# STATE OF CALIFORNIA – EMPLOYMENT DEVELOPMENT DEPARTMENT

## VOLUNTARY PLAN PROCEDURES

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The *Employers’ Guide to Voluntary Plan Procedures*, DE 2040, is designed to assist employers and their agents in the administration of approved VPs. Comments, questions, or suggestions are welcome. Information regarding VPs may be obtained at:

Voluntary Plan Group (VPG)
916-653-6839 (Phone)
916-319-1438 (Fax)

By mail
Employment Development Department
Disability Insurance Branch, MIC 29VP
Voluntary Plan Group
PO Box 826880, Sacramento, CA 94280-0001

EDD website
[www.edd.ca.gov/disability](http://www.edd.ca.gov/disability)

Employers, third-party administrators, and Disability Insurance (DI) Branch staff actively participate in the Voluntary Plan Advisory Group (VPAG). The VPAG meets twice yearly to discuss VP issues and legislation, share common concerns, clarify VP claim procedures, and exchange ideas to improve the VP program. For information about joining the VPAG, contact the VPG at 916-653-6839.

In addition, the VPG mails a yearly General Release Letter in the fall to all VP employers. The letter provides information and instructions regarding critical changes for the following year. Copies of the General Release Letter may be obtained at [www.edd.ca.gov/Disability/VP_Forms_and_Publications.htm](http://www.edd.ca.gov/Disability/VP_Forms_and_Publications.htm).
OVERVIEW

California State Disability Insurance (SDI) is a partial wage replacement insurance plan for California workers. The SDI program is state-mandated and funded through employee payroll deductions. SDI provides two, short-term benefits to eligible workers:

- Disability Insurance (DI)
- Paid Family Leave (PFL)

DI provides a maximum of 52 weeks of benefits to eligible workers who have a loss of wages when they are unable to work due to a non-work-related illness or injury, or due to pregnancy or childbirth.

PFL provides up to six weeks of benefits in a 12-month period for individuals who must take time off work to care for a seriously ill family member or to bond with a new child.
PROGRAM OVERVIEW

Purpose of the Program

A Voluntary Plan (VP) is a private short-term disability insurance that an employer may offer to its California employees as a legal alternative to the mandatory SDI coverage. The purpose of the SDI and VP programs is to compensate an individual, in part, for a wage loss due to illness or an injury that is not work-related. Both criteria (wage loss and illness/injury) must be met in order to establish entitlement to benefits. A disability is considered any day in which, because of a physical or mental condition, an employee is unable to perform their regular or customary work. Completion of a vocational rehabilitation plan establishes new regular or customary work in that occupation.

Employer and employee groups may establish a VP with mutual consent of the employer and a majority of the employees. An employee may choose SDI coverage even though a VP is available where they work.

Reference: California Unemployment Insurance Code (CUIC), sections 2601, 2626, and 3254.

An employer can administer a self-insured VP or obtain coverage from an admitted insurer. If a VP employer provides DI coverage in lieu of the state plan, then it must also provide PFL coverage. Provisions for PFL are contained in the CUIC. Requirements for PFL are consistent with DI except where specific guidelines exist for PFL. For specific PFL guidelines, visit www.edd.ca.gov/disability.

Legal Requirements

The VP program is governed by the laws outlined in sections 3254-3272 of the CUIC. The CUIC requires, but is not limited to, the following:

- An individual covered by a VP will have the same rights as if they were covered under SDI.
- The VP will provide at least one right or benefit that is greater than the rights provided by SDI.
- Each claimant must receive at least the same weekly benefit amount (WBA), MBA, and duration of benefits as if covered by SDI.
- The VP will amend its provisions to match any increase in rights or benefits that SDI implements as a result of legislation or approved regulation.
- The cost to the employee will not be greater than the cost for SDI.
Administrative Authority

A VP may offer benefits that exceed those of SDI, but cannot be more restrictive. A VP cannot impose restrictions on eligibility that are not imposed by SDI. The CUIC contains the laws that govern the SDI program and grants the Director of the EDD the right to issue regulations interpreting the law. These regulations are contained in the California Code of Regulations (CCR), Title 22.

Third-Party Administrator (TPA)

The TPA is a private company that consults and assists an employer in administering their EDD-approved VP. The roles and responsibilities of the TPA depend on the contract negotiated with the employer. The EDD will only conduct business with the designated TPA on file. VP employers must formally designate a TPA using the TPA Authorization Form. The form can be obtained by contacting the VPG at 916-653-6839 or VPProgram@edd.ca.gov.

The CUIC does not contain requirements for becoming a TPA and the state does not require TPAs to be licensed. An individual or corporation, such as an insurance company, can become a TPA by contracting with a VP employer.

Note: An employer is not required to have a TPA to establish a VP.
SMALL BUSINESS THIRD-PARTY ADMINISTRATOR (SBTPA)

An SBTPA is a business that has been approved by the EDD to administer a VP for payment of DI and PFL benefits on behalf of its clients. A prospective SBTPA applicant must submit a Small-Business Third-Party Administrator Voluntary Plan Application Pursuant to AB 2778, DE 2778, to the EDD for approval.

The SBTPA applicant must meet all of the following criteria at the time of submitting the application:

- Administer VPs on behalf of its clients pursuant to a written agreement in a manner approved by the EDD Director.
- Have at least 1,000 California domiciled clients, 80 percent of whom have fewer than 20 employees.
- Process payroll for its California domiciled clients.
- Offer WC insurance to its California domiciled clients through an affiliated California domiciled insurance company.

Reference: CUIC, Section 3254.1.

SBTPA Application Procedures

An applicant who has met the requirements in Section 3254.1 of the CUIC may submit the DE 2778 to the EDD along with the following:

- The SBTPA plan text.
- All enrollment literature that will be used to solicit employer and employee consent.
- All supporting documentation that will help determine the qualification for SBTPA approval.

The required SBTPA application and all required documentation should be mailed to the EDD (see address on page v).

Notice of SBTPA VP Application Approval

The EDD will notify the SBTPA applicant of their application status within 30 days from the date the application was received. Upon approval, the SBTPA applicant will be authorized to establish a VP and solicit enrollment into the plan by existing and future clients.

Clients of the SBTPA who want to participate in the SBTPA VP must follow the procedures and submit an Application to Participate in a Small-Business Third-Party Administrator (SBTPA) Administered Voluntary Plan for Unemployment Compensation Disability (UCD) Benefits, DE 2520AU.
Procedures to Participate in SBTPA VP

The SBTPA must provide all enrollment literature with a copy of the EDD-approved plan text to clients. Prospective employers and the SBTPA must follow the procedures outlined below:

- Prior to submitting the application DE 2520AU to the SBTPA, the employer must conduct employee elections to obtain consent of a majority (51 percent) of its eligible employees.

- The SBTPA must examine the completed DE 2520AU for accuracy and resolve any deficiencies with the employer.

- Once the application is acceptable, the SBTPA and employer must sign the application to accept the responsibilities indicated in the application.

- The SBTPA is required to make copies of the signed DE 2520AU and distribute the copies accordingly:
  - Send the original signed DE 2520AU and election documents to the EDD (see address on page v).
  - Provide copies to the SBTPA client employers.
  - Retain copies of the DE 2520AU and election documents for a minimum of five years.

For more information on SBTPA VP, contact the VPG at 916-653-6839.
APPROVAL

Application

To provide coverage under a VP, an employer must submit an Application for Approval of Self-Insured Voluntary Plan of Disability Benefits, DE 2520BV, and a proposed plan text to the EDD for approval. The DE 2520BV must be submitted prior to the requested effective date.

The DE 2520BV application may be obtained by contacting the VPG at 916-653-6839 or at: www.edd.ca.gov/pdf_pub_ctr/de2520bv.pdf.

Any employer who operates a VP without EDD approval will be responsible for all SDI contributions withheld from the wages of employees. The EDD will not reimburse the employer for any benefits paid while operating under an unapproved VP.

Approval Requirements

The following conditions must be met for approval:

- Employer must have at least one employee.
- At least one right or benefit afforded to the covered employees must be greater than the benefits provided by SDI.
- A security deposit must be posted with the EDD.
- The employer must guarantee that the VP will meet all obligations.
- The VP coverage must be made available to all California employees or to employees in a separate establishment maintained by the employer in California, except:
  - Part-time employees who work less than half of the employer's standard workweek.
  - Short-term employees who are hired for a period not expected to exceed two weeks.
  - All employees are in one or more geographic employment location(s).
- A majority of eligible employees have consented to the plan in writing.
- Employees who are eligible for coverage must be given the right to reject the VP and be covered by SDI.
- All covered employees must be given a written document that states their rights and benefits under the VP.
- The employer has consented to the plan and has agreed to make the payroll deductions required.
- The plan provides for the inclusion of future employees.
- If the plan provides for insurance, the forms of the policy are to be issued by an admitted disability insurer.
- The plan is in effect for a period of not less than one year and, thereafter, continuously unless withdrawn by the employer or terminated by the EDD.
AMENDMENTS TO APPROVED PROVISIONS

Amendments Mandated by Law

The EDD will notify VP employers when legislation is enacted that affects VP plans. Legislative changes usually take effect on January 1. The EDD will notify employers of the required changes and will establish a deadline by which the employer must submit a revised plan text for the amendment. An employer may choose to incorporate a legislative change into the plan text prior to the effective date of the legislation. A copy of the revised plan text must be submitted to the EDD, no later than 45 days from the date the employer implements any change. Additionally, a revised plan text must be submitted to the EDD within 45 days from the effective date mandated by law.

If legislation provides a change in the contribution rate or wage ceiling, an amendment to the plan text is necessary if an employer makes a change. Employees must be notified prior to the effective date of the rate change. A copy of the employee notice must be provided to the EDD, however a revised plan text need not be sent when the only change is the contribution rate.

Note: When the employer is required to submit a revised plan text to the EDD, the revised items must be clearly noted in the text or referenced in a cover letter. A copy of the notice or the statement of coverage will not be accepted in lieu of revised plan text.

You may request a suggested plan text containing sample language from the VPG.

Reference: CUIC, Section 3271.

Amendments Initiated by the Employer

When an employer chooses to amend previously approved VP provisions, they must first notify the employees and provide the EDD with the following:

- A copy of the revised Plan Text. The notice or statement of coverage to employees will not be accepted by the EDD in lieu of the revised Plan Text.
- A copy of the notice or the statement of coverage distributed to employees to inform them of the changes.

Note: The notice to employees should specify the provisions of the amendment and advise them of their right to withdraw from the plan as of the amendment effective date. An employee may withdraw from the plan by providing written notice within 10 days of the amendment effective date.

