Employment Development Department
State of California

SDI ONLINE TUTORIAL

File a Disability Claim

Last Updated: January 2024

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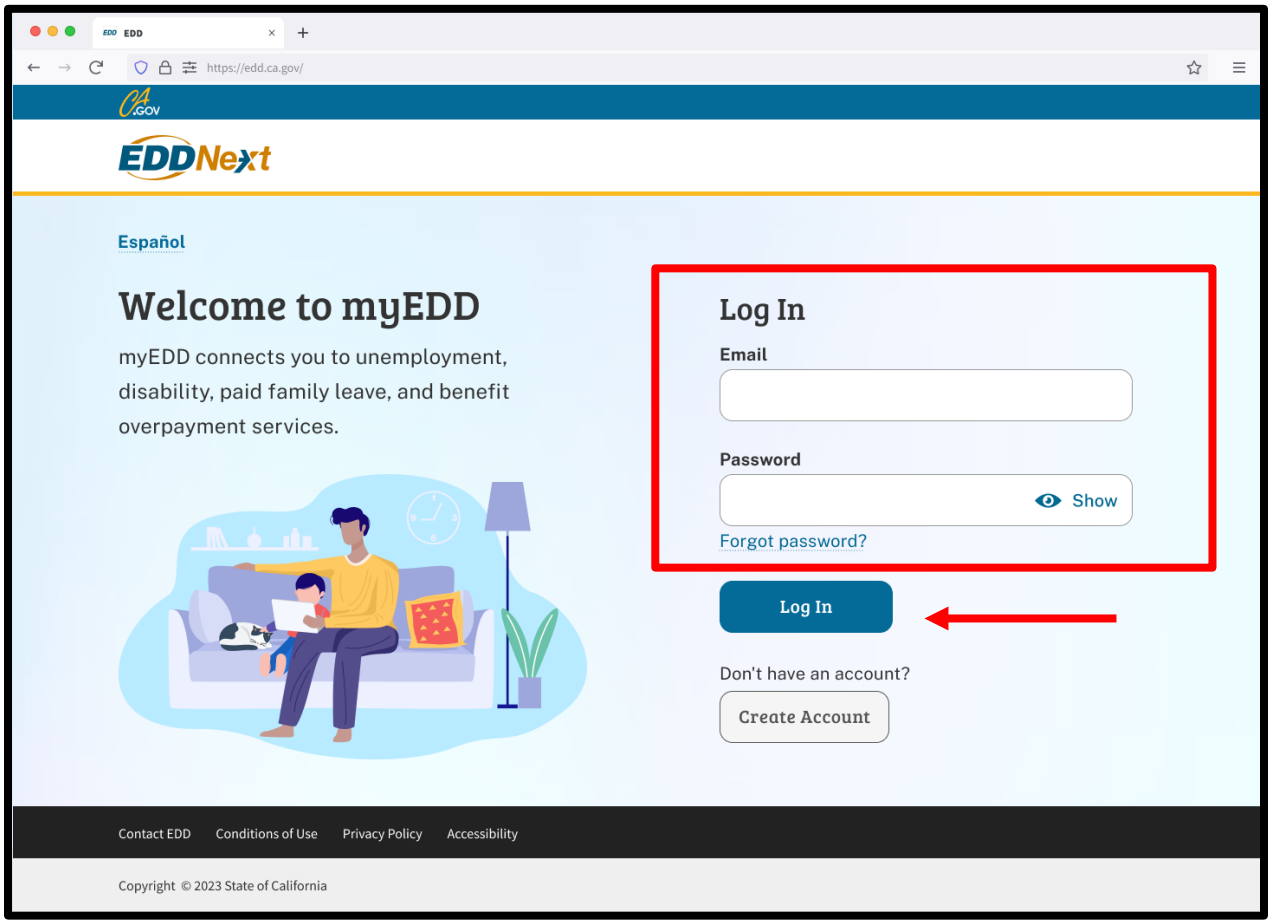
Employment Development Department
State of California

File a Disability Insurance Claim

Learn more about how to file a claim for disability benefits.

Get Started



Note

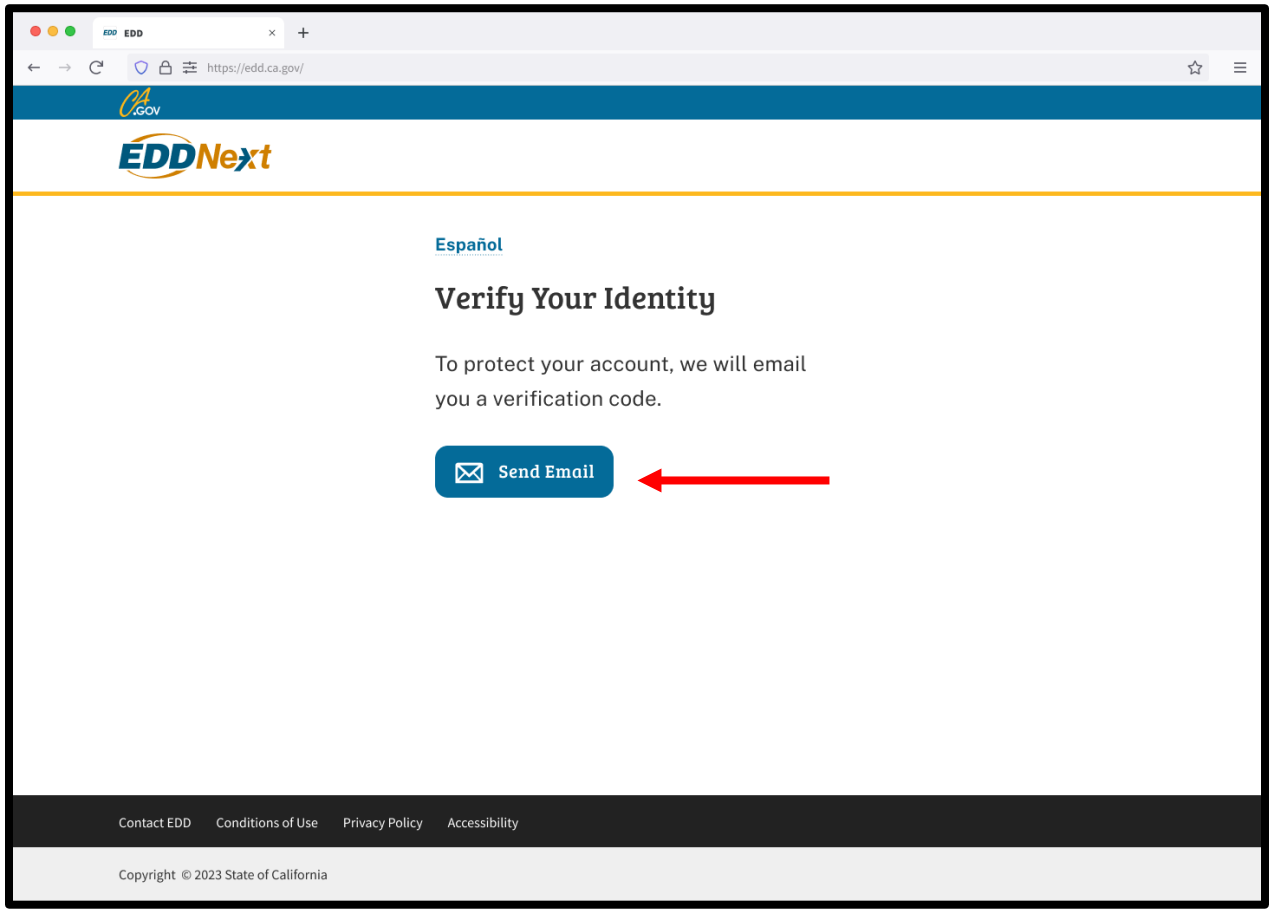
For Spanish, select **Español**.

Important

We lock your account for one hour after too many failed attempts to enter your password. You can wait one hour to try again or reset your password.

Log in to myEDD to access SDI Online and file a disability claim:

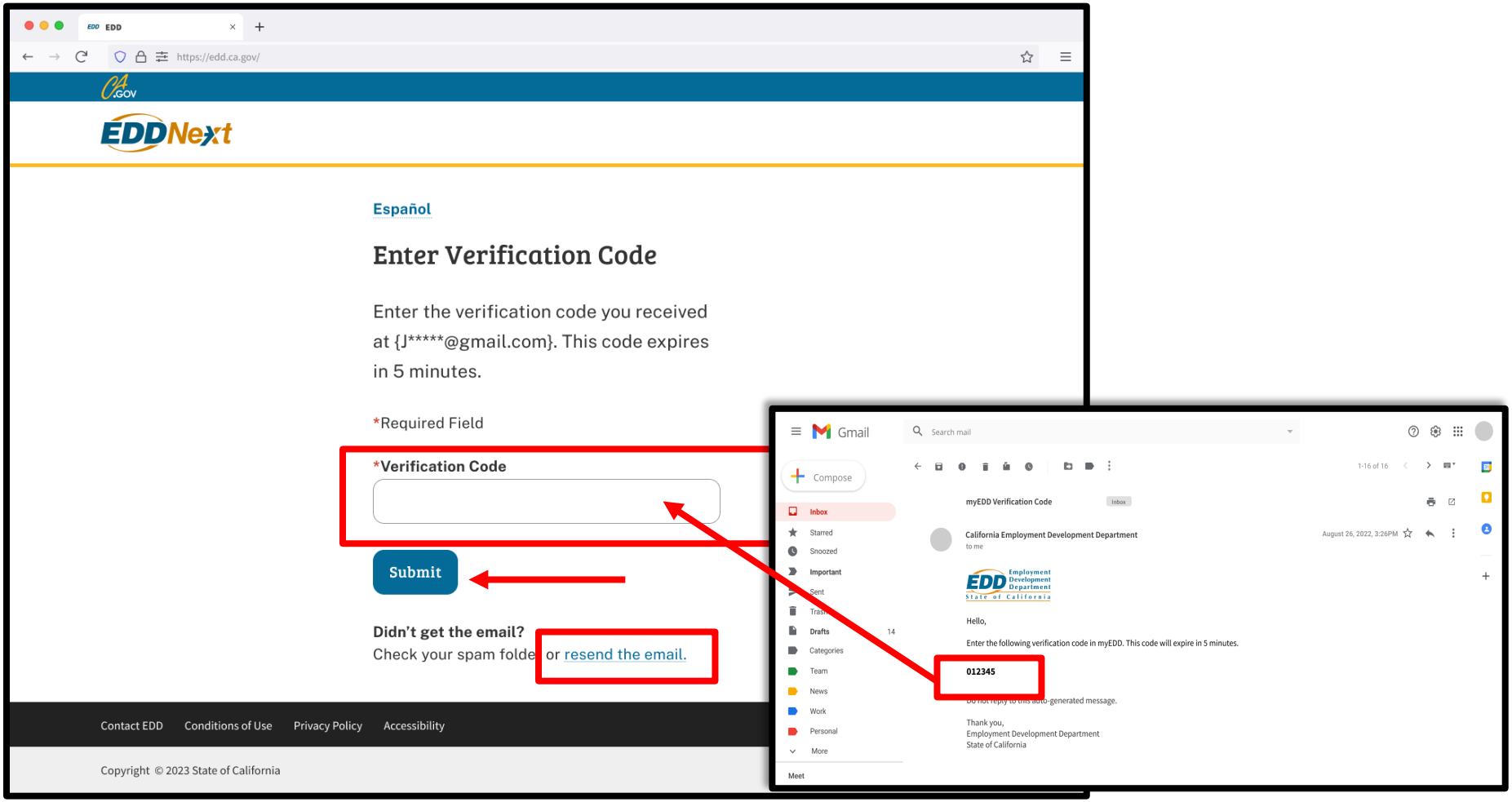
1. Visit myEDD.
2. Enter the email and password used to create you myEDD account.
3. Select **Log In**.



