbox](#) [New: 0 , Total: 0][Saved Drafts](#) [Total: 0]

My Forms Available to Submit for

Below is a list of forms available for submission. Please note that not all forms will be available at all times. If a form for the same dates has already been submitted or mailed, do not submit a duplicate form. Please allow 5-7 business days for the form to be processed.

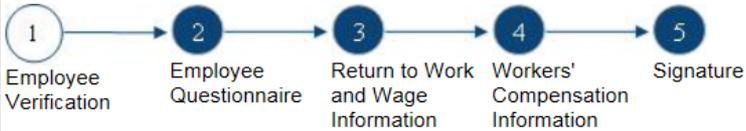
[2503 Employer Notice of DI Claim](#)

My Forms Submitted for

No Results Found

Under the **My Forms Available to Submit** section, select the **2503 Employer Notice of DI Claim** link.

Verify Employee



You are currently on Step 1 Employee Verification

*Indicates Required Field

Section 1 - Employee Information

Name: Jane Doe

Social Security Number: _____

Claim ID: DI-1000-022-250

Claim Effective Date: 10-01-2014

Section 2 - Form Information

The California Unemployment Insurance Code, Section 2707.1, requires that you complete and return this form by the due date listed below.

Issue Date:

Due Date:

Section 3 - Verify Employment

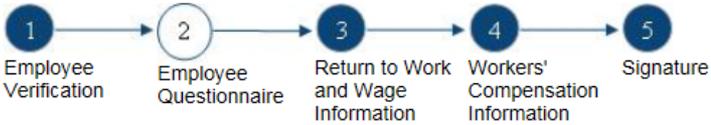
*Was the employee shown above ever employed by you? Yes No

Next Cancel

Verify the **Employee Information** section. Select **Yes** to confirm that the person was ever employed by you. Select **Next**.

Note: If the employee has **ever** been employed by your company, select **Yes**.

Employee Questionnaire



You are currently on Step 2 Employee Questionnaire

*Indicates Required Field

Section 4A - Employee Status

Employee's Date of Birth: (MMDDYYYY)

*Employment Status Current Employee Former Employee

If "Former Employee," reason no longer working Select

If "Other," please explain:

Separation Date: (MMDDYYYY)

*Hours worked per week (Exclude Overtime Pay):

*Hourly Rate(\$):

Reported Last Day Worked:

*Do your records show a different ACTUAL last day of work than shown above in 'Reported Last Date worked'? Yes No

If "Yes," please provide the correct last day worked: (MMDDYYYY)

The last day worked was: Full day Partial day

If "Partial Day," number of hours worked:

Hourly Rate (\$):

Previous

Next

Save as Draft

Cancel

Complete the **Employee Status** section and select **Next**.

Note: Select **Save as Draft** at any point in the process to complete the form at a later time.

1 Employee Verification → 2 Employee Questionnaire → 3 Return to Work and Wage Information → 4 Workers' Compensation Information → 5 Signature

You are currently on Step 3 Return to Work and Wage Information

*Indicates Required Field

Section 4B - Return to Work Information

*Has the employee returned to work? Yes No

If "Yes," date returned to work: (MMDDYYYY)

Return to work status:

If "Other/Explain," please explain:

Section 4C - Voluntary Plan Information

*At the time the employee's disability began, did your company have a state-approved voluntary plan for disability insurance benefits instead of the state plan? Yes No

If "Yes," enter the plan number:

Is this employee covered? Yes No

If "No," provide a non-coverage explanation:

Section 4D - Wage Information

*Will the employee's wages be coordinated/integrated with the State Disability Insurance benefits (Less State Disability Insurance)? Yes No

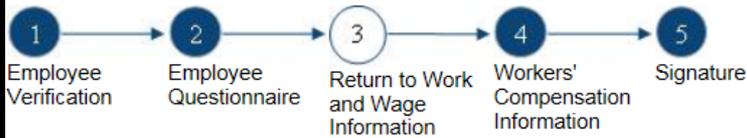
If "No," has or will the employee receive wages in the form of paid sick leave, vacation, personal time off, holiday, bonus, commission, or other type of payment while disabled? Yes No

[Previous](#) [Next](#) [Save as Draft](#) [Cancel](#)

Complete the **Return to Work and Wage Information** page and select **Next**.