Approval of Amendments

The EDD will approve the amended plan text if it continues to meet VP standards that are outlined in the CUIC and the CCR, and one of the following is satisfied:

- Written verification by the employer that an amendment notice has been distributed to the covered employees at least 10 days prior to the effective date. Employees must be given the right to withdraw from the plan on the amendment effective date by providing written notice to the employer within 10 days after the effective date.
- Written verification by the employer that a majority of the VP employees have consented to the amendment. The amendment cannot take effect prior to the date the majority of the covered employees provide their written consent.
• Written verification by the employer that all employees adversely affected by the amendment consented to the amendment. The amendment cannot take effect prior to the date all adversely affected employees provide their written consent.

Any VP amendments must be submitted to the EDD for approval no later than 45 days after the amendment effective date, along with the necessary certification as explained above. The VPG is available to review any proposed amendment or materials prior to distribution to employees to ensure compliance with the requirements.

If an amendment is applicable only to new or future employees, notification of such change should be transmitted to the EDD on or before the amendment effective date. The consent of the covered employees is not required since the reduction in rights or benefits does not affect current employees.

Reference: CUIC, Section 3271; CCR, Title, Section 3271-1(b).

Successorship

When all or part of a business covered by a VP is acquired or sold, the rules of successorship, contained in Section 3254.5 of the CUIC, apply. It is the responsibility of the predecessor and successor to notify the EDD of acquisition within 30 days of the transaction and whether or not the VP will continue. The successor will be deemed to consent with the provisions of the VP if they fail to notify the EDD of determination to withdraw. The CUIC allows for continuation of the VP with an abbreviated application process.

To maintain approval of the plan, the successor employer must submit:

• An Application for Approval of Voluntary Plan for Successor, DE 2041.
• A current copy of the Plan Text and any amendments.
• A security deposit.

The surviving plan may be entitled to the predecessor’s plan assets and will be responsible for payment of claims in progress as well as all new claims.

Plan coverage will remain the same as it was under the predecessor, however, the plan may be amended through the amendment process. The application and information about security deposits should be requested from the VPG.

The successor may choose to withdraw from the VP program as of the date of the acquisition. When a VP is withdrawn, the predecessor retains any plan funds, pays claims in progress, and pays any claims submitted with an effective date prior to VP withdrawal.
TRUST FUND

Employee contributions withheld for VP coverage and any income derived from this fund are trust funds. The funds must be accurately accounted for by employers. Contributions from covered employees, must be set up in a separate ledger account, which is credited with plan revenue. The ledger account must only be charged with benefits and allowable administrative costs incurred that are deducted from the trust fund in operating the plan. In addition, it must show all income to the plan (including loans to fund the VP), the payment of benefits, and allowable costs, separate and apart from all other operations of the employer.

Interest and dividend income earned by the VP trust fund must be credited to the fund and reported on the Annual Report of Self-Insured Voluntary Plan (VP) Transactions, DE 2568V.

Reference: CCR, Title 22, Section 3260-1(a).

VP trust funds must be maintained in a separate, specifically identifiable account in a financial institution, or they may be transmitted, including any interest or income, directly to the admitted disability insurer.

Reference: CCR, Title 22, Section 3261-1.

Employee Contributions

An employer is authorized to deduct from a VP employee’s wages an amount that does not exceed the current SDI plan rate. The SDI rate is established each year by the EDD Director.


The employee contributions may only be used for the following purposes:

- Payment of benefits as provided by the plan.
- Reasonable expenses arising in the administration of self-insured plans.
- Assessments levied by the EDD as provided under the CUIC.

Employee Contribution Adjustments

The VP employer is prohibited from increasing the amount of deductions, except:

- On an anniversary of the plan effective date.
- On the effective date of an increase in the taxable rate under CUIC, Section 984.
- On the effective date of an increase in the limitation on taxable wages under CUIC, Section 985.

Reference: CUIC, sections 984, 985, and 3254(h).

Employer Contributions

The employer may provide:

- A lesser contribution rate than the SDI rate.
- Specified contributions on behalf of covered employees.
- All operating expenses of the VP.

Reference: CUIC, Section 3260.
Approved Voluntary Plan Disability Insurance (VPDI) Administrative Expenses

The EDD will approve the following expenses:

- Medical examination fees that are paid to determine whether a claimant’s disability continues.
- Security deposit costs and premiums.
- Quarterly administrative assessments paid to the EDD.
- Fees paid to a TPA.
- Stationery, postage, and office supplies and equipment expenses required to administer the VP.
- Salary expenses for staff-time devoted to VP activities.
- Proportional share of office space, equipment, and operating expenses for VP operation.
- Other expenses as approved by the EDD.

Reference: CCR, Title 22, Section 3267-2(b).

Use of Excess Employee Contributions to Provide Other Benefits

Employee contributions withheld for VP coverage are trust funds. They may only be used for the purpose of providing benefits to the employee group covered by the VP. Employee contributions or income resulting therefrom may not be diverted for the employer’s own use or profit.

The CUIC allows the employer to use accumulated excess trust funds to provide additional benefits if approved by the EDD.

A plan insured by an admitted disability insurer, any accumulated excess of employee contributions above the net cost of premiums, after premium dividends or experience rate credits, and assessments made by the Department in connection with the plan, must inure to the benefit of the employee group covered by the plan commensurate with their contributions or in an otherwise fair and equitable manner.

Methods of using excess VP funds must be fair and equitable percentages and amounts contained therein, would include but are not limited to the following:

Example 1: All employees contribute at a rate of 1.0 percent. The excess VP funds are used to reduce that rate to 0.7 percent for all employees.

Example 2: Two classes of employees are distinguished. Class A contributes at a rate of 1.0 percent. Class B contributes at a rate of 0.8 percent. A rate reduction of 25 percent for each class would be allowable, resulting in Class A contributing at 0.75 percent and Class B at 0.6 percent.

Reference: CCR, Title 22, Section 3260-1.
REQUIRED REPORTS

Annual Report of Self-Insured Voluntary Plan (VP) Transactions, DE 2568V

The VP employer or an authorized TPA is required to submit a DE 2568V to the EDD by February 15th of the following year. Failure to comply with this requirement may result in termination of the VP. If an employer has multiple related plans, they must complete a separate DE 2568V to report each plan’s individual transactions. In completing the DE 2568V, the employer cannot use funds from one plan to cover the deficit in another plan. VP deficits covered by the employer may be in the form of a non-refundable contribution or a loan to the plan fund, which must be reported as income to the plan receiving the funds.

Reference: CCR, Title 22, Section 3267-2(a).

The DE 2568V is available in an electronic PDF form or Microsoft Word document. An employer or plan administrator may obtain the DE 2568V several ways:

- Request a copy by mail or fax.
- Obtain the PDF version from the EDD website at: www.edd.ca.gov.

The completed DE 2568V should be submitted to the EDD by:

- Email to vp68v@edd.ca.gov.
- Mail (see address on page v).
- Fax to 916-319-1438.

Amended DE 2568V Reports

Any changes to the DE 2568V must be reported to the EDD by submitting an amended report. Any changed entry must be clearly noted as an amendment. Place a check mark in the “Amended” box located at the top of the form.

Tax Reporting

Employers who have EDD approval to operate a VP are exempt from remitting SDI contributions for those employees who have elected VP coverage. However, the employer must remit SDI contributions for those employees who choose SDI coverage. VP employers are required to complete a Quarterly Contribution Return, DE 3D, to report VP-covered wages, SDI-covered wages, and for the computation of the VP assessment. Employers who have only SDI coverage follow a different process.

Most EDD taxes can be filed electronically through Employer Services Online, under “e-Services for Business” at: www.edd.ca.gov.
Commonly Used Tax Forms

<table>
<thead>
<tr>
<th>Form Name</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Contribution Return, DE 3D</td>
<td>• Report of VP and SDI quarterly wages and withholdings.</td>
</tr>
<tr>
<td>Quarterly Adjustment Form for Voluntary Plan Disability Insurance Employers, DE 938</td>
<td>• Adjustment of wages and/or Personal Income Tax (PIT) withholding by individual.</td>
</tr>
<tr>
<td></td>
<td>• Reporting additional wages and/or PIT.</td>
</tr>
<tr>
<td></td>
<td>• Filing a claim for refund.</td>
</tr>
<tr>
<td></td>
<td>• Adjusting incorrectly reported wages, withholdings, or contributions.</td>
</tr>
</tbody>
</table>

Please direct any questions regarding tax-related forms or services to the EDD Taxpayer Assistance Center at 1-888-745-3886.

SECURITY DEPOSIT

Security Deposit Requirements

The VP employer must submit a security deposit as part of the VP approval process. The deposit is used to cover the potential liability of the VP and will be used to reimburse the EDD if the employer fails to pay any assessments established in connection with the VP.

The formula used to determine the minimum required deposit amount is as follows:

- Employers estimated taxable wages from previous year \times 0.5 \times \text{Current SDI Contribution Rate} = \text{VP Security Deposit}.

The amount of security in excess of the minimum $1,000 required by the CUIC is determined by the number of employees covered, the size of the payroll, the class of risks, the financial standing of the employer, and any other relevant factors as determined by the EDD.

**Reference: CUIC, Section 3258.**

The security deposit must be made in one of the following forms:

- Cash, in the form of a check, may be sent to the EDD to secure the employer’s VP obligations (see page 14).
- Irrevocable Letter of Credit (LOC) from a United States financial institution (see page 14).
- Guarantee bond issued by an admitted surety insurer (see page 14).
Cash Deposit

When the security deposit is made by cash, an Agreement Regarding Deposit of Cash, DE 2545V, must be completed and submitted with the cash deposit. This form must include:

- VP name.
- Cash deposit amount.
- Signature, printed name, and title of the authorized representative.
- Corporate seal and be notarized.

The cash deposit should be in the form of a check made payable to “EDD-Voluntary Plan Security Deposit.” Clearly indicate on the check:

- The identification of its purpose.
- The principal or corporate VP employer name and the VP number.

When the cash deposit is received by the EDD, it is sent to the Fiscal Programs Division (FPD) for deposit into an interest bearing account, the Special Deposit Fund. A receipt is subsequently issued to the employer once the funds have been deposited by the FPD.

The rates for the quarterly earnings on cash deposits are based on the State Controller’s Office Surplus Money Investment Fund Apportionment Yield Rates at the following web address: [www.sco.ca.gov/ard_yield_rates.html](http://www.sco.ca.gov/ard_yield_rates.html).

Letter of Credit

For security deposits using an LOC, the employer is responsible for providing a form the same as, or similar to, the sample LOC provided by the EDD to an issuing bank or savings institution. The LOC must be issued by and payable at any branch of the issuing bank or savings institution in the continental U.S., Alaska, or Hawaii. The bank submits the LOC directly to the EDD, and upon EDD approval, the LOC is transmitted to the State Treasurer’s Office (STO) for deposit. The EDD will issue a receipt to the employer.

