Employment Development Department
State of California

Claim for Disability Insurance (DI) Benefits

The State Disability Insurance (SDI) program provides worker-funded benefits to eligible workers who have a full or partial loss of wages due to disabilities that are not work related. The California Unemployment Insurance Code (CUIC) states that a disability is any illness or injury, either physical or mental, that prevents you from doing your regular or customary work. Disability also includes elective surgery and disabilities related to pregnancy or childbirth.

Please read instruction and information pages (A through D) before completing the enclosed forms.

For faster processing, file your claim using SDI Online at edd.ca.gov. If you file online, do NOT mail this form to the Employment Development Department (EDD).

DO NOT COMPLETE THIS FORM IF YOU ARE:

- Insured by a Voluntary Plan. Ask your employer for the proper forms.
- Filing for Non-Industrial Disability Insurance benefits. State government employees refer to your personnel office.

If you cannot complete this form due to your disability, or if you are an authorized representative filing for benefits on behalf of an incapacitated or deceased claimant, call 1-800-480-3287 or visit the EDD website to send an online message using Ask EDD at **askedd.edd.ca.gov**.

HOW TO COMPLETE THIS FORM

- Use black ink only.
- Type or write clearly **within** the boxes provided.
- Enter your Social Security number on all pages of the claim form including attachments.
- Do not fax the form.
- Mail the completed form to the EDD in the envelope provided. Submit your claim no earlier than nine days after the first day your disability begins, but no later than 49 days after your disability begins. **You may lose benefits if your claim is late.**

1. Complete **ALL** items in "PART A – CLAIMANT'S STATEMENT" and **sign box A40.** Errors or missing information **may cause your claim to be returned and delay payment.** For box A13, the United States Postal Service will not deliver mail to a private mail box unless it is preceded by the initials "PMB."
2. Have your physician/practitioner complete and sign "Part B – PHYSICIAN/PRACTITIONER'S CERTIFICATE." Certification may be made by a licensed physician or practitioner authorized to certify to a patient's disability or serious health condition pursuant to CUIC, section 2708. If you are under the care of an accredited religious practitioner, obtain a *Claim for Disability Insurance Benefits - Religious Practitioner's Certificate* (DE 2502) by calling 1-800-480-3287 and ask your religious practitioner to complete and sign it. **Rubber stamp signatures are not accepted.**
3. **You should carefully decide the date you want your claim to begin because it may affect your benefit amount.** See "YOUR BENEFIT AMOUNTS" on page B for information.
4. If you have a work-related disability, complete questions A31 to A38. If your workers' compensation claim has been accepted, denied, or delayed, please include the status letter from the carrier.
5. Place the completed, signed form(s) in the envelope provided. A claim is complete when "PART A – CLAIMANT'S STATEMENT" and "PART B – PHYSICIAN/PRACTITIONER'S CERTIFICATE" are received. Claims are generally processed within 14 days.
6. Keep these instructions and information pages (A through D) for future reference.

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 1-866-490-8879 (voice). TTY users, please call the California Relay Service at 711.

BASIC ELIGIBILITY. DI benefits can be paid only after you meet all of the following requirements:

- You must be unable to do your regular or customary work for at least eight consecutive days.
- You must be employed or actively looking for work at the time you become disabled.
- You must have lost wages because of your disability or, if unemployed, have been actively looking for work.
- You must have earned at least $300 in wages from which SDI deductions were withheld during your established base period (see "YOUR BENEFIT AMOUNTS" in the next column).
- You must be under the care and treatment of a licensed physician/practitioner or accredited religious practitioner during the first eight days of your disability. (The beginning date of a claim can be adjusted to meet this requirement.) You must remain under care and treatment to continue receiving benefits.
- You must complete and submit a claim form within 49 days of the date you became disabled or you may lose benefits.
- Your physician/practitioner must complete the medical certification of your disability. A licensed midwife or nurse-midwife may complete the medical certification for disabilities related to normal pregnancy or childbirth. If you are under the care of a religious practitioner, request a DE 2502 from the SDI office. Certification by a religious practitioner is acceptable only if the practitioner has been accredited by the EDD.

We may require an independent medical examination to determine your initial or continuing eligibility.

INELIGIBILITY. You may apply for benefits even if you are not sure you are eligible. If you are found to be ineligible for all or part of a period claimed, you will be notified of the ineligible period and the reason. You may not be eligible for DI benefits if you:

- are claiming or receiving Unemployment Insurance or Paid Family Leave benefits.
- became disabled while committing a crime resulting in a felony conviction.
- are receiving Workers' Compensation benefits at a weekly rate equal to or greater than the SDI rate.
- are in jail or prison because you were convicted of a crime.
- are a resident in an alcoholic recovery home or drug-free residential facility that is **not** both licensed **and** certified by the state in which the facility is located.
- fail to submit to an independent medical examination when requested to do so.

FRAUD. Under sections 2101, 2116, and 2122 of the California Unemployment Insurance Code, it is a violation to willfully make a false statement or knowingly conceal a material fact in order to obtain the payment of any benefits, such violation being punishable by imprisonment and/or by a fine not exceeding $20,000 or both. To detect and discourage fraud, SDI continually monitors claim payments, vigorously investigates suspicious activity, and will seek restitution and conviction through prosecution.

YOUR RESPONSIBILITIES.

- File your claim and other forms completely, accurately, and in a timely manner. If a form is late, attach a written explanation of the reason(s) to the form.
- Thoroughly read the instructions on this and all other forms your receive from SDI. If you are not sure what is required, contact the SDI office.
- Report to SDI in writing, electronically, or by telephone any:
  - change of address or telephone number.
  - return to part-time or full-time work.
  - recovery from your disability.
  - income you receive.