To protect your account, we ask you to verify your identity every time you log in. In this example, the identity verification option is by email.

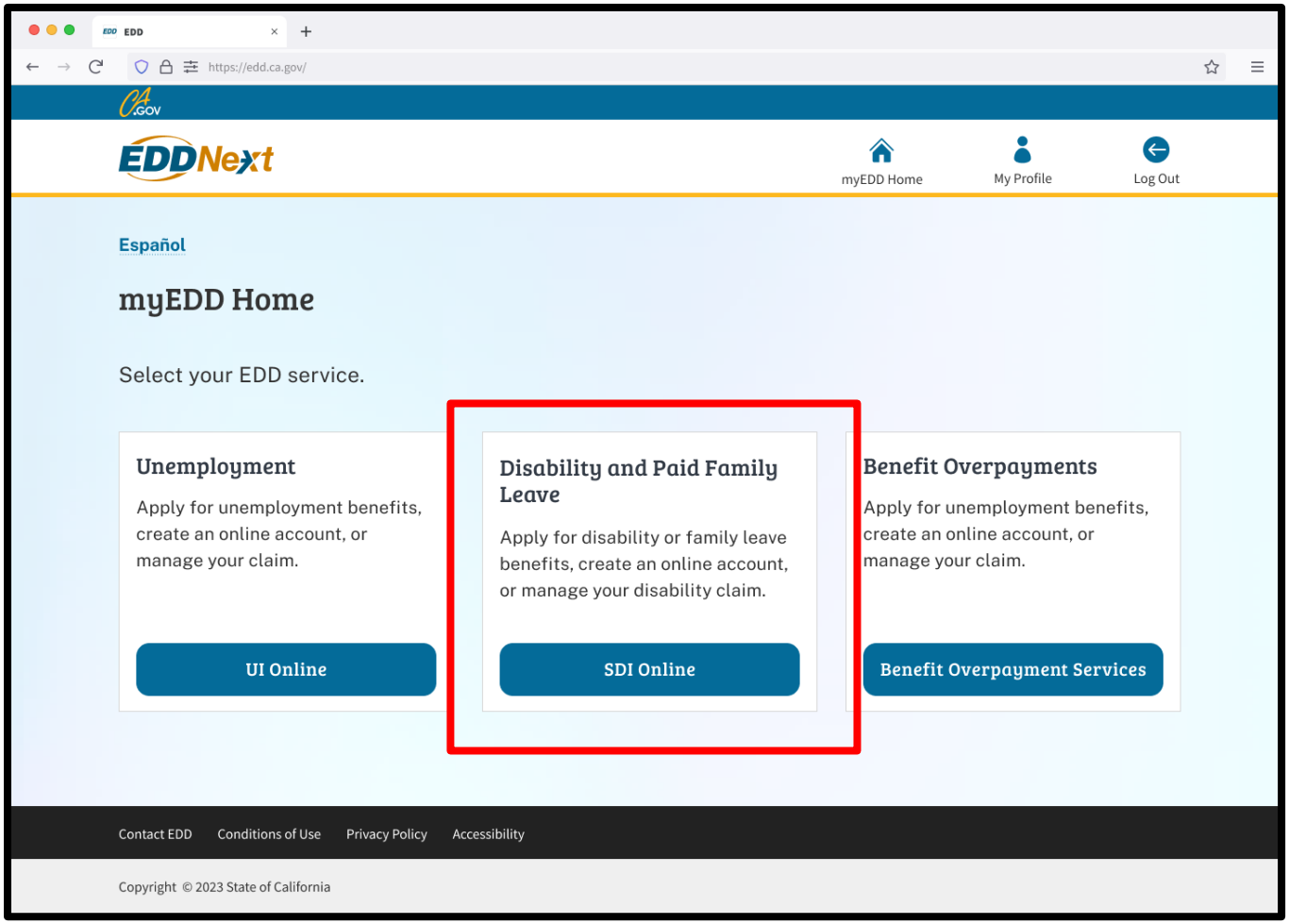
Select **Send Email.**

If you set up the login verification option as text message or phone call, follow the instructions based on that option.

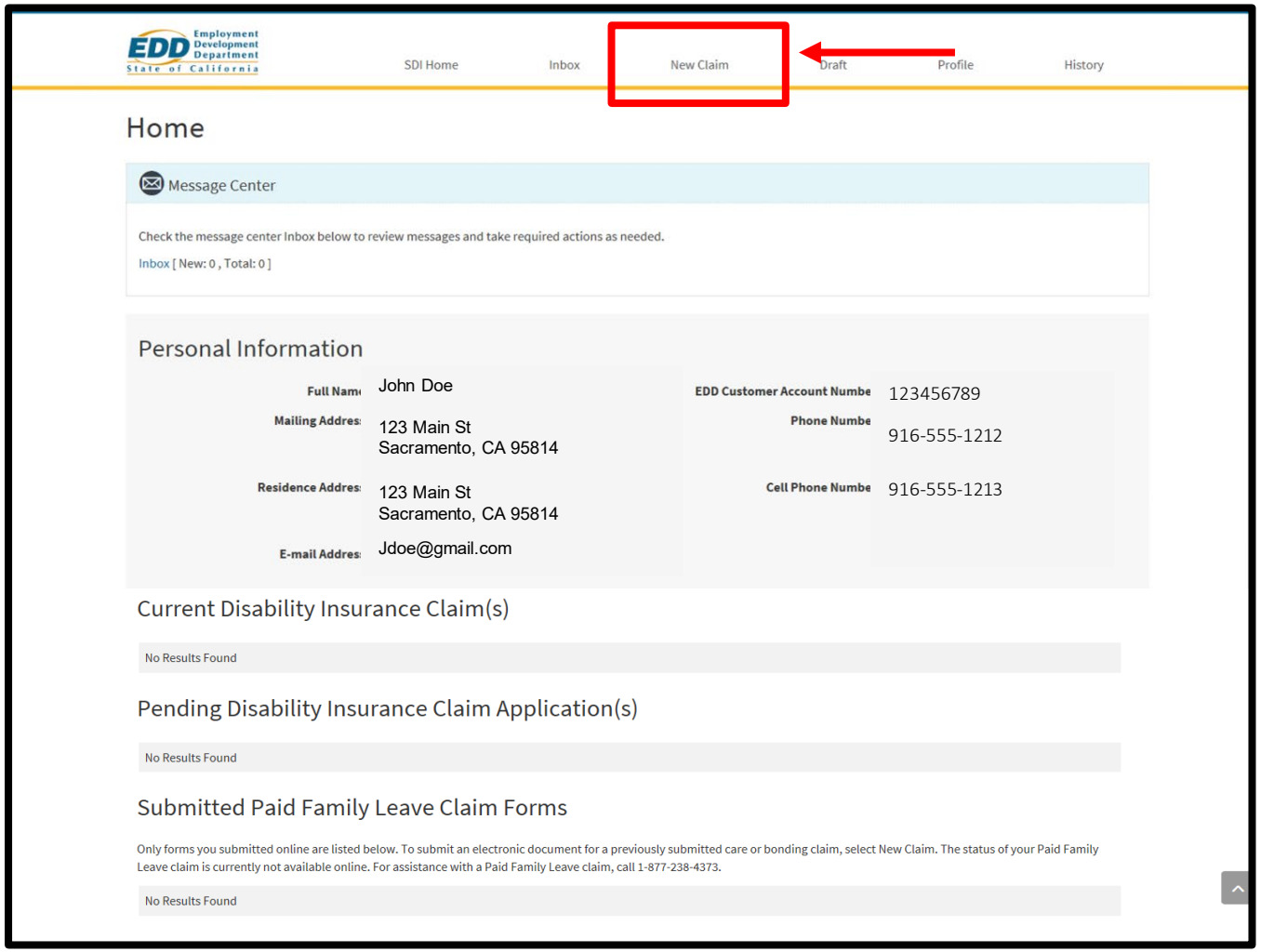


Check your email for your verification code. This code expires in five minutes. Check your spam or junk folder if you do not get this email.

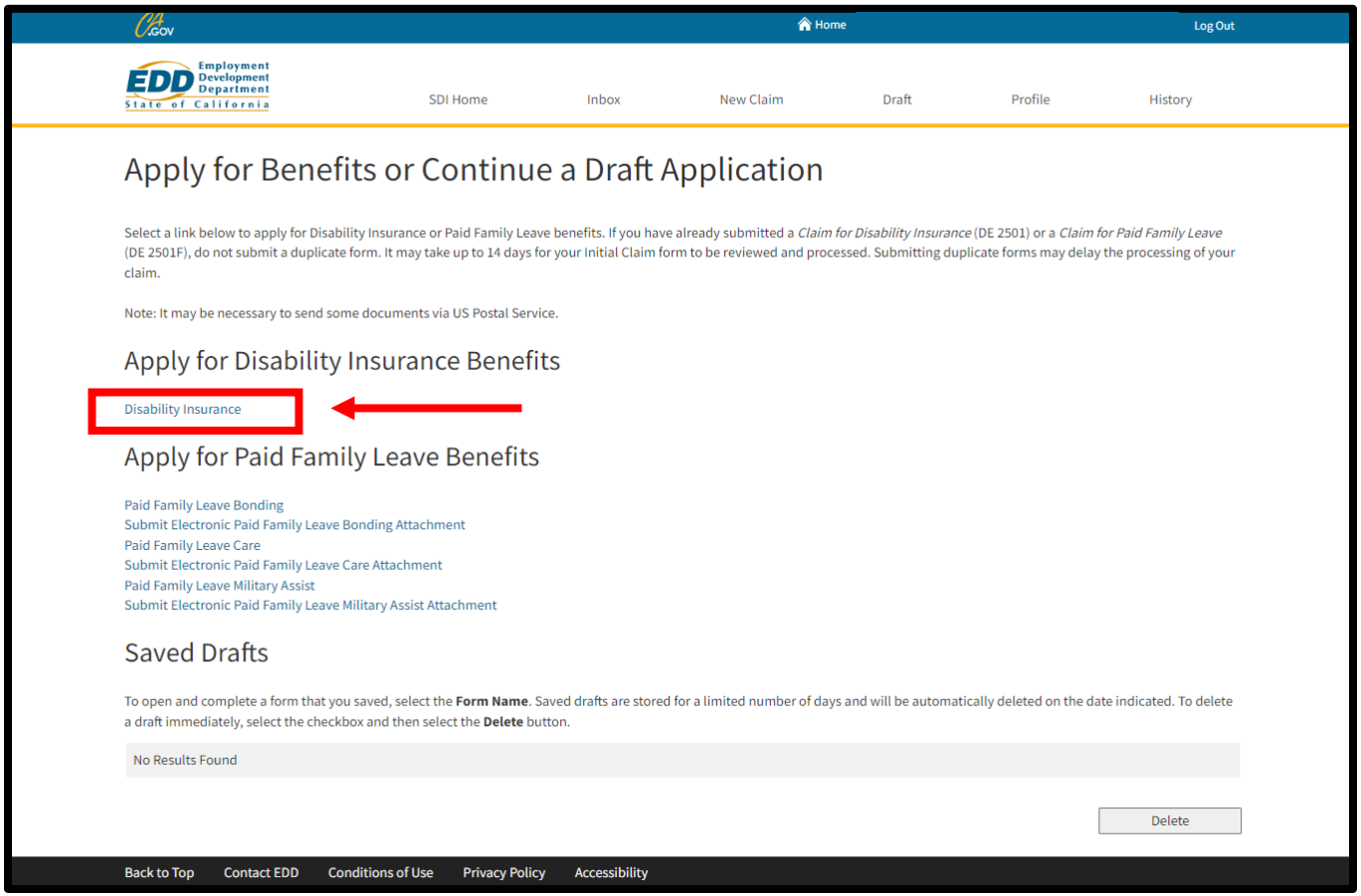
- Enter your verification code and select **Submit**.
- Select **resend the email** if you do not get a code.



