Employment Development Department
State of California

SDI Online Tutorial:
SDI Online Employer Form Submission

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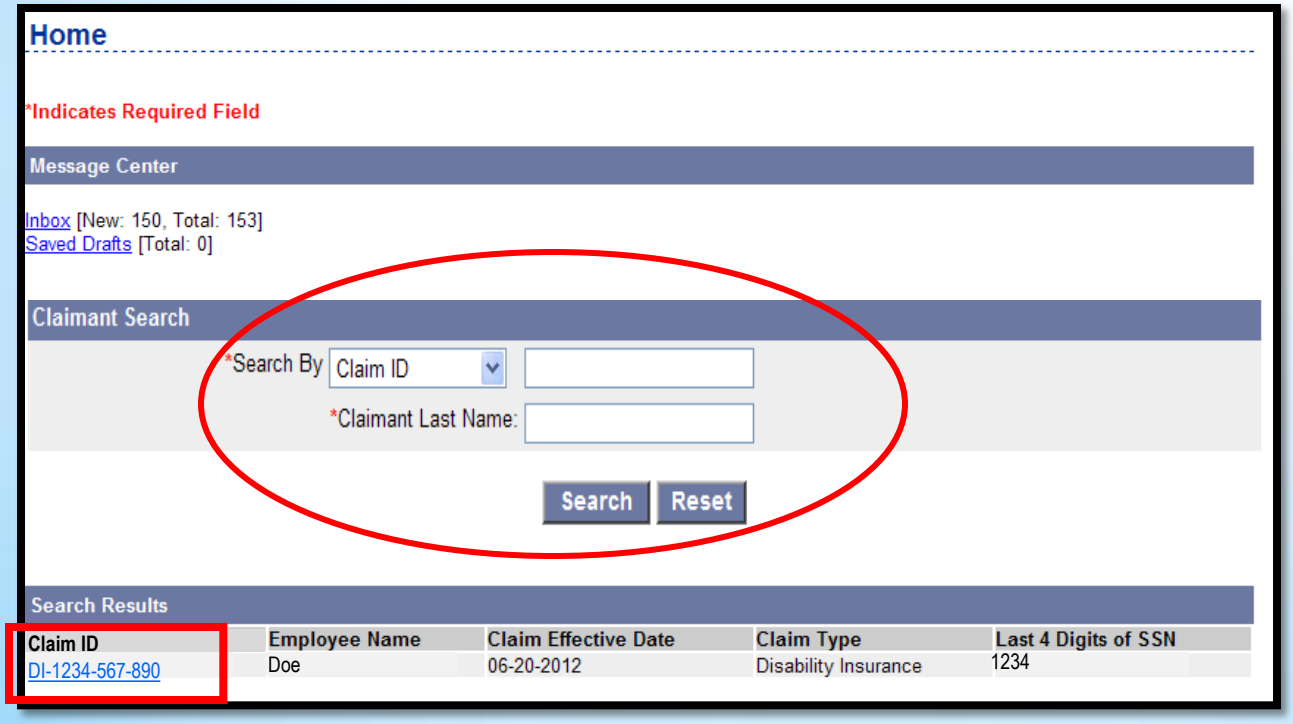
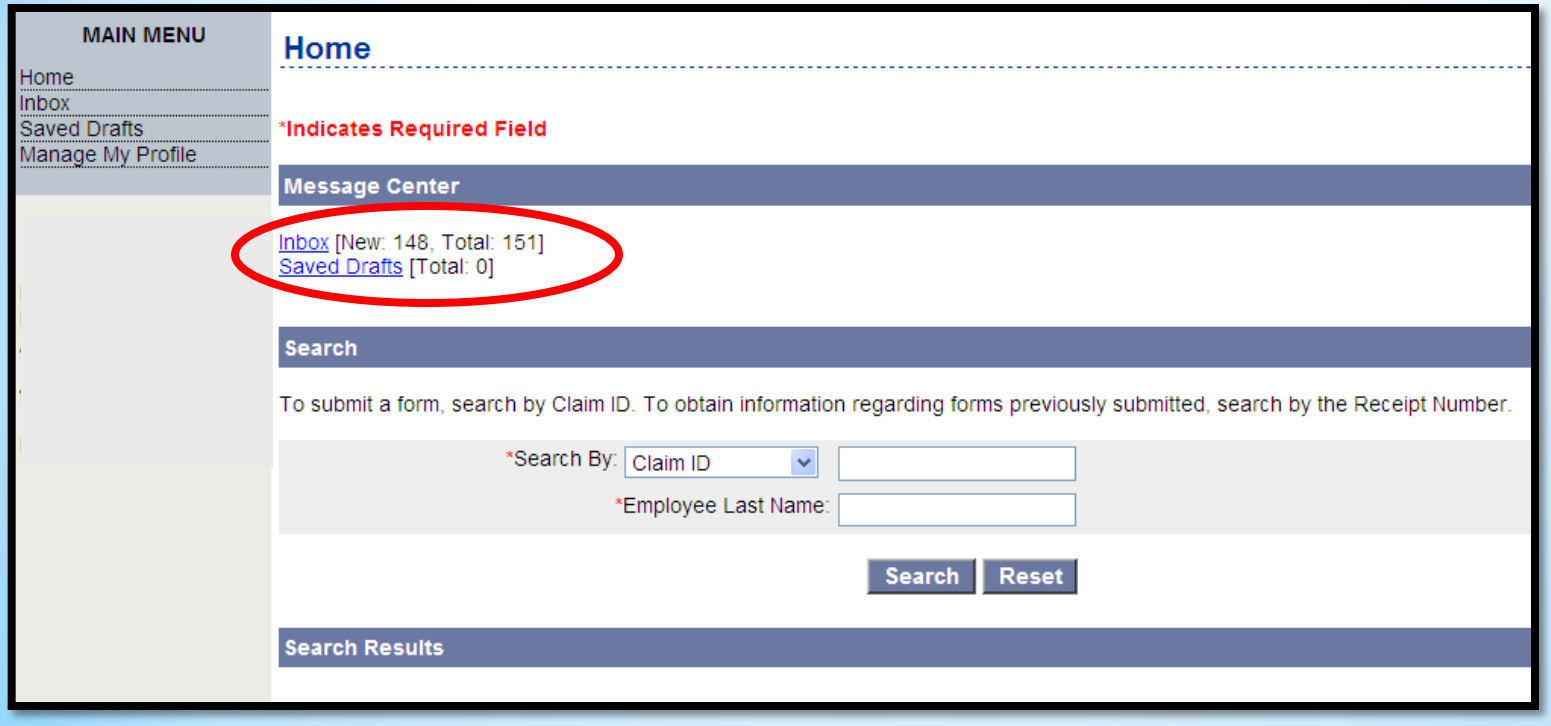
Employment Development Department
State of California

SDI Online Tutorial:
Submit a DE 2503, Notice to Employer of Disability Insurance Claim Filed



To complete forms using the **Claimant Search** option, select **Claim ID** and enter **Claimant Last Name.**

Select the **Claim ID** under **Search Results** to begin completing the DE 2503, Notice to Employer of Disability Insurance Claim Filed.



The DE 2503, Notice to Employer of Disability Insurance Claim Filed may also be listed within the Inbox.

You may also start a form and save it as a draft for each Claimant.