Guarantee Bond

When the security deposit is made by guarantee bond, a Guarantee Bond, DE 2544V, must be executed by the employer and an admitted surety company, and submitted directly to the EDD in duplicate. Upon EDD approval, the EDD will forward the guarantee bond to the STO for custody. The DE 2544V should be completed as follows:

- Enter the employer name, address, and VP number in the upper left box of the form.
- Enter the effective date of the bond that corresponds with the required effective date.
  - For a new plan, this will be the plan effective date.
  - A bond submitted to replace a canceled bond must be dated to coincide with the cancellation date.
  - A replacement bond, at the employer’s discretion, may carry any effective date, presuming the current bond has been in effect for at least one year.
- Enter the amount of the bond that is required.
- An officer of the corporation must sign the bond for principal. The officer’s name and title should be clearly indicated. Print the officer’s name under the signature.
• If the principal is a corporation, the corporate seal must be affixed. If there is no corporate seal, then the officer’s signature must be notarized.

• A representative must sign for the surety company. If this representative is a designated attorney-in-fact, a power of attorney must be attached. If an officer of the surety signs, that person’s title should appear under their name.

• The surety must affix its corporate seal.

• Mail the original and one copy of the guarantee bond to the EDD for processing.

**Submitting Riders to Guarantee Bond**

A new guarantee bond is not required to adjust the amount of a guarantee bond or to change a name. Changes can be accomplished by completing a rider to the guarantee bond in the following manner:

• The rider must correctly reference the guarantee bond by bond number, effective date, and amount. This information may describe either the first-issued bond or the current status of the bond that resulted from one or more prior riders.

• If the rider affects the amount of the bond, clearly state the new penal sum.

• The beginning date of the requested change determines the effective date of the rider.

**Example:** If the employer’s name changed on February 1, 2017, the effective date of the rider is February 1, 2017.

• The rider must be signed by an officer of the principal or sent to the EDD directly by the principal to verify knowledge of the change effected by the rider.

• The rider must be signed on behalf of the surety company. A corporate officer or an attorney-in-fact may sign the rider. If it is signed by an attorney-in-fact, a power of attorney must be attached.

• The original and one copy of the rider must be submitted to the EDD for processing.

**Joint Principal Bonds**

A guarantee bond may be issued for the purpose of securing a group of related plans. The proper format is to have the bond issued in a single principal name with the total amount required by all plans. A rider should name each of the joint principals and allocate the specific amount of liability for each.

Note: The cost of joint principal bonds should be allocated proportionately to all plans covered by the bond and should not be charged to one specific plan.
Changes to Security Deposits

Employers must adjust their security deposits when the difference between the existing security and the required amount is greater than five percent.

Security deposits should be reviewed when the following changes occur:

- SDI contribution rate.
- Estimated total wages.

Replacement of Security Deposit

The employer is required to replace the original security deposit if:

- The surety cancels a guarantee bond.
- The LOC is not renewed by the financial institution.

Note: Failure to maintain an adequate security deposit may be grounds for the EDD to terminate the VP.

Substitution of Security

With EDD approval, an employer may make substitutions to the type of security deposit or the surety company writing a guarantee bond. The general procedures for deposit of each type of security will apply. When substitution is made with a guarantee bond, the prior deposit remains with the EDD to secure the potential VP liabilities beginning prior to the effective date of the substitution. The prior deposit may be held up to 36 months from the effective date of the guarantee bond that was placed as a substitute security.

Security Review Worksheet (SRW), DE 2544SRW

The employer is responsible for providing the EDD with an annual review of the amount of security deposit in relation to the current work force, state contribution rate, and projected wages, and make necessary adjustments to increase or decrease the amount of deposit. The employer should submit the calculations and rationale explaining the reasoning for the proposed adjustment. The EDD reviews the adequacy of the security deposited with the STO and notifies the employer if adjustments must be made. The review is due on or before April 15th annually. The DE 2544SRW can be obtained from the EDD website at: www.edd.ca.gov/Disability/VP_Forms_and_Publications.htm.

Note: Failure to maintain an adequate security deposit may be grounds for the EDD to terminate the VP.

Release of Security Deposit

The security deposit is held by the STO for the duration of the VP and is released when all liability against the plan has been resolved following withdrawal or termination of the VP. This may be up to a period of 12 calendar quarters (36 months) from the withdrawal or termination date. Earlier release may be requested for good cause and must be approved by the EDD. A security deposit may be released if a substitute is submitted for deposit. The employer must maintain premiums for any guarantee bond or LOC until the security is released.

Reference: CCR, Title 22, Section 3258-1(b).
WITHDRAWAL AND TERMINATION

Request for Withdrawal

Once a VP has been approved, the plan must remain in effect for at least one year. After one year, the employer may request withdrawal on the plan anniversary date or the date that there has been a change in the state contribution rate or when the benefit schedule is enacted. The EDD must receive written notice no less than 30 days prior to the requested withdrawal date.

The VP employer remains responsible for payment of all claims filed prior to the date of withdrawal. The VP employer is also responsible for claims that were submitted after the VP withdrawal where the disability or family leave began prior to the effective date of the withdrawal.

Reference: CUIC, Sections 3254(g) and 3254.1.

After a VP is withdrawn, the employer must continue to file the Annual Report of Self Insured Voluntary Plan (VP) Transactions, DE 2568V, and DE 2544SRW until all liabilities against the plan have been resolved and the EDD returns the security deposit back to the employer. The employer must maintain premiums for any guarantee bond or LOC until the security is released.

Reference: CUIC, Section 3267; CCR, Title 22, Section 3267-2 (c).

An employer who withdraws from the VP program should notify employees about the withdrawal of the VP once they receive the Notice of Voluntary Plan Withdrawal Approval from the EDD. The employer should inform the employees that they are no longer a VP employer and advise them to contact the EDD to file DI and PFL claims.

Unpaid liabilities of the VP will be recovered from the VP employer through an assessment and the security deposit.

Reference: CUIC, Sections 3254(g) and 3254.1.

Termination by the Employment Development Department (EDD)

The EDD may terminate a VP when terms or conditions of the plan have been violated. Some causes for plan termination are:

- Failure to pay benefits.
- Failure to pay benefits timely.
- Failure to maintain an adequate security deposit.
- Misuse of VP trust funds.
- Failure to submit reports as required by EDD regulations.
- Failure to comply with CUIC and CCR provisions.
- Participation level falls below 50 percent of employees.

If the EDD identifies a cause for terminating a VP, the EDD will send a Notice of Intent to Terminate the Voluntary Plan to the employer. If the VP fails to conform to the required instructions outlined in the notice within the required time frame specified, subsequently a Termination Notice will be sent. The notice will
specify an effective date of termination generally coinciding with the initiating event. The termination notice will inform the employer of the right to appeal the EDD’s decision to the California Unemployment Insurance Appeals Board (CUIAB) within 10 days of the date of the notice. On the effective date of termination, all trust fund money in the plan must be remitted to the EDD for deposit into the Disability Fund. Wages become subject to SDI withholdings on the effective date of the termination. The payment of benefits and the transfer of the VP trust fund to the EDD may not be delayed during an employer’s appeal of the termination. The employer should inform the employees of the effective date that they are no longer a VP employer and advise them to contact the EDD to file DI and PFL claims.

Reference: CUIC, Sections 1126, 1136, and 3262.

Disposition of Excess Employee Contributions Following Withdrawal

Prior to the expiration of 12 calendar quarters after withdrawal or termination of a plan, the employer must submit a proposal for disbursement of any remaining excess trust funds in its custody to the EDD. Employers may remit excess trust funds to the EDD for deposit into the Disability Fund or disburse the funds in a fair and equitable manner to the employees who contributed to the excess, once the proposal has been approved by the EDD.

Please refer to CCR, Title 22, Section 3260-1 for guidelines on how to disburse excess funds or contact the VPG at 916-653-3869.

The CCR, Title 22 can be accessed at www.ccr.oal.ca.gov/.
COVERAGE DETERMINATION PROCEDURES

Determining Liability: VP or SDI

The initial determination that must be made is whether the VP or SDI is liable to insure the employee. Company records should indicate which coverage the employee has selected.

VP coverage may begin on the date that the employee elects to be covered by the VP rather than SDI. If the employee is required to work for the company for a specific period of time before coverage becomes effective, SDI will cover the employee.

A signed rejection slip, or other documentation must be on file for any employee who chooses to be covered by SDI. The rejection documentation must be made available to the EDD upon request.

Determination of liability must be based on the date that the:

- Disability or family leave began.
- For DI claims only: Condition reached a point where the employee was unable to perform their regular or customary work.

This date may be different from the stated claim date or the first day that the employee is entitled to receive benefits. For DI claims, while accidents establish a clear beginning of the disability, chronic conditions may require investigation. Personnel records, attendance information, and discussion with the supervisor may be necessary to determine when the condition became disabling. A medical condition may exist for some time and not prevent an employee from doing their regular or customary work. That same condition may worsen to a degree that constitutes “disability” under the law and entitles the employee to disability benefits.

Liability for coverage must be determined before a decision can be made regarding eligibility for benefits.

Reference: CUIC, Section 2626.

VP Liability After Job Termination

Generally, VP coverage ends at midnight on the day of employment termination.

Example: An employee is fired and then injured in an automobile accident before midnight that day on their way home. This employee is covered under the VP.

The VP is also liable in the following situations:

- When a disabling condition or the need for family leave precedes the termination or begins before the end of coverage.
- When an employee continues working in order to finish a job or train a replacement, even though a disabling condition or family leave has commenced.
- When an employee resigns from a position because of a disability or family leave rather than request a medical leave, even if the actual reason for the resignation is not disclosed to the employer.

Reference: CCR, Title 22, Section 3254-3(a)(5).
Liability of Coverage Referral to DI

If a VP believes that SDI is liable for a claim originally filed with the VP, a copy of that claim should be mailed to:

EDD VPG
PO Box 120831
San Diego, CA 92112-0831

The referral should include the following information:

- Medical certification, which consists of:
  - Diagnosis, and if no diagnosis has yet been established, provide a detailed statement of symptoms.
  - Diagnostic ICD-10 code.
  - Certifying physician/practitioner’s original signature and license number.
- The employee’s occupation.
- Whether or not VP benefits were paid, and if so, the dollar amount and the period that it was paid.
- A clear explanation of why SDI should accept liability for the claim.
- Any other pertinent information that would assist in determining liability of coverage.

Claims referred to SDI must contain an original signature on the medical certification. A stamped signature is not acceptable. Before sending a copy of the claim to SDI, the VP employer must secure an original signature either on the initial claim form, on a new claim form, or on a separate statement from the physician/practitioner.

The VP should allow the SDI office 25 days from the date of referral to respond. A copy of the referral letter must be sent to the claimant.

Reference: CCR, Title 22, Section 2712-2.

Full Coverage Referral to VP

When the EDD receives a claim that is determined to be the responsibility of a VP, a Full Coverage Referral to Voluntary Plan, DE 5022, will be sent to the VP. Unless prohibited by confidentiality laws, a copy of the SDI claim form, SDI benefit rate information, and other pertinent information will be attached. If SDI paid benefits on the claim, the payment period and total amount paid will also be provided on the referral form. The VP is allowed 25 days from the date of mailing to respond to the referral. The investigation to determine coverage liability should be conducted promptly to ensure a response is provided to the EDD within the 25-day period.

