Analysis Resolution and Correspondence Organization
PO Box 2068
Rancho Cordova, CA 95741-2068 888-745-3886

APPLICATION FOR ELECTIVE COVERAGE OF DISABILITY INSURANCE (Excluded Family Employment)

Reference: **Section 702.5 of the California Unemployment Insurance Code**

PLEASE PRINT OR TYPE

FOR DEPARTMENT USE ONLY	
ACCOUNT NUMBER	STATISTICAL CODE
EFFECTIVE DATE	DATE EMPLOYER NOTIFIED
APPROVED BY	DATE APPROVED
SEND	NUMBER OF EMPLOYEES

IMPORTANT

This form is not an application for an account number under the compulsory provisions of the California Unemployment Insurance Code (CUIC). Do not complete this form unless both the owner of the entity described herein and its family employees, excluded under Section 631 of the CUIC, wish to have the employees' services voluntarily covered for State Disability Insurance* under the provisions of Section 702.5 of the CUIC.

1. Employer Name | Social Security Number

2. Business Name

3. Business Address | Number and Street | City and State | ZIP Code

4. Mailing Address | Number and Street | City and State | ZIP Code

5. Your Employer Payroll Tax Account Number(s), if any

6. Nature of Business (Check One)

☐ Retail Trade ☐ Service ☐ Manufacturing ☐ Agricultural
☐ Wholesale Trade ☐ Repairing ☐ Contracting ☐ Other

Describe product or service: | Manufacturers: List principal products in order of importance:

7. If your business is seasonal, in what months do you operate?

8. Do you expect to remain in business for the next eight (8) calendar quarters?

9. What types of services are performed by excluded family employees?

10. Do you report (or are you required to report) to Social Security for excluded family employees?

☐ Yes
☐ No (Please explain)

11. How many employees will be covered by this agreement?

12. What is the number of locations at which your business is conducted in California?

List locations covered by this application.

13. Deductions should not be made from your employees' wages for the purpose of paying contributions until your application has been approved. If deductions have already been made, indicate beginning date.

Deducted From (Date)	Amount $	Were such deductions made on all employees covered by this application?

14. On what date do you desire elective coverage to begin?

☐ First Day of Current Quarter ☐ First Day of Next Quarter

*Includes Paid Family Leave (PFL).

CONTINUED ON REVERSE

List the name(s), age(s), relationship, and Social Security number(s) of those electing the coverage. The signature of each employee electing the coverage is required for this election. (If more space is needed, please attach a continuation sheet with the needed information and signatures.)		Is this person currently performing normal and customary services in connection with the operation of your business? (If no, explain below.)	Has this person filed a claim for benefits within the last three months?	How long has the person been working in your business?	Will you pay wages to this person? If so, how often? (Weekly, monthly, etc.)
Name Age Relationship		☐ Yes ☐ No	☐ Yes ☐ No	Month(s)	☐ Yes ☐ No
Signature	Social Security Number				How often?
Name Age Relationship		☐ Yes ☐ No	☐ Yes ☐ No	Month(s)	☐ Yes ☐ No
Signature	Social Security Number				How often?
Name Age Relationship		☐ Yes ☐ No	☐ Yes ☐ No	Month(s)	☐ Yes ☐ No
Signature	Social Security Number				How often?
Name Age Relationship		☐ Yes ☐ No	☐ Yes ☐ No	Month(s)	☐ Yes ☐ No
Signature	Social Security Number				How often?

Explanation

NOTE: If your application is approved, the elective coverage agreement will be subject to all of the requirements and conditions of Sections 631, 702.5, 704, and 707 of the CUIC. Eligibility for State Disability Insurance* benefits under the CUIC does not begin with the commencement date of coverage. Generally, a minimum of seven (7) months must elapse from the commencement date of coverage before a valid claim may be filed based solely on wages reportable under your election.

CERTIFICATION:

I, the undersigned, certify that the statements made in this application are true and correct to my best knowledge and belief. I hereby elect and make application to have the excluded family services considered as employment subject to the CUIC for State Disability Insurance only. The elective agreement is to be in effect for at least two complete calendar years or until termination of employment in my business. The elective agreement may be terminated by filing a request for termination by January 31 of any year following two complete years of elective coverage.

Employer Signature ▶	Date	Residence Address Number and Street	
Business Phone	Residence Phone	City and State	ZIP Code

NOTE: The employees who are covered by election under Section 702.5 of the CUIC are also subject to the California Personal Income Tax (PIT) withholding law. Agricultural employees are not subject to the California PIT withholding law unless both the employer and employee agree to have the state PIT withheld.

Wages and Contributions, Section 702.5:

Contributions to be paid for “Family Employment” elective coverage are to be based upon actual wages paid to covered family members for services performed up to a maximum wage limitation for the year for each family member.

There is no provision in this section to permit the contributions to be based on other than actual wages paid.

The amount of any disability benefits paid will also be determined on the basis of wages paid.

Social Security Number Disclosure:

The disclosure of your Social Security number is mandatory under the Federal Tax Reform Act of 1976. The number will be used for identification purposes and will be available only to authorized personnel within the Employment Development Department (EDD) and other government agencies as permitted in Sections 322 and 1095 of the CUIC.

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 888-745-3886 (voice) or TTY 800-547-9565.

*Includes PFL