Message Center

Items Requiring Attention and Notices

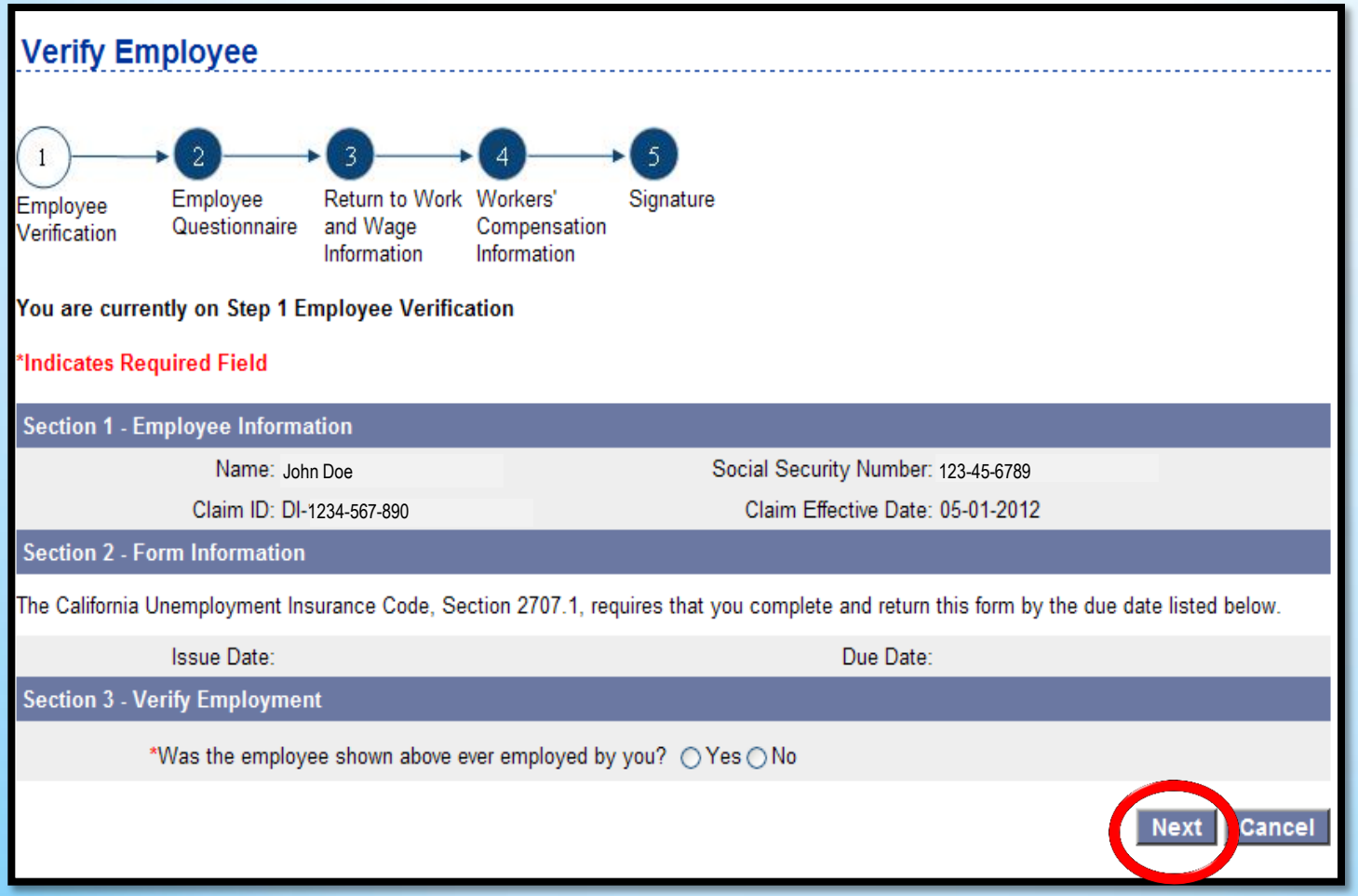
It is important to read the instructions on all EDD claims carefully. Completing a form early (before the due date) may cause a difference in benefit payment amount.

Claimant Name	Date of Birth	Subject	Sent Date	Due Date	Type	Read?	Action
John Doe		DE 2503, Notice to Employer of SDI Claim Filed	09-29-2011	10-01-2011	Requires Attention	Yes	Delete
John Doe		DE 2503, Notice to Employer of SDI Claim Filed	09-29-2011	10-01-2011	Requires Attention	No	Delete
John Doe		DE 2503, Notice to Employer of SDI Claim Filed	09-28-2011	09-30-2011	Requires Attention	Yes	Delete

By selecting **Items Requiring Attention and Notices**, you will be taken to the **Message Center.**

Please note: DE 2503 form requests generally will not appear here. You will receive a hard copy DE 2503 and can use the search option to find the claim to complete the form.

If the form was sent electronically, select the **DE 2503, Notice to Employer of SDI Claim Filed** from the **Subject** column to begin completing the form.



Verify Employee

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

You are currently on Step 1 Employee Verification

*Indicates Required Field

Section 1 - Employee Information

Name: John Doe
Social Security Number: 123-45-6789
Claim ID: DI-1234-567-890
Claim Effective Date: 05-01-2012

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:

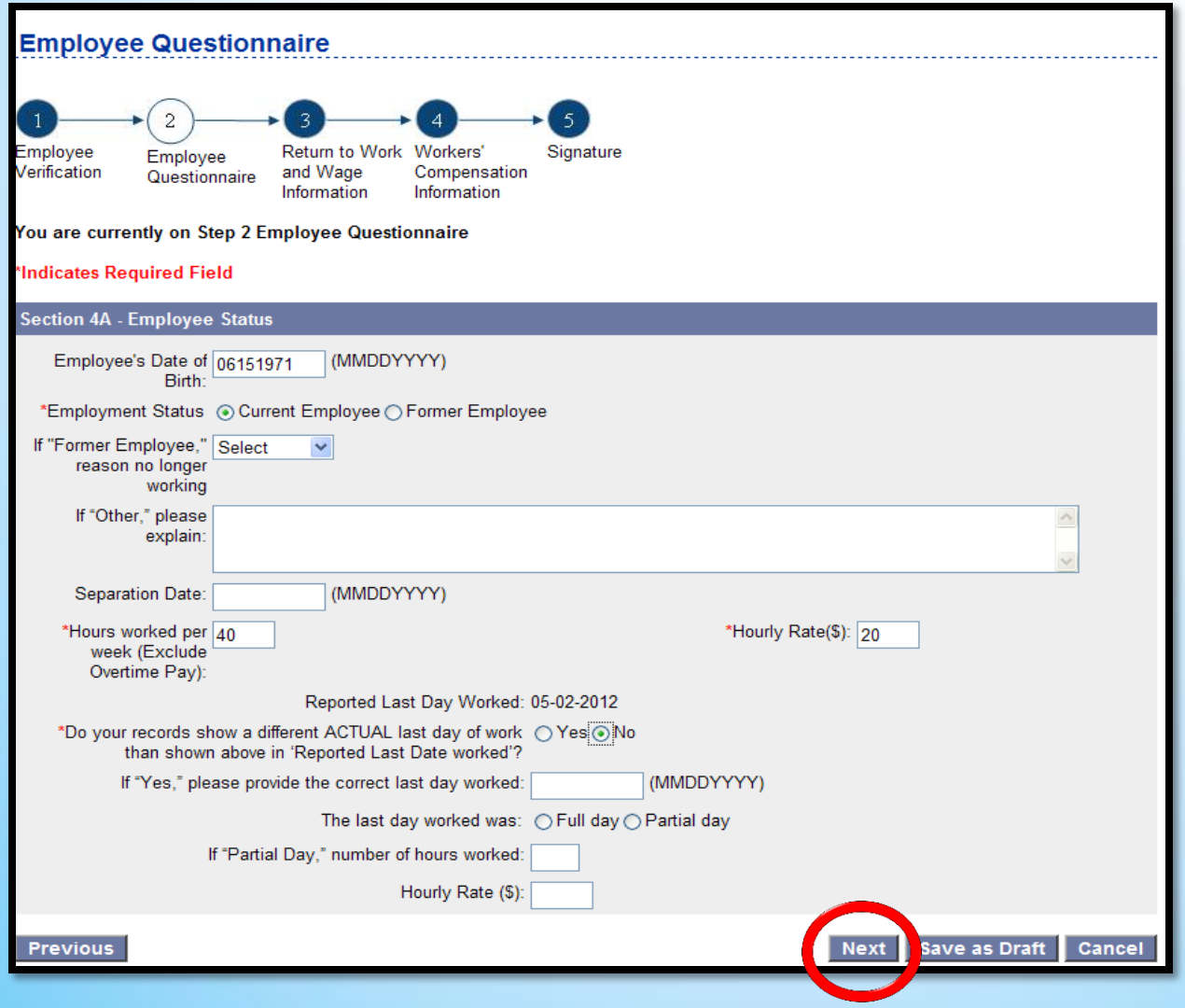
Section 3 - Verify Employment

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

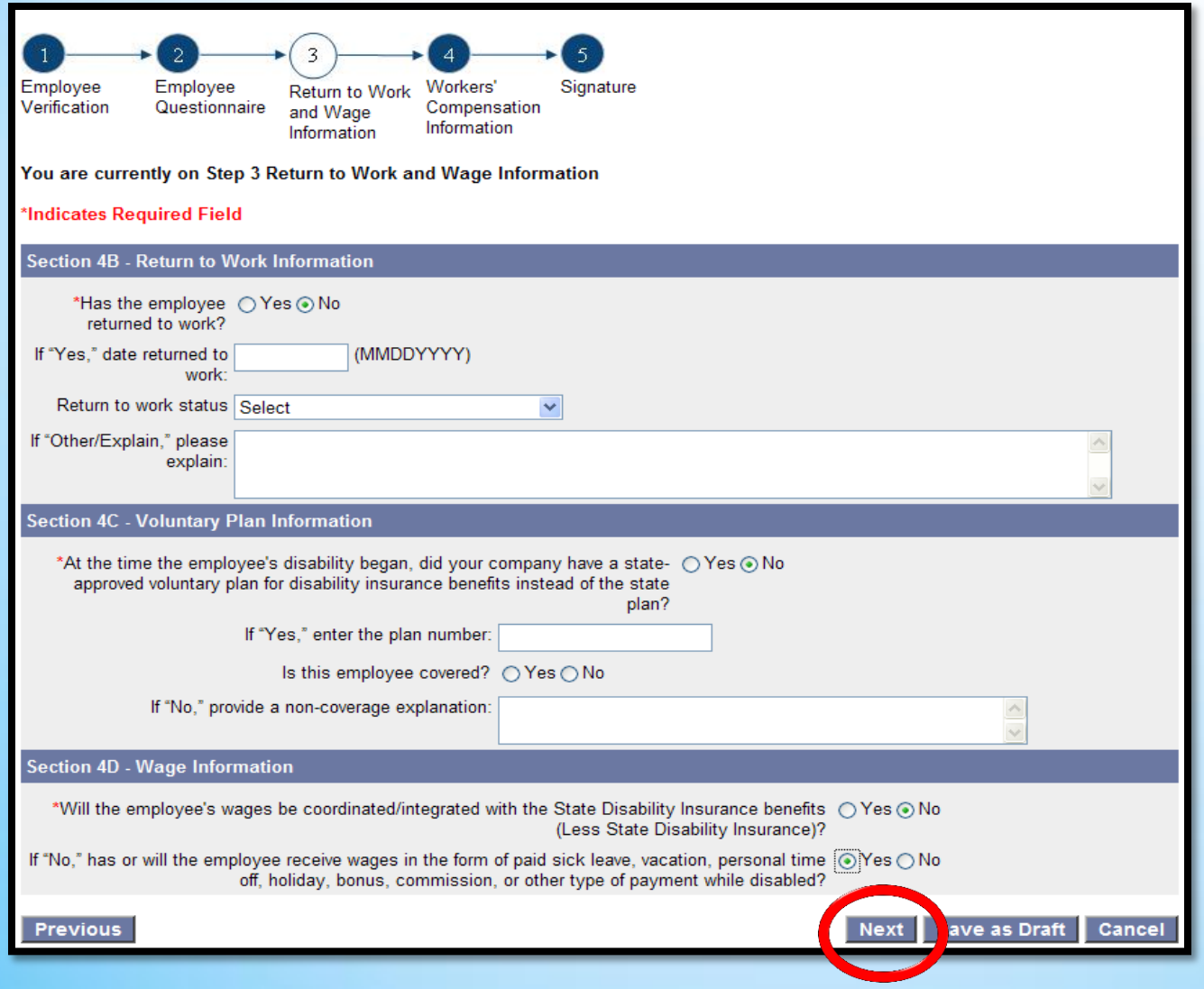
Next Cancel

Verify the Employee Information and Employment. Select **Next.**

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

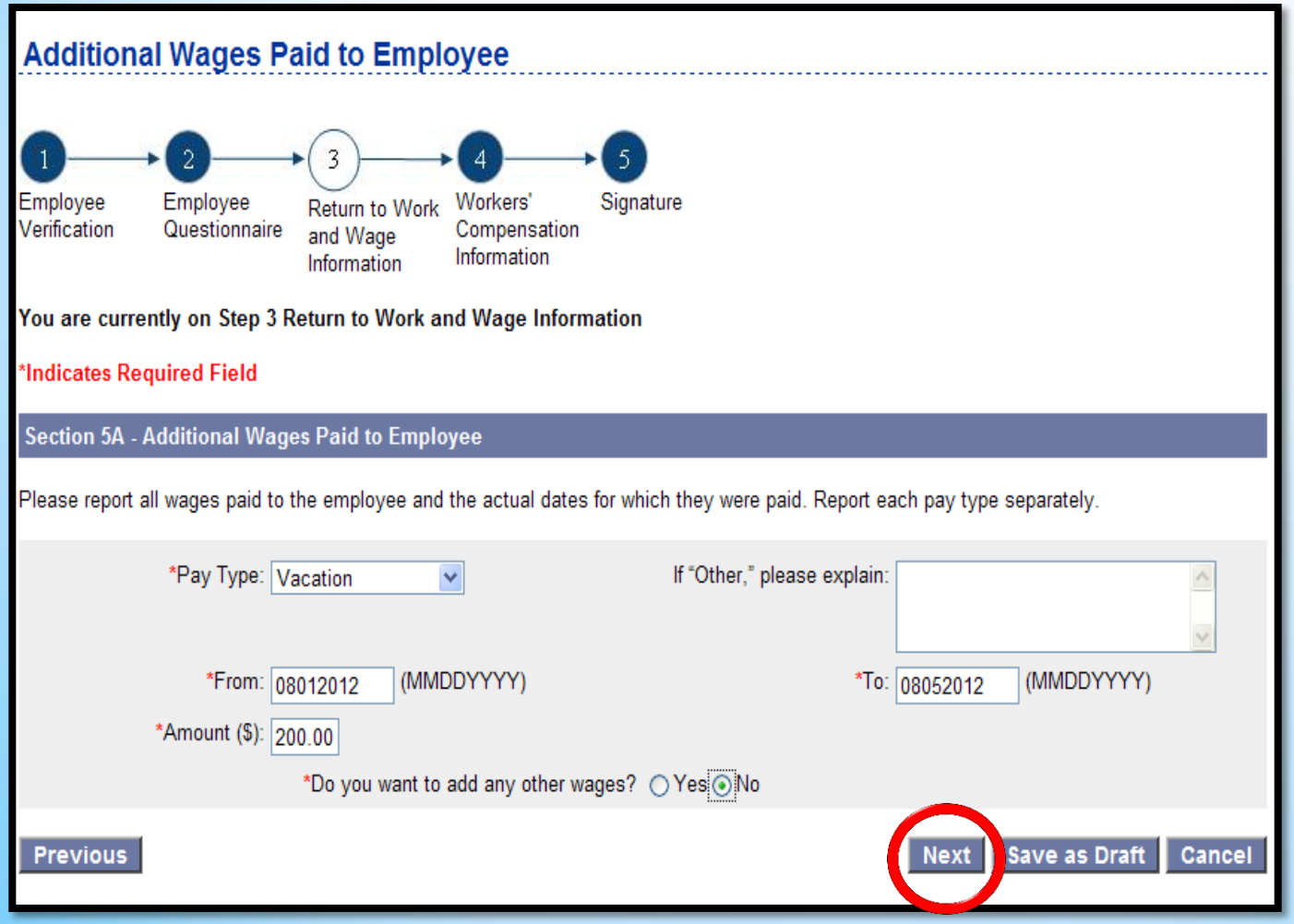


Complete the **Employee Questionnaire** and select **Next**.