Note: If the employee received wages that are not being coordinated with SDI benefits, you must answer additional questions regarding wages paid to the employee.

Added Additional Wages Paid to Employee



You are currently on Step 3 Return to Work and Wage Information

Section 5B - Additional Wages Summary

Please select the "Add" button to report wages paid to the employee in the form of sick leave, vacation, personal time off, holiday, bonus, commission, or other payment while disabled. You must add at least one wage.

No Results Found

Previous

Next

Add

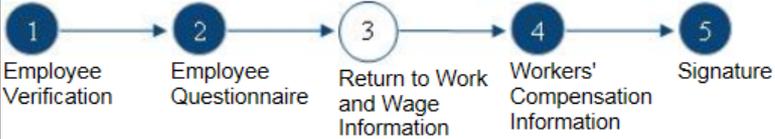
Save as Draft

Cancel

If you selected **Yes** to indicate the employee received wages on the **Return to Work and Wage Information** page, the system directs you to the **Added Additional Wages Paid to Employee** page.

Select **Add** to enter the type of pay, dates, and the amount paid to the employee.

Additional Wages Paid to Employee



You are currently on Step 3 Return to Work and Wage Information

*Indicates Required Field

Section 5A - Additional Wages Paid to Employee

Please report all wages paid to the employee and the actual dates for which they were paid. Report each pay type separately.

*Pay Type:

If "Other," please explain:

*From: (MMDDYYYY)

*To: (MMDDYYYY)

*Amount (\$):

*Do you want to add any other wages? Yes No

Previous

Next

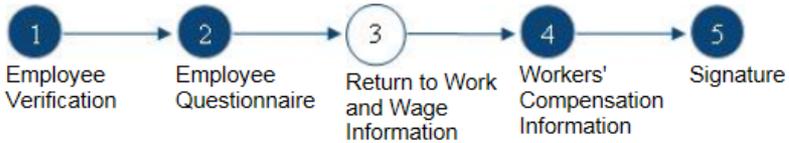
Save as Draft

Cancel

Enter the applicable **Additional Wages Paid to Employee** information and select **Next**.

Note: This page will only display if you selected **Yes** to additional wages paid to employee.

Added Additional Wages Paid to Employee



You are currently on Step 3 Return to Work and Wage Information

Section 5B - Additional Wages Summary

Please select the "Add" button to report wages paid to the employee in the form of sick leave, vacation, personal time off, holiday, bonus, commission, or other payment while disabled. You must add at least one wage.

Pay Type	Amount	From	To	Action
Vacation	\$300.00	10-01-2014	10-05-2014	Delete

Previous

Next

Add

Save as Draft

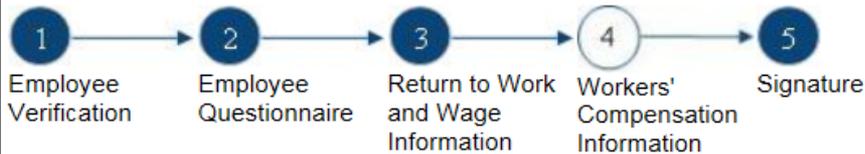
Cancel

Verify the information you entered under **Additional Wages Summary** is correct and select **Next**.

If necessary, select **Add** to enter additional wages paid.

Note: This page will only display if you selected **Yes** to additional wages paid to an employee.

Workers' Compensation Information



You are currently on Step 4 Workers' Compensation Information

*Indicates Required Field

Section 6 - Work-related Injury

*Has the employee reported a work-related or occupational illness? Yes No

Previous

Next

Save as Draft

Cancel

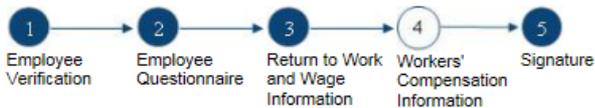
If you are directed to this page, complete the **Work-related Injury** question and select **Next**.