From the myEDD homepage, select **SDI Online**.



Select **New Claim** from the main menu.



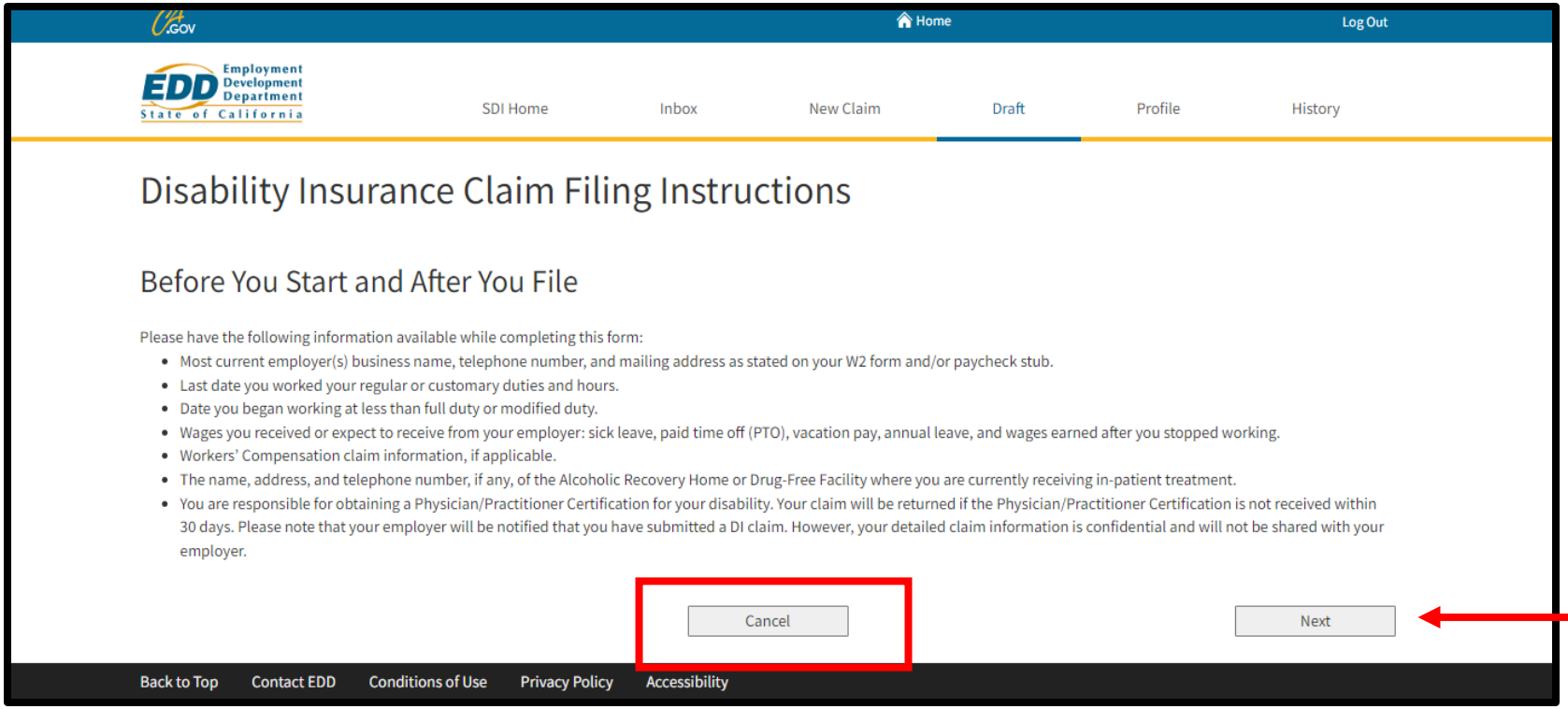
Select **Disability Insurance** under Apply for Disability Insurance Benefits to complete your section of the disability application.

Note

Submit your claim no earlier than the first day your disability begins, but no later than 49 days after your disability begins, or you may lose benefits.

Important

If you already submitted a claim, do not submit another claim. It can take up to 14 days for your claim to be reviewed and processed.

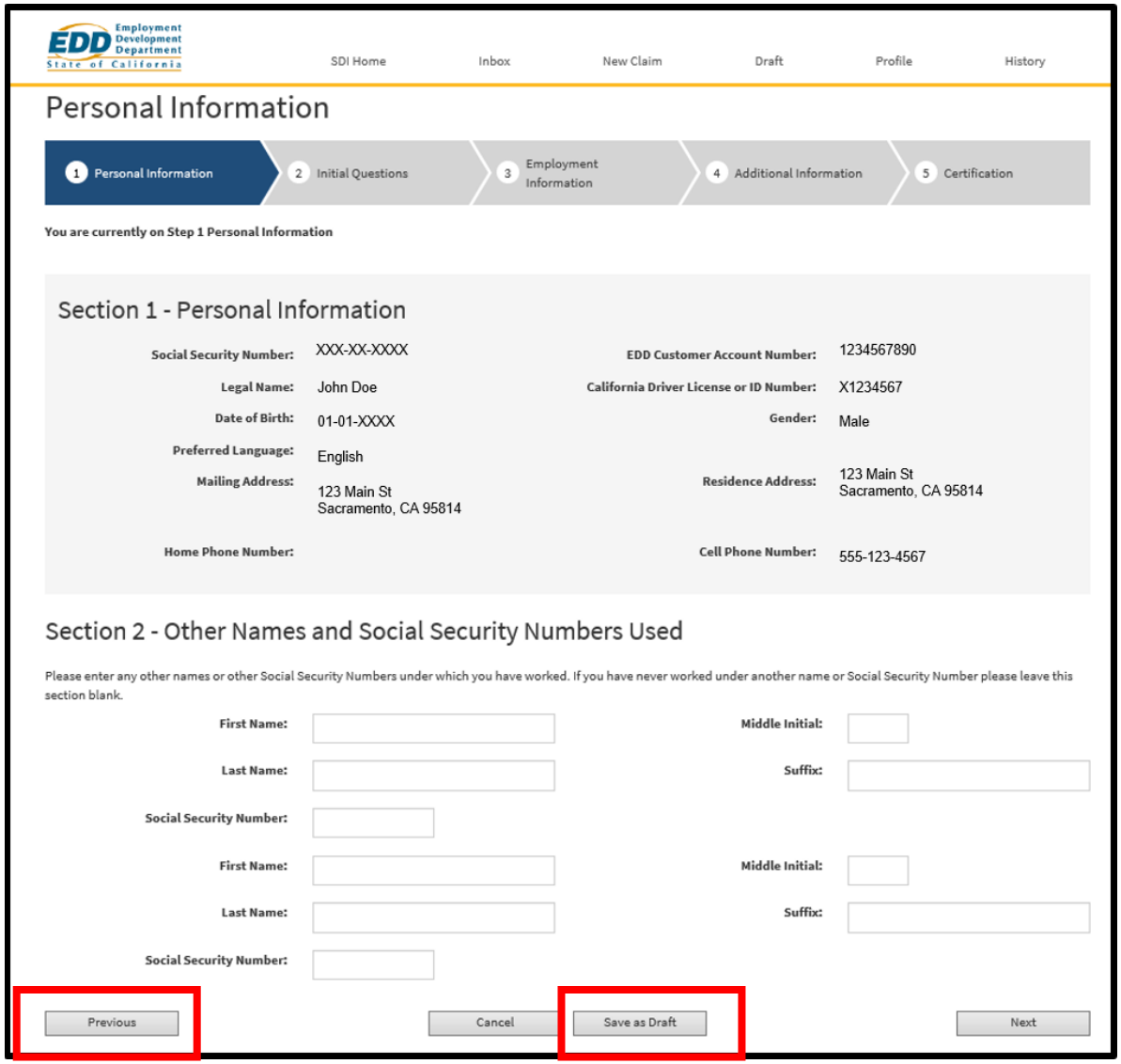


Review the Disability Insurance Claim Filing Instructions screen. It has important information you need to file a disability claim.

Select **Next** to continue.

Note

Selecting **Cancel** at any time will cancel the claim and return you to your SDI Online homepage.



The system automatically fills certain fields of the application.

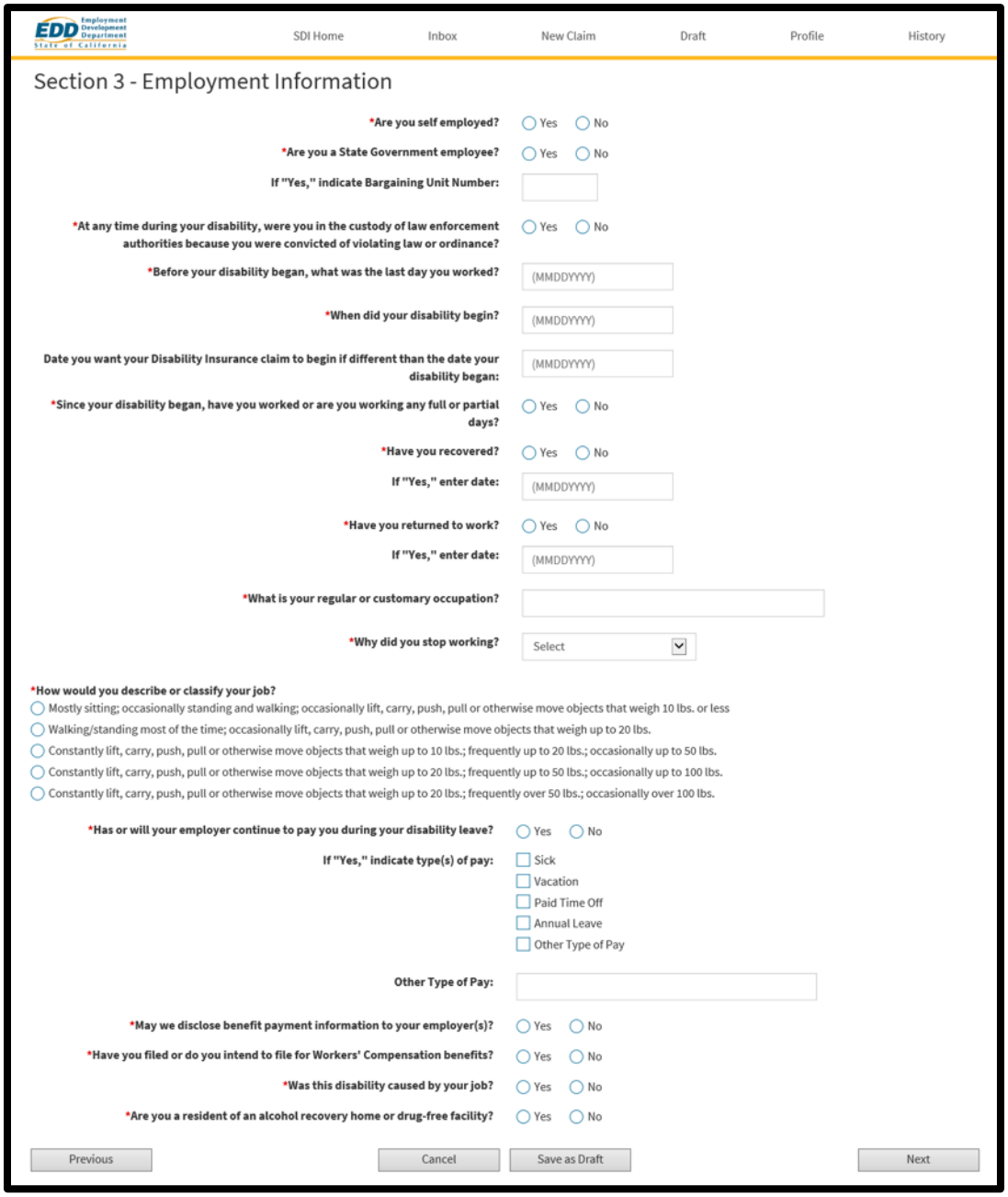
Verify the information in Section 1 and complete any open fields in Section 2, as appropriate.

