

## APPEAL FORM

If you disagree with the Notice of Determination(s) and/or Determination(s)/Rulings by the EDD, you may appeal the decision(s) to the California Unemployment Insurance Appeals Board (CUIAB) by completing this form and explaining why you disagree. You must sign the form and return it to the EDD at the office address listed on the notice that you are appealing. **YOU HAVE 30 DAYS FROM THE MAIL DATE OF THE NOTICE TO FILE A TIMELY APPEAL.** If you appeal after the 30-day period, you must include the reason for the delay. The administrative law judge (ALJ) will determine whether you had good cause for the delay. If the ALJ determines you did not have good cause to submit your appeal late, your appeal will be dismissed.

**CLAIMANTS:** While your appeal is pending, **you must continue to certify for benefits.** If you are found eligible, you can be paid only for periods for which you have certified and have met all other eligibility requirements.

NOTE: Claimants for Disaster Unemployment Assistance (DUA) have 60 days to file an appeal. Employers appealing the *Notice of Determination or Assessment*, DE 3807, have 30 days to file an appeal.

### SECTION I APPELLANT INFORMATION

**INSTRUCTIONS:** The following information must be provided by the Appellant (the claimant or employer who is appealing a notice), or by the authorized agent or representative of the Appellant. The signature of the Appellant or agent is required. Please use **BLACK INK** when filling out this form.

Claimant Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Do you need a translator?  Yes  No If yes, what language/dialect? \_\_\_\_\_

Appellant Address: \_\_\_\_\_ Telephone No.: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Street No., Apt. No., or P.O. Box

\_\_\_\_\_ Fax No.: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
City State ZIP Code

E-mail Address: \_\_\_\_\_ Cell Phone No.: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

- I authorize the CUIAB to send confidential information regarding my appeal to the e-mail address listed above.  
 I authorize the CUIAB to send confidential information regarding my appeal by text message or voice mail to the cell phone number listed above.

#### **Complete this section for employer appeals only**

Employer Account Number: \_\_\_\_\_ Agent Name (if applicable): \_\_\_\_\_

Agent Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
Street No., Apt. No., or P.O. Box

### SECTION II APPELLANT STATEMENT

**INSTRUCTIONS:** Explain the reason for your appeal and why you disagree with the decision(s). If required, attach additional pages to this form and write your name and Social Security number on each page.

I disagree with the determination in the notice dated \_\_\_\_\_ because

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Appellant or Agent: \_\_\_\_\_ Date: \_\_\_\_\_

