



**Paid Family Leave Claimant Overview**  
State Disability Insurance Program  
Employment Development Department



# Five Things To Know About Paid Family Leave

1

Provides up to 8 weeks of partially paid leave in a 12-month period.

2

Three Claim Types:  
Care  
Bonding  
Military Assist

3

Can be used intermittently over a 12-month period.

4

There is no waiting period. Payment begins the first day of leave.

5

State Disability Insurance (SDI) is employee funded. It is not government assistance.



# Paid Family Leave and Caregivers

California's Paid Family Leave (PFL) pays eligible employees up to eight weeks of benefits to be there for the moments that matter most.

PFL Care provides partially paid leave if you are:

- ▶ Caring for a seriously ill or injured child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner.
- ▶ Caring for an out-of-state or out-of-country family member.

You receive approximately 60 to 70 percent of your salary while using PFL.

# Paid Family Leave and Bonding

PFL Bonding provides up to eight weeks of partially paid leave for parents to bond with a new child within the child's first year.

- ▶ Use to bond with a biological, foster, or adopted child.
- ▶ Requires documentation showing proof of relationship such as the child's birth certificate, birth record, or foster/adoptive placement agreement.

You receive approximately 60 to 70 percent of your salary while using PFL.



# Disability Insurance, Paid Family Leave, and New/Expecting Mothers



New mothers file for Disability Insurance (DI) followed by PFL, for example:



\*You can break up your eight weeks of PFL. You do not have to use it all at once.



# Paid Family Leave and Military Assist

PFL Military Assist pays eligible workers up to eight weeks of benefits to assist a spouse, registered domestic partner, parent, or child in the US Military during a qualifying event.

- ▶ A qualifying event is defined as a military event or essential need resulting from the family member's order, call, or notification of deployment to a foreign country.
- ▶ Requires supporting military documentation and supporting documentation for the qualifying event.

You receive approximately 60 to 70 percent of your salary while using PFL.

# Filing a Paid Family Leave Claim

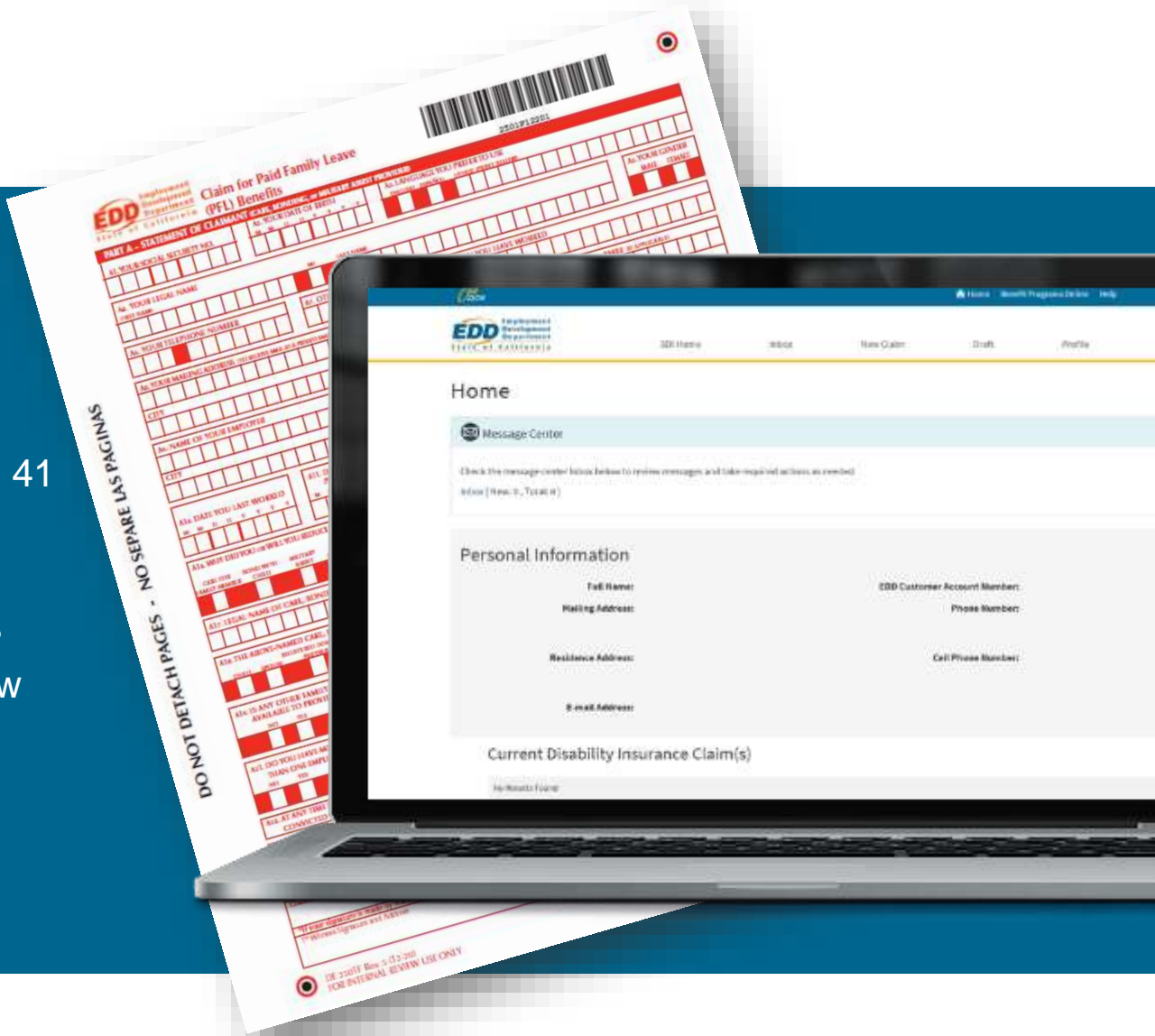
Individuals must complete and submit their PFL claim within 41 days from the date their family leave begins by:



**SDI Online:** Filing electronically through SDI Online is strongly recommended because it expedites the review process.



**Mail**



\*A PFL claim form will be mailed to new moms at the end of their pregnancy-related DI claim.

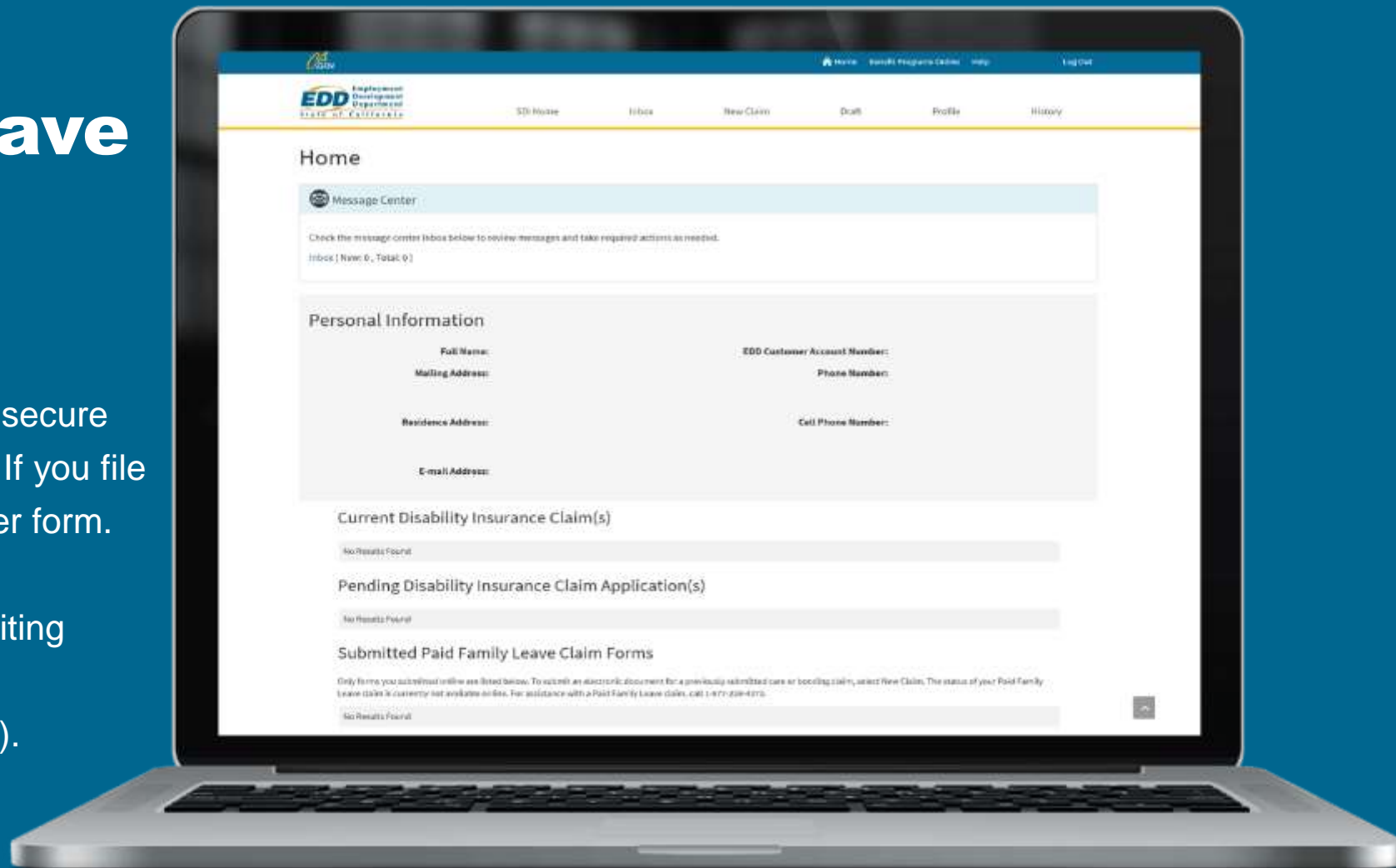
# Paid Family Leave and SDI Online



Online

SDI Online is a fast, convenient, and secure way to submit your PFL claim online. If you file electronically, do not send in the paper form.

Create or access your account by visiting [SDI Online](https://edd.ca.gov/en/disability/SDI_Online/) (edd.ca.gov/en/disability/SDI\_Online/).







Claim for Paid Family Leave (PFL) Benefits



2501F12001

**PART A - STATEMENT OF CLAIMANT (CARE, BONDING, OR MILITARY ASSIST PROVIDER)**

A1. YOUR SOCIAL SECURITY NO. A2. YOUR DATE OF BIRTH A3. LANGUAGE YOU PREFER TO USE

A4. YOUR LEGAL NAME (FIRST NAME) (LAST NAME) A5. YOUR GENDER (MALE) (FEMALE)

A6. YOUR TELEPHONE NUMBER A7. OTHER LAST NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED

A8. YOUR MAILING ADDRESS (INDICATE MAILING ADDRESS IF DIFFERENT FROM YOUR HOME ADDRESS. YOU MUST HAVE THE NUMBER IN THE "CITY" FIELD. (P.O. BOXES ARE NOT ACCEPTED))

