Employment Development Department
State of California

REPORT OF VOLUNTARY PLAN FAMILY LEAVE (VPFL) CLAIM

PLEASE READ INSTRUCTIONS BEFORE COMPLETING THIS FORM

A. CLAIMANT INFORMATION (CARE, BONDING, OR MILITARY ASSIST PROVIDER)

COMPLETE SECTION A, ITEMS 1 – 17 AND SUBMIT WITHIN 15 DAYS AFTER RECEIPT OF A FIRST CLAIM FOR PAID FAMILY LEAVE BENEFITS. (RETAIN A COPY OF COMPLETED SECTION A)

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 ☐ MALE ☐ FEMALE 6. DATE OF BIRTH

7. VOLUNTARY PLAN NUMBER	8. VOLUNTARY PLAN EMPLOYER NAME	9. CLAIMANT'S PHONE

CLAIM INFORMATION

10. TYPE OF VPFL CLAIM (CHECK ONE): ☐ FAMILY CARE CLAIM ☐ CHILD BONDING ☐ MILITARY ASSIST

IS THIS BONDING CLAIM RELATED TO AN SDI OR VP PREGNANCY CLAIM? ☐ YES ☐ UNKNOWN

11. LEGAL NAME OF CARE, BONDING, OR MILITARY ASSIST RECIPIENT (REQUIRED):

12. DATE OF BIRTH OF CARE, BONDING, OR MILITARY ASSIST RECIPIENT (REQUIRED):

13. IF THE BONDING RECIPIENT IS A FOSTER OR ADOPTED CHILD, DATE OF PLACEMENT WITH THE CLAIMANT:

14. DO YOU WANT STATE AWARD INFORMATION? ☐ NO ☐ YES

IF "YES," ENTER THE NAME AND ADDRESS (INCLUDING ZIP CODE) OF EMPLOYER OR PLAN ADMINISTRATOR.

Name:

Address:

15. (REQUIRED) TYPE/PRINT NAME OF PERSON COMPLETING SECTION A	16. PHONE NUMBER	17. DATE

FOR DEPARTMENT USE ONLY

CLAIM EFFECTIVE DATE	WEEKLY BENEFIT AMOUNT	MAXIMUM BENEFIT AMOUNT
	$	$

B. WITHIN 35 DAYS AFTER FINAL PAYMENT FOR EACH FAMILY LEAVE PERIOD (ON RETAINED COPY), COMPLETE SECTION B, ITEMS 18 – 28 AND SUBMIT.

18. VPFL WEEKLY BENEFIT AMOUNT	19. FIRST DAY PAID	20. LAST DAY PAID

21. NUMBER OF DAYS BENEFITS PAID	22. WERE ONE OR MORE DAYS PAID AT LESS THAN THE FULL DAILY RATE? ☐ YES ☐ NO	23. TOTAL AMOUNT OF BENEFITS PAID	24. TOTAL AMOUNT DIVERTED TO SATISFY SUPPORT OBLIGATION

25. CLAIM STATUS (CHECK ALL APPROPRIATE)

☐ BENEFITS EXHAUSTED ☐ CLAIMANT RETURNED TO WORK ☐ BENEFITS DENIED (ATTACH DENIAL LETTER)

☐ RE-ESTABLISHED CLAIM ☐ ADJUSTMENT

26. **(REQUIRED)** TYPE OR PRINT NAME OF PERSON COMPLETING SECTION B	27. PHONE NUMBER	28. DATE

Instructions for completing the Report of Voluntary Plan Family Leave Claim, DE 2523F

Any missing information may result in returning the form and delaying the award information.

Section A: Complete items 1-17 and return within 15 days after receipt of a first claim for VPFL benefits. (California Code of Regulations, title 22, section 3267-1). Submit to address below. Retain copy of completed Section A.

Items 1-14, Information regarding the care/bonding/military assist 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 claim effective 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 six digit voluntary plan number.
8. Enter the voluntary plan employer's name.
9. Enter the claimant's phone number.
10. Check the appropriate box for care for family member, bond with child, or military assist. 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, check the "Unknown" box.
11. Enter the legal name of the care, bonding, or military assist recipient who will receive family care.
12. Enter the date of birth of care, bonding, or military assist recipient (required).
13. Enter the date that the foster or adopted child was placed in the claimant's home.
14. Check the appropriate box. If "Yes" is checked, enter the employer or plan administrator name and address in the box below. The Department will mail the award information to the address provided.
15. Enter the printed name of the person completing Section A.
16. Enter the phone number of the person completing Section A.
17. Enter the current date.

Section B: Information regarding benefits. On retained copy of completed Section A, complete Items 18 – 28 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).

18. Enter the Voluntary Plan weekly benefit amount.
19. Enter the first date for which benefits were paid.
20. Enter the last date for which benefits were paid.
21. Enter the number of days for which benefits were paid.
22. Check the appropriate box. If the claimant was paid less than his/her full daily benefit rate for one or more days, check the "Yes" box. If the claimant did not receive less than his/her full daily benefit rate for any days which benefits were paid, check the "No" box.
23. Enter the total dollar amount of benefits paid.
24. 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 23.

25. Check 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, bonding, or military assist claim within the past 12 months.

    Adjustment: Use if a previous report was submitted, and this is a correction or change to that report.

26. Enter the printed name of the person completing Section B.
27. Enter the phone number of the person completing Section B.
28. Enter the current date.

MAIL COMPLETED FORM TO:

EDD-Paid Family Leave (PFL)
PO Box 997017
Sacramento, CA 95899-7017