Keep an appointment for an independent medical examination, if requested.

- **Include your name and Social Security number or Claim ID number on all correspondence.**

YOUR RIGHTS. Information about your claim will be kept confidential, except for the purposes allowed by law. California Civil Code, section 1798.34, gives you the right to inspect any personal records maintained about you by the EDD. Section 1798.35 permits you to request that the record be corrected if you believe it is not accurate, relevant, timely, or complete. Certain types of information that would generally be considered personal are exempt from disclosure to you: medical or psychological records where knowledge of the contents might be harmful to the subject (Civil Code, section 1798.40); records of active criminal, civil, or administrative investigations (Civil Code, section 1798.40). If you are denied access to records which you believe you have a right to inspect or if your request to amend your records is refused, you may file an appeal with the SDI office. You may request a copy of your file by calling SDI at 1-800-480-3287.

You also have the right to appeal any disqualification, overpayment, or penalty. Specific instructions on how to appeal will be provided on any appealable document you receive. If you file an appeal and you remain disabled, you must continue to complete and return continued claim certifications.

YOUR BENEFIT AMOUNTS. Your claim begins on the date your disability began. SDI calculates your weekly benefit amount using your base period. The date your disability began determines your base period, unless the claim effective date is adjusted by SDI. If you want your claim to begin later so that you will have a different base period, please call SDI at 1-800-480-3287 before you file your claim.

This base period covers 12 months and is divided into four consecutive quarters. Your base period includes wages subject to SDI tax which you were paid approximately 5 to 17 months before your disability claim begins. Your base period does not include wages being paid at the time the disability begins. For a disability claim to be valid, you must have at least $300 in wages in the base period. Using the following, you may determine the base period for your claim.

- If your claim begins in January, February, or March, your base period is the 12 months ending last September 30.
- If your claim begins in April, May, or June, your base period is the 12 months ending last December 31.
- If your claim begins in July, August, or September, your base period is the 12 months ending last March 31.
- If your claim begins in October, November, or December, your base period is the 12 months ending last June 30.

The quarter of your base period in which you were paid the highest wages determines your **weekly benefit amount**. **You may not change the beginning date of your claim or adjust your base period after you have established a valid claim.**

Your **daily benefit amount** is your weekly benefit amount divided by seven. Your **maximum benefit amount** is 52 times your weekly benefit amount or the total wages subject to SDI tax paid in your base period, whichever is less. Exceptions are as follows:

- For employers and self-employed individuals who elect SDI coverage, the maximum benefit amount is 39 times the weekly rate.
- For residents in a state licensed and certified alcoholic recovery home or drug-free residential facility, the maximum payable period is 90 days. (However, disabilities related to or caused by acute or chronic alcoholism or drug abuse which are being medically treated do not have this limitation.)

Contact the SDI office to inquire and provide additional information if your situation fits any of these circumstances: If you do not have sufficient base period wages and you remain disabled, you may be able to establish a valid claim by using a later beginning date. If you do not have enough base period wages and you were actively seeking work for 60 days or more in any quarter of the base period, you may be able to substitute wages paid in prior quarters. Additionally, you may be entitled to substitute wages paid in prior quarters either to make your claim valid or to increase your benefit amount if during your base period you were in the U.S. military service, received Workers' Compensation benefits, or did not work because of a labor dispute.

HOW BENEFITS ARE PAID. When your completed "PART A – CLAIMANT'S STATEMENT" and "PART B – PHYSICIAN/ PRACTIONER'S CERTIFICATE" are received, the SDI office will notify you by mail of your weekly and maximum benefit amounts and may request additional information if needed to determine your eligibility. If you are eligible to receive benefits, you have an option in how you receive your benefit payments. The EDD issues benefit payments by the EDD Debit Card℠ or by check. The EDD Debit Card is the fastest and most secure way to receive your benefits. You do not have to accept the EDD Debit Card, to receive your benefits by check mailed from the EDD allow 7-10 days for delivery by US mail. The majority of claims are processed and payments are issued within 14 days of receipt of both the claimant's and the physician/practitioner's portions of the claim. **The first seven days of your claim is a non-payable waiting period.**

If you are eligible for further benefits, additional payments will be sent automatically or a continued claim certification form for the next period will be enclosed. Usually, the certification periods are for two weeks; however, the period will vary under certain circumstances. You will be paid 1/7 of your weekly benefit amount for each calendar day you are eligible unless benefits are reduced for some reason. (See "BENEFIT REDUCTIONS" below.) If you receive DI benefits in place of Unemployment Insurance or Paid Family Leave benefits, the amounts paid will be reported to the Internal Revenue Service. Contact the Internal Revenue Service for more specific tax information.

BENEFIT REDUCTIONS. Under certain circumstances, you may not be eligible for a period of your claim or you may be entitled only to partial benefits. SDI will determine whether or not benefits must be reduced. The types of income shown in the following list should be reported to SDI even though they may not always affect your benefits. Failure to report your income could result in an overpayment, penalties, and a false statement disqualification.

- Sick leave pay
- Self-employment income
- Military pay
- Commissions
- Wages, including modified duty wages
- Residuals
- Part-time work income
- Bonuses
- Workers' Compensation benefits
- Insurance settlements
- Holiday pay

In addition, your benefits may be reduced because of a prior Unemployment Insurance, Paid Family Leave, or DI overpayment or for delinquent court-ordered support payments.