CITY STATE/PROV ZIP OR POSTAL CODE COUNTRY (IF NOT USA)

A9. NAME OF YOUR EMPLOYER MAILING ADDRESS

CITY STATE/PROV ZIP OR POSTAL CODE EMPLOYER'S PHONE NUMBER

A10. DATE YOU LAST WORKED A11. DATE YOU WANT YOUR PFL CLAIM TO BEGIN A12. DATE YOU RETURNED OR WILL RETURN TO WORK A13. DID YOU WORK OR WILL YOU CONTINUE TO WORK DURING YOUR FAMILY LEAVE PERIOD? (YES) (NO)

A14. WHY DID YOU OR WILL YOU REDUCE YOUR WORK HOURS OR STOP WORKING? (CARE FOR CHILDREN) (CARE FOR ELDERLY) (MILITARY) (OTHER) (EXPLAIN) A15. WHAT IS YOUR OCCUPATION? A16. SELECT YOUR PREFERRED PAYMENT METHOD (DEBIT CARD) (CHECK)

A17. LEGAL NAME OF CARE, BONDING, OR MILITARY ASSIST PROVIDER (FIRST NAME) (LAST NAME)

A18. THE ABOVE-NAMED CARE, BONDING, OR MILITARY ASSIST PROVIDER IS YOUR: (SPOUSE) (PARENT) (CHILD) (GRANDCHILD) (SIBLING) (Nephew) (Niece) (Other) (Explain)

A19. IS ANY OTHER FAMILY MEMBER READY, WILLING, AND ABLE AND AVAILABLE TO PROVIDE CARE FOR THE SAME PERIOD YOU ARE CLAIMING PFL BENEFITS? (YES) (NO) A20. HAVE YOU CLAIMED OR DO YOU PLAN TO CLAIM WORKERS' COMPENSATION BENEFITS FOR ANY PORTION OF THE PERIOD COVERED BY THIS CLAIM? (YES) (NO)