If your personal information has changed, select **Save as Draft** and update your SDI Online profile.

Select **Next** to move to the next step.

Note

Select **Save as Draft** at any time to complete the form later. Select **Previous** to return to the previous screen. **Do not** use your browsers “back” button.

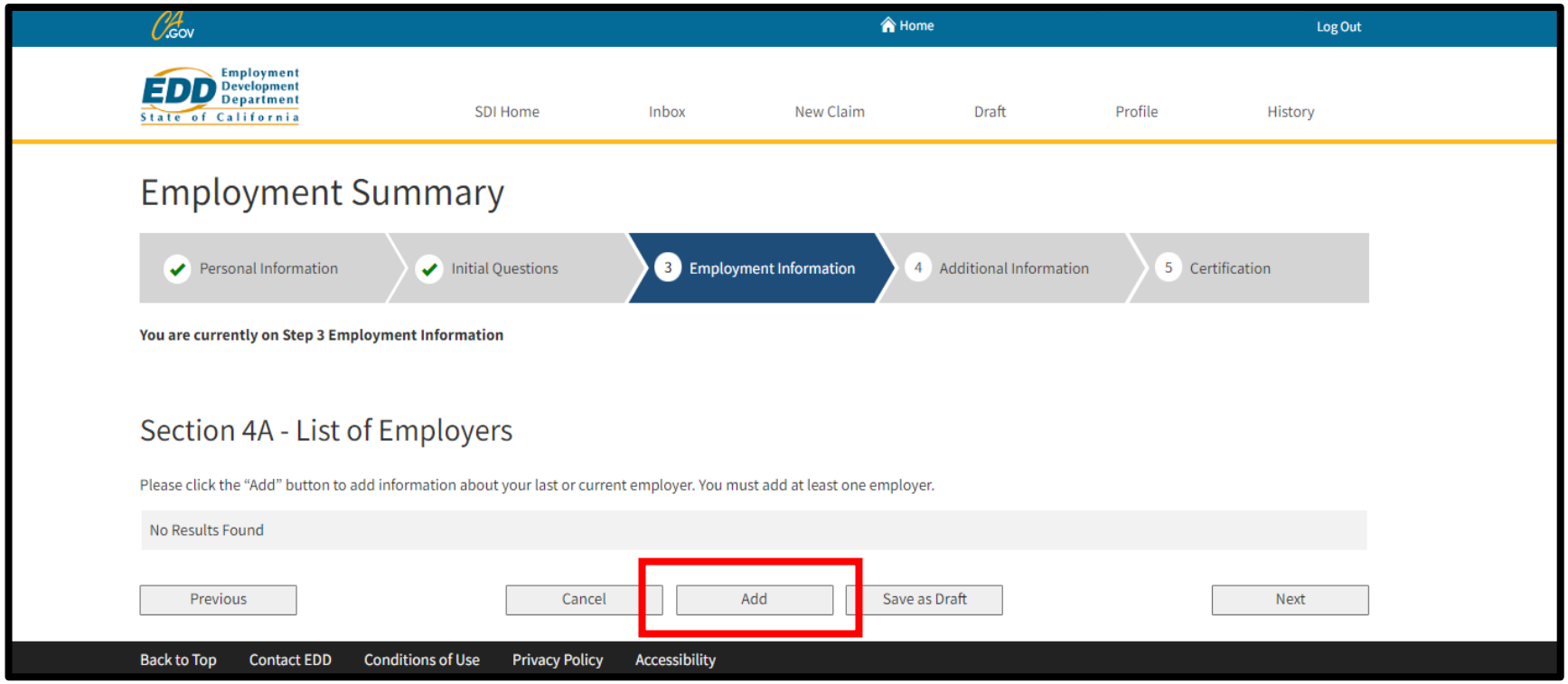


Complete Section 3 - Employment Information.

- Make sure all dates and information are correct to avoid a delay of benefits.

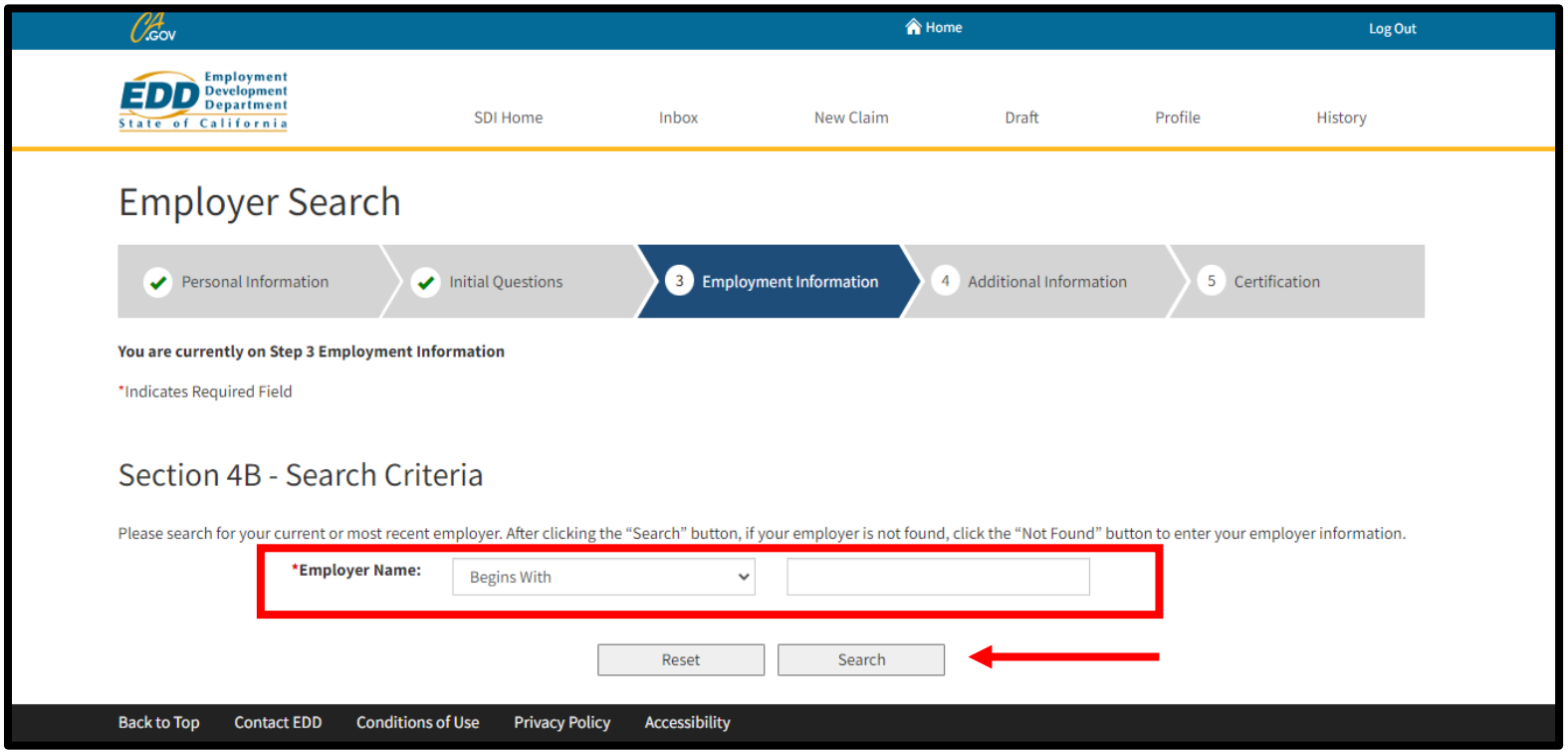
You must complete the fields marked with a red asterisk (*).

Select **Next**.



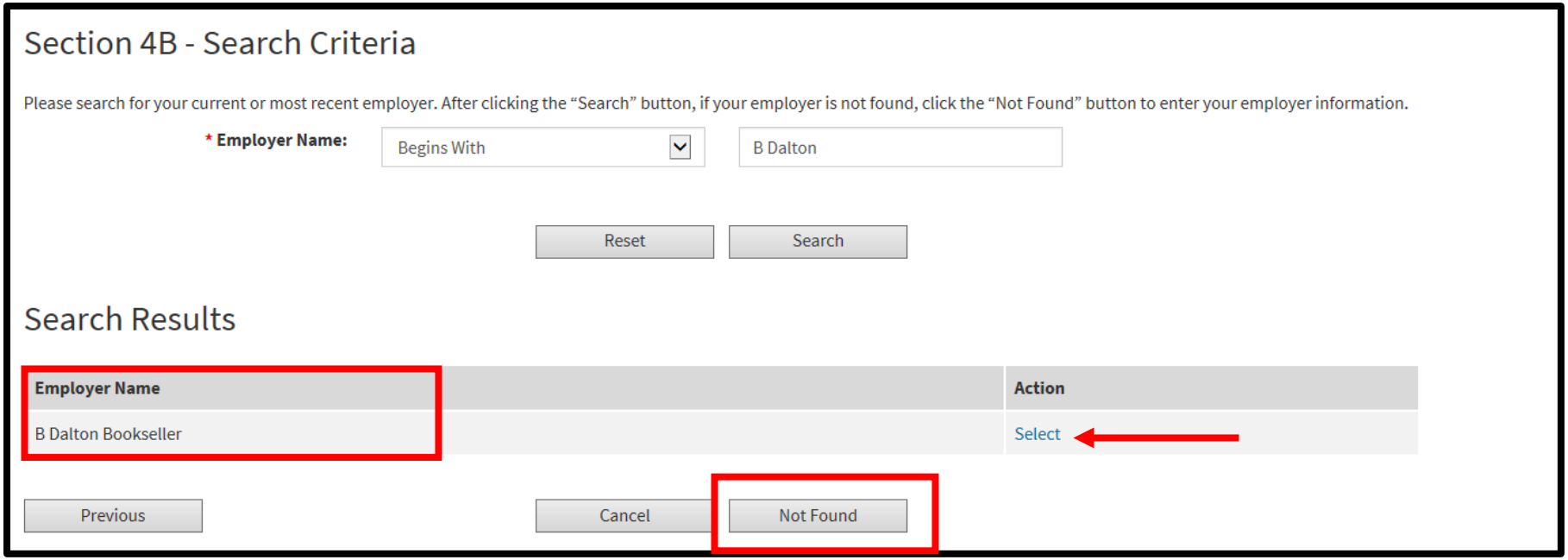
Select **Add** to enter information about your current employer.

- You must add at least one employer to continue.