BENEFIT INTERRUPTION and TERMINATION. A *Notice of Final Payment* will be issued when records show you have:

- been paid to your physician/practitioner's estimated date of recovery. If you are still disabled, ask your physician/ practitioner to complete and return the *Physician/Practitioner's Supplementary Certificate* (DE 2525XX) (enclosed with the Notice of Final Payment).
- recovered or returned to your work. If you return to work and become disabled again, immediately submit a new claim form and report the date(s) you worked.

OVERPAYMENT. An overpayment results when you receive DI benefits you were not entitled to receive. Once SDI determines that you were overpaid, the SDI office will contact you to explain the reason for your overpayment. It is important that you complete and return all information requests, as there are some instances when an overpayment can be waived. If it is determined that you were overpaid and the overpayment cannot be waived, you must repay this money. Benefits issued after an overpayment is established may be reduced by 25 to 100 percent to collect your overpayment. You will receive a *Notice of Overpayment Offset* (DE 826) if a reduction is taken for either a DI, Paid Family Leave, or Unemployment Insurance overpayment.

DISQUALIFICATION. All available information will be considered before paying or disqualifying your claim. Benefits will be paid only for the days to which you are entitled. If payment of benefits is denied or reduced, you will be issued a *Notice of Determination* (DE 2517) stating the reason for the disqualification and the time period.

If you deliberately report incorrect information or if you willfully omit or withhold information, false statement disqualifications of up to 92 days are assessed. This may apply if you accept disability benefit payments you know include days for which you should not be paid, such as days after you returned to work. In addition, any resulting overpayment will be increased by a 30 percent penalty assessment.

SPECIAL CIRCUMSTANCES.

Work-related Disability. If you have suffered a work-related injury or illness, report it to your employer and have your physician/ practitioner submit a report to your employer's Workers' Compensation insurance carrier. If the Workers' Compensation insurance carrier delays or refuses payments, SDI may pay you benefits while your case is pending. However, SDI will pay benefits only for the period you are disabled and will file a lien to recover benefits paid. NOTE: SDI and Workers' Compensation are two separate programs. You cannot legally be paid full benefits from both programs for the same period. However, if your Workers' Compensation benefit rate is less than your SDI rate, SDI may pay you the difference between the two rates. For Workers' Compensation information and assistance, call your local Workers' Compensation Appeals Board office. You will find their listing in the State government pages of your telephone book under California, State of; Industrial Relations Department; Workers' Compensation Appeals Board.

Pregnancy. As with any medical condition, the disability period begins with the first day you are unable to do your regular or customary work. DI benefits will be paid for the period of time supported by your physician/practitioner's certification. Pregnancy-related disability claims should NOT be submitted until after the eighth day following the date your physician/practitioner certifies you are disabled.

Bonding with a New Child. Contact the EDD's Paid Family Leave program at 1-877-238-4373. With the final DI benefit payment issued to a new mother, a transition bonding claim form, *Claim for Paid Family Leave (PFL) Benefits – New Mother* (DE 2501FP) will be sent automatically by mail or electronically to your online State Disability Insurance Online Service account if established.

Child Support Questions. Contact the Department of Child Support Services at 1-866-249-0773.

Spousal or Parental Support Questions. Contact the District Attorney's office administering the court order.

Family Care. If a family member must stop work to care for you, or if you stop work to care for a seriously ill family member, please visit **edd.ca.gov** or contact the EDD's Paid Family Leave program at 1-877-238-4373 for more information.

Long-term or Permanent Disability. If you expect your disability to be long-term or permanent, contact the Social Security Administration well before you exhaust your DI benefits. For information, call the Social Security Administration toll-free at 1-800-772-1213.

Rehabilitation. If you have a disability which prevents you from getting or keeping a job, the Department of Rehabilitation may be able to assist you with vocational training, education, career opportunities, independent living, and use of assistive technology.

Job Training. Contact a One-Stop Career Center (1-877-872-5627 or **servicelocator.org**) for services available in your area.

Seeking Work. Contact the EDD for information and assistance concerning employment opportunities and Unemployment Insurance benefits.

Death of Claimant. If a person receiving DI benefits dies, an heir or legal representative should report the death to SDI. Benefits are payable through date of death.

EDD Debit Card Fee Disclosures

Monthly Fee	Per purchase	ATM withdrawal	Cash reload
$0	**$0**	**$0** in-network **$1.00**** out-of-network	**N/A**
ATM balance inquiry			$0
Customer service			$0 per call
Inactivity			$0
We charge 5 other types of fees. Here are some of them:			
Replacement card, express delivery			$10.00
Each international transaction			2%

*This document entitled 'Fee Disclosure and Other Important Disclosures' is included with, and incorporated in, the California Employment Development Department Debit Card Account Agreement.

**Fees can be lower depending on how and where this card is used.

See the materials you received with your card for free ways to access your funds and balance information.

No overdraft/credit features.

Your funds are eligible for FDIC insurance.

For more information about prepaid cards, visit **cfpb.gov/prepaid**.

Find details and conditions for all fees and services in the cardholder agreement.