A21. DID YOU HAVE MORE THAN ONE EMPLOYER? (YES) (NO) A22. IF YOUR EMPLOYER(S) CONTINUED OR WILL CONTINUE TO PAY YOU DURING YOUR FAMILY LEAVE, INDICATE TYPE OF PAY: (Sick) (Vacation) (Other) (Explain) A23. MAY WE DISCLOSE BENEFIT PAYMENT INFORMATION TO YOUR EMPLOYER? (YES) (NO)

A24. AT ANY TIME DURING YOUR PFL LEAVE, WERE YOU IN THE CUSTODY OF LAW ENFORCEMENT AUTHORITIES BECAUSE YOU WERE CONVICTED OF VIOLATING A LAW OR ORDINANCE? (YES) (NO)

A25. Declaration and Signature. By my signature on this claim statement I (I) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was providing care for (including work or participating in a qualified activity with the care recipient) above (2) authorize EDD to release my personal information as shown on this claim as the care recipient's primary caregiver as defined in the California Code of Regulations and (3) authorize my employer to disclose (2) all facts concerning my employment that are within their knowledge and (3) authorize release and use of information as stated in the Information Collection and Access portion of this form. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine (or both), a felony, and/or penalty of perjury under the following statements, including any accompanying statements in oral files of my knowledge and belief, true, correct and complete. I agree that disclosure of this statement shall be as valid as the original and I understand that applications contained in this claim statement are general for a period of 10 years from the date of my signature or the effective date of the claim, whichever is later.

Claimant's Signature (DO NOT PRINT) If signature is made by mark (X), please place mark here. Date Signed (mm / dd / yyyy)

If your signature is made by mark (X), it must be attested by two witnesses with their addresses: (1) Witness Signature and Address (2) Witness Signature and Address

DO NOT DETACH PAGES - NO SEPAR LAS PAGINAS

DE 2501F Rev 5 (12-20) FOR INTERNAL REVIEW USE ONLY

# Filing a Paid Family Leave Care Claim



By mail

A properly completed PFL care claim will include:

- ▶ Part A – Statement of Claimant
- ▶ Part C – Statement of Care Recipient
- ▶ Part D – Physician/Practitioner’s Certification

Obtain the *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F) application by ordering through Online Forms and Publications

(forms.edd.ca.gov/forms), or by calling 1-877-238-4373.

\*Spanish applications are available for download only through Online Forms and Publications.





2501F12201

**PART A - STATEMENT OF CLAIMANT (CARE, BONDING, OR MILITARY ASSIST PROVIDER)**

A1. YOUR SOCIAL SECURITY NO. A2. YOUR DATE OF BIRTH A3. LANGUAGE YOU PREFER TO USE

A4. YOUR LEGAL NAME A5. YOUR GENDER

A6. YOUR TELEPHONE NUMBER A7. OTHER LAST NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED

A8. YOUR MAILING ADDRESS (SEE INSTRUCTIONS ON HOW TO COMPLETE THIS SECTION) (SEE INSTRUCTIONS)

CITY STATE/PROV ZIP OR POSTAL CODE COUNTRY (IF NOT USA)

A9. NAME OF YOUR EMPLOYER MAILING ADDRESS

CITY STATE/PROV ZIP OR POSTAL CODE EMPLOYER'S PHONE NUMBER

A10. DATE YOU LAST WORKED A11. DATE YOU WANT YOUR PFL CLAIM TO BEGIN A12. DATE YOU RETURNED OR WILL RETURN TO WORK A13. DID YOU WORK (OR WILL YOU CONTINUE TO WORK) DURING YOUR FAMILY LEAVE PERIOD?

A14. WHY DID YOU OR WILL YOU REDUCE YOUR WORK HOURS OR STOP WORKING? A15. WHAT IS YOUR OCCUPATION?

A16. LEGAL NAME OF CARE, BONDING, OR MILITARY ASSIST PROVIDER (FIRST / MIDDLE INITIAL / LAST)

A17. THE ABOVE-NAMED CARE, BONDING, OR MILITARY ASSIST PROVIDER IS YOUR:

A18. IS ANY OTHER FAMILY MEMBER READY, WILLING, AND ABLE AND AVAILABLE TO PROVIDE CARE FOR THE SAME PERIOD YOU ARE CLAIMING PFL BENEFITS? A19. HAVE YOU CLAIMED OR DO YOU PLAN TO CLAIM WORKERS' COMPENSATION BENEFITS FOR ANY PORTION OF THE PERIOD COVERED BY THIS CLAIM?

