

REPORT OF VOLUNTARY PLAN FAMILY LEAVE (VPFL) CLAIM

PLEASE READ INSTRUCTIONS BEFORE COMPLETING THIS FORM

| CLAIMANT INFORMATION (FAMILY MEMBER PROVIDING CARE) | | |
|---|--|---|
| COMPLETE ITEMS 1 – 13 AND 23 – 25. SUBMIT WITHIN 15 DAYS AFTER RECEIPT OF A FIRST CLAIM FOR PAID FAMILY LEAVE BENEFITS. | | |
| 1. SOCIAL SECURITY NUMBER ____ - ____ - ____ | 2. CLAIMANT'S NAME (FIRST, MIDDLE, LAST) | 3. CLAIM EFFECTIVE DATE |
| 4. CLAIMANT'S MAILING ADDRESS STREET/PO BOX CITY STATE ZIP CODE | | 5. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |
| 7. VOLUNTARY PLAN NUMBER 99 - | 8. VOLUNTARY PLAN EMPLOYER NAME | |
| CLAIM INFORMATION | | |
| 9. TYPE OF VPFL CLAIM (CHECK ONE): <input type="checkbox"/> FAMILY CARE CLAIM <input type="checkbox"/> CHILD BONDING CLAIM <i>IS THIS BONDING CLAIM RELATED TO AN SDI OR VP PREGNANCY CLAIM?</i> <input type="checkbox"/> YES <input type="checkbox"/> UNKNOWN | | |
| 10. FAMILY CARE/BONDING RECIPIENT'S NAME: _____ | | |
| 11. FAMILY CARE/BONDING RECIPIENT'S DATE OF BIRTH: ___/___/___ | | |
| 12. IF THE BONDING RECIPIENT IS A FOSTER OR ADOPTED CHILD, DATE OF PLACEMENT WITH THE CLAIMANT: ___/___/___ | | |
| 13. DO YOU WANT STATE AWARD INFORMATION? <input type="checkbox"/> NO <input type="checkbox"/> YES (IF "YES", YOU MUST COMPLETE THE ADDRESS AREA AT THE BOTTOM OF THIS PAGE.) | | |
| FOR DEPARTMENT USE ONLY | | |
| CLAIM EFFECTIVE DATE | WEEKLY BENEFIT AMOUNT \$ | MAXIMUM BENEFIT AMOUNT \$ |

| COMPLETE ITEMS 14 – 25 AND SUBMIT WITHIN 35 DAYS AFTER FINAL PAYMENT FOR EACH FAMILY LEAVE PERIOD. | | | |
|---|--|---|---|
| 14. VPFL WEEKLY BENEFIT AMOUNT | 15. NUMBER OF WAITING PERIOD DAYS ASSESSED | 16. FIRST DAY PAID | 17. LAST DAY PAID |
| 18. NUMBER OF DAYS BENEFITS PAID | 19. WERE ONE OR MORE DAYS PAID AT LESS THAN THE FULL DAILY RATE? | 20. TOTAL AMOUNT OF BENEFITS PAID \$ | 21. TOTAL AMOUNT DIVERTED TO SATISFY SUPPORT OBLIGATION \$ |
| 22. CLAIM STATUS (CHECK ALL APPROPRIATE) <input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> CLAIMANT RETURNED TO WORK <input type="checkbox"/> BENEFITS DENIED (ATTACH DENIAL LETTER) <input type="checkbox"/> RE-ESTABLISHED CLAIM <input type="checkbox"/> ADJUSTMENT | | | |
| 23. (REQUIRED) TYPE OR PRINT NAME OF PERSON COMPLETING THIS FORM | 24. TELEPHONE NUMBER () | 25. DATE | |

SUBMIT COMPLETED FORM AS FOLLOWS:

**PRINT AND MAIL TO THE PFL OFFICE, P.O. BOX 997017, SACRAMENTO, CALIFORNIA 95799-7017
 IN THE AREA BELOW, ENTER THE NAME AND ADDRESS (INCLUDING ZIP CODE) OF THE EMPLOYER OR PLAN ADMINISTRATOR IF REQUESTING STATE AWARD INFORMATION.**

**INSTRUCTIONS FOR COMPLETING THE
REPORT OF VOLUNTARY PLAN FAMILY LEAVE CLAIM, DE 2523F**

Complete items 1-13 and 23-25, and return within 15 days after receipt of a first claim for VPFL benefits. (California Code of Regulations, title 22, section 3267-1). Any missing information may result in returning the form and delaying the award information.

Items 1-13, Information regarding the family care/child bonding provider and his/her family member.

1. Enter all digits of VPFL claimant's social security number (SSN). (A claim cannot be processed without an accurate SSN. The use of an incorrect SSN can result in erroneous notices to the claimant and employer.)
2. Enter the VPFL claimant's full name.
3. Enter the date the VPFL claim began. This is the date the claimant has given as the first date he/she wants benefits to begin.
4. Enter the VPFL claimant's current mailing address.
5. Enter a check mark in the appropriate box.
6. Enter the month, day, and year of the VPFL claimant's date of birth.
7. Enter the voluntary plan number beginning with 99-_____.
8. Enter the voluntary plan employer's name.
9. Enter an "X" in the appropriate box for family care or child bonding. If the VP previously paid benefits on a disability pregnancy claim, and the claimant is now requesting child-bonding benefits for the same child, check the "Yes" box. If unsure of the type of claim previously paid, mark the "Unknown" box.
10. Enter the name of the care recipient (family member) who will receive family care or the name of the child with whom the claimant will bond.
11. Enter the birth date of the care recipient (family member) or the child with whom the claimant will bond.
12. Enter the date that the foster or adopted child was placed in the claimant's home.
13. Enter an "X" in the appropriate box. If "Yes" is checked, enter the employer or plan administrator name and address at the bottom of the first page, and the Department will mail the award information to the address provided.

Items 14-25, Information regarding benefits. Complete and return within 35 days after final payment for each period of Voluntary Plan Family Leave (California Code of Regulations, title 22, section 3267-1).

14. Enter the Voluntary Plan weekly benefit amount.
15. Enter the number of non-payable waiting period days assessed prior to issuance of the first benefit check. If no waiting period was assessed, enter a "0".
16. Enter the first date for which benefits were paid.
17. Enter the last date for which benefits were paid.
18. Enter the number of days for which benefits were paid.
19. Enter "yes" if the claimant was paid less than his/her full daily benefit rate for one or more days. Enter "no" if the claimant did not receive less than his/her full daily benefit rate for any days which benefits were paid.
20. Enter the total dollar amount of benefits paid.
21. Enter the amount of PFL benefits that were diverted to satisfy a support obligation. (Enter the amount of benefits withheld under the Support Intercept Program.) This amount must be included in the total of item 19.
22. Enter an "X" in the boxes that apply to the current claim status.
Benefits Exhausted: The total maximum benefit amount was paid on the claim.
PFL claimant has returned to work: Self-explanatory
Benefits Denied: No benefits have been paid. Include with this form a copy of the claimant's denial letter. You are required to notify the claimant in writing if you deny benefits in whole or in part. A copy of that letter must be sent to the Department with the DE 2523F.
Re-established claim: This applies if there has been a break in benefit payment periods for the same or different care recipient or child-bonding claim within the past 12 months.
Adjustment: Use if a previous report was submitted, and this is a correction or change to that report.
23. Enter the printed name of the person completing the form.
24. Enter the telephone number of the person completing the form.
25. Enter the current date.

MAIL COMPLETED FORM TO:

**EDD-Paid Family Leave (PFL)
P.O. Box 997017
Sacramento, CA 95799-7017**