A response accepting or denying liability must be returned to the EDD office. Failure to respond by the deadline constitutes a denial and will result in SDI paying the claim and possibly filing an appeal.

If the VP accepts liability, it should respond to the EDD using the DE 5022. Payments to the claimant should begin immediately, if otherwise eligible. The VP must promptly reimburse SDI if benefits were paid on the claim.
If the VP denies liability, a clear explanation of the reason must be provided. Communication with the SDI representative who sent the referral notice may provide clarity and prevent an appeal. A copy of the denial letter must be sent to the claimant and must contain a statement of appeal rights. The claimant has 30 days and SDI has 30 days, from the date of denial to appeal the decision.

Reference: CCR, Title 22, Sections 2712-2 and 5021.

Action After the EDD Referral Response

If SDI accepts coverage, the EDD will respond in writing and begin payment on the claim if otherwise eligible. If SDI does not accept coverage or does not respond within the specified time, the employer must make a determination of eligibility and, if appropriate, begin immediate payment of the claim at no less than the SDI benefit amount. Review the claim to determine if a disputed coverage appeal will be filed. The VP has 30 days from the date of the SDI denial or 30 days from the deadline for EDD’s response to file an appeal.

Simultaneous Coverage

An individual with more than one employer may be simultaneously covered by more than one plan. This may be a combination of SDI and VP coverage. For SDI to be a party to “simultaneous coverage,” the claimant must have a valid SDI award and be otherwise eligible for DI or PFL benefits.

If it is agreed that more than one plan is liable for payment, each liable plan must pay an equal share of the SDI benefit amount. Each VP that is liable for payment must also pay the difference between the full SDI WBA and their full VP WBA, as described in the plan text.

Note: SDI counts as only one plan regardless of the number of SDI employers for which the claimant works.

Examples:

1. The claimant has three employers at the time their disability or family leave began, two SDI and one VP. SDI would pay half of the SDI benefit amount; the VP would pay half of the SDI benefit amount, plus the difference (if any) between the SDI and the VP benefit amounts.

2. The claimant works for two VP employers and one SDI employer. SDI would pay one-third of the SDI benefit amount; each VP would pay one-third of the SDI benefit amount, plus the difference (if any) between the SDI and the VP benefit amounts.

3. The claimant works for one VP and one SDI employer. The claimant has only worked for the VP employer for four months and for the SDI employer for one month. The claimant has no prior California earnings subject to SDI tax, and therefore has an invalid award with SDI and will not receive benefits. However, if the provisions of the VP allow immediate coverage based upon current earnings and not the typical base period earnings, the VP would be liable for the entire payment of benefits.

4. If the claimant works for a VP employer and an exempt employer, such as the federal government, the VP is liable for one half of the SDI benefit amount.

A disability or the need for family leave may prevent the claimant from performing their regular or customary work for one or all of their employers. Conversely, their disability or family leave may not necessarily affect all jobs. Only the coverage of the employment affected by their leave is liable for payment of benefits. If the claimant is able to return to one job, but not all, it changes the payment liability. Only the coverage for the employment from which the claimant's disability continues remains liable for payment. Liability increases in proportion to the number of remaining plan(s). If only one plan remains liable, it must pay 100 percent of the benefit rate.
When SDI receives a claim and suspects that simultaneous coverage may exist with a VP, a *Simultaneous Coverage Referral to Voluntary Plan*, DE 5022SC is forwarded to the VP. The VP may also gain knowledge of potential simultaneous coverage from information supplied by the claimant. The VP claim form should ask the claimant the following:

- If the employee was working for another employer at the time of their disability or family leave.
- If the employee is unable to work due to their disability or family leave with another employer.
- If that employer has a VP.

**Reference: CUIC, Section 3253, CCR, Title 22, Section 3253-1.**

### Calculating Simultaneous Coverage Benefits

In Table 1, the claimant has two employers; one employer has a VP, the other has SDI. The claimant’s disability prevents them from working both jobs and simultaneous coverage is agreed upon by both the VP and SDI:

- Employer “A” is covered by a VP that pays 70 percent of net salary, which equals $400 per week.
- Employer “B” is covered by SDI, which pays $224 per week.

<table>
<thead>
<tr>
<th>Employer “A”</th>
<th>Weekly Benefit Award (WBA)</th>
<th>Simultaneous Coverage Liability</th>
<th>Amount Claimant Receives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>70 percent of net salary = $400</td>
<td>½ of SDI WBA ($224 ÷ 2) = $112 70 percent of Net Salary - SDI WBA ($400 - $112) = $288</td>
<td>$288 from VP</td>
</tr>
<tr>
<td>Employer “B”</td>
<td>SDI WBA = $224</td>
<td>½ of SDI WBA ($224 ÷ 2) = $112</td>
<td>$112 from SDI</td>
</tr>
</tbody>
</table>

**Claimant’s Total WBA**

$400
Child Support Interception Deductions

The VP is required to make deductions from benefits that are payable to individuals identified by the California Department of Child Support Services (DCSS) as having unmet spousal and/or child support obligations. The DCSS notifies SDI of individuals who have delinquent support obligations and/or subsequent changes in the obligation. This information is matched against VP claims for which SDI has received a Report of Voluntary Plan Disability Claim, DE 2523. Using the VP referral address, SDI notifies the VP of the action that must be taken beginning with the next benefit check issued to the claimant.

The notification may provide information regarding:

- An initial support obligation.
- A change in the county responsible for enforcing a support obligation.
- A change in the withholding percentage.
- A termination of the support obligation.

The notification will provide the name, address, and phone number of the county responsible for enforcing the support obligation. The amount withheld is a specified percentage up to 25 percent, and is calculated on the net entitlement including any benefits redirected, rounded down to the next whole dollar. The VP employer may retain up to $2 for actual administration costs from the amount withheld. The amount withheld is mailed directly to the district attorney’s office in the county responsible for the support obligation.

Before or with the first reduced benefit payment, the claimant must be notified of the reason for the reduction, the right to appeal the benefit reduction, and the name, address, and phone number of the county DCSS office where the withheld amount will be sent. The claimant should direct questions concerning the support obligation to the county DCSS office.

The claimant may file a timely appeal within 30 days from the date of the employer notice by contacting SDI. Pending the appeal decision, the support intercept process continues. If the appeal decision rules in favor of the claimant, the county is responsible for refunding money to the claimant, if appropriate.

Deductions made per an order assigning salary or wages to satisfy judgments for child support must cease when notification of support obligation is received from SDI. In addition, once withholdings have begun as the result of notification from the EDD, any new orders assigning salary or wages received must be returned to the judgment creditor.

In each case, an explanation should be provided to the judgment creditor as follows:

“As a result of changes in the law, Disability Insurance benefits are no longer subject to withholding in satisfaction of orders assigning salary or wages. Section 704.120 of the California Code of Civil Procedure now permits benefits to be intercepted only when requested by a county support enforcement agency in accordance with California Unemployment Insurance Code Section 2630 and Welfare and Institutions Code Section 11350.5.”

The employer must total the intercepted amount and report it on the close out copy of the DE 2523 form in box 18. Any amount withheld to satisfy support obligations is treated as if it were paid directly to the individual as VP benefits.

Reference: CUIC, Section 2630.
Disputed Coverage Process

When there is a dispute, whether benefits are payable from the state plan or from one or another VP(s), benefits must be paid from the plan against which the claim was first filed.

Two levels of arbitration exist to settle any disagreement:

1. A hearing before the Administrative Law Judge (ALJ).
2. Review by the CUIAB.

The dispute of coverage is unrelated to whether the employee is eligible for benefits. “Disputed coverage” determines only whether SDI or the VP is liable to insure the individual. It does not presume that benefits must be paid. The plan that accepts liability, either directly or by default, then determines whether or not the employee meets eligibility criteria for benefits.

Reference: CUIC, Section 2712.

Filing a Disputed Coverage Appeal

To file a disputed coverage appeal, complete an Appeal for Determination of Coverage, DE 1000DC. DE 1000DC may be obtained from any SDI office. For a current list of SDI offices, visit www.edd.ca.gov/disability/Contact_DI.htm. For information on the appropriate Office of Appeals for your area, call SDI Customer Service at 916-657-5113.

PROVISION AND LIMITATIONS

The provisions and exclusions of SDI are contained in the CUIC and CCR, Title 22. Except where clearly provided otherwise, the rights of individuals who receive SDI benefits are equally applicable to those who receive VP benefits. A VP may not be more restrictive than SDI; however, it may be more beneficial. The provisions by which a VP will provide more liberal eligibility requirements must be clearly stated in the Plan Text.

Reference: CUIC, Section 3254; CCR, Title 22, Section 3254-1(c).

The following standards for SDI claims represent the minimum requirements that must be met by a VP. Except for benefit redirection, these standards also apply to SDI claims. If the VP has more liberal provisions, the specific provisions of the VP text apply and must be followed.

Types of Wages

Wages include the following types of payments, and may conflict with DI and PFL benefits when allocated to a period during a claim:

- Earnings for part-time or light-duty work
- Sick pay (see conflicting wages below)
- Holiday pay (see conflicting wages below)
- Back pay
- Bonus pay
• Commissions
• “In lieu of” notices
• Military compensation
• Money awarded by the Fair Employment Practices Commission in lieu of wages for a specific period
• Return payments
• Retroactive wages

Reference: CUIC, Section 2656.

Conflicting Wages:

• Sick pay and/or holiday pay is not considered to be “wages” for benefit purposes when payment is made because of a termination of employment.
• Holiday pay is not considered to be “wages” when paid after the commencement of a disability.
• The Supreme Court has ruled that dismissal and severance payments of any kind, by whatever name, are not wages for any purpose relating to disability benefits.
• Vacation pay is never considered wages for benefit purposes.

Reference: CUIC, Sections 1265.5, 1265.6, 1265.7, and 1265.9.

Release of Information

The SDI claim form advises claimants that SDI records are available to other governmental entities. Similarly, the reported information required on VP claims becomes part of state records and are subject to release. Employers should inform their employees of this policy.

ELIGIBILITY DETERMINATION PROCEDURES

Eligibility Criteria

VPDI benefits may be paid after the claimant has met the plan requirements, which may not be more restrictive than the following:

• Must be unable to do regular or customary work for at least eight consecutive days.
• Must be employed or actively looking for work at the time their disability begins.
• Must have lost wages because of their disability or, if unemployed, have been actively looking for work.
• Must have earned at least $300 from which VP deductions were withheld during a previous period, unless the VP is employer funded.
• Must be under the care and treatment of a licensed physician/practitioner or accredited religious practitioner during the first eight days of their disability.
The beginning date of a claim can be adjusted to meet the plan requirements. The following must occur:

- Claimant must remain under care and treatment to continue receiving benefits.
- The claimant must complete and mail a VPDI claim form within 49 days from the date their disability begins or they may lose benefits.
- The physician/practitioner (as defined by CUIC, Section 2708) must complete the medical certification verifying the claimant's disability.