If you select **Yes**, you will be directed to the **Worker's Compensation Information** page to provide additional information .

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Workers' Compensation Information



You are currently on Step 4 Workers' Compensation Information

*Indicates Required Field

Section 7 - Workers' Compensation Carrier Information

Please enter Workers' Compensation Carrier information below. If you do not have a Workers' Compensation Carrier, enter the employer's name and address.

*Workers' Compensation Insurance Company Name:

US International

*Address Line 1:

Address Line 2:

*City:

*State: CA

*ZIP Code:

Section 8 - Workers' Compensation Claim Information

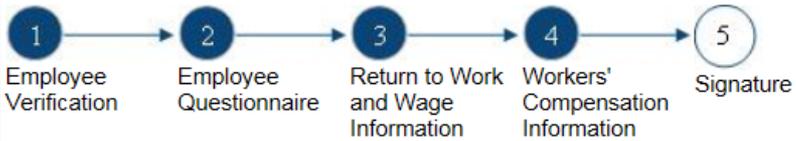
Enter the date(s) of injury as shown on the Workers' Compensation claim. If it was a cumulative trauma injury, enter the date the injury began.

Date of Injury: <input type="text"/> (MMDDYYYY)	Date of Injury: <input type="text"/> (MMDDYYYY)
Date of Injury: <input type="text"/> (MMDDYYYY)	Date of Injury: <input type="text"/> (MMDDYYYY)
Claim Number: <input type="text"/>	
Adjuster's Name: <input type="text"/>	Adjuster's Phone Number: <input type="text"/> Ext: <input type="text"/>
	(No dashes or spaces)
WC Status: <input type="text"/>	
Additional Comments: <input type="text"/>	

[Previous](#)[Next](#)[Save as Draft](#)[Cancel](#)

Enter applicable **Workers' Compensation Information** and select **Next**.

Submit Form



You are currently on **Step 5 Signature**

*Indicates Required Field

Section 9 - Signature

Submitted by: John Money

* By checking this box, I am indicating my signature for submission.

Previous

Submit

Save as Draft

Cancel

To submit the form, select the box to authorize an electronic signature and select **Submit**.



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Confirmation

Form Successfully Submitted

Please print this page for your records. If a printer is unavailable at this time, please record the Form Receipt Number below. You will not be able to access your confirmation page and Form Receipt Number after this window is closed. To retrieve this form in the future, you will need the Form Receipt Number. You may retrieve forms submitted using the claimant search on your home page.

Form Receipt Number: [R10000000123456](#)

You will receive a **Form Receipt Number** on the **Confirmation** page. Save the number for future reference. Select the **Form Receipt Number** link to view the form submitted.

Submit a Disability Insurance Eligibility Workers' Compensation, DE 2578A

Home

*Indicates Required Field

Message Center

[Inbox](#) [New: 0, Total: 0]

[Saved Drafts](#) [Total: 0]

Search

To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by the Receipt Number.

*Search By:

*Employee Last Name:

Search Results

Claim ID	Employee Name	Claim Effective Date	Claim Type	Last 4 Digits of SSN
DI1000022250	Jane Doe	10-01-2014	Disability Insurance	2276

On the **Home** page, select **Claim ID** from the drop down menu and enter **Employee Last Name**. Select **Search**.

Under **Search Results** Select the **Claim ID** link.

Claim Summary

Claim Summary

Claimant Name: Jane Doe

Claim ID: DI-1000-022-250

Claim Effective Date: 10-01-2014

My Message Center Regarding

[Inbox](#) [New: 1 , Total: 2]

[Saved Drafts](#) [Total: 0]

My Forms Available to Submit for

Below is a list of forms available for submission. Please note that not all forms will be available at all times. If a form for the same dates has already been submitted or mailed, do not submit a duplicate form. Please allow 5-7 business days for the form to be processed.