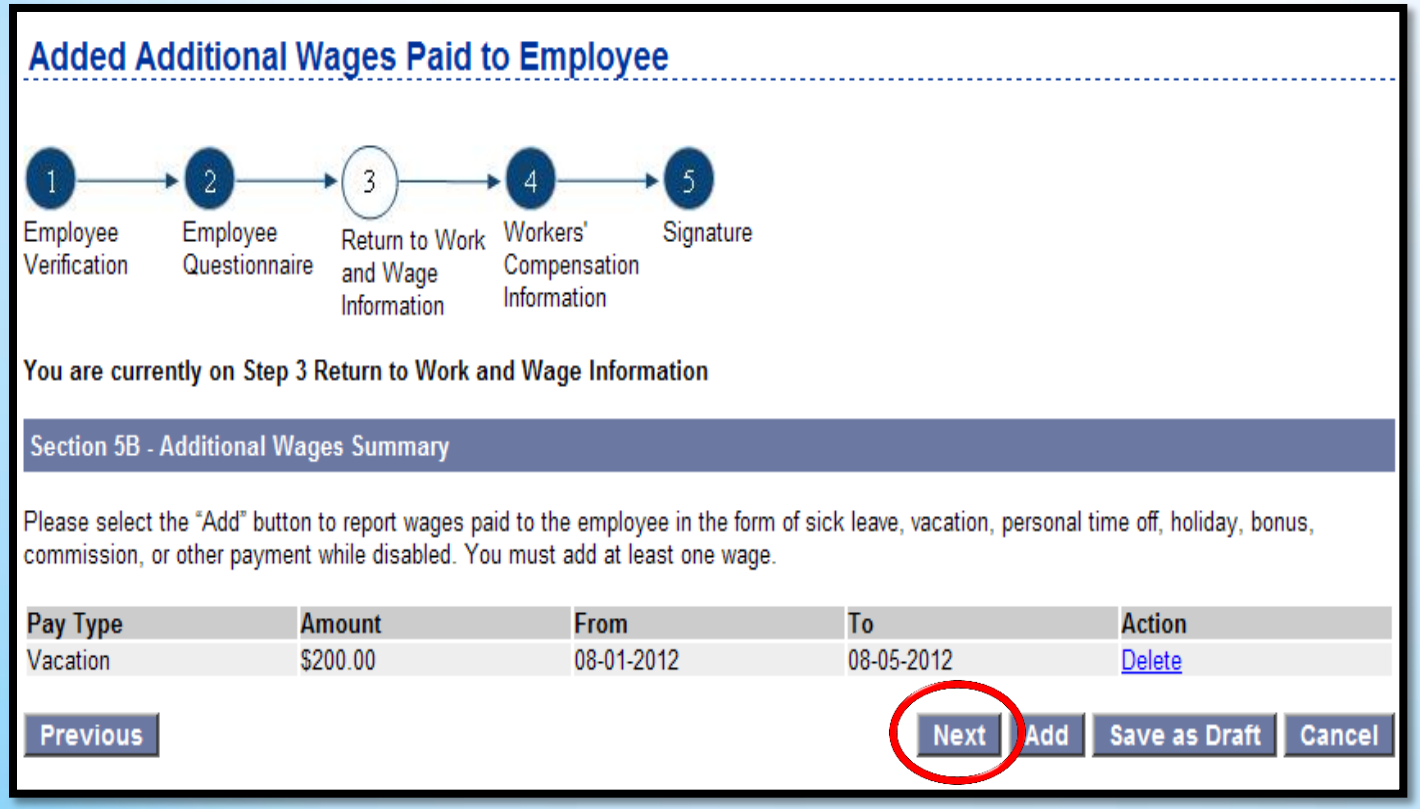
Complete the **Return to Work and Wage Information** and select **Next**.

Tip: If you select **Yes** on the final question, you must answer questions regarding additional wages paid to the employee.



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

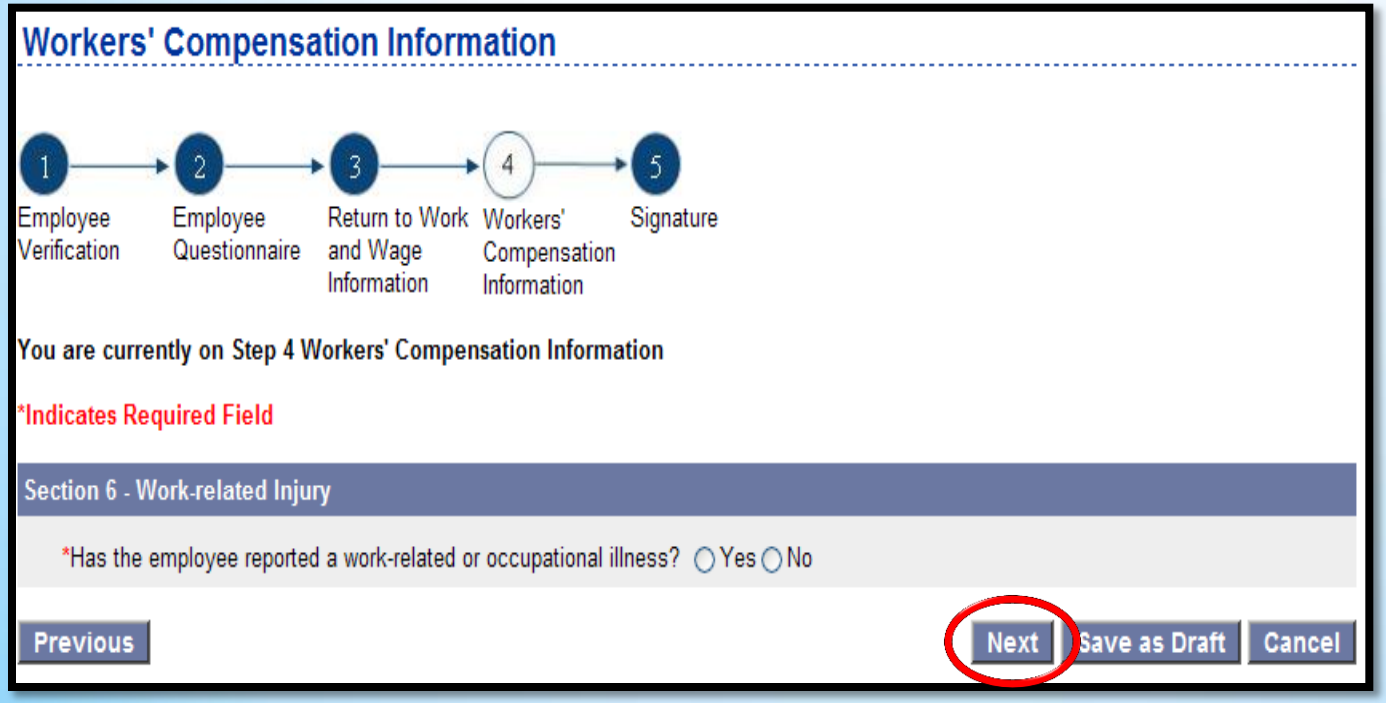
Tip: This page will only display if you selected **Yes** to additional wages paid to employee.



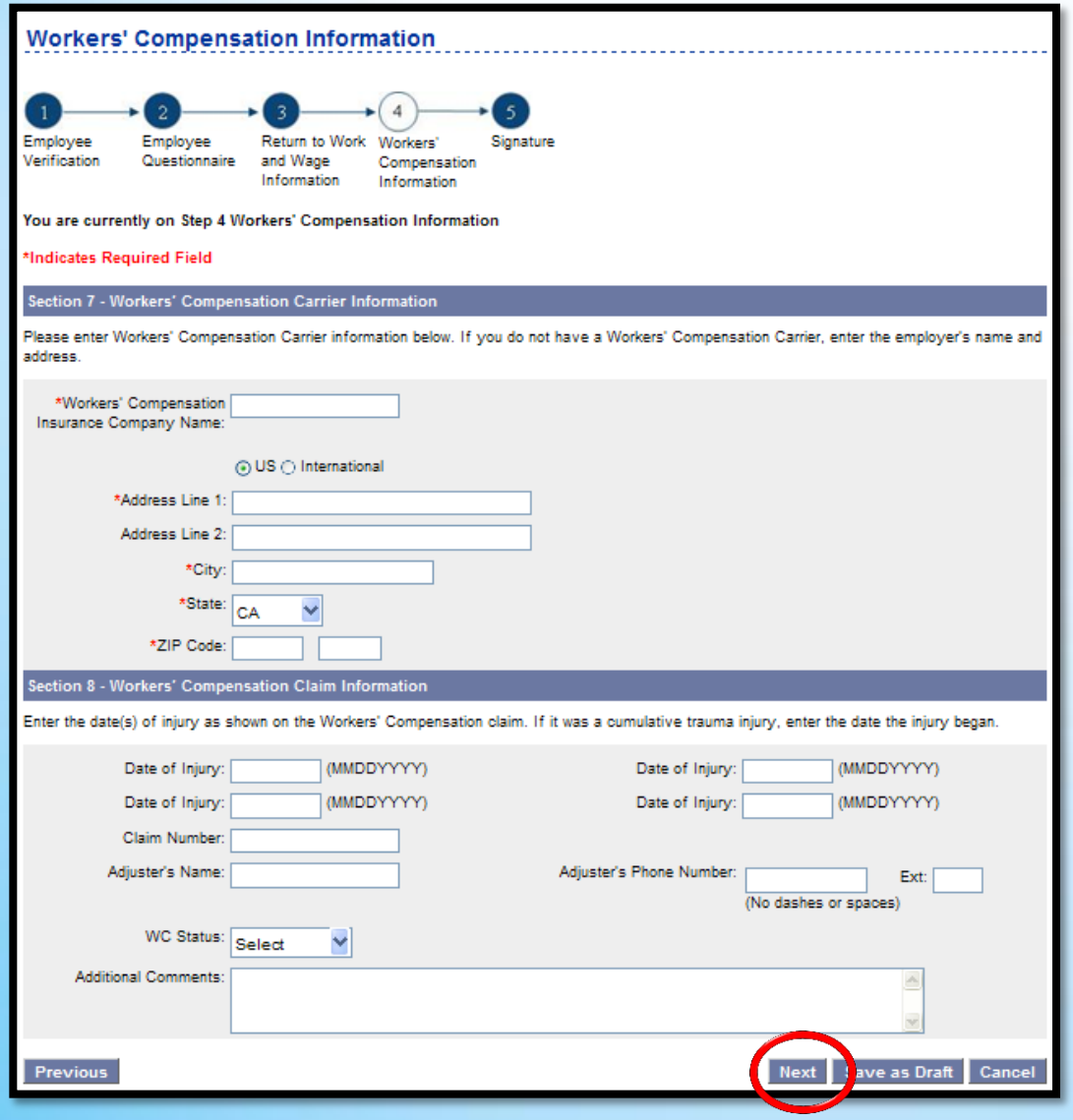
Verify the information you entered under **Additional Wages Summary** and select **Next**.