A20. DID YOU HAVE MORE THAN ONE EMPLOYER? A21. IF YOUR EMPLOYER(S) CONTINUED OR WILL CONTINUE TO PAY YOU DURING YOUR FAMILY LEAVE, INDICATE TYPE OF PAY: A22. MAY WE DISCLOSE BENEFIT PAYMENT INFORMATION TO YOUR EMPLOYER(S)?

A23. AT ANY TIME DURING YOUR PFL LEAVE, WERE YOU IN THE CUSTODY OF LAW ENFORCEMENT AUTHORITIES BECAUSE YOU WERE CONVICTED OF VIOLATING A LAW OR ORDINANCE?

A24. Declaration and Signature. By my signature on this claim statement (I) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was providing care for, bonding with, or participating in a qualified event with the employee named above (I) authorize EDD to release my personal information as shown on this claim as the claim requires, except information which may be necessary to file a claim for disability benefits or workers' compensation or disability benefits or to determine the amount of any benefits payable under the California Labor Code or any other law, regulation, or contract. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine (or both), a felony, and penalty of perjury under the following statement, including any accompanying statements in or out of view of my knowledge and belief, true, correct, and complete. I agree that photocopies of this statement shall be as valid as the original and I understand that such copies are contained in this claim statement are general for a period of 10 years from the date of my signature or the effective date of the claim, whichever is later.

Claimant's Signature: THIS MUST PRINT: If signature is made by mark (X), please place mark here. Date Signed (mm / dd / yyyy)

If your signature is made by mark (X), it must be attested by two witnesses with their addresses:  
1st Witness Signature and Address 2nd Witness Signature and Address

# Filing a Paid Family Leave Bonding Claim

 By mail

A properly completed PFL bonding claim will include:

- ▶ Part A – Statement of Claimant.
- ▶ Part B – Bonding Certification.
- ▶ Supporting documentation verifying the relationship between you and the new child.

Obtain the DE 2501F application by ordering through [Online Forms and Publications](https://forms.edd.ca.gov/forms) ([forms.edd.ca.gov/forms](https://forms.edd.ca.gov/forms)), or by calling 1-877-238-4373.

\*Spanish applications are available for download only through [Online Forms and Publications](https://forms.edd.ca.gov/forms).



Claim for Paid Family Leave (PFL) Benefits



DE 2501F 12/01

**PART A - STATEMENT OF CLAIMANT (CARE, BONDING, OR MILITARY ASSIST PROVIDER)**

A1. YOUR SOCIAL SECURITY NO. A2. YOUR DATE OF BIRTH A3. LANGUAGE YOU PREFER TO USE

A4. YOUR LEGAL NAME (FIRST NAME) (LAST NAME) A5. YOUR GENDER (MALE) (FEMALE)

A6. YOUR TELEPHONE NUMBER A7. OTHER LAST NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED

A8. YOUR MAILING ADDRESS (INDICATE MAIL STOP OR PO BOX NUMBER, IF APPLICABLE) (CITY) (STATE/PROV) (ZIP OR POSTAL CODE) (COUNTRY, IF APPLICABLE)

A9. NAME OF YOUR EMPLOYER MAILING ADDRESS (CITY) (STATE/PROV) (ZIP OR POSTAL CODE) EMPLOYER'S PHONE NUMBER

A10. DATE YOU LAST WORKED A11. DATE YOU WANT YOUR PFL CLAIM TO BEGIN A12. DATE YOU RETURNED OR WILL RETURN TO WORK A13. DID YOU WORK OR WILL YOU CONTINUE TO WORK DURING YOUR FAMILY LEAVE PERIOD?

A14. WHY DID YOU OR WILL YOU REDUCE YOUR WORK HOURS OR STOP WORKING? (CARE FOR) (BOND WITH) (MILITARY) (OTHER EXPLAIN) A15. WHAT IS YOUR OCCUPATION? A16. SELECT YOUR PREFERRED PAYMENT METHOD (DEBIT CARD) (CREDIT CARD) (CHECK)

A17. LEGAL NAME OF CARE, BONDING, OR MILITARY ASSIST PROVIDER (FIRST NAME) (LAST NAME)

A18. THE ABOVE-NAMED CARE, BONDING, OR MILITARY ASSIST RECEIPT IS YOUR: (CHILD) (SPOUSE) (SPOUSE'S DOMESTIC PARTNER) (MILITARY ASSIST) (OTHER EXPLAIN)