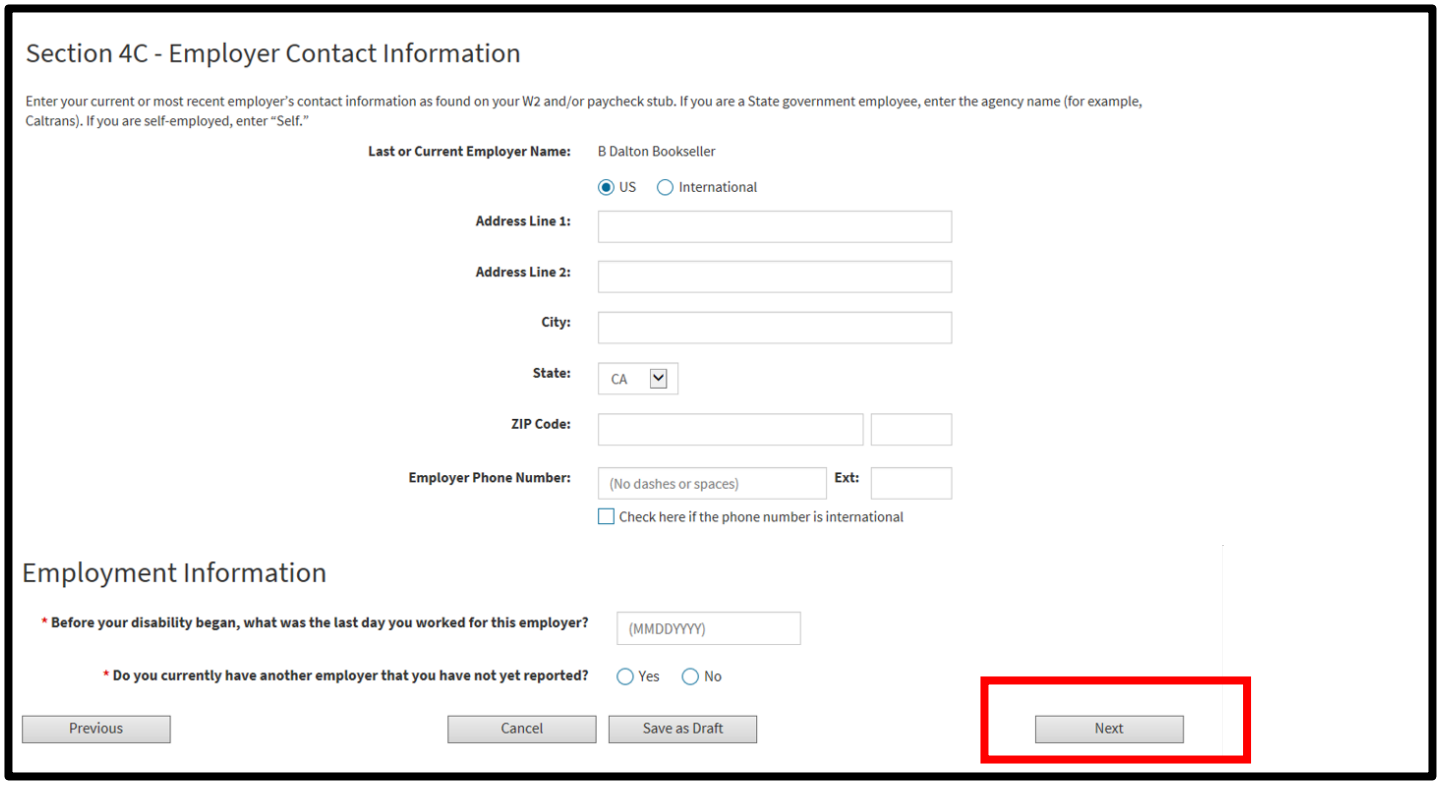
To search for your employer, select a search option. Search options include "Begins With," "Exact," and "Sounds Like."

- Enter your employer's name as shown on your W-2 or paystub.
- Select **Search** to continue.



If your employer's name populates in the Search Results table, click **Select** under the Action column.

If your employer is not listed under Search Results, select **Not Found** and skip to page 17.



If you selected your employer from the search results in Section 4B, you are asked to complete the Employer Contact Information and Employment Information sections (if you selected **Not Found** in Section 4B, skip to the next page).

- Add your current employer's business name, phone number, and mailing address as shown on your W-2 or paystub. If unsure what address to enter, ask your employer.
- If you have more than one employer, enter additional employers by selecting **Yes** to "Do you currently have another employer that you have not yet reported?"

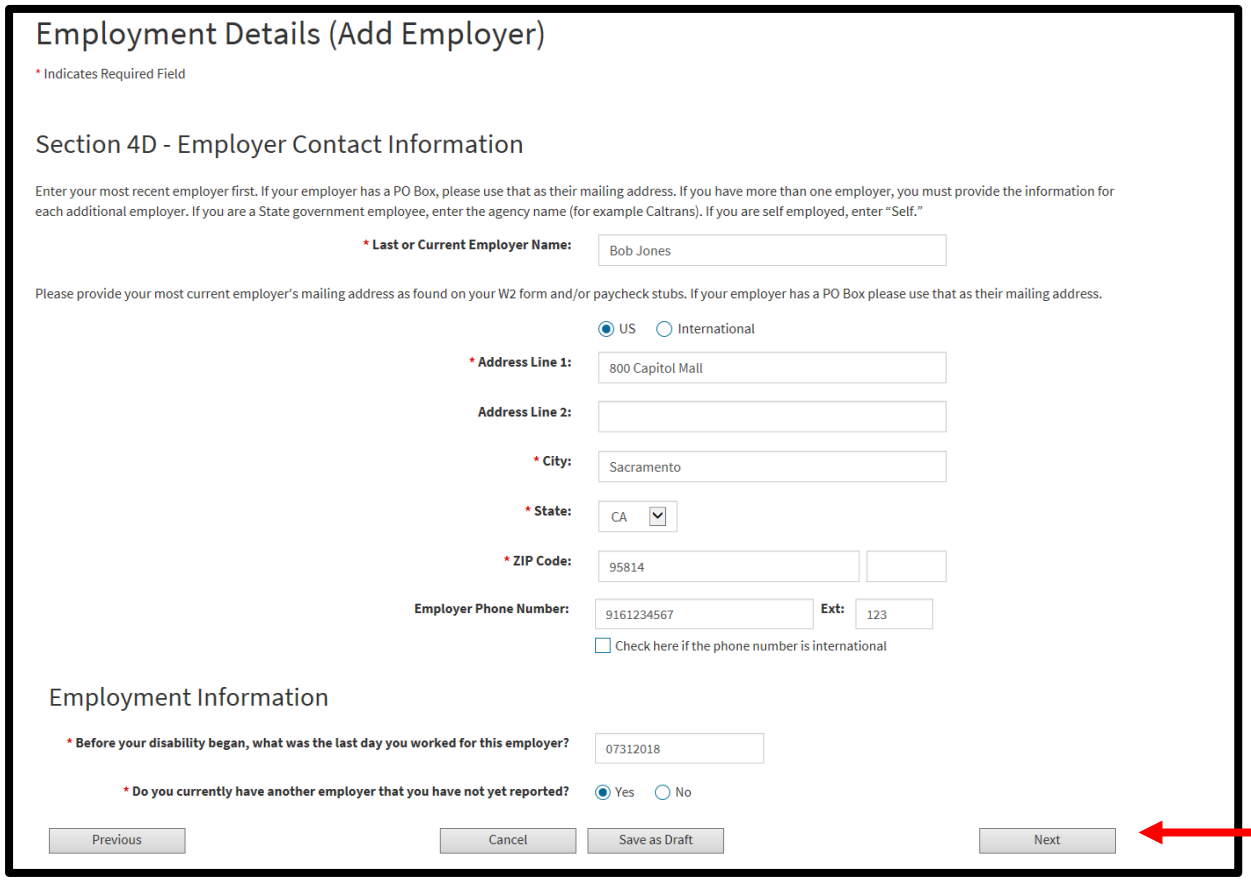
Select **Next**.

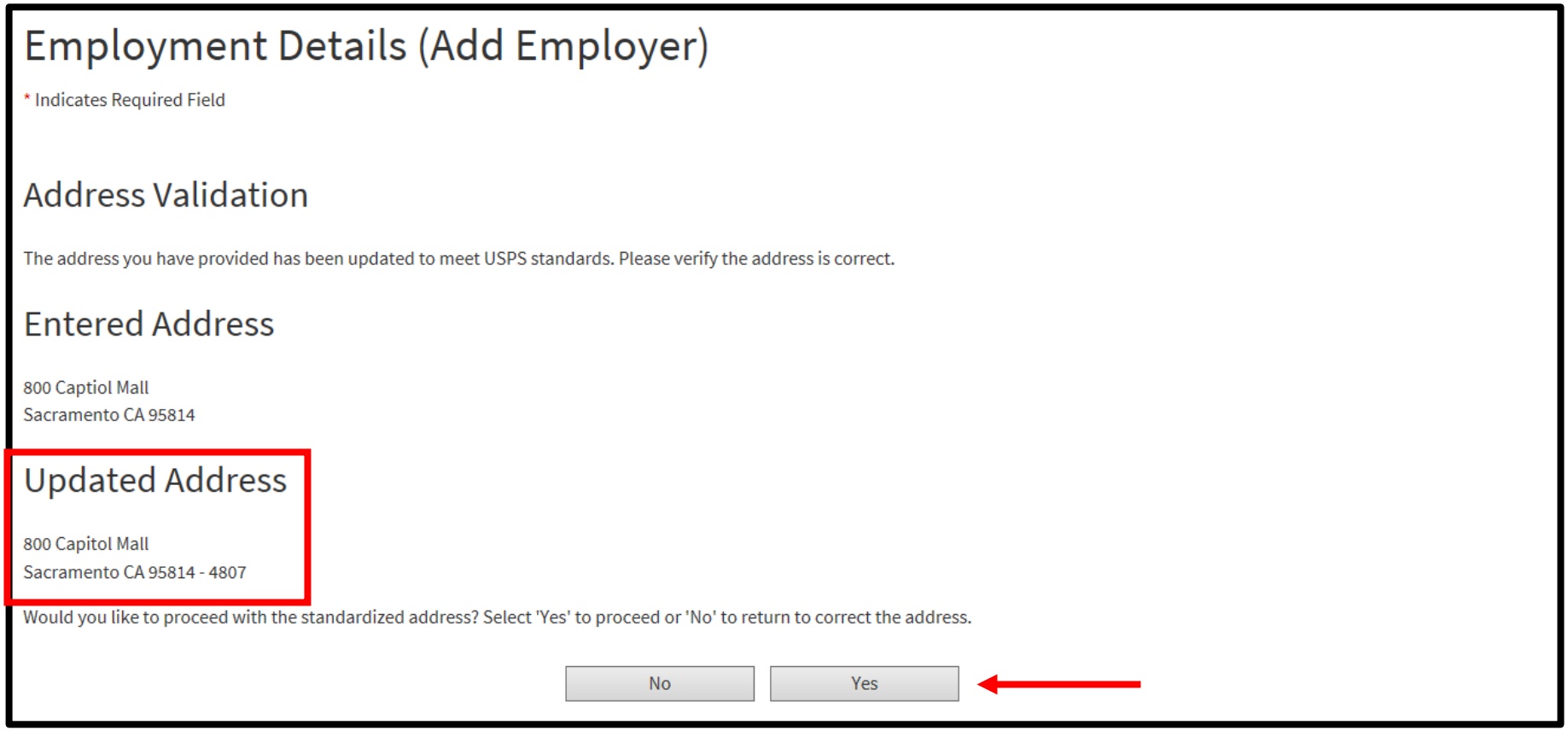
If you selected **Not Found** in Section 4B, add your current employer's business name, phone number, and mailing address as shown on your W-2 or paystub under Section 4D – Employer Contact Information. If unsure what address to enter, ask your employer.

- To enter additional employers, select **Yes** to "Do you currently have another employer that you have not yet reported?"

You must complete the fields marked with a red asterisk (*).