Note: If the claimant is under the care of a religious practitioner, request a Claim for Disability Insurance Benefits Religious Practitioners Certificate, DE 2502, from SDI. Certification by a religious practitioner is acceptable only if the practitioner has been accredited by the EDD.

The VP may request an independent medical examination (IME) to determine the initial or continuing eligibility.

### Ineligibility of Voluntary Plan Disability Insurance (VPDI) Benefits

Employees should be encouraged to apply for benefits even if they are not sure of eligibility. If employees are found to be ineligible for all or part of a period claimed, the employer is required to notify the employee of the ineligible period and the reason. The claimant may not be eligible for VPDI benefits if:

- They do not have a loss of wages.
- They are claiming or receiving Unemployment Insurance (UI) or PFL benefits.
- The disability begins while committing a crime resulting in a felony conviction.
- They are in jail, prison, recovery home, or any other place because they were convicted of a crime.
- They are receiving WC benefits at a weekly rate equal to or greater than the SDI rate.
- They fail to have an IME when requested to do so.

### Claim Form Intake

The CUIC requires that a claim for DI benefits be submitted on a specified form, however, the VP employer has the flexibility in how a claim for benefits can be established. Some employers choose to fashion a form after the DI claim form. The Claim for Disability Insurance (DI) Benefits, DE 2501, may be obtained by calling the VPG at 916-653-6839 or by email at DIVPAC@edd.ca.gov.

An actual claim form may not be required, but the reporting information required by the EDD and medical certification must be obtained.

**Reference: CUIC, Section 2706.**

### SDI Online

SDI Online is an electronic claim filing system that allows claimants to file DI and PFL claims and access DI claim information. It also allows VP administrators to access and submit forms through an online account. The system provides automated options that are simple to use and available 24 hours a day, 7 days a week.

Please see page 37 for more information about SDI Online.

VP employers use the DE 2523 or the DE 2523F to report the initial filing and close out of a VPDI or VPFL claim. These forms are also used to request award information from SDI for any claimant.

Employers are required to notify the EDD within 15 days after receipt of a claim for DI benefits using a DE 2523 or for PFL benefits using the DE 2523F. A final DE 2523 must be submitted within 35 days after final payment is made for each period of disability or PFL. Both the initial and final report must be submitted to the EDD via fax, U.S. postal mail or online at www.edd.ca.gov (see instructions on pages 27 and 28).

The DE 2523 or DE 2523F must be filed for each claim received by the VP, including accepted disputed coverage referrals, unless the period of disability is less than eight days. However, effective January 1, 2018, the seven day waiting period will be eliminated for PFL. In addition, when a claim is disallowed for any reason, a denial letter that includes appeal rights must be mailed to the claimant. A copy of the denial letter must be attached to the DE 2523 or DE 2523F.

The DE 2523 and DE 2523F forms are available at www.edd.ca.gov/Disability/VP_Forms_and_Publications.htm.

Submit the completed DE 2523 as follows:

<table>
<thead>
<tr>
<th>Method</th>
<th>Version</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDI Online (recommended)</td>
<td>• Register to submit forms through the EDD's online system.</td>
</tr>
<tr>
<td>Fax: 858-268-5446 Attn: VP Claims Analyst</td>
<td>• Electronic PDF • Hard copy</td>
</tr>
<tr>
<td>Mail: Employment Development Department Disability Insurance Branch Voluntary Plan Group PO Box 120831 San Diego, CA 92112-0831</td>
<td>• Electronic PDF • Hard copy</td>
</tr>
<tr>
<td>Email: <a href="mailto:DIVPG@edd.ca.gov">DIVPG@edd.ca.gov</a></td>
<td>• Word document</td>
</tr>
</tbody>
</table>

Request for State Plan Award

By law, each VP claimant must be paid a weekly rate at least equal to what they would have received if covered by SDI. Since SDI uses all wages in this calculation, the SDI award may exceed the VP benefit calculation. A VP must request SDI award information for any claimant whose VP benefit is calculated at less than the SDI maximum.

To request SDI award information, complete question 11 on the DE 2523 or question 14 on the DE 2523F. This procedure should only be used as a guide to determine adequate VP payments, not as a calculation of the VP benefit. If the SDI award is not received within 10 days, contact the VPG at DIVPG@edd.ca.gov.

Reference: CCR, Title 22, Section 3268-1.
Report of Payment Adjustment on the DE 2523 or DE 2523F

If a close out DE 2523 or DE 2523F has been submitted, and the period of leave is extended and/or supplemental benefits are paid, prepare a new DE 2523 or DE 2523F as follows:

DE 2523:
- Complete items 1-14, claimant information.
- Complete items 15-22, total of all days and amounts paid, including those previously reported.
- Check the “adjustment” box in item 19.
- Check any other applicable boxes.
- Send the DE 2523 to the EDD (see address below).

DE 2523F:
- Complete items 1-17, claimant information.
- Complete items 18-29, entering the total of all days and amounts paid, including those previously reported.
- Check the “adjustment” box in item 26.
- Check any other applicable boxes.
- Send the DE 2523F to the EDD (see address below).

Correction of the DE 2523 or DE 2523F

To correct any erroneous information submitted on the DE 2523 or DE 2523F, such as Social Security number, year of birth, or mailing address; write a letter to the EDD and report the error and correction of each item that is to be changed from the initial report. Do not prepare a new DE 2523 or DE 2523F to show corrections.

Send the letter to the following addresses respectively:

DE 2523:
Employment Development Department
Disability Insurance Branch
PO Box 120831
San Diego, CA 92112-0831

DE 2523F:
Employment Development Department
Disability Insurance Branch
PO Box 45011
Fresno, CA 93718-5011

How to Submit a DE 2523 or DE 2523F Using SDI Online

1. Go to [www.edd.ca.gov/Benefit_Programs_Online.htm](http://www.edd.ca.gov/Benefit_Programs_Online.htm).
2. Select the “Benefit Programs Online” (BPO) link.
3. Log in to your BPO account with your email and password. If you do not have a BPO account, select the “Register” link.
4. Select the “SDI Online” link.
6. Complete the required fields on the “Voluntary Plan Options” page and select “Next”.
7. On the “Submit Claim Information and Final Report” page, enter the rest of the information from the DE 2523 or DE 2523F and select “Submit”.

8. The confirmation page will display the Claim ID and receipt number. Please record both numbers because you will need them later to access SDI Online and view related award information.

**How to Submit a DE 2523 or DE 2523F Final Report Using SDI Online**

1. Follow the above steps 1 - 4.

2. On the “Voluntary Plan” page, in the “Claim Search” section, choose “Claim ID” from the “Search By” drop-down list.

3. Enter the Claim ID number.

4. Enter the claimant's last name in the “Claimant Last Name” field and select “Search.”

5. Select the appropriate claim by selecting “Claim ID.”

6. In the “Forms Available to Submit” section, select “Submit Final Report.”

7. Enter the closeout information in the “Final Report Information” section and select the “Submit” button.

8. The confirmation page will display the Claim ID and receipt number. Please record both numbers for future reference.

**BENEFIT DETERMINATION PROCEDURES**

**Calculation of State Award**

The SDI WBA and MBA are based on wages paid to the claimant during a 12-month base period. Only wages subject to the SDI tax can be considered, and those wages must total at least $300 in the base period.

Exceptions:

- If a claimant earned less than $300 in the base period, and the claim begins during a UI benefit year, the UI base period may be substituted.
- If the claimant served in the military, received WC benefits, or did not work because of a trade dispute during the base period, prior wages may be substituted to increase the benefit.
- A person who is determined ineligible for any benefit amount because of extended unemployment may also be able to substitute prior wages to establish a benefit amount.

Effective January 1, 2018, WBA Calculation changes: Assembly Bill 908 eliminates the waiting period for PFL, and requires that for disability or family leave periods commencing on or after January 1, 2018, but before January 1, 2022, the SDI WBA will be computed as follows:

1. If the claimant's highest quarterly earnings are less than $929, their WBA is $50.

2. If the claimant's highest quarterly earnings are between $929 and $5,229.98, the WBA is approximately 70 percent of their earnings.

3. If the claimant's highest quarterly earnings are more than $5,229.98, their WBA is approximately 60 percent of their earnings.

For disability periods commencing before January 1, 2018, the WBA computation for SDI benefits will remain at 55 percent as outlined in current law.
Each VP claimant must be paid a VPFL benefit at least equal to what they would have been paid if covered under SDI. A claimant’s state award might exceed the VP benefit calculation since the state uses all subject wages in its calculation. Therefore, a VP must obtain the state award information for any claimant whose VPDI or VPFL benefit is calculated at less than the state maximum.

**Reference:** CUIC, Sections 2611(b), 2612, 2652, 2658, 2776, and 2777.

Qualifying wages from all employers during the base period are considered in the calculation of the WBA. Base period wages do not need to include wages from the current employer in order to qualify for benefits (i.e., wages do not need to be strictly VP employer wages to be qualifying wages for VP disability benefits).

The MBA is 52 times the WBA or the total wages subject to SDI tax paid in the claimant’s base period, whichever is less. The base period is determined by the effective date of the claim as follows:

<table>
<thead>
<tr>
<th>If claim begins:</th>
<th>The base period is the 12 months ending the previous:</th>
</tr>
</thead>
<tbody>
<tr>
<td>January, February, March</td>
<td>September 30</td>
</tr>
<tr>
<td>April, May, June</td>
<td>December 31</td>
</tr>
<tr>
<td>July, August, September</td>
<td>March 31</td>
</tr>
<tr>
<td>October, November, December</td>
<td>June 30</td>
</tr>
</tbody>
</table>

**Reference:** CUIC, Sections 2610, 2655(c), and 2655(d).

For additional information about WBAs, visit the EDD website at [www.edd.ca.gov/disability](http://www.edd.ca.gov/disability) or call toll-free at 1-800-480-3287 for DI or 1-877-238-4373 for PFL.

**Calculation of Benefits When Receiving Wages**

Receipt of wages, earned or not earned, may not always preclude payment of benefits. Benefits are paid to compensate for a wage loss due to a disability or family leave. When a wage loss is identified, and all other eligibility requirements are met, the individual is eligible for benefits. However, the SDI benefit amount will be reduced if the amount of wages paid plus the SDI benefit exceed the claimant’s regular wage immediately prior to the commencement of the disability or family leave, excluding overtime.

**Scenario:** The claimant’s regular wage prior to their disability was $450 per week. The maximum weekly benefit entitlement under the VP is $250 per week.

**Example 1:** The claimant is unable to work and is not paid any wages by the employer. The claimant is eligible for $250 per week in VP benefits, the maximum entitlement.