All Fees	Amount	Details
Spend Money		
Per purchase with PIN	$0	
Per purchase with signature	$0	
Get Cash in the U.S.		
ATM withdrawal, in-network	$0	"In Network" refers to Bank of America ATMs. Locations can be found at **www.bankofamerica.com/eddcard**. You will not be charged a fee by Bank of America.
ATM withdrawal, out-of-network	$1.00	You will be charged this fee after 2 free for each deposit. "Out of Network" refers to all the ATMs outside of Bank of America ATMs. You may also be charged a fee by the ATM operator even if you do not complete a transaction.*
Bank teller cash withdrawal	$0	Available at financial institutions that accept Visa cards. Limited to available balance only.
Emergency cash transfer, domestic	$15.00	All emergency cash transfers must be initiated through the Prepaid Debit Card Customer Service Center.
Information		
Customer service	$0	
Online account information	$0	
Account alert service	$0	
ATM balance inquiry	$0	
Using your card outside the U.S.		
Each international transaction	2%	Of total U.S. Dollar amount of transaction
International ATM withdrawal	$1.00	This is the Bank of America fee. You may also be charged a fee by the ATM operator, even if you do not complete a transaction.
Other		
Online funds transfer	$0	
Replacement card, domestic	$0	
Replacement card, express delivery	$10.00	Additional charge
Replacement card, international	$10.00	Additional charge
Inactive account	$0	

*ATM owners may impose an additional "convenience fee" or "surcharge fee" for certain ATM transactions (a sign should be posted at the ATM to indicate additional fees); however you will not be charged any additional convenience fee or surcharge fee at a Bank of America ATM. A Bank of America ATM means an ATM that prominently displays the Bank of America name and logo.
Your funds are eligible for FDIC insurance. Your funds are insured up to $250,000 by the FDIC in the event Bank of America, N.A. fails, if specific deposit insurance requirements are met. See **fdic.gov/deposit/deposits/prepaid.html** for details.
No overdraft/credit feature.
Contact Bank of America by calling 1.866.692.9374, 1.866.656.5913 (TTY), or 1.423.262.1650 (Collect, when calling outside the U.S.), by mail at Bank of America, PO Box 8488, Gray, TN 37615-8488, or visit **www.bankofamerica.com/eddcard**.
For general information about prepaid accounts, visit **cfpb.gov/prepaid**.
If you have a complaint about a prepaid account, call the Consumer Financial Protection Bureau at 1-855-411-2372 or visit **cfpb.gov/complaint**.

FEDERAL PRIVACY ACT. The EDD requires disclosure of Social Security numbers to comply with California Unemployment Insurance Code, sections 1253 and 2627; with California Code of Regulations, Title 22, sections 1085, 1088, and 1326; with Code of Federal Regulations, Title 20, Part 604; and with U.S. Code, Title 8, sections 1621, 1641, and 1642.

INFORMATION COLLECTION AND ACCESS. State law requires the following information to be provided when collecting information from individuals:

Agency Name:	**Title of Official Responsible for Information Maintenance**:
Employment Development Department (EDD)	Manager, EDD State Disability Insurance Office

Local Contact Person:	**Contact Information:**
Manager, EDD State Disability Insurance Office	You may contact State Disability Insurance by calling 1-800-480-3287. A list of State Disability Insurance local office locations can be found on the Internet at **edd.ca.gov/disability/Contact_DI.htm**. The address and phone number of State Disability Insurance will also appear on the "Notice of Computation," DE 429D, issued at the time your benefit determination is made.

Maintenance of the information is authorized by:

California Unemployment Insurance Code, sections 2601 through 3272.

California Code of Regulations, Title 22, sections 2706-1, 2706-3, 2708-1, and 2710-1.

Consequences of not providing all or any part of the requested information:

- Failure to supply any or all information may cause delay in issuing benefit payments or may cause you to be denied benefits to which you are entitled.
- If you willfully make a false statement or representation or knowingly withhold a material fact to obtain or increase any benefit or payment, the EDD will disqualify you from receiving benefits and/or services and may initiate criminal prosecution against you.

Principal purpose(s) for which the information is to be used:

- To determine eligibility for Disability Insurance benefits.
- To be summarized and published in statistical form for the use and information of government agencies and the public (your name and identification will not appear in publications).
- To be used to locate persons who are being sought for failure to provide child, spousal, or other court-ordered support.
- To be used by other governmental agencies to determine eligibility for public social services under the provisions of California Welfare and Institutions Code, Division 9.
- To be used by the EDD to carry out its responsibilities under the California Unemployment Insurance Code.
- To be exchanged pursuant to California Unemployment Insurance Code, section 322, and California Civil Code, section 1798.24, with other governmental departments and agencies, both federal and state, which are concerned with any of the following:
  (1) Administration of an Unemployment Insurance program.
  (2) Collection of taxes which may be used to finance Unemployment Insurance or State Disability Insurance.
  (3) Relief of unemployed or destitute individuals.
  (4) Investigation of labor law violations or allegations of unlawful employment discrimination.
  (5) The hearing of workers' compensation appeals.
  (6) Whenever necessary to permit a state agency to carry out its mandated responsibilities where the use to which the information will be put is compatible with the purpose for which it was gathered.
  (7) When mandated by state or federal law. Disclosures under California Unemployment Insurance Code, section 322, will be made only in those instances in which it furthers the administration of the programs mandated by that Code.
- Pursuant to California Unemployment Insurance Code, sections 1095 and 2714: (1) Information may be revealed to the extent necessary for the administration of public social services, to the Director of Social Services or his/her representatives, or to the Director of Child Support Services or his/her representatives; (2) Claimant identity may be released to the Department of Rehabilitation.
- Information shall be disclosed to authorized agencies in accordance with California Unemployment Insurance Code, sections 1095 and 2714.

Employment Development Department
State of California

Claim for Disability Insurance (DI) Benefits

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Claimant Social Security Number	000000000

Claimant Name (First)	(MI)	(Last)
Sample		Claimant

I authorize

Geoff Booker

(Person/Organization providing the information) to furnish and disclose all my health information and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability for which this claim is filed that are within their knowledge to the following employees of the California Employment Development Department (EDD): Disability Insurance Branch examiners, their direct supervisors/managers and any other EDD employee who may have a need to access this information in order to process my claim and/or determine eligibility for State Disability Insurance benefits.