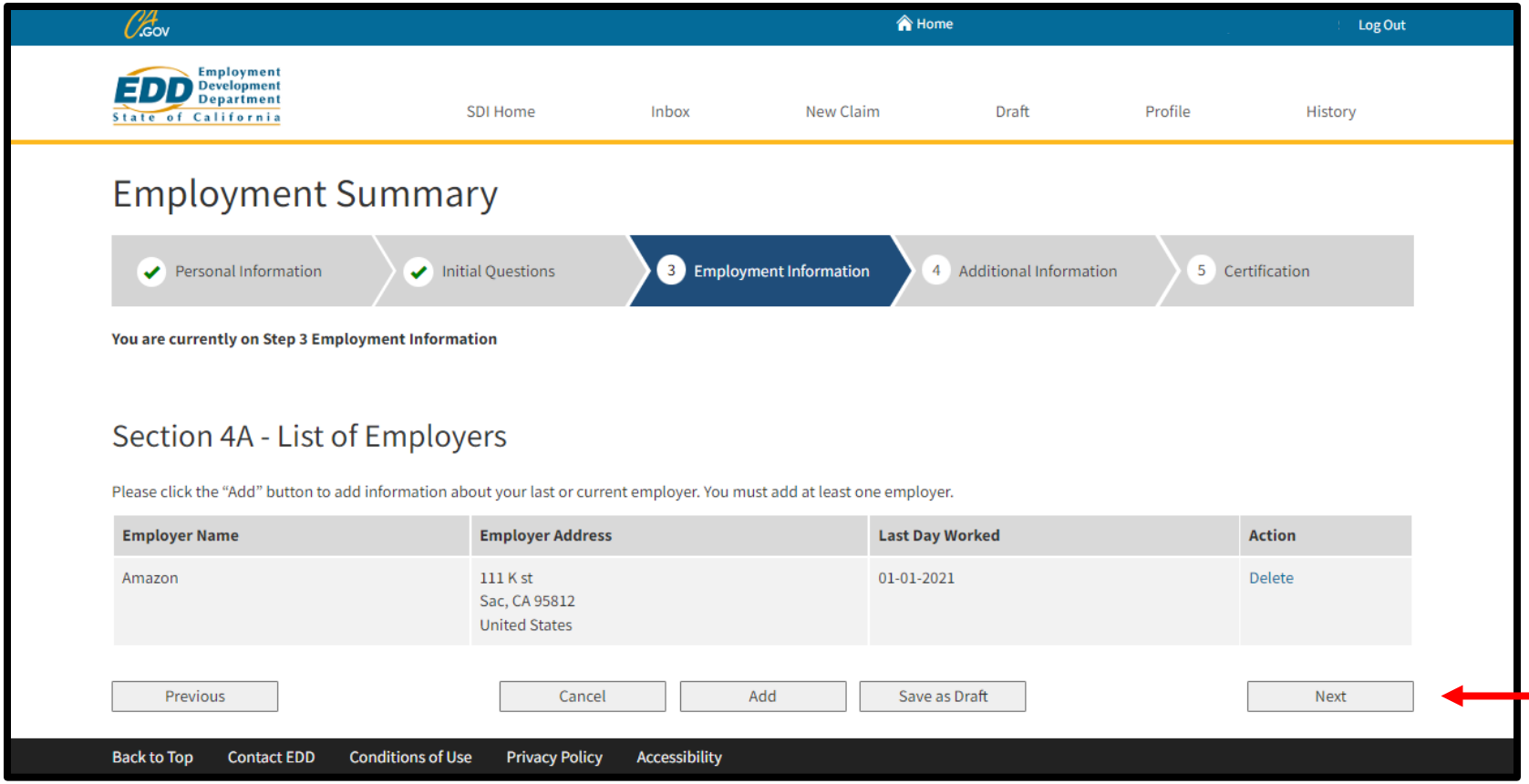
Select **Next**.





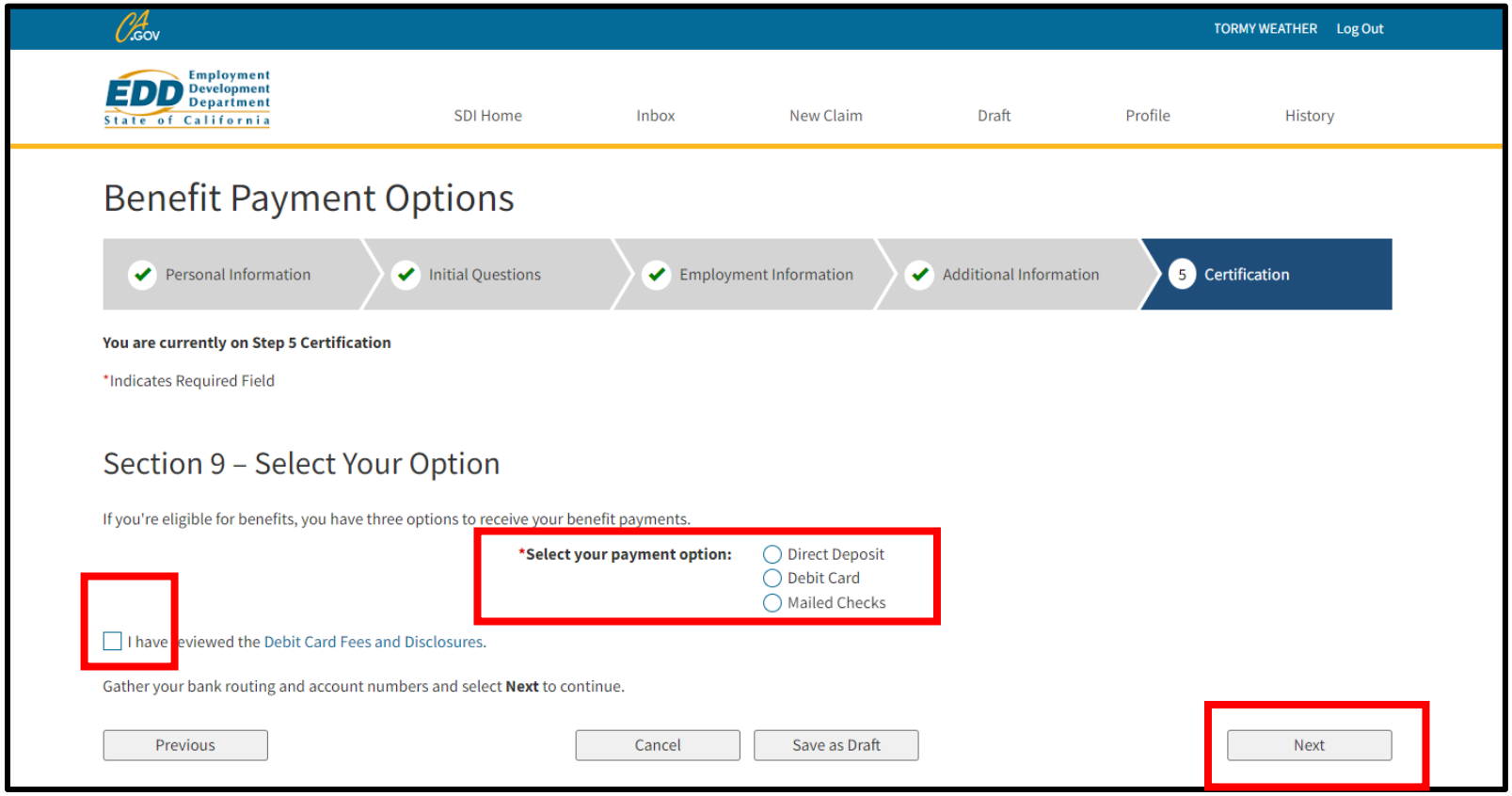
The system may adjust the employer address to follow USPS standards.

- Select **Yes** to confirm the Updated Address section is correct.
- Select **No** to go back to the previous screen and re-enter the address.



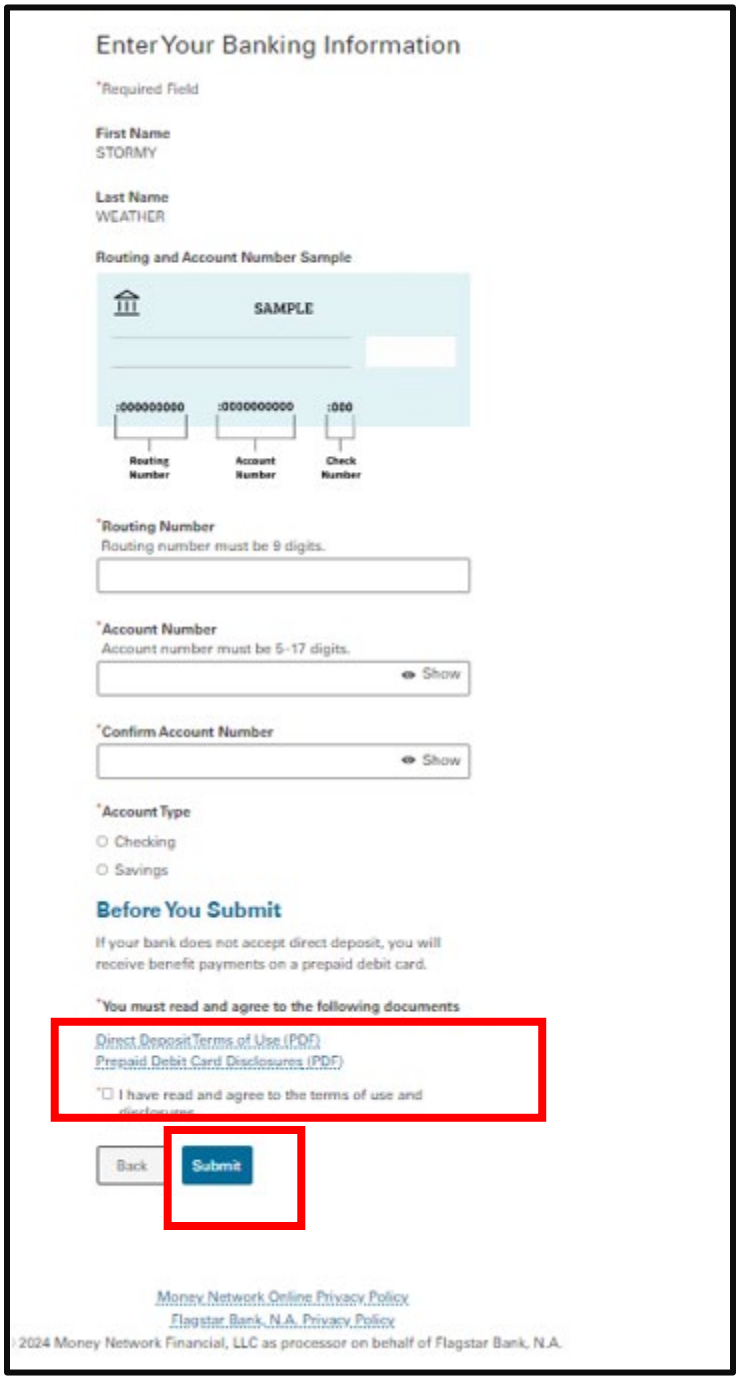
Once you add all your current employers, review the information listed under Section 4A – List of Employers.

- Select **Next** if everything is correct.
- Select **Delete** under the Action column if your employer's information is incorrect.



Complete Section 9 to choose your benefit payment option.

Select the **“I have reviewed”** box to confirm you have reviewed the disclosures, then select Next.



If you select Direct Deposit, you will be asked to provide your banking information.