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

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



Complete the question under **Section 6 – Work-related Injury** and select **Next**.



Workers' Compensation Information

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

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: (MMDDYYYY) Date of Injury: (MMDDYYYY)

Date of Injury: (MMDDYYYY) Date of Injury: (MMDDYYYY)

Claim Number:

Adjuster's Name: Adjuster's Phone Number: Ext:

(No dashes or spaces)

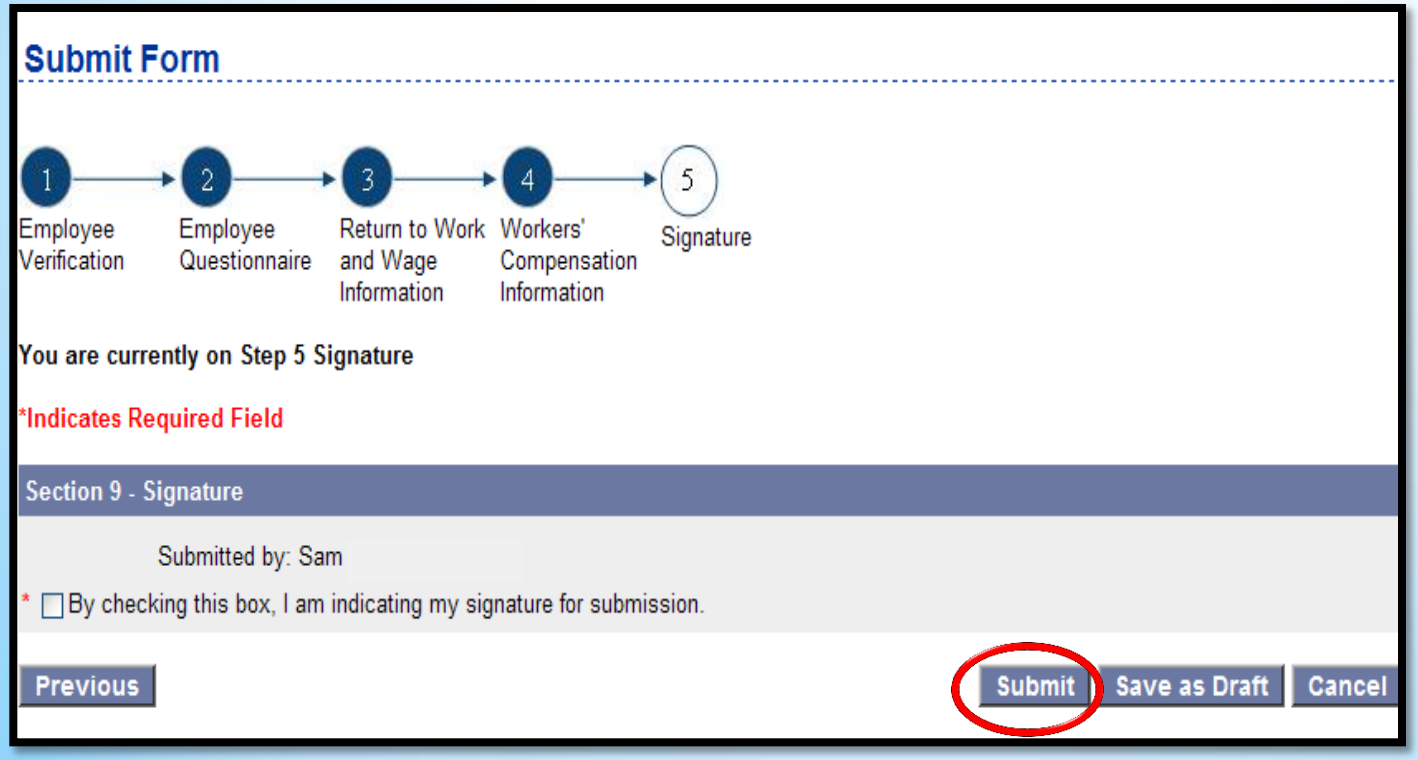
WC Status: Select

Additional Comments:

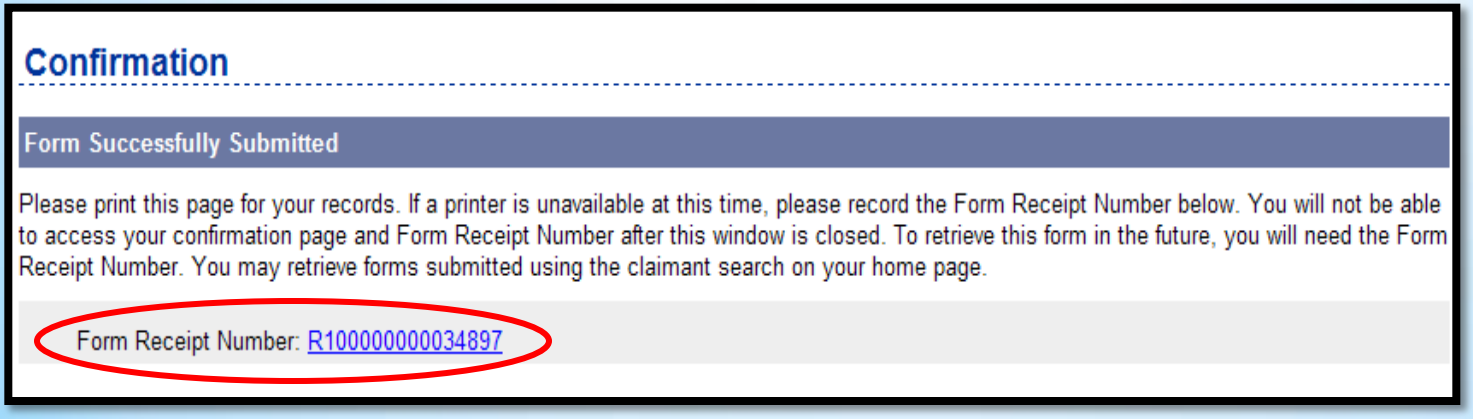
Previous Next Save as Draft Cancel

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

Tip: This page will only display if you selected **Yes** to a work-related injury or illness.



To submit the form, check the box under **Section 9 – Signature** and select **Submit**.