[2503 Employer Notice of DI Claim](#)

[2546PE Employee's Job Duties](#)

[2578A Employer Work Comp Form](#)

My Forms Submitted for

No Results Found

Under My Forms Available to Submit select the 2578A Employer Work Comp Form link.

Inbox

Message

Subject: DE 2578A, Notice of Potential Industrial Injury

Sent Date: 10-15-2014

Due Date: 10-17-2014

Message: An individual filed a claim for Disability Insurance benefits from information contained on the disability insurance claim form, it appears a claim for workers' compensation insurance may be in order. In order, that we may properly process this claim for state Disability Insurance, we would appreciate your answering the following questions, PLEASE RETURN WITHIN TWO WORKING DAYS. Please select the "Forms Available to Submit" hyperlink to submit the "DE2578A, Notice of Potential Industrial Injury".

Link to Form: [Forms Available to Submit](#)

Claim ID: DI-1000-022-250

Supporting Documentation

No Results Found

Delete

Select the **Forms Available to Submit** link to access the DE 2578A.

Workers' Compensation Information



You are currently on Step 2 WC Information

*Indicates Required Field

Workers' Compensation Insurance Information

What was the date of injury?: (MMDDYYYY)

Workers' Compensation Claim Number:

Workers' Compensation Carrier Information

*Name:

Policy Number:

*Address Line 1:

Address Line 2:

*City:

*State: CA

*ZIP Code:

*Phone Number:

(No dashes or spaces)

Any additional information that you can give us regarding the denial or granting of workers' compensation benefits or information as to why a claim was not filed will be greatly appreciated.

Previous

Next

Save as Draft

Cancel

Complete the **Workers' Compensation Insurance Information** and the **Workers' Compensation Carrier Information** then select **Next**.

Attorney Information



You are currently on Step 3 Attorney Information

*Indicates Required Field

Attorney Contact Information

*If an application for adjudication is or has been filed with the workers' compensation appeals board, Yes No will you be represented by legal counsel?:

Name of Attorney:

Address Line 1:

Address Line 2:

City:

State: CA

ZIP Code:

Phone Number:

(No dashes or spaces)

Previous

Next

Save as Draft

Cancel

Complete the **Attorney Contact Information** (if applicable) and select **Next**.

Certify Form for Submittal

1 → 2 → 3 → 4
Industrial Injury WC Information Attorney Information Certification

You are currently on Step 4 Certification

*Indicates Required Field

Certification

By checking this box, I declare under penalty of perjury that the foregoing responses are, to the best of my knowledge and belief, true, correct, and complete.

[Previous](#) [Submit](#) [Save as Draft](#) [Cancel](#)

To submit the form, select the box to authorize an electronic signature and select **Submit**.

You will receive a **Form Receipt Number** on the **Confirmation** page. Save this number for future reference. Select the **Form Receipt Number** link to view the form.

Submit an Employer's Statement of Job Duties, DE 2546PE

Home

*Indicates Required Field

Message Center

[Inbox](#) [New: 0, Total: 0]

[Saved Drafts](#) [Total: 0]

Search

To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by the Receipt Number.

*Search By:
*Employee Last Name:

Search Results

Claim ID	Employee Name	Claim Effective Date	Claim Type	Last 4 Digits of SSN
DI1000022250	Jane Doe	10-01-2014	Disability Insurance	2276

On the **Home** page, select **Claim ID** from the drop down menu and enter the **Claim ID Number** and the **Employee Last Name**. Select **Search**.

Under **Search Results** Select the **Claim ID** link.

Claim Summary

Claim Summary

Claimant Name: Jane Doe

Claim ID: DI-1000-022-250

Claim Effective Date: 10-01-2014

My Message Center

[Inbox](#) [New: 1 , Total: 2]

[Saved Drafts](#) [Total: 0]

My Forms Available to Submit

Below is a list of forms available for submission. Please note that not all forms will be available at all times. If a form for the same dates has already been submitted or mailed, do not submit a duplicate form. Please allow 5-7 business days for the form to be processed.