**Example 2:** The claimant is released by the treating physician/practitioner to return to work half time, earning $225 in wages per week. The claimant has a $225 per week wage loss, and is eligible for $225 per week in VP benefits, the amount equal to the wage loss.

**Example 3:** The claimant is released by the treating physician/practitioner to return to work 15 hours per week, earning $169 in wages per week. The claimant has a $281 per week wage loss and is eligible for $250 per week in VP benefits, the maximum entitlement.
The claimant is paid the calculated maximum VP benefit amount, or the amount of the wage loss, whichever is less. Benefits calculated for partial weeks must use one-seventh or one-fifth the wage and benefit amount as specified in the plan text.

The wages may be paid by the VP employer paying DI/PFL or by a different employer. Claimants may return to light work, part-time work, or less than “regular or customary work” as a result of their disability or family leave. The claimant or care recipient may also seek work with another employer doing less than regular or customary work and the claimant may still have a wage loss. In this case, the claimant must submit a record of wages to the VP paying benefits so that benefit entitlement may be calculated.

Reference: CUIC, Sections 140.5 and 2656.

### Calculation of Partial Benefits

When benefits are paid for a partial week, the calculation must conform to the statement in the plan text. SDI pays one-seventh of the WBA for each day of disability or family leave. This means that the claimant may be paid for days of the week not usually worked (e.g., weekends and holidays). The claim and benefits may begin on a day that the claimant would not have been scheduled to work (e.g., Saturday or Sunday). If a VP calculates benefits on a five-day week, a comparison to the SDI computation must be done to insure the adequacy of benefit amounts.

Reference: CUIC, Section 2656.

### Claimant’s Right to Recalculation of Benefits

When the EDD receives a Report of Voluntary Plan Disability Claim, DE 2523, or the Report of Voluntary Plan Family Leave (VPFL) Claim, DE 2523F, the basic information is entered into SDI Online. A Notice of Computation, DE 429D and the Explanation of Notice of Computation, DE 429DI, is mailed to the claimant. The claimant should review and verify the wages used to calculate the SDI award. If the claimant’s situation fits any of the circumstances listed for a substitution of wages on the DE 429DI, they have the right to request a recalculation of benefits from SDI. Since the VP benefit must meet or exceed the SDI award in all cases, this recalculation may affect the VP benefit.

There may also be wage errors or omissions on the DE 429D. Wages may have been reported but credited to an incorrect Social Security number. It is the claimant’s responsibility to contact an EDD office to submit wage verification and to request a recalculation.

Reference: CUIC, Sections 2707.3 and 2707.4; CCR, Title 22, Section 3254-1(a).
Benefit Redirection

VP claimants may choose to have a portion of their VP benefits redirected to pay or reimburse all or a part of the cost of their employee-paid benefits. The redirection of VP benefits may be made at the time the individual applies for VP benefits or at any time the individual is receiving benefits. Claimants are not required to have benefits redirected. The request must be in writing and must specify the weekly amount of the VP benefits to be directed to the employee-paid benefit(s).

The authorization form must allow the claimant to:

- Authorize in writing the weekly amount of the VP benefits to be redirected for the payment of the employee paid benefit.
- Terminate or change the terms of the voluntary redirection of benefits at any time. If the claimant is legally declared incompetent, the spouse of the claimant, in the absence of any other legally authorized representative, has the right to continue or cancel the authorization.

Reference: CUIC, Section 1345.

Payment of Benefits

If a claimant is determined eligible for benefits, they should be paid within 14 days of receipt of a properly completed claim.

Reference: CUIC, Sections 2701.5 and 3264; CCR, Title 22, Section 3267-1.

Denial of Benefits

Although a claimant or care recipient may have a disability that prevents them from doing their regular or customary work, they may not be eligible for benefits for some or all days of the disability of family leave period. The allowable reasons and the legal references for benefit disqualification include, but are not limited to the following:

- Late filing of the initial or continued claim.

Reference: CUIC, Sections 2706.1 and 2706.2; CCR, Title 22, Section 2706-3.

- Not being under the care and treatment of a physician/practitioner, although regulations allow payment of benefits for up to seven days prior to the first day of care and treatment.

Reference: CUIC, Section 2708; CCR, Title 22, Section 2706-1.

- Receiving full wages.

Reference: CUIC, Section 2656.

- Receiving WC benefits in an amount greater than the DI benefit amount.

Reference: CUIC, Section 2629.

- Incarceration as the result of a criminal conviction or the disability is a result of the commission of an arrest, investigation, or prosecution of a crime that results in a felony conviction.

Reference: CUIC, Sections 2680 and 2681.
A claimant may not be eligible for a portion of benefits if the wage loss is less than their SDI benefit amount. In these situations, the employee is entitled to benefits equal to the wage loss. Allowable reasons for partial benefit disqualification include:

- Light or limited work, at less than their regular weekly wage.
- Part-time return to work, at less than their regular weekly wage.
- Sick leave pay at less than their regular weekly wage.
- Receipt of temporary or permanent WC benefits at less than the DI or PFL benefit amount.

When VP benefits are disallowed in whole or in part, a written notice of disqualification must be sent to the claimant. A copy of the notice must be attached to the follow-up copy of the DE 2523 or DE 2523F when it is submitted to the EDD. A claimant may assume that unreasonable delay in payment is a denial of benefits and may request a hearing before an ALJ.

The written notice must include:

- The dates benefits were disqualified.
- An explanation of why benefits were disqualified for those dates.
- Information advising the claimant of the right to appeal the disqualification.

If and when the period and reason for disqualification ends, benefit payments must continue the same weekly and maximum benefit amount allowed by the plan, provided all other eligibility criteria are met.

**Reference:** CUIC, Section 2656.

**Claimant’s Right to Appeal Denial of Benefits**

When a claimant is denied any or all benefits, they must be informed of the right to appeal in the manner prescribed by the CUIC. To appeal a denial of benefits, the claimant must send a letter to any EDD office postmarked no more than 30 days from the date of the notice of denial of benefits. The letter should include the following:

- Claimant’s name.
- Claimant’s signature.
- Claimant’s Social Security number.
- The reason for appealing the decision.

The EDD office will complete the required forms and forward them to the appropriate Office of Appeals.

**Reference:** CUIC, Section 2707.2.

**The Administrative Law Judge or California Unemployment Insurance Appeals Board (CUIAB) Decisions**

When an ALJ or the CUIAB decides that a claimant is entitled to benefits, the VP must pay benefits within 15 days of the mailing of the notice of decision.

The VP’s and/or claimant’s right to appeal an ALJ decision to the CUIAB does not override the effect of the ALJ decision. Benefits must be paid timely pending the decision of the CUIAB.

**Reference:** CUIC, Section 3265(a).
Payment of Benefits Pending Appeal Decision

In some circumstances, payment of benefits is required pending the outcome of an ALJ decision. If eligible to continue receiving full benefits pending the outcome of the appeal they must:

- File a timely appeal.
- Submit a signed promise to the VP to repay benefits if an ALJ rules the claimant was not entitled.
- Certify to benefits pending the ALJ decision.

Reference: CCR, Title 22, Section 2706-5.

CLAIMS AND CERTIFICATION

Claim Effective Date (CED)

A claim begins on the date the claimant’s disability or family leave began. SDI calculates the WBA using the claimant’s base period. The date the disability or family leave began determines the base period unless the CED is adjusted by SDI.

Claimant Certification

The claimant must sign and file the claim form for it to be accepted.

Medical Certification

Except as described below, California law states that DI and PFL benefits will be paid with medical certification from a treating medical or osteopathic physician, surgeon, optometrist, dentist, osteopath, chiropractor, podiatrist, psychologist, or practitioner (as defined by CUIC, Section 2708) acting within the scope of their practice. Effective January 1, 2017, physician assistant was added to the definition of practitioner. Effective January 1, 2010, Assembly Bill 2188 (Chapter 378, Statutes 2010) amended Section 2708(e)(2) of the CUIC to allow a nurse practitioner to certify to a disability, other than normal pregnancy or childbirth, after performance of a physical examination and collaboration with a physician and surgeon.

Note: This notice does not apply to or change any current procedures for certification by licensed midwives or certified nurse midwives. These two categories of providers may continue to certify claims for normal pregnancy or childbirth only.

Reference: CUIC, Section 2708.
Other Options for Certification

A claimant or care recipient who is hospitalized or under the care of any U.S. government medical facility may submit a certificate signed by an authorized medical officer of that facility, provided that the disability is shown on the claimant's or care recipient's hospital chart. A claimant or care recipient who is hospitalized in or by authority of a California county hospital may submit a certificate signed by the registrar of that facility, provided that the disability is shown on the claimant's or care recipient's hospital chart. A religious practitioner who is duly authorized and accredited by a bona fide church, sect, denomination, or organization may certify to a disability or the need for care and provide an estimated duration. SDI maintains a list of accredited religious practitioners. If medical verification is needed, the VP or TPA may contact the EDD.

Verification of License

At times, it may be necessary for the VP to verify the medical provider's credentials. When verification is needed, send a written request to:

Employment Development Department  
Disability Insurance Branch  
Attn: Physician/Practitioner Verification  
PO Box 826880, MIC 29  
Sacramento, CA 94280-0001

The verification request must contain the complete name, address, license number, and phone number of the individual in question. If the information is on file, a response will be sent within two weeks. If the individual has not been previously verified and placed on the approved list, an investigation will be necessary. The length of this process varies, depending on the nature of the investigation. Information from foreign countries may take up to a year. The VP may suggest that the claimant or care recipient obtain medical certification from an accredited physician/practitioner in order to expedite benefit payments.

SDI is authorized to suspend processing claims from foreign physicians/practitioners who are under investigation for filing false claims when SDI does not have legal remedies to conduct a criminal investigation or prosecution in the foreign country. A foreign physician/practitioner who has been convicted of filing false SDI claims may not file a certificate in support of a new or existing claim for benefits for a period of five years from the date of conviction.

Reference: CUIC, Section 2708(d).

Medical Clarification on New Claims

An initial claim for benefits must be supported by medical certification which includes:

- A diagnosis or, where no diagnosis has yet been obtained, a detailed statement of symptoms.
- An ICD-10 code.
- A statement of medical facts including secondary diagnoses, when applicable.

When initially completing the claim form, the physician/practitioner must provide a return-to-work date or the date the care recipient will no longer require care, even if it is only an estimate. The claimant must inform the VP if they are able to return to work at an earlier date in order to prevent an overpayment of benefits.

Reference: CUIC, Section 2708(a).
Extended Medical Information

The recovery/return-to-work date presented in the initial medical certification may be extended. The VP must include a notice with the final benefit check, identifying it as the last payment unless another medical certification for the disability or the need for care is received. The claimant, by law, has 20 days to submit an extension. The requirements for a medical extension are the same as for a new claim in terms of who may certify and the information required. If the continued medical information is postmarked beyond 20 days from the request date or notice of final payment, a disqualification may be issued for those days affected by the lateness. The disqualification may be waived for good cause.