I understand that EDD is not a health plan or health care provider, so the information released to EDD may no longer be protected by federal privacy regulations. (45 CFR Section 164.508(c)(2)(iii)). EDD may disclose information as authorized by the California Unemployment Insurance Code.

I agree that photocopies of this authorization shall be as valid as the original.

I understand I have the right to revoke this authorization by sending written notification stopping this authorization to EDD, DI Branch MIC 29, PO Box 826880, Sacramento, CA 94280. The authorization will stop on the date my request is received. I understand that the consequences for my revoking this authorization may result in denial of further State Disability Insurance benefits.

I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by EDD or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

I understand that I am signing this authorization voluntarily and that payment or eligibility for my benefits will be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization may result in an incomplete claim form that cannot be processed for payment of State Disability Insurance benefits.

I understand I have the right to receive a copy of this authorization.

Claimant Signature (Do Not Print)	Date Signed
Sample Claimant	12252015

Your disability claim can also be filed online at www.edd.ca.gov

PLEASE PRINT WITH BLACK INK.

PART A - CLAIMANT'S STATEMENT

A1. YOUR SOCIAL SECURITY NUMBER: 000000000

A2. IF YOU HAVE PREVIOUSLY BEEN ASSIGNED AN EDD CUSTOMER ACCOUNT NUMBER, ENTER THAT NUMBER HERE: No

A3. CALIFORNIA DRIVER LICENSE OR ID NUMBER: Z1234567

A4. GENDER: MALE X FEMALE

A5. IF YOU EVER USED OTHER SOCIAL SECURITY NUMBERS, ENTER THOSE NUMBERS BELOW

A6. STATE GOVERNMENT EMPLOYEE (IF "YES" INDICATE BARGAINING UNIT#): YES X NO UNIT#

A7. YOUR DATE OF BIRTH: 01011900

A8. YOUR LEGAL NAME (FIRST) (MI) (LAST) SUFFIX: Sample Claimant

A9. OTHER NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED
(FIRST) (MI) (LAST) SUFFIX

(FIRST) (MI) (LAST) SUFFIX

A10. YOUR HOME AREA CODE AND TELEPHONE NUMBER: 999 0236789

A11. YOUR CELL AREA CODE AND TELEPHONE NUMBER: 111 0020047

A12. LANGUAGE YOU PREFER TO USE
ENGLISH SPANISH CANTONESE VIETNAMESE ARMENIAN PUNJABI TAGALOG OTHER
X

A13. YOUR MAILING ADDRESS, PO BOX OR NUMBER/STREET/APARTMENT, SUITE, SPACE#, OR PMB# (PRIVATE MAIL BOX): 123 Any Street

CITY: Anytown STATE: CA ZIP OR POSTAL CODE: 12345 COUNTRY (IF NOT U.S.A.)

A14. YOUR RESIDENCE ADDRESS, REQUIRED IF DIFFERENT FROM YOUR MAILING ADDRESS
NUMBER/STREET/APARTMENT OR SPACE#

CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)

A15. YOUR LAST OR CURRENT EMPLOYER - IF YOUR LAST OR CURRENT EMPLOYMENT WAS SELF-EMPLOYMENT, ENTER "SELF" AND FILL-IN THIS OPTION. SELF
NAME OF YOUR EMPLOYER [STATE GOVERNMENT EMPLOYEES: PROVIDE THE AGENCY NAME (FOR EXAMPLE: CALTRANS)]: Roadrunner Pastries

NUMBER/STREET/SUITE# (STATE GOVERNMENT EMPLOYEES: PLEASE PROVIDE THE ADDRESS OF YOUR PERSONNEL OFFICE): 647 Armistice Way

CITY: Anywhere STATE: CA ZIP OR POSTAL CODE: 66222 COUNTRY (IF NOT U.S.A.)

EMPLOYER'S TELEPHONE NUMBER: 499 3111111

A16. AT ANY TIME DURING YOUR DISABILITY, WERE YOU IN THE CUSTODY OF LAW ENFORCEMENT AUTHORITIES BECAUSE YOU WERE CONVICTED OF VIOLATING A LAW OR ORDINANCE? YES X NO

A17. BEFORE YOUR DISABILITY BEGAN, WHAT WAS THE LAST DAY YOU WORKED?: 12012015

A18. WHEN DID YOUR DISABILITY BEGIN?: 12162015

A19. DATE YOU WANT YOUR CLAIM TO BEGIN IF DIFFERENT THAN THE DATE ENTERED IN A18: M M D D Y Y Y Y

A20. SINCE YOUR DISABILITY BEGAN, HAVE YOU WORKED OR ARE YOU WORKING ANY FULL OR PARTIAL DAYS? YES X NO

A21 A. IF YOU RECOVERED, ENTER DATE: M M D D Y Y Y Y

A21 B. IF YOU RETURNED TO WORK, ENTER DATE: M M D D Y Y Y Y

PART A - CLAIMANT'S STATEMENT - CONTINUED

A22. PLEASE RE-ENTER YOUR SOCIAL SECURITY NUMBER: 000000000

A23. WHAT IS YOUR REGULAR OR CUSTOMARY OCCUPATION? Pastry Chef

A24. WHY DID YOU STOP WORKING? (SELECT ONLY ONE BOX)

- [X] ILLNESS, INJURY, OR PREGNANCY
- [ ] LAYOFF
- [ ] UNPAID LEAVE OF ABSENCE
- [ ] VOLUNTARILY QUIT OR RETIRED
- [ ] TERMINATED
- [ ] OTHER REASON

A25. HOW WOULD YOU DESCRIBE OR CLASSIFY YOUR JOB?