[2503 Employer Notice of DI Claim](#)

[2546PE Employee's Job Duties](#)

[2578A Employer Work Comp Form](#)

My Forms Submitted

No Results Found

Select the **2546PE Employee's Job Duties** link.

Employer's Statement of Job Duties

*Indicates Required Field

Section 1 - Employee Information

Name: Jane Doe

Social Security Number: XXX-XX-2276

Claim ID: DI-1000-022-250

Claim Effective Date: 10-01-2014

Section 2 - Form Information

Please complete and submit this form by the due date listed below.

Issue Date: 10-15-2014

Due Date: 10-22-2014

Section 3 - Job Information

The information you submit will provide the EDD with a description of the employee's regular and customary work duties.

*Job Title:

*Number of hours worked
per day:

*Number of days worked per
week:

*Has the above-named employee returned to work? Yes No

If "Yes," return to work date (MMDDYYYY)

Return to Work Status Full Time Part Time

Next

Save as Draft

Cancel

Verify the **Employee Information** and enter the **Job Information**.

Select **Next**.

Employee's Job Duties: Part 1 of 3

*Indicates Required Field

Section 4 - Motion

Indicate frequency and number of hours a day the employee is required to do the following specific types of activities.

Activity	Frequency	Number of Hours Per Day
Sitting	None	
Walking	None	
Standing	None	
Bending	None	
Squatting	None	
Climbing	None	
Kneeling	None	
Twisting	None	

Section 5 - Reaching

Reaching or working above shoulder level
Reaching or working below shoulder level

Section 6 - Hands

Simple grasping required
Power grasping required
Pushing and/or pulling required
Fine manipulation required

Section 7 - Feet

*Does the job require the use of a foot pedal?

Previous

Employee's Job Duties: Part 2 of 3

*Indicates Required Field

Section 8 - Vision

*Is the employee required to perform the following activities?

If "Yes"

Section 9 - Hearing

*Is the employee required to perform the following activities?

If "Yes"

Section 10 - Lifting and Carrying

Please check all the boxes that apply.

Weight

10 lbs. or less
11 to 25 lbs.
26 to 50 lbs.
51 to 75 lbs.
76 to 100 lbs.
More than 100 lbs.

Longest distance employee can lift or carry

Heaviest weight lifted or carried

Section 11 - Equipment Operation

*Is the employee required to operate the following equipment?

If "Yes"

Previous

Employee's Job Duties: Part 3 of 3

*Indicates Required Field

Section 12 - Working Conditions

Check the box next to the working condition(s) that apply to this employee and provide a description.

Working near hazardous equipment and/or machinery

Walking on uneven ground

Exposure to dust, gas, or fumes

Exposure to extremes in temperature or humidity

Working at heights

*Is this job still available to the employee when he/she is able to return to work? Yes No

*Can the requirements of this job be modified if necessary to accommodate the employee's disability? Yes No

If "No," please explain:

Additional Comments:

Previous

Next

Save as Draft

Cancel

Complete Parts 1, 2, and 3 of the **Employee's Job Duties**.

Select **Next**.

Submit Form

***Indicates Required Field**

Section 13 - Signature

Submitted by: Nelly

*Title:

By checking this box, I declare under penalty of perjury that the foregoing are, to the best of my knowledge and belief, true, correct, and complete.

Previous **Submit** **Save as Draft** **Cancel**

To submit the form, fill in your job position within the company in the **Title** field and select the box to authorize an electronic signature. Select **Submit**.

You will receive a **Form Receipt Number** on the **Confirmation** page. Save the number for future reference. Select the **Form Receipt Number** link to view the form submitted.

Visit www.edd.ca.gov/disability for more information about State Disability Insurance.

For help with SDI Online for employers, call
855-342-3645.

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), or through the California Relay Service at 711.