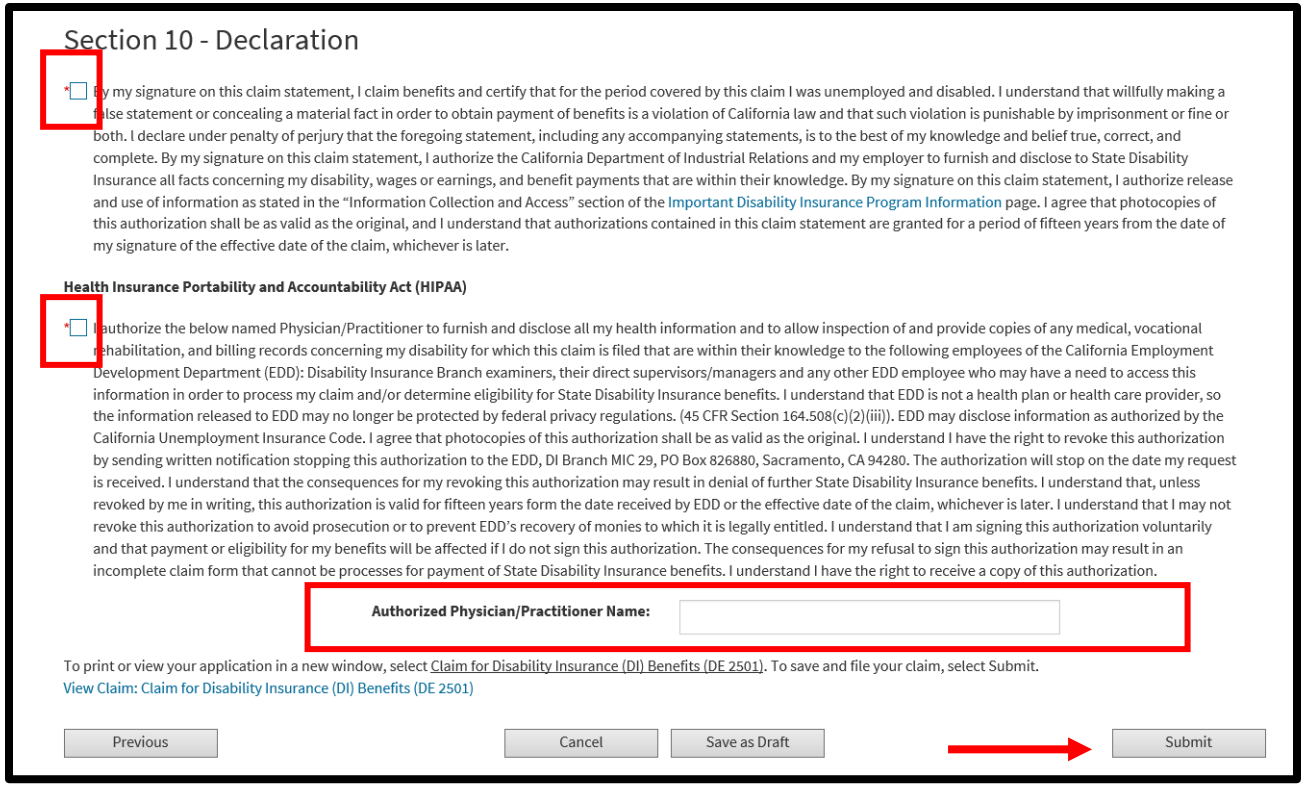
You must select and open the “terms of use” documents and disclosures before you can submit your information.

Select Submit to continue.

In Section 10 – Declaration, select both boxes to authorize an electronic signature and release of information. Both boxes must be selected to complete your claim.

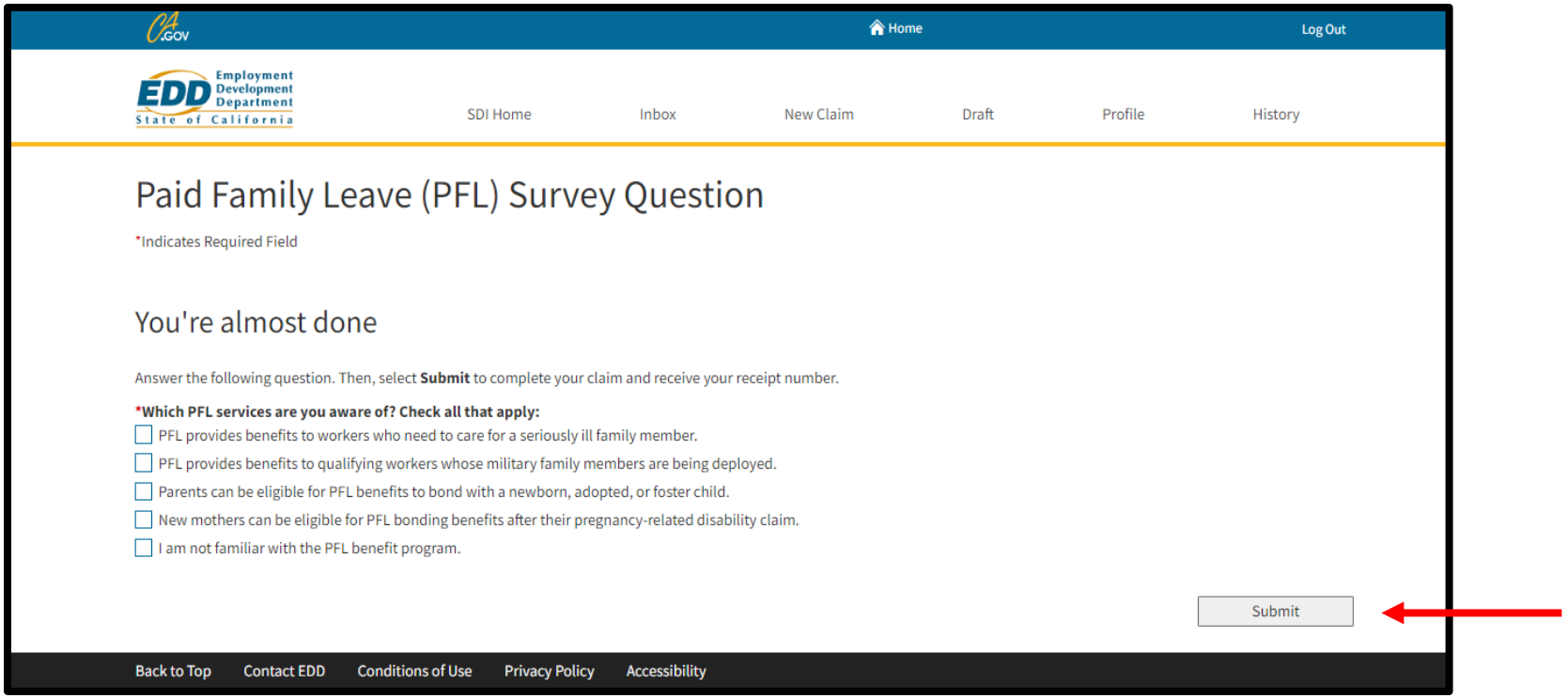
Enter the name of your licensed health professional in the Authorized Physician/Practitioner Name field.

Select **Submit** to send your claim to us.

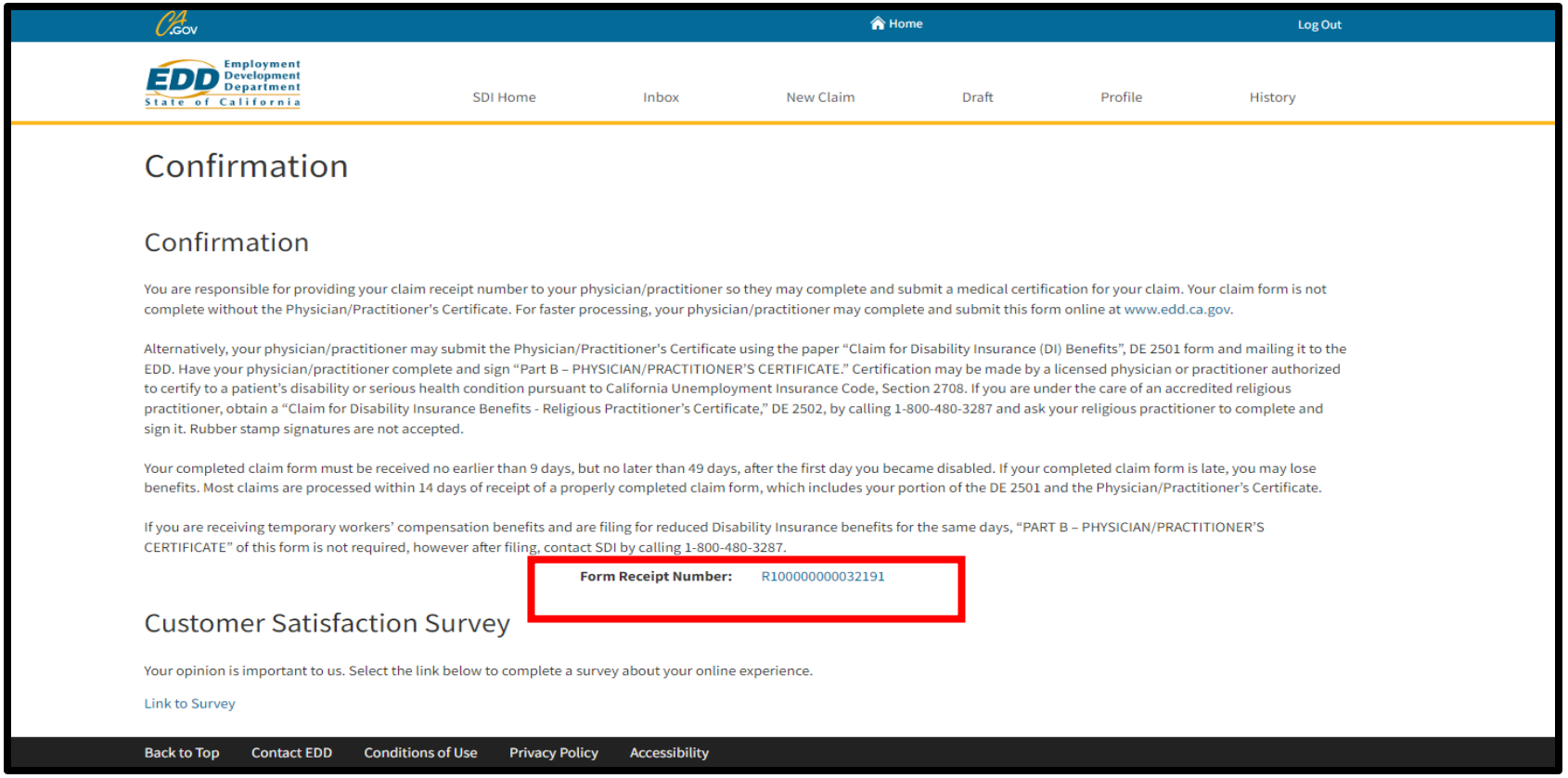


Important

You cannot modify the form after you select Submit.



Complete the survey and select **Submit**.



Your claim is assigned a **Form Receipt Number** on the confirmation screen.

Note

Save this number and give it to your licensed health professional so they can submit the medical certification.

Important

Your claim is not complete. Your licensed health professional can complete the medical certificate through SDI Online or by completing Part B of the paper *Claim for Disability Insurance (DI) Benefits* (DE 2501) form.

Employment Development Department
State of California

Complete Paper Claim Forms

Learn more about how to complete and submit a paper claim form for disability benefits.