Confirmation

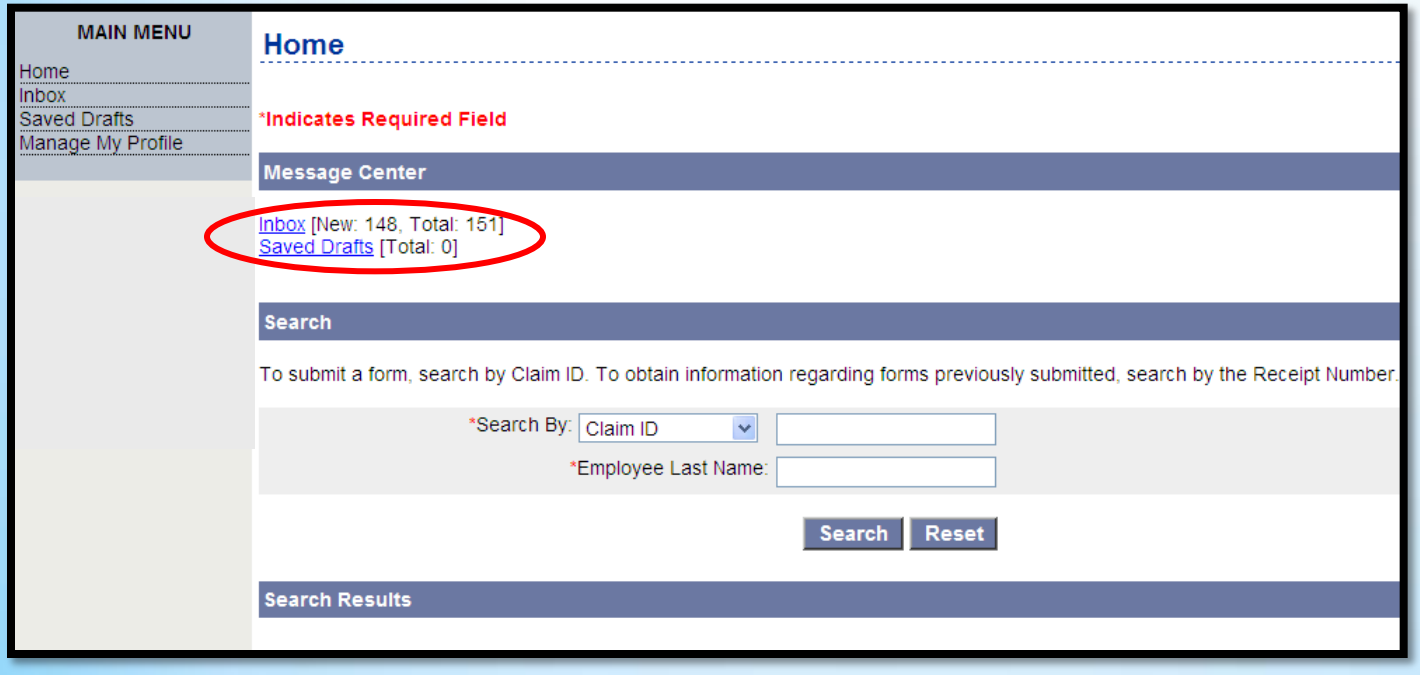
Form Successfully Submitted

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: R100000000034897

You will receive a **Form Receipt Number** on the **Confirmation** page. Save this number for future reference.

Select the **Form Receipt Number** to view the form.



Employers may save drafts of forms and return to complete the forms later. On the home page, select **Saved Drafts** to access the forms.

Tip: When a draft is accessed, SDI Online takes you to the beginning of the form.

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
2501 Claim for DI Benefits B	JEREMY	08-16-2012	ANANIAS E	09-15-2012	Delete
2501 Claim for DI Benefits B	JEREMY	08-16-2012	ANANIAS E	09-15-2012	Delete

The **Saved Drafts** page displays a list of forms that were started, but not completed or submitted.

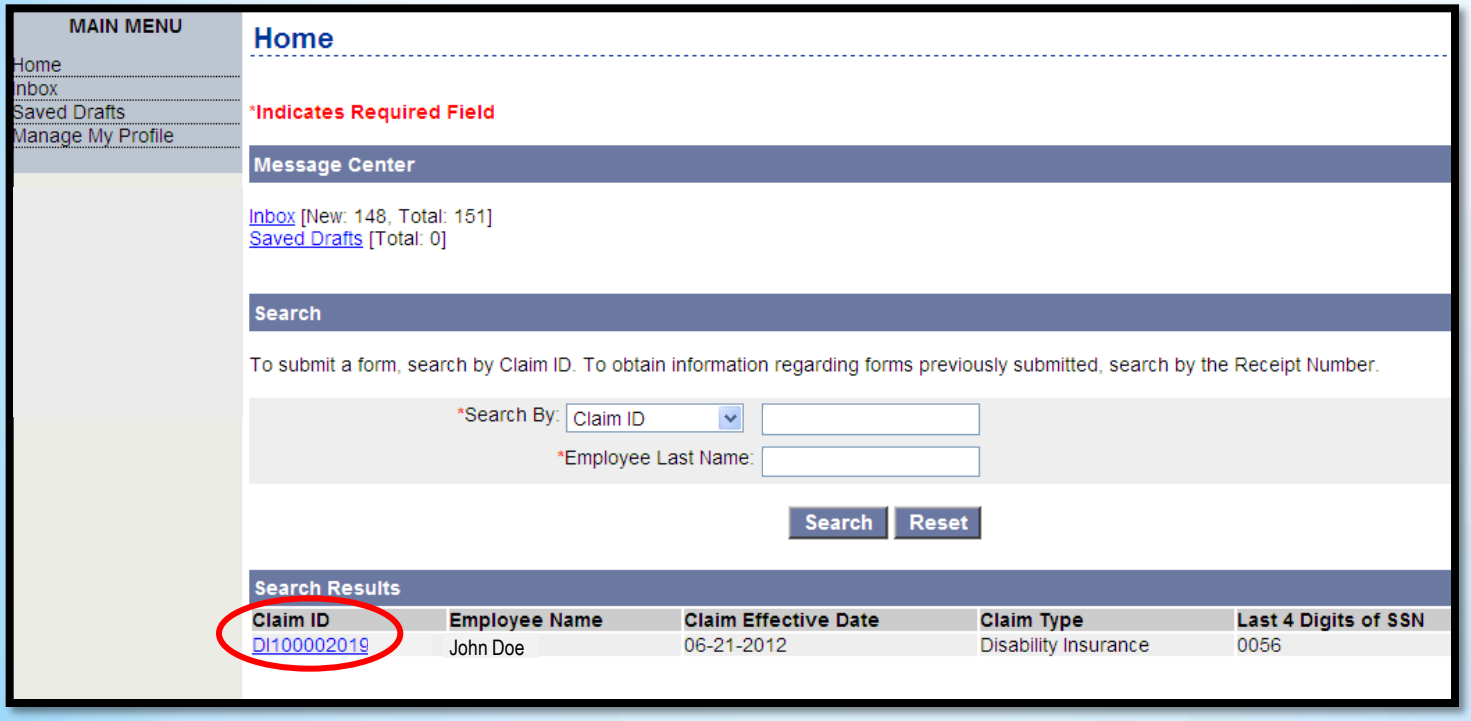
Select the form under the **Form Name** column to view and complete the form.

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

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

Employment Development Department
State of California

SDI Online Tutorial:
Submit a DE 2578A, Disability Insurance Eligibility—Workers' Compensation



At the **Home** screen, select **Claim ID** and enter **Employee Last Name**.

Select the **Claim ID** under **Search Results**.

Select the **2578A Employer Work Comp Form** to begin completing the form.

Notice of Potential Industrial Injury

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

You are currently on Step 1 Industrial Injury

***Indicates Required Field**

Employee Information

Name: John Doe

Social Security Number:

Claim ID:

Claim Effective Date: 06-21-2012

Form Due Date

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

Form Due Date: 07-12-2012

Establish Potential Industrial Injury

*Has a workers' compensation claim been filed?: ◯ Yes ◯ No

Next | Save as Draft | Cancel

Verify the Employee Information and Employment. Select **Next.**

Workers' Compensation Information

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

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 Information** and select **Next**.

Attorney Information

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

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, will you be represented by legal counsel?: ○ Yes ○ No

Name of Attorney:

Address Line 1:

Address Line 2:

City:

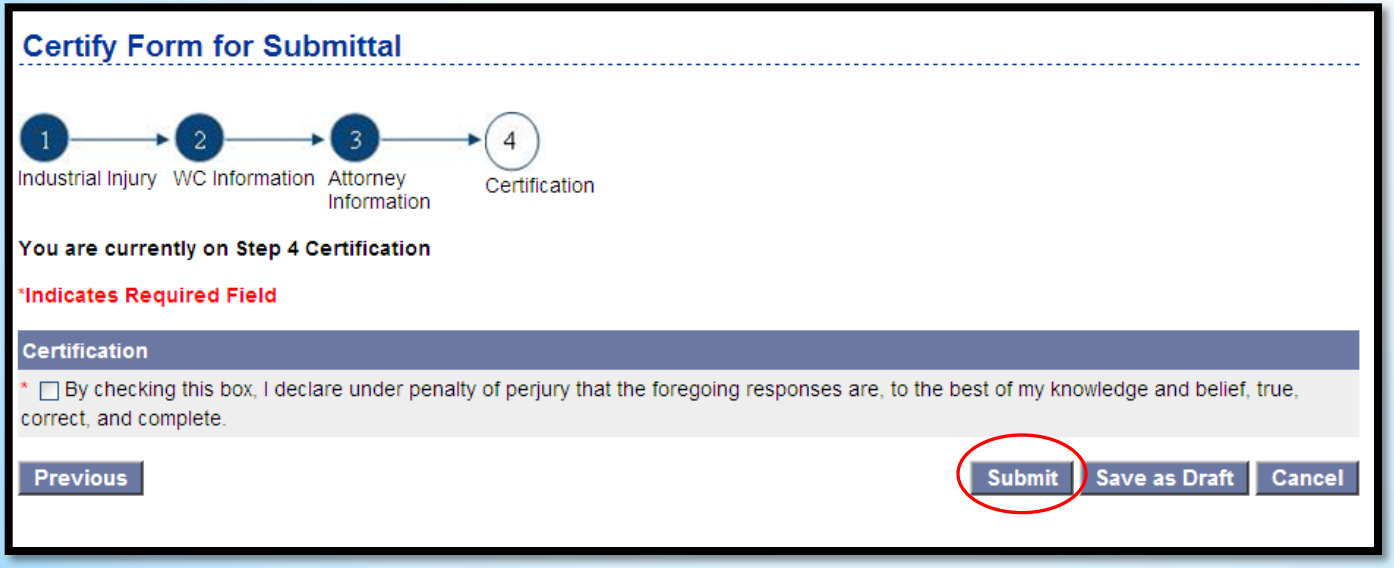
State: CA

ZIP Code:

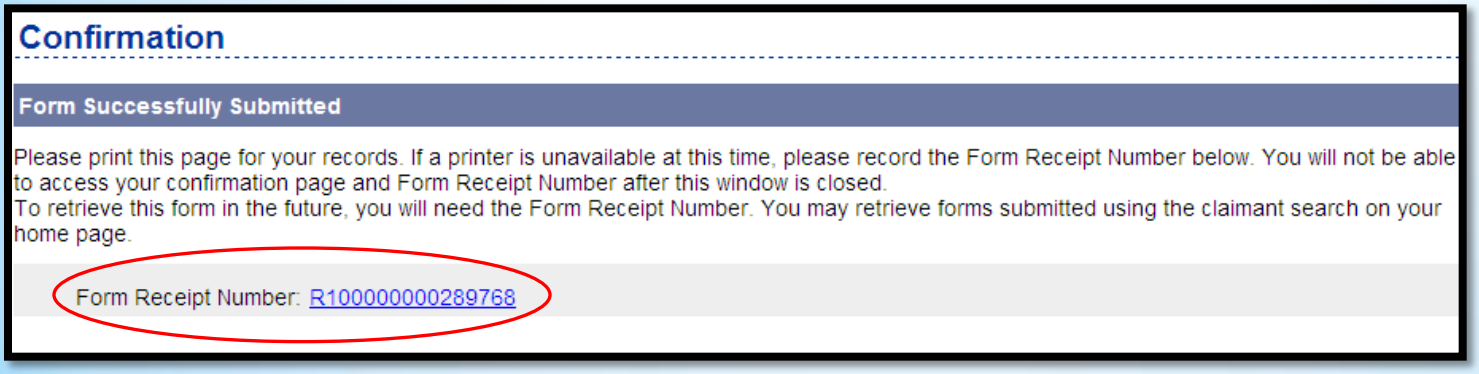
Phone Number:
(No dashes or spaces)

Previous | Next | Save as Draft | Cancel

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



To submit the form, check the box under **Certification** and select **Submit**.



Confirmation

Form Successfully Submitted

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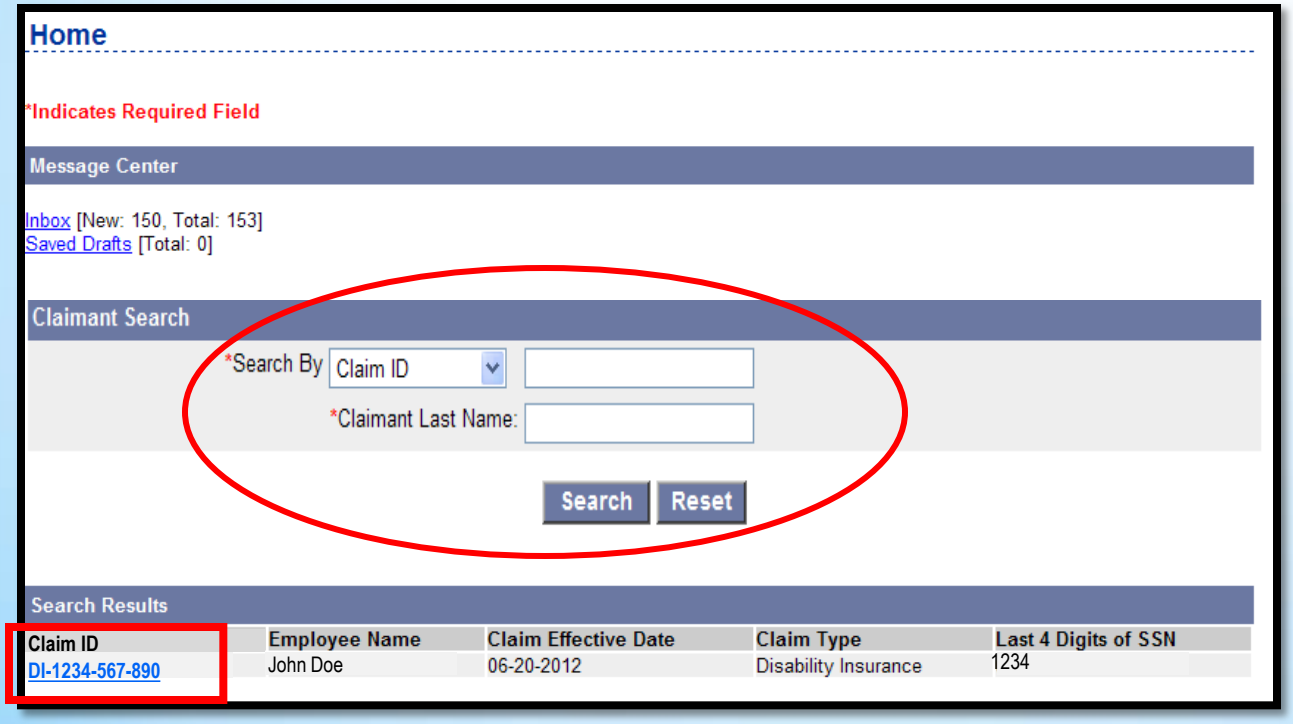
To retrieve this form in the future, you will need the Form Receipt Number. You may retrieve forms submitted using the claimant search on your home page.

Form Receipt Number: R100000000289768

You will receive a **Form Receipt Number** on the **Confirmation** page. Save this number for future reference.

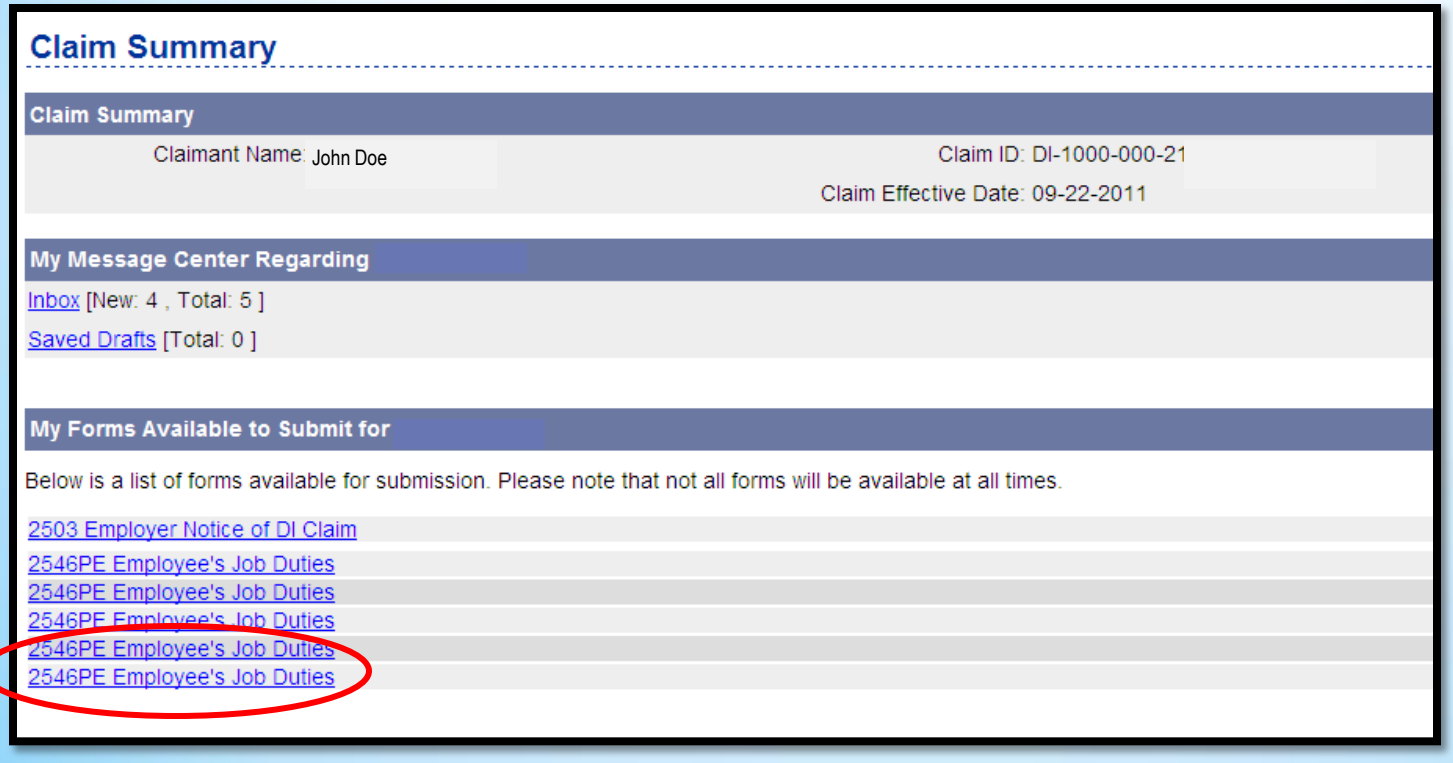
Select the **Form Receipt Number** to view the form.