- [ ] Mostly sit; occasionally stand or walk; occasionally lift, carry, push, pull, or otherwise move objects that weigh 10 lbs. or less.
- [ ] Mostly walk/stand; occasionally lift, carry, push, pull, or otherwise move objects that weigh up to 20 lbs.
- [ ] Constantly lift, carry, push, pull, or otherwise move objects that weigh up to 10 lbs.; frequently up to 20 lbs.; occasionally up to 50 lbs.
- [X] Constantly lift, carry, push, pull, or otherwise move objects that weigh up to 20 lbs.; frequently up to 50 lbs.; occasionally up to 100 lbs.
- [ ] Constantly lift, carry, push, pull, or otherwise move objects that weigh over 20 lbs.; frequently over 50 lbs.; occasionally over 100 lbs.

A26. IF YOUR EMPLOYER(S) CONTINUED OR WILL CONTINUE TO PAY YOU DURING YOUR DISABILITY, INDICATE TYPE OF PAY:

SICK [ ] VACATION [ ] Paid Time Off (PTO) [ ] ANNUAL [ ] OTHER (EXPLAIN)

A27. MAY WE DISCLOSE BENEFIT PAYMENT INFORMATION TO YOUR EMPLOYER(S)?

YES [ ] NO [ ]

A28. SECOND EMPLOYER NAME (IF YOU HAVE MORE THAN ONE EMPLOYER)

Cosmic Cookies

NUMBER/STREET/SUITE#

469 Thrifty Way

CITY: Bluebell | STATE: CA | ZIP OR POSTAL CODE: 84369 | COUNTRY (IF NOT U.S.A.):

BEFORE YOUR DISABILITY BEGAN, WHAT WAS THE LAST DAY YOU WORKED FOR THIS EMPLOYER? 12162015 | EMPLOYER'S TELEPHONE NUMBER:

A29. IF YOU HAVE MORE THAN 2 EMPLOYERS CHECK HERE. [ ]

A30. IF YOU ARE A RESIDENT OF AN ALCOHOLIC RECOVERY HOME OR A DRUG-FREE RESIDENTIAL FACILITY, PROVIDE THE FOLLOWING:

NAME OF FACILITY

NUMBER/STREET/SUITE#

CITY | STATE | ZIP OR POSTAL CODE | AREA CODE AND TELEPHONE NUMBER

A31. HAVE YOU FILED OR DO YOU INTEND TO FILE FOR WORKERS' COMPENSATION BENEFITS?

- [ ] YES - COMPLETE ITEMS A32 THROUGH A38
- [ ] NO - SKIP ITEMS A33 THROUGH A38

A32. WAS THIS DISABILITY CAUSED BY YOUR JOB?

- [ ] YES
- [ ] NO

A33. DATE(S) OF INJURY SHOWN ON YOUR WORKERS' COMPENSATION CLAIM

MM DD YYYY MM DD YYYY MM DD YYYY MM DD YYYY

A34. WORKERS' COMPENSATION INSURANCE COMPANY NAME | AREA CODE AND TELEPHONE NUMBER | EXTENSION (IF ANY)

NUMBER/STREET/SUITE#

CITY | STATE | ZIP CODE | WORKERS' COMPENSATION CLAIM NUMBER

PART A - CLAIMANT'S STATEMENT - CONTINUED

A35. PLEASE RE-ENTER YOUR SOCIAL SECURITY NUMBER 0 0 0 0 0 0 0 0 0

A36. WORKERS' COMPENSATION ADJUSTER'S NAME | AREA CODE AND TELEPHONE NUMBER | EXTENSION (IF ANY)

A37. EMPLOYER'S NAME SHOWN ON YOUR WORKERS' COMPENSATION CLAIM | AREA CODE AND TELEPHONE NUMBER | EXTENSION (IF ANY)

A38. YOUR ATTORNEY'S NAME (IF ANY) FOR YOUR WORKERS' COMPENSATION CASE | AREA CODE AND TELEPHONE NUMBER | EXTENSION (IF ANY)

ATTORNEY'S ADDRESS NUMBER/STREET/SUITE#

CITY | STATE | ZIP CODE | WORKERS' COMPENSATION APPEALS BOARD/ADJ CASE NUMBER

A39. SELECT YOUR PREFERRED PAYMENT METHOD ☐ EDD DEBIT CARD℠ ☐ CHECK

A40. Declaration and Signature. By my signature on this claim statement, I claim benefits and certify that for the period covered by this claim I was unemployed and disabled. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law and that such violation is punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to the best of my knowledge and belief true, correct, and complete. By my signature on this claim statement, I authorize the California Department of Industrial Relations and my employer to furnish and disclose to State Disability Insurance all facts concerning my disability, wages or earnings, and benefit payments that are within their knowledge. By my signature on this claim statement, I authorize release and use of information as stated in the "Information Collection and Access" portion of this form (see Informational Instructions, page D). I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.

CLAIMANT'S SIGNATURE (DO NOT PRINT) OR SIGNATURE MADE BY MARK (X): Sample Claimant | DATE SIGNED: 12162015

A41. IF YOUR SIGNATURE IS MADE BY MARK (X), CHECK THE BOX AND IT MUST BE ATTESTED BY TWO WITNESSES WITH THEIR ADDRESSES. ☐

1st WITNESS SIGNATURE (PRINT AND SIGN) | DATE SIGNED (M M D D Y Y Y Y)

NUMBER/STREET/APARTMENT OR SPACE#, PO BOX OR PRIVATE MAIL BOX ADDRESSES NOT ACCEPTABLE.