A19. IS ANY OTHER FAMILY MEMBER READY, WILLING, AND ABLE AND AVAILABLE TO PROVIDE CARE FOR THE SAME PERIOD YOU ARE CLAIMING PFL BENEFITS? (YES) (NO) A20. HAVE YOU CLAIMED OR DO YOU PLAN TO CLAIM WORKERS' COMPENSATION BENEFITS FOR ANY PORTION OF THE PERIOD COVERED BY THIS CLAIM? (YES) (NO)

A21. DID YOU HAVE MORE THAN ONE EMPLOYER? (YES) (NO) A22. IF YOUR EMPLOYER IS CONTINUING OR WILL CONTINUE TO PAY YOU DURING YOUR FAMILY LEAVE, INDICATE TYPE OF PAY: (SALARY) (OTHER EXPLAIN) A23. MAY WE DISCLOSE BENEFIT PAYMENT INFORMATION TO YOUR EMPLOYER? (YES) (NO)

A24. AT ANY TIME DURING YOUR PFL LEAVE, WERE YOU IN THE CUSTODY OF LAW ENFORCEMENT AUTHORITIES BECAUSE YOU WERE CONVICTED OF VIOLATING A LAW OR ORDINANCE? (YES) (NO)

A25. Declaration and Signature. By my signature on this claim statement I (I) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was providing care for, bonding with, or participating in a qualified event with the spouse named above (2) authorize EDD to release my personal information as shown on this claim as the claim requires, except information which may be necessary for the State to determine if I am eligible for benefits (3) I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine (or both) (4) I declare under penalty of perjury that the foregoing statements, including any accompanying statements in oral files of my knowledge and belief are correct and complete. I agree that reproduction of this statement shall be as valid as the original and I understand that applications contained by this claim statement are good for a period of 90 days from the date of my signature or the effective date of the claim, whichever is later.

Claimant's Signature (DO NOT PRINT) Signature to be made by mark (X), please place mark here. Date Signed (mm/dd/yyyy)

If your signature is made by mark (X), it must be attested by two witnesses with their addresses: Witness Signature and Address Witness Signature and Address

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# Filing a Paid Family Leave Military Assist Claim

By mail

A properly completed PFL military assist claim will include:

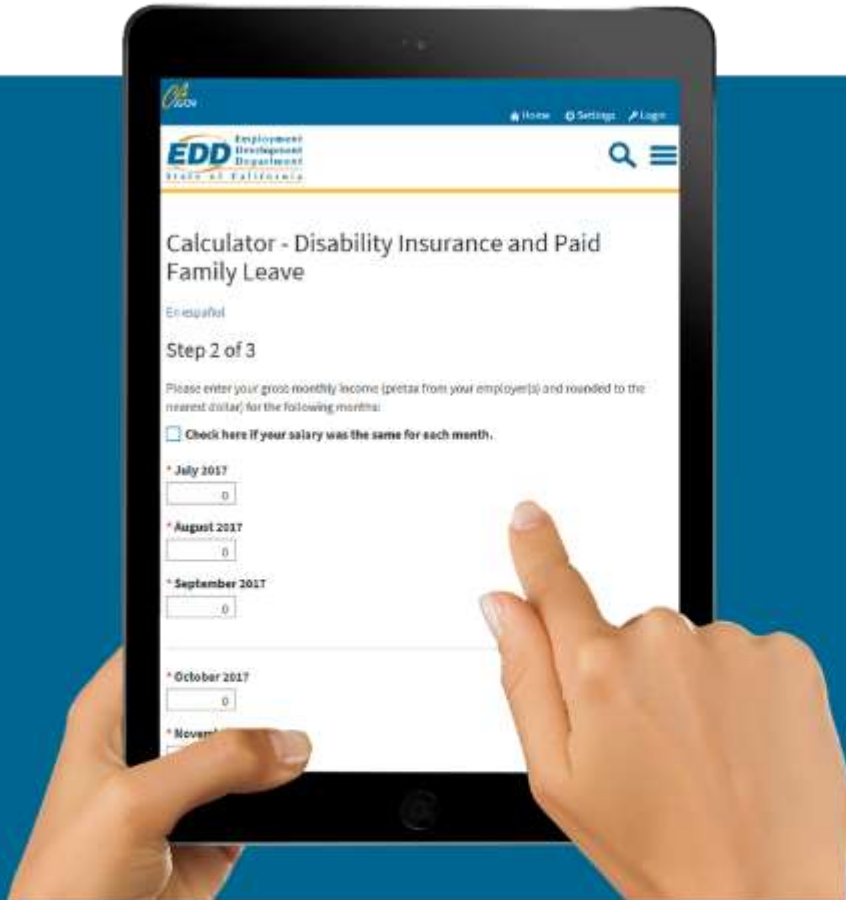
- ▶ Part A – Statement of Claimant.
- ▶ Part E – Military Assist Certification.
- ▶ Supporting military documentation and supporting documentation for the qualifying event.