Reference: CUIC, Section 2708.

Approved Treatment Facilities

If a DI claimant has been referred by certified medical authority and participates as a resident either in an approved alcoholic recovery home or drug-free residential facility, certification of referral to the residential facility is necessary. California Department of Health Care Services (DHCS) must approve the alcoholic recovery home or drug-free residential facility. In these cases, the duration of benefit payments is limited.

Thirty days of initial benefits are allowed for treatment in an approved alcoholic recovery home, and may be extended up to 60 additional days, for a total of 90 payable days.

Forty-five days of initial benefits are allowed in a drug-free residential facility, and may be extended up to 45 additional days, for a total of 90 payable days. SDI maintains a list of approved facilities. All approved facilities must be licensed and certified. Verification of approved alcoholic recovery homes or drug-free residential facilities may be requested in writing by providing the facility name and address to the EDD. See page 30 for address and send it attention to Facility Verification.

Reference: CUIC, Sections 2626.1 and 2626.2.

SDI may return information that a facility is not currently approved. In this case, the VP may request SDI to notify the facility that the DHCS states that the facility is not licensed and certified. SDI will inform the facility how to request approval from the DHCS.

Claims submitted from unapproved facilities are not payable. However, if other medical information indicates that the claimant is following a prescribed course of treatment, the claimant may be eligible for benefits. A prescribed course of treatment may include therapy under the direct medical supervision of a physician, whether in or out of a hospital setting. Visits with a physician for purposes of evaluation alone do not constitute medical treatment.

Independent Medical Examination

The VP has the right to require additional medical information to verify medical eligibility for continued benefits, including requiring an Independent Medical Examination (IME). The VP is responsible for the cost of the exam and any related tests, which can be deducted from the trust fund. IME requests are governed by the following general principles:

- The request for an examination must be reasonable.
- The IME physician must be directed to submit an independent and impartial opinion.
- The IME and any lab work or x-ray should only be extensive enough to determine the claimant’s ability or inability to perform regular or customary work or the care recipient’s need for care.
• The IME physician must provide an estimated date of return to work or date care is no longer needed, if applicable.

Any claimant or care recipient who fails to submit to a reasonable IME is subject to disqualification.

Exception: Residents of alcohol recovery homes or drug-free residential facilities and individuals who depend entirely upon prayer or spiritual means for healing are not required to submit to an IME.

Reference: CUIC, Section 2627(c) and 3306.

The claimant’s or the care recipient's failure to do the following can result in disqualification from receiving benefits:

• Failure to contact the IME physician within the time prescribed. The claimant will be disqualified from receiving VPDI or VPFL benefits beginning on the eighth day after the date the IME request was mailed to the claimant.

• Failure to report for the examination or cancellation of the appointment. The claimant will be disqualified from receiving benefits beginning with the date of the IME, or the date of the cancellation, whichever is earlier.

• Failure to comply with the request for an IME but later agrees to submit to one. The disqualification ends on the day before the examination was performed.

Upon receipt of the IME report, the VP must determine a claimant's eligibility for VPDI or VPFL using the following criteria:

• If the IME physician confirms or extends the treating physician/practitioner’s original estimated recovery date or date care is no longer needed, the VP may use the treating physician/practitioner’s original recovery date.

• If the IME physician confirms the disability or the need for care on the date of the IME, but states the claimant or care recipient may be able to return to work sooner than the claimant’s or care recipient's physician/practitioner stated, the VP must pay benefits at least to the IME physician’s estimated recovery date or date care is no longer needed. Additional medical evidence may be requested from the claimant's or care recipient's physician/practitioner to support payment of benefits beyond that date.

• If the IME physician states the claimant is able to perform their regular or customary work or the care recipient does not require care on the date of the IME, the VP must review all available medical information and determine the claimant’s eligibility for VPDI or VPFL benefits. If the VP determines the claimant or care recipient is able to perform their regular or customary work on the date of the IME, disqualification of benefits begins on that date.

Reference: CUIC, Section 2627(c) and 3306; CCR, Title 22, Section 2627(c)-1.

Pregnancy

Claims related to pregnancy, before and/or after delivery, are subject to the same laws and regulations as other DI claims. There is no required or prescribed duration for such claims. All of the requirements previously stated for medical certification, disability from regular or customary employment, and wage loss are applicable.

Reference: CUIC, Section 2626.
Late Claims

The CUIC considers a claim timely if it is filed within 41 days from the first compensable day. Therefore, by including the seven-day waiting period, DI allows 49 days from the date of disability for a timely claim, using the postmark date as the reference point. PFL does not require a seven-day waiting period. To submit a timely claim, it must be submitted within 41 days from the first day of family leave. If the VP allows a longer time for filing a timely claim, the plan text must contain information on the criteria for timeliness.

If a claim is postmarked beyond the allowable time, the claim date is adjusted and benefits are denied or suspended for the duration of lateness. Benefits are then payable from the adjusted claim date.

Example: The disability began on March 1 and the claim form is postmarked June 1. Since the timely filing period is 49 days, this claim is timely through April 18. Late filing is calculated for the period April 19 through June 1, which is 44 days. The claim date is adjusted by denying 44 days from March 1 to April 13. The adjusted claim date is April 14. The waiting period is April 14 through April 20, and benefits are paid beginning April 21.

Reference: CUIC, Section 2706.1.

Overlapping Disabilities

Benefits payable to an employee covered by a VP are the continuing liability of the VP regardless of any subsequent disabling condition occurring during the same disability benefit period. Once a valid claim is established, the benefit period is extended by any additional disabling conditions that occur before the employee is released to return to work for the initial condition.

SDI ONLINE REGISTRATION

SDI Online is an electronic claim filing system for claimants, physicians/practitioners, VPs, and employers. The EDD encourages VP employers and TPAs to register for SDI Online and use the system to submit VP forms to the EDD online.

Once registered, it is very easy to use SDI Online to submit the Report of Voluntary Plan Disability Claim, DE 2523, or Report of Voluntary Plan Family Leave (VPFL) Claim, DE 2523F. If a VP employer or TPA submits the DE 2523 online to request claimant award information, the system will process the request within 48 hours and post the award information in the SDI Online Inbox of the VP or TPA. The DE 2523F can be submitted online; however, the SDI Online system is not able to provide PFL award information. Once the DE 2523F has been received, PFL award information will be mailed to the claimant.

Registering with Benefit Programs Online (BPO) and SDI Online

Prior to registering with SDI Online, VP employers and/or authorized TPAs must visit the EDD web portal, BPO, at www.edd.ca.gov/Benefit_Programs_Online.htm and register.

Registering With BPO:

- On BPO homepage, select “Register” and agree to “Terms and Conditions.”
- Create Profile: email, password, security questions, personal image, and security check.
- Review and submit registration.

After submitting the registration, a link will be sent to the email address provided. Open the email and click the link to complete the registration for BPO. Once BPO registration is completed, you must now register with SDI Online.
Registering With SDI Online:

- Log in to BPO at [www.edd.ca.gov/Benefit_Programs_Online.htm](http://www.edd.ca.gov/Benefit_Programs_Online.htm).
- Select “SDI Online.”
- Under Voluntary Plan, select “Visit the Voluntary Plan page for contact information.”
- Contact the VPG via email or the telephone number provided on the website.
- Complete the form and remit to the EDD at [VPProgram@edd.ca.gov](mailto:VPProgram@edd.ca.gov).
- The EDD will process the form and send a Notice of Online Account Registration, DE 8509, via the email provided.
- Upon receipt of the confirmation email, log in to BPO. Select SDI Online and click “Agree.”

SDI Online can now be accessed to submit DE 2523 and DE 2523F (See page 28). For future access just log in to BPO and select SDI online.
PFL PROVISIONS

Provisions

For California workers covered by SDI, PFL provides up to six weeks of benefits for employees who must take time off of work to care for a seriously ill child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner, or to bond with a new child.

Eligibility for VPFL

Employees covered by an employer’s VP are also covered for VPFL. If an admitted insurer provides your company’s DI coverage, then it must also provide PFL coverage.

An employee may submit a claim for VPFL benefits for the following reasons:

- To care for a seriously ill child, spouse, parent, parent-in-law, grandparent, grandchild, sibling, or registered domestic partner.
- To bond with the employee's new child or the new child of the employee's spouse or registered domestic partner.
- To bond with a child in connection with the adoption or foster care placement of the child with the employee or the employee's spouse or registered domestic partner.

A serious health condition means an illness, injury, impairment, or physical or mental condition that requires at-home or inpatient care in a hospital, hospice, or residential medical care facility or continuing treatment by a physician/practitioner.

Ineligibility for VPFL

The claimant may not be eligible for VPFL benefits if:

- They do not have a loss of wages.
- They are receiving DI, UI, or WC.
- They are not working or looking for work at the time their family leave begins.
- The need for care is not supported by the certificate from the care recipient's treating physician/practitioner.
- They are in jail, prison, recovery home, or any other place because they were convicted of a crime.

VPFL WAGES AND BENEFIT PAYMENT

Calculation of State Award

An individual’s PFL claim begins on the date they first began to care for a seriously ill family member or bond with a new child. PFL calculates the WBA using their base period. The date the PFL claim begins determines an individual’s base period.

An individual who wants their PFL claim to begin later so that there is a different base period should call PFL at 877-238-4373 before filing a claim.
Note: An individual may not change the beginning date of their claim or adjust a base period after establishing a valid claim.

The WBA for VPFL claims is based on wages paid to the claimant during a 12-month base period. Similarly, the minimum earnings of $300 in the base period are required to establish a valid claim, and the 55 percent wage replacement rate for the WBA also applies for claims commencing before January 1, 2018.

Effective January 1, 2018, WBA Calculation changes: Assembly Bill 908 eliminates the waiting period for PFL, and requires that for disability or family leave periods commencing on or after January 1, 2018, but before January 1, 2022, the SDI WBA will be computed as follows:

1. If the claimant's highest quarterly earnings are less than $929, their WBA is $50.
2. If the claimant's highest quarterly earnings are between $929 and $5,229.98, the WBA is approximately 70 percent of their earnings.
3. If the claimant's highest quarterly earnings are more than $5,229.98 their WBA is approximately 60 percent of their earnings.

For disability periods commencing before January 1, 2018, the WBA computation for SDI benefits will remain at 55 percent as outlined in current law.

Each VP claimant must be paid a VPFL benefit at least equal to what they would have been paid if covered under SDI. A claimant's state award might exceed the VP benefit calculation since the state uses all subject wages in its calculation. Therefore, a VP must obtain the state award information for any claimant whose VPDI or VPFL benefit is calculated at less than the state maximum.

VP employers may request state award information for VPFL claims on the required Report of Voluntary Plan Family Leave (VPFL) Claim, DE 2523F. PFL state award information cannot be obtained electronically. PFL manually mails award information. VP employers may request state award information no earlier than 10 days after submitting a DE 2523F. Send requests via email to DIBPFLV225@edd.ca.gov.