CITY | STATE | ZIP CODE

2nd WITNESS SIGNATURE (PRINT AND SIGN) | DATE SIGNED (M M D D Y Y Y Y)

NUMBER/STREET/APARTMENT OR SPACE#, PO BOX OR PRIVATE MAIL BOX ADDRESSES NOT ACCEPTABLE.

CITY | STATE | ZIP CODE

A42. ☐ CHECK THIS BOX IF YOU ARE THE PERSONAL REPRESENTATIVE SIGNING ON BEHALF OF CLAIMANT AND COMPLETE THE FOLLOWING:

I, (FIRST) (MI) (LAST), REPRESENT THE CLAIMANT IN

THIS MATTER AS AUTHORIZED BY ☐ DECLARATION OF INDIVIDUAL CLAIMING DISABILITY INSURANCE BENEFITS DUE AN INCAPACITATED OR DECEASED CLAIMANT, DE 2522 (SEE INSTRUCTION & INFORMATION A, UNDER HOW TO APPLY #4) ☐ POWER OF ATTORNEY (ATTACH COPY)

PERSONAL REPRESENTATIVE'S SIGNATURE (DO NOT PRINT) | DATE SIGNED (M M D D Y Y Y Y)

Claim for Disability Insurance (DI) Benefits -
Physician/Practitioner's Certificate
PLEASE PRINT WITH BLACK INK.

PART B - PHYSICIAN/PRACTITIONER'S CERTIFICATE

B1. PATIENT'S SOCIAL SECURITY NUMBER: 000000000

B2. PATIENT'S FILE NUMBER: 69-642-38

B3. IF YOU KNOW THE PATIENT'S ELECTRONIC RECEIPT NUMBER, ENTER IT HERE: R

B4. PATIENT'S DATE OF BIRTH: 01011900

B5. PATIENT'S NAME (FIRST) (MI) (LAST): Sample Claimant

B6. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER: 634-027930

B7. STATE **OR** COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED IN B6: STATE CA COUNTRY

B8. PHYSICIAN/PRACTITIONER LICENSE TYPE: MD

B9. SPECIALTY (IF ANY):

B10. PHYSICIAN/PRACTITIONER'S NAME AS SHOWN ON LICENSE
(FIRST) (MI) (LAST) SUFFIX: Geoff Booker

B11. PHYSICIAN/PRACTITIONER'S ADDRESS
MAILING ADDRESS, PO BOX OR NUMBER/STREET/SUITE#: 269 Commerce
CITY: Anywhere STATE: CA ZIP OR POSTAL CODE: 72694 COUNTRY (IF NOT U.S.A.):

COUNTY HOSPITAL/GOVERNMENT FACILITY ADDRESS
FACILITY NAME (IF APPLICABLE):
FACILITY ADDRESS, NUMBER/STREET/SUITE#:
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.):

B12. THIS PATIENT HAS been UNDER MY CARE AND TREATMENT FOR THIS MEDICAL PROBLEM
FROM 12162015 TO MMDDYYYY [X] CHECK HERE TO INDICATE YOU ARE STILL TREATING THE PATIENT
AT INTERVALS OF: [ ] DAILY [ ] WEEKLY [X] MONTHLY [ ] AS NEEDED [ ] OTHER

B13. AT ANY TIME DURING YOUR ATTENDANCE FOR THIS MEDICAL PROBLEM, HAS THE PATIENT BEEN INCAPABLE OF PERFORMING HIS/HER REGULAR OR CUSTOMARY WORK?
[X] YES - ENTER DATE DISABILITY BEGAN 12162015 [ ] NO - SKIP TO B33
WAS THE DISABILITY CAUSED BY AN ACCIDENT OR TRAUMA? [ ] YES [ ] NO
MMDDYYYY IF YES, INDICATE THE DATE THE ACCIDENT OR TRAUMA OCCURRED.

B14. DATE YOU RELEASED OR ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR OR CUSTOMARY WORK
("UNKNOWN", "INDEFINITE", ETC., NOT ACCEPTABLE.) MMDDYYYY
[ ] CHECK HERE TO INDICATE PATIENT'S DISABILITY IS PERMANENT AND YOU NEVER ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR OR CUSTOMARY WORK

B15. IF PATIENT IS NOW PREGNANT OR HAS BEEN PREGNANT, PLEASE CHECK THE APPROPRIATE BOX AND ENTER THE FOLLOWING:
[ ] ESTIMATED DELIVERY DATE: MMDDYYYY [ ] DATE PREGNANCY ENDED: MMDDYYYY
TYPE OF DELIVERY, IF PATIENT HAS DELIVERED: [ ] VAGINAL [ ] CESAREAN

PART B - PHYSICIAN/PRACTITIONER'S CERTIFICATE - CONTINUED

B16. PLEASE RE-ENTER PATIENT'S SOCIAL SECURITY NUMBER: 000000000

B17. IF THE PATIENT HAS NOT DELIVERED AND YOU DO NOT ANTICIPATE RELEASING THE PATIENT TO RETURN TO REGULAR OR CUSTOMARY WORK PRIOR TO THE ESTIMATED DELIVERY DATE, ENTER THE **NUMBER OF DAYS** THAT THE PATIENT WILL BE DISABLED POSTPARTUM, FOR EACH DELIVERY TYPE:

VAGINAL DELIVERY: CESAREAN DELIVERY:

B18. IN CASE OF AN ABNORMAL PREGNANCY AND/OR DELIVERY, STATE THE COMPLICATION(S) CAUSING MATERNAL DISABILITY

B19. ICD DIAGNOSIS CODE(S) FOR DISABLING CONDITION THAT PREVENT THE PATIENT FROM PERFORMING HIS/HER REGULAR OR CUSTOMARY WORK (REQUIRED)

(Check only one box)

EXAMPLE OF HOW TO COMPLETE ICD CODES

ICD-9 320.1 ☐ ICD-9

ICD-10 G00.1 ☒ ICD-10

PRIMARY 552.92XA

SECONDARY

SECONDARY

SECONDARY

B20. DIAGNOSIS (REQUIRED) - IF NO DIAGNOSIS HAS BEEN DETERMINED, ENTER A DETAILED STATEMENT OF SYMPTOMS

Broken left forearm closed fracture

B21. FINDINGS - STATE NATURE, SEVERITY, AND EXTENT OF THE INCAPACITATING DISEASE OR INJURY, INCLUDE ANY OTHER DISABLING CONDITIONS

Unable to use left arm and hand

B22. TYPE OF TREATMENT/MEDICATION RENDERED TO PATIENT

Cast immobilize arm

B23. IF PATIENT WAS HOSPITALIZED, PROVIDE DATES OF ENTRY AND DISCHARGE MM DD YYYY TO MM DD YYYY

☐ CHECK HERE TO INDICATE THE PATIENT IS STILL HOSPITALIZED

B24. ☐ CHECK HERE IF PATIENT IS DECEASED, PLEASE PROVIDE DATE OF DEATH MM DD YYYY

CITY COUNTY STATE

PART B - PHYSICIAN/PRACTITIONER'S CERTIFICATE - CONTINUED

B25. PLEASE RE-ENTER PATIENT'S SOCIAL SECURITY NUMBER: 0 0 0 0 0 0 0 0 0

B26. WAS THE PATIENT SEEN PREVIOUSLY BY ANOTHER PHYSICIAN/PRACTITIONER OR MEDICAL FACILITY FOR THE CURRENT DISABILITY/ILLNESS/INJURY?

[ ] YES [X] NO [ ] UNKNOWN IF YES, WHAT WAS THE DATE OF FIRST TREATMENT? M M D D Y Y Y Y

B27. DATE AND TYPE OF SURGERY/PROCEDURE MOST RECENTLY PERFORMED OR TO BE PERFORMED

M M D D Y Y Y Y

M M D D Y Y Y Y WAS THE PATIENT UNABLE TO WORK IMMEDIATELY PRIOR TO THE SURGERY OR PROCEDURE? [ ] YES [ ] NO

IF YES, PLEASE PROVIDE THE FIRST DATE THE PATIENT WAS UNABLE TO WORK BEFORE THE SURGERY OR PROCEDURE

B28. ICD PROCEDURE CODE(S) [ ] ICD-9 [ ] ICD-10

CPT CODE(S) (DO NOT INCLUDE MODIFIERS)

B29. WAS THIS DISABLING CONDITION CAUSED AND/OR AGGRAVATED BY THE PATIENT'S REGULAR OR CUSTOMARY WORK? [ ] YES [X] NO

B30. ARE YOU COMPLETING THIS FORM FOR THE SOLE PURPOSE OF REFERRAL/RECOMMENDATION TO AN ALCOHOLIC RECOVERY HOME OR DRUG-FREE RESIDENTIAL FACILITY AS INDICATED BY THE PATIENT IN QUESTION A30? [ ] YES [X] NO

B31. DATE YOUR PATIENT BECAME A RESIDENT OF A DRUG OR ALCOHOL FACILITY (IF KNOWN) M M D D Y Y Y Y

B32. WOULD DISCLOSURE OF THE INFORMATION ON THIS FORM BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL TO YOUR PATIENT? [ ] YES [ ] NO

B33. **PHYSICIAN/PRACTITIONER'S:** I CERTIFY UNDER PENALTY OF PERJURY THAT THE PATIENT IS UNABLE TO PERFORM HIS/HER REGULAR OR CUSTOMARY WORK BECAUSE OF THE LISTED DISABLING CONDITION(S). I HAVE PERFORMED A PHYSICAL EXAMINATION AND/OR TREATED THE PATIENT. I AM AUTHORIZED TO CERTIFY A PATIENT DISABILITY OR SERIOUS HEALTH CONDITION PURSUANT TO CALIFORNIA UNEMPLOYMENT INSURANCE CODE SECTION 2708.

PHYSICIAN/PRACTITIONER'S ORIGINAL SIGNATURE - **RUBBER STAMP IS NOT ACCEPTABLE**	DATE SIGNED	AREA CODE/PHONE NUMBER
Geoff Booker	12172015	4230024693

UNDER SECTIONS 2116 AND 2122 OF THE CALIFORNIA UNEMPLOYMENT INSURANCE CODE, IT IS A VIOLATION FOR ANY INDIVIDUAL WHO, WITH INTENT TO DEFRAUD, FALSELY CERTIFIES THE MEDICAL CONDITION OF ANY PERSON IN ORDER TO OBTAIN DISABILITY INSURANCE BENEFITS, WHETHER FOR THE MAKER OR FOR ANY OTHER PERSON, AND IS PUNISHABLE BY IMPRISONMENT AND/OR A FINE NOT EXCEEDING $20,000. SECTION 1143 REQUIRES ADDITIONAL ADMINISTRATIVE PENALTIES.