Obtain the DE 2501F application by ordering through [Online Forms and Publications](https://www.edd.ca.gov/forms) (forms.edd.ca.gov/forms), or by calling 1-877-238-4373.

\*Spanish applications are available for download only through [Online Forms and Publications](https://www.edd.ca.gov/forms).



# Calculating the Benefit Amount



Your weekly benefit amount is determined by your highest quarter of earnings in your “base period” (wages subject to SDI tax earned 5-18 months prior to your claim start date).

The “base period” covers a 12-month period and is broken into four consecutive quarters. For example, if your PFL claim begins in April, May, or June, your weekly benefit amount is calculated from your highest quarter of earnings paid to you between January 1 and December 31 of the prior year.

Simplify this process by using the [Paid Family Leave Calculator](https://edd.ca.gov/en/disability/PFL_Calculator/) ([edd.ca.gov/en/disability/PFL\\_Calculator/](https://edd.ca.gov/en/disability/PFL_Calculator/)) to estimate your weekly benefit amount.

# Determining Paid Family Leave Eligibility

Have you paid into California's SDI program (usually noted as CASDI on a paystub) in the past 5-18 months prior to taking leave?

- ▶ **“YES”** – You are most likely eligible for benefits.
- ▶ **“NO”** – Not all employees pay into SDI, so you may not be eligible for benefits.

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Review paystubs before assuming eligibility.

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Eligibility is **not** based on length of service or the number of employees your company has on staff.

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Citizenship and immigration status do **not** affect eligibility.

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Payment is not guaranteed until the claim has been approved by the Employment Development Department.

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**Only eight weeks of benefits** can be claimed per 12-month period.



# Employment Status and Paid Family Leave



Your eligibility is determined by whether you have paid into California's SDI in the past 5-18 months.



Unemployed Californians must have collected Unemployment Insurance or be actively looking for work to qualify for PFL.

You may still qualify for PFL if you are seasonal, part-time, or unemployed.



If self-employed, you may be eligible if you are contributing to the Disability Insurance Elective Coverage program.



# Job Protections

Does the SDI program provide job protection?

No, the program does not provide job protection, just paid benefits.

However, other state and federal laws may apply while you are using your leave.

# Job Protections (Cont.)

Laws that may apply while receiving DI or PFL benefit payments:

- ▶ Family and Medical Leave Act (FMLA)
- ▶ California Family Rights Act (CFRA)
- ▶ Fair Employment and Housing Act (FEHA)
- ▶ Pregnancy Disability Leave (PDL)

Speak with your employer to obtain unpaid job-protected leave. Visit the [California Civil Rights Department](http://calcivilrights.ca.gov) ([calcivilrights.ca.gov](http://calcivilrights.ca.gov)) and the [US Department of Labor](http://dol.gov) ([dol.gov](http://dol.gov)) to learn more.





## For more information, visit:

- ▶ Paid Family Leave  
([edd.ca.gov/PaidFamilyLeave](http://edd.ca.gov/PaidFamilyLeave))

## Contact EDD

- ▶ English: 1-877-238-4373
- ▶ Spanish: 1-877-379-3819
- ▶ Cantonese: 1-866-692-5595
- ▶ Vietnamese: 1-866-692-5596
- ▶ Armenian: 1-866-627-1567
- ▶ Punjabi: 1-866-627-1568
- ▶ Tagalog: 1-866-627-1569
- ▶ TTY: 1-800-445-1312





# Tell Your Paid Family Leave Story

California's PFL allows you to be there for the moments that matter.

Share your PFL story by tagging @CA\_EDD on Instagram.



#MomentsMatter  
#PFL  
#PaidLeave  
#CAPFL  
#CAPaidFamilyLeave



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). TTY users, please call the California Relay Service at 711.