**VPFL Claims for the Same Care Recipient**

Periods of family leave for the same care recipient within a 12-month period shall be considered one benefit period.

*Reference: CUIC, Section 3302.1(b).*

Note: The claimant cannot receive more than six weeks of PFL benefits in a 12-month period.

**VPDI Pregnancy Claims Transitioning to VPFL Bonding Claims**

If an employee has a pregnancy-related VPDI claim and transitions to a VPFL bonding claim it shall be considered one disability benefit period.

*Reference: CUIC, Section 3302.1(c).*

Note: VPFL claimants filing transitional claims from pregnancy to bonding are entitled up to six weeks of VPFL benefits, regardless of the amount paid or duration of the VPDI pregnancy claim or the amount of wages in the base period used to calculate the VPDI WBA.

**Continued Claims**

A VPFL continued claim is for the same care or bonding recipient within the same 12-month period, subsequent to a first or re-established claim where there is no interruption of benefits.
VPFL Re-established Claims

A VPFL re-established claim is a claim filed subsequent to a first claim within the same 12-month period. A re-established claim occurs when there is an interruption of the period for which benefits are claimed for the same care or bonding recipient, or benefits are claimed for a new care recipient.

Shift in Liability Due to Re-established Claims

Liability for PFL claims may rest with more than one plan (VP or SDI) during the 12-month period that begins when a claimant establishes a valid VPFL claim. When more than one plan is liable for coverage within the 12-month period, correct calculation of a claimant’s benefit amount requires factoring in benefits from all plans to ensure the claimant receives the proper payment.

When a claimant files a VPFL claim, the VP employer must send a Report of Voluntary Plan Family Leave (VPFL) Claim, DE 2523F to the EDD. If the EDD or a different VP employer has paid PFL benefits during the same 12-month period, the EDD will alert the VP of the existence of the prior claim.

If the prior claim was paid by the EDD, the EDD will forward a copy of the PFL claim payment history to the VP employer, along with the name and date of birth of the care recipient. No other information will be shared unless written authorization from the care recipient is first obtained by the EDD. The VP will be advised to contact the claimant for additional information.

Conversely, when the EDD receives a PFL claim, the EDD will have record of any prior VPFL claims during the 12-month period, provided the VP employer has sent the required opening and/or closing DE 2523F.

Simultaneous Coverage Claims

A claimant who works for more than one employer may be simultaneously covered by more than one plan. A VPFL claimant who is employed by both an SDI and a VP employer may be eligible for simultaneous coverage benefits provided the claimant has a wage loss from both employers.

Disputed Coverage (or Disputed Liability) Claims

When a dispute arises over whether benefits are payable from the state plan or from one or another VP, benefits must be paid from the plan that received a claim first, pending determination of the dispute.

Reference: CUIC, Section 2712.

Two levels of administrative proceedings will resolve disputes regarding liability for DI or PFL claims. The first is a hearing before an ALJ. The second is review of the ALJ’s decision (if appealed) by the CUIAB.

“Disputed coverage” is unrelated to a claimant’s eligibility for benefits. A disputed coverage proceeding is held only to determine whether SDI or the VP is liable to insure the claimant. There is no presumption in a disputed coverage proceeding that the claimant is eligible. The plan that accepts liability determines whether the claimant meets eligibility criteria for benefits.

The EDD uses a Full Coverage Referral to Voluntary Paid Family Leave (PFL) Plan, DE 5022F, to refer claims to the VP employer. VPs must send their disputed coverage VPFL claims to:

Employment Development Department
Disability Insurance Branch
Paid Family Leave
PO Box 45011
Fresno, CA 93718-501
Filing a VPFL Disputed Coverage Appeal

The EDD, or the VP may appeal a denial of VPFL coverage within 30 days of the date the notice of denial was mailed. In disputed coverage cases where a denial of coverage is not furnished, an appeal shall be filed after 25 days and within 55 days from the date the appellant sends a request for payment of benefits to the EDD or VP.

To file a disputed coverage appeal, complete an Appeal for Determination of Coverage, DE 1000DC. DE 1000DC may be obtained from any SDI office. For a current list of SDI offices, visit www.edd.ca.gov/disability/Contact_DI.htm. For information on the appropriate Office of Appeals for your area, call SDI Customer Service at 916-657-5113.

If eligible, the employee shall be paid benefits by the plan that initially received the claim, pending disposition of the disputed coverage appeal. See Appeal of Denial of VPFL Benefits for additional information.

Reference: CUIC, Section 2712; CCR, Title 22, Section 5007(b).

Conflicting Wages

Similar to SDI, receipt of other wages or benefits may be in conflict with VPFL benefits. Sick leave pay, paid time off, or other types of leave provided by the employer are considered wages and are in conflict with PFL and VPFL. As with SDI, employers may coordinate any type of wage continuation pay with VPFL.

The law provides that employers have the option to require employees to use up to two weeks of earned but unused vacation pay prior to receiving VPFL. Unlike VPDI, those two weeks of vacation pay are in conflict with VPFL, and VPFL benefits will not be payable during the same period. After the initial two weeks, vacation pay will no longer be in conflict with VPFL.

Appeal of Denial of VPFL Benefits

The appeals process for VPFL claims is the same as for SDI and VPDI claims. When a claimant is denied any or all benefits, they must be informed in writing of the right to appeal. To appeal a denial of VPFL benefits, the claimant must send a letter to the following address:

Employment Development Department
Disability Insurance Branch
Paid Family Leave
PO Box 997017
Sacramento, CA 95899-7017

The letter must be postmarked no later than 30 days from the date of the notice of denial of benefits. The letter should include the claimant's name, signature, Social Security number, and the reason for appealing the decision. Upon receipt of a PFL appeal, the EDD will complete the required forms and forward them to the appropriate Office of Appeals.

Reference: CUIC, Section 2707.2; CCR, Title 22, Section 5007(c).

Claimant’s Right to Benefits Pending Appeal

In some circumstances, an employee may elect to continue to receive benefits pending the outcome of a timely appeal to an ALJ when the VP had determined the employee initially eligible and subsequently found the employee to be ineligible.

Reference: CCR, Title 22, Section 2706-5.
MEDICAL CERTIFICATION

Medical Determinations and Independent Medical Examinations

When VPFL benefits are provided for wage loss due to care of a child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner with a serious health condition, the following information is required:

- Diagnosis.
- ICD code if not yet obtained, a detailed statement of symptoms.
- Date, if known, when the condition commenced.
- Statement that the care recipient’s serious health condition warrants the need for care.
- An estimate of the amount of time the physician/practitioner believes that employee is needed to care for the care recipient.
- Probable duration of the condition.
- A physician/practitioner must certify the need for full- or part-time care by the employee. This may include, but is not limited to, providing psychological comfort and arranging third-party care.

Reference: CUIC, Section 2708.

The VP employer may require the care recipient to submit to an IME to determine the following:

- Whether a serious health condition exists.
- Whether the care recipient requires care.
- The period of time that the care recipient requires care.

Reference: CUIC, Section 3306(b).
Audit and Compliance Review

The CUIC authorizes the EDD to review the records of all approved VPs to ensure that they are being properly administered by the employer in accordance to CUIC, CCR, Title 22 and the employer’s plan text and to protect and preserve the solvency of the Disability Fund. Employers are required to make records available to the EDD for review.

The EDD conducts annual audits and has established a criteria used to identify employers eligible for an audit. The purpose of the audit is to perform a compliance review by ensuring that program objectives are met as outlined in the engagement letter sent to the auditee upon selection. The audit usually takes place where the claim and/or financial records are located or the EDD may request the employer to provide copies of the records at a California location, if located out-of-state.

The auditor will send an audit report to the employer within 90 days of conclusion of the audit. If findings are identified, the employer will be required to implement any corrective action recommendations and/or submit any amended reports, plan texts or other documents requested. Failure to comply could be cause for termination of the VP.

For any questions regarding the VP compliance audit, contact the VPG at 916-653-6839.

Reference: CUIC, Section 3267.
Workers’ Compensation (WC) Benefit Reduction

Although a VP pays compensation for injury or illness that is not work-related, in some cases benefits are payable along with payments for industrial injury or illness. The CUIC allows for payment of SDI or VP benefits reduced by “other benefits.” “Other benefits” are defined as temporary disability (TD) and permanent disability (PD) under a WC or employer’s liability law.

Reference: CUIC, Section 2629.

If an individual is receiving WC benefits in an amount less than the calculated VP benefit, the VP must pay the difference between the WC benefit amount and the VP benefit amount.

Employees who sustain an injury on the job should be instructed to file both a WC and a VP claim. If the amount of TD or PD equals to or exceeds the VP benefit amount, the VP claim is disqualified (not eligible for payment) until the claimant returns to work and/or the “other benefits” cease.

Conflicting Medical Information

WC benefits may cease when the insurance carrier or self-insured employer has medical documentation indicating that the claimant has recovered or is able to return to their regular or customary work. However, the claimant’s treating physician/practitioner may continue to certify that the disability continues. In the case of conflicting medical opinions, the VP may pay benefits at the rate described in the VP text or may deny benefits. If VP benefits are denied, a denial letter must be sent to the claimant advising of the right and method to appeal the decision.

Payment of Benefits Under Lien

When information indicates that the disability resulted from a work related illness or injury, a valid VP claim must be paid if one of the following exists:

- Current proof from the WC insurance carrier or self-insured employer that TD benefits are not being paid.
- Current proof showing the claimant is not entitled to TD for the period in question (i.e., A Notice of Final Check letter stopping TD or denying those benefits).
- A current Application for Adjudication obtained from the State of California Division of Workers’ Compensation, substantiating the above, containing either a date-received stamp or a Workers’ Compensation Appeals Board (WCAB) case number.

The VP should file a lien against the WC insurance carrier/self-insurer when benefits are paid on an undecided, work-related disability claim. If the WC insurer later concedes liability or is ruled liable for a period that was paid by the VP, the plan is entitled to reimbursement up to the WC rate. The required form for filing a lien may be obtained by contacting the WCAB at:

Workers’ Compensation Appeals Board
455 Golden Gate Avenue, 2nd floor
San Francisco, CA 94102
Phone 415-703-1870
Limitation of Delay in Payment

VP benefits may not be delayed except where the claimant is receiving or the employer or insurer has agreed to commence payment of benefits (e.g., TD of PD).

The VP is required to make an initial determination of the claimant’s entitlement to WC benefits upon filing the DI claim. If the claim is deemed to be industrial, the employee must be informed that benefits will be paid pending receipt of WC benefits if the employer or insurer fails to agree to pay or allow WC benefits within 14 days of notification of industrial injury.

Reference: CUIC, Section 2629.1.
STATE OF CALIFORNIA

LABOR AND WORKFORCE DEVELOPMENT AGENCY

EMPLOYMENT DEVELOPMENT DEPARTMENT

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 800-745-3886 (voice). TTY users, please call the California Relay Service at 711.