SDI Online Tutorial:
Submit a DE 2546PE, Employer's Statement of Job Duties



To complete forms using the **Claimant Search** option, select **Claim ID** and enter **Claimant Last Name.**

Select the **Claim ID** under **Search Results**.



Select the **2546PE Employee's Job Duties** to begin completing the form.

Employer's Statement of Job Duties

*Indicates Required Field

Section 1 - Employee Information

Name: John Doe
Social Security Number: XXX-XX-
Claim ID: DI-1000-000-
Claim Effective Date: 09-22-2011

Section 2 - Form Information

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

Issue Date: 10-31-2011
Due Date: 11-07-2011

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

Activity	Frequency
Reaching or working above shoulder level?	None
Reaching or working below shoulder level?	None

Section 6 - Hands

Activity	Right Hand	Left Hand	Not Required
Simple grasping required	☐	☐	☐
Power grasping required	☐	☐	☐
Pushing and/or pulling required	☐	☐	☐
Fine manipulation required	☐	☐	☐

Section 7 - Feet

*Does the job require the employee to use his/her feet to operate foot controls or for repetitive movement? ○ Yes ○ No

Previous | Next | Save as Draft | Cancel

Complete part one of the **Employee's Job Duties**.

Select **Next.**

Employee's Job Duties: Part 2 of 3

*Indicates Required Field

Section 8 - Vision

*Is the employee required to have good vision? ◯ Yes ◯ No

If "yes", state the reason:

Section 9 - Hearing

*Is the employee required to have good hearing? ◯ Yes ◯ No

If "yes", state the reason:

Section 10 - Lifting and Carrying

Please check all the boxes that apply and indicate the frequency per day the employee is required to lift and/or carry any of the following weights.

Weight	Lift	Frequency	Carry	Frequency
10 lbs. or less	☐	None	☐	None
11 to 25 lbs.	☐	None	☐	None
26 to 50 lbs.	☐	None	☐	None
51 to 75 lbs.	☐	None	☐	None
76 to 100 lbs.	☐	None	☐	None
More than 100 lbs.	☐	None	☐	None

Longest distance employee must carry weight: feet

Heaviest weight employee must carry: lbs for feet

Section 11 - Equipment Operation

*Is the employee required to drive cars, trucks, forklifts, or other moving equipment? ◯ Yes ◯ No

If "Yes", describe or explain:

Previous | Next | Save as Draft | Cancel

Complete part two of the **Employee's Job Duties**.

Select **Next.**

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

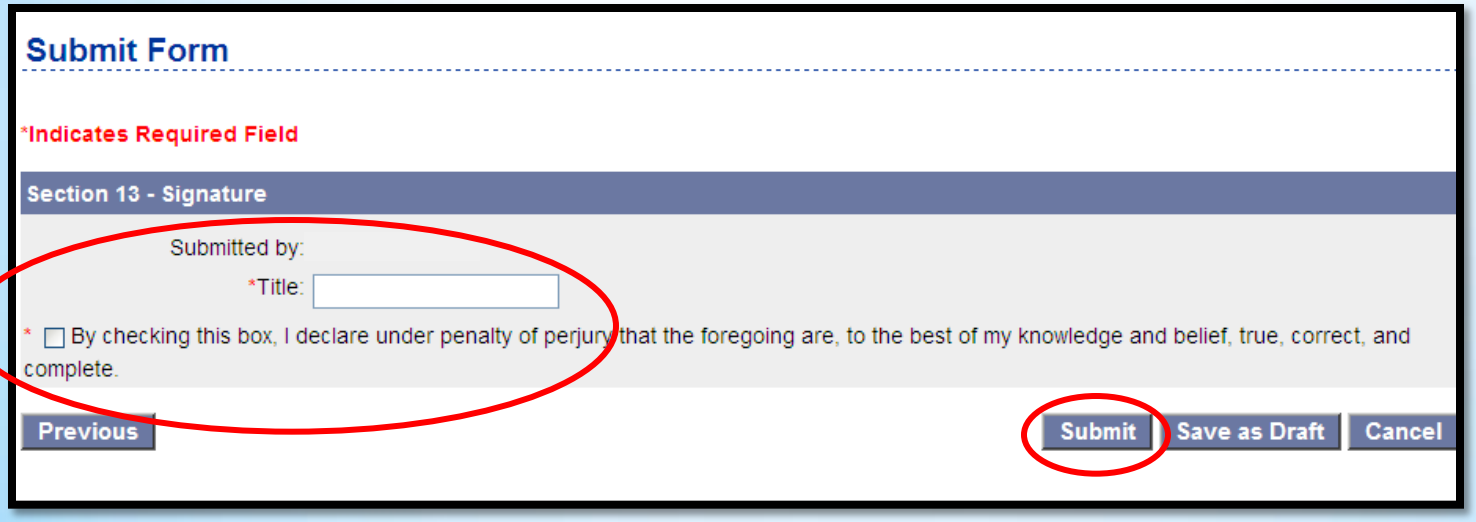
If "No," please explain:

Additional Comments:

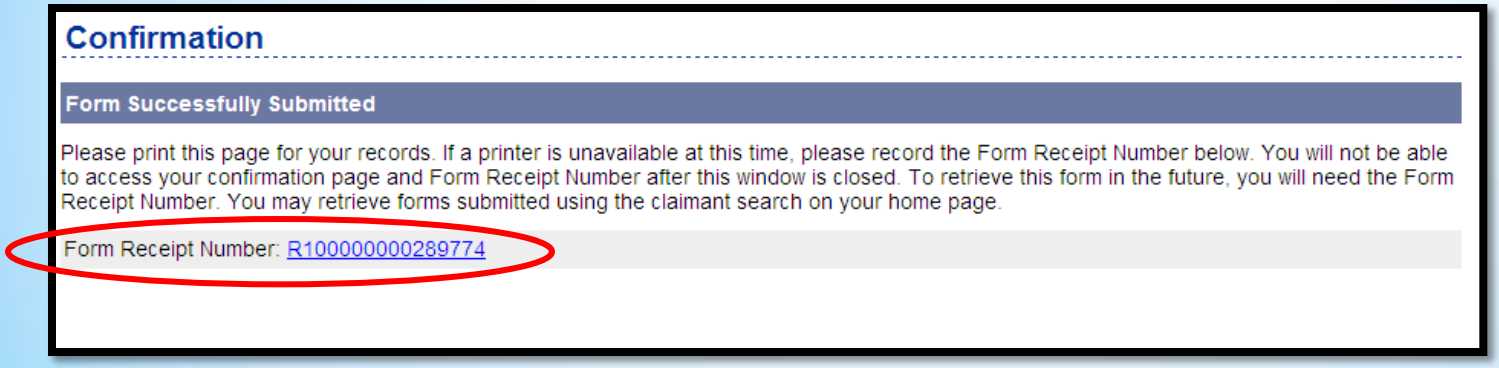
Previous | Next | Save as Draft | Cancel

Complete part three of the **Employee's Job Duties**.

Select **Next.**



To submit the form, fill in your **Title** and check the box under **Section 13 – Signature** and select **Submit**.



Confirmation

Form Successfully Submitted

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Form Receipt Number: R100000000289774

You will receive a **Form Receipt Number** on the **Confirmation** page. Save this number for future reference.

Select the **Form Receipt Number** to view the form.

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

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 1-800-480-3287 (voice), or TTY 1-800-563-2441.