Get Started

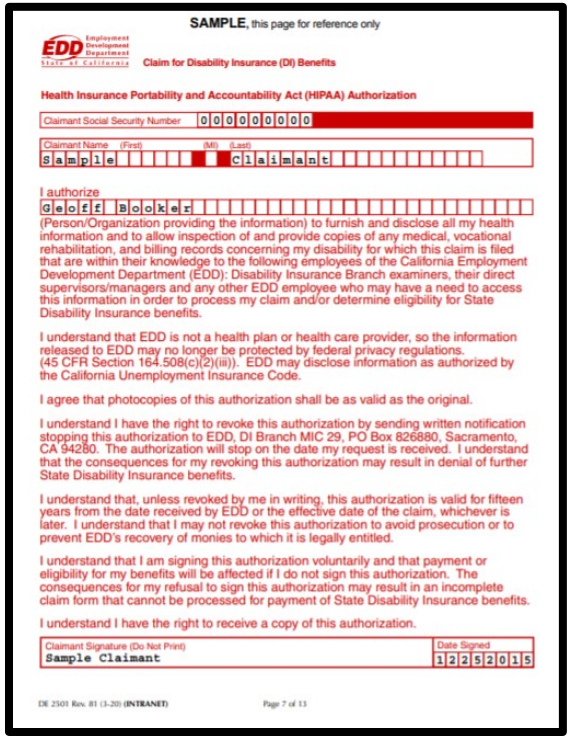
Complete the *Claim for Disability Insurance (DI) Benefits* (DE 2501) to apply for disability benefits

Your claim is considered complete when both parts of the DE 2501 form are submitted:

- Part A - Claimant's Statement (pages 1-4)
- Part B - Physician/Practitioner's Medical Certificate (pages 5-7)

Important

If you already applied online, do not file a paper claim form. It can delay benefits.



SAMPLE, this page for reference only

EDD 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.

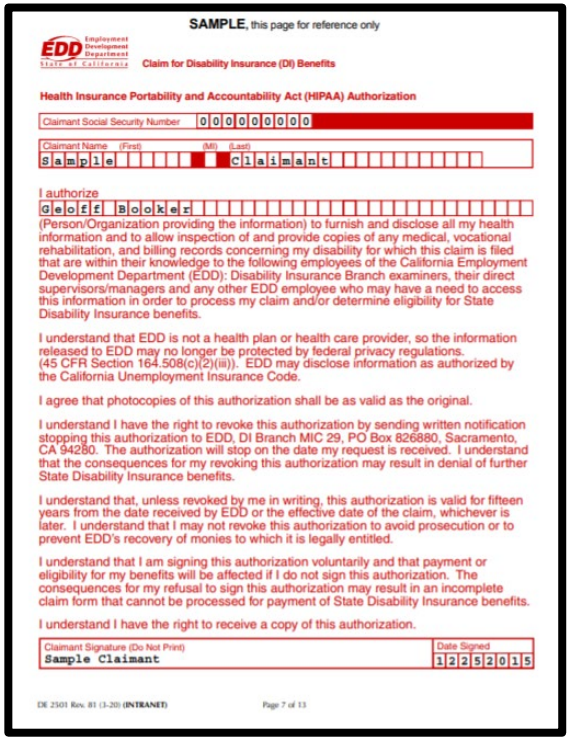
Claimant Signature (Do Not Print) Sample Claimant
Date Signed 12252015

DE 2501 Rev. 81 (3-20) (INTRANET) Page 7 of 13

SAMPLE
Claim for Disability Insurance (DI) Benefits
(DE 2501)

How to get a paper DE 2501 form

- Order a form online to have it mailed to you.
- Visit an SDI Office.
- Call 1-800-480-3287 to request a paper form be mailed to you.
- Get the form from your licensed health professional or employer.



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EDD 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 Booxer
(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.

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

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

DE 2501 Rev. 81 (3-20) (INTRANET) Page 7 of 13

SAMPLE
Claim for Disability Insurance (DI) Benefits (DE 2501)

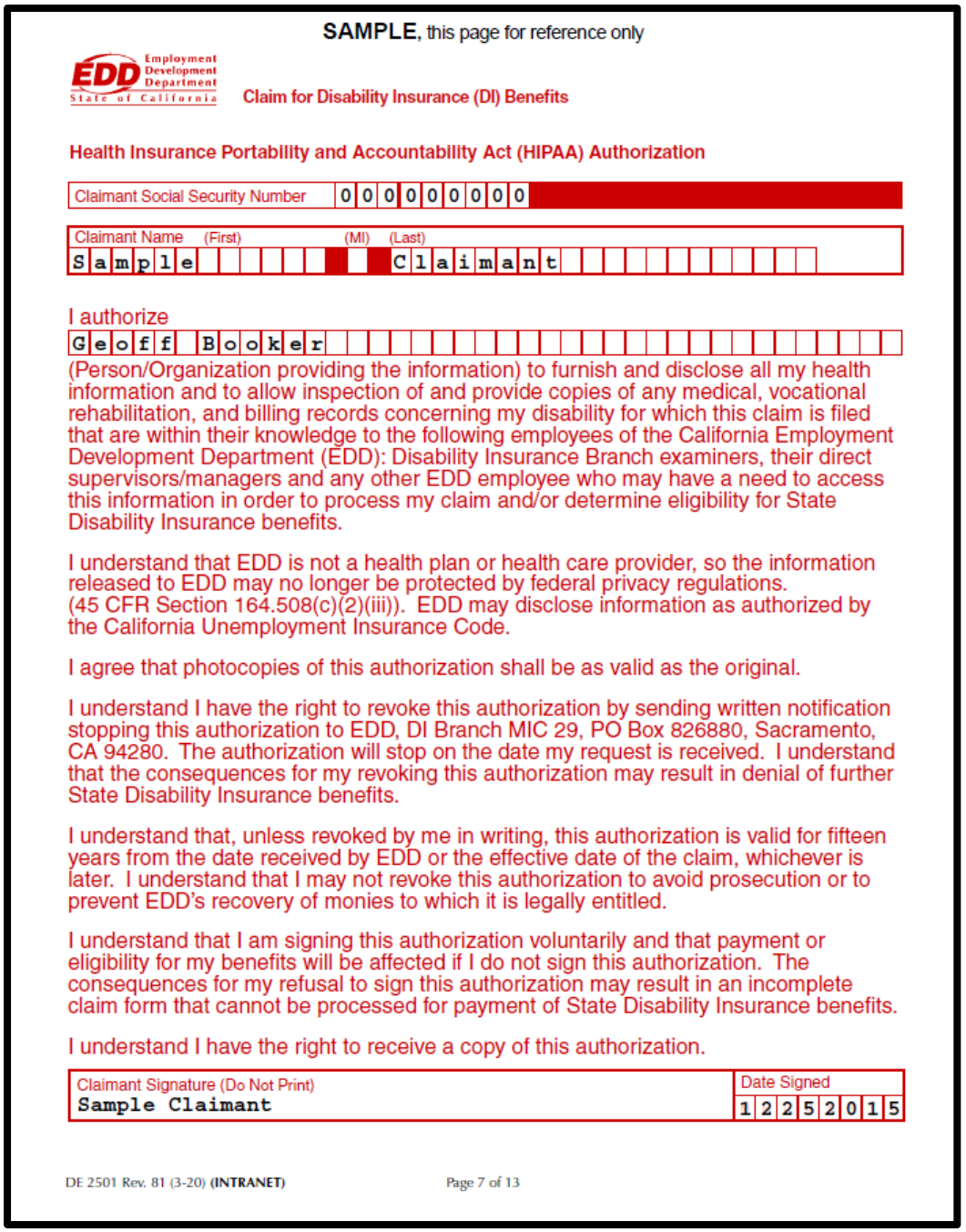
To avoid delays when completing your paper claim form

Do

- Use black ink only.
- Type or write clearly **within** the boxes provided.
- Mail the completed form in the pre-addressed envelope provided.

Don't

- Do not send photocopied or faxed forms.
- Do not mail the paper form if you already filed a claim online.



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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): Sample Claimant

Date Signed: 12252015

DE 2501 Rev. 81 (3-20) (INTRANET) Page 7 of 13

Claim for Disability Insurance (DI) Benefits (DE 2501) – Page 1

Health Insurance Portability and Accountability Act (HIPAA) Authorization form.

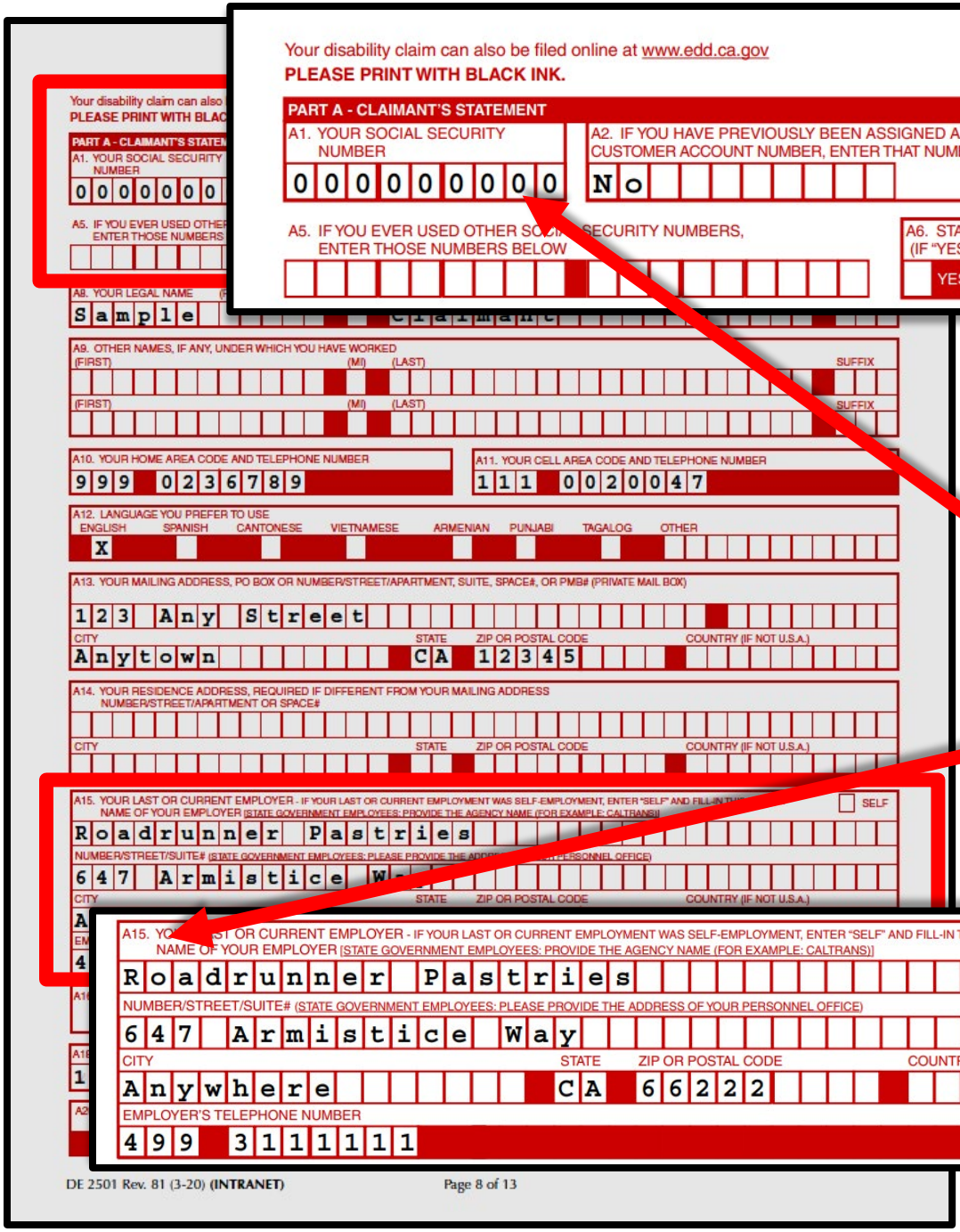
- Sign and date the HIPAA Authorization and enter the name of your licensed health professional.

You must complete all questions on pages 1-4.

Note

The application comes with important claim information, filing instructions, and debit card fee disclosures.

Review all information before completing your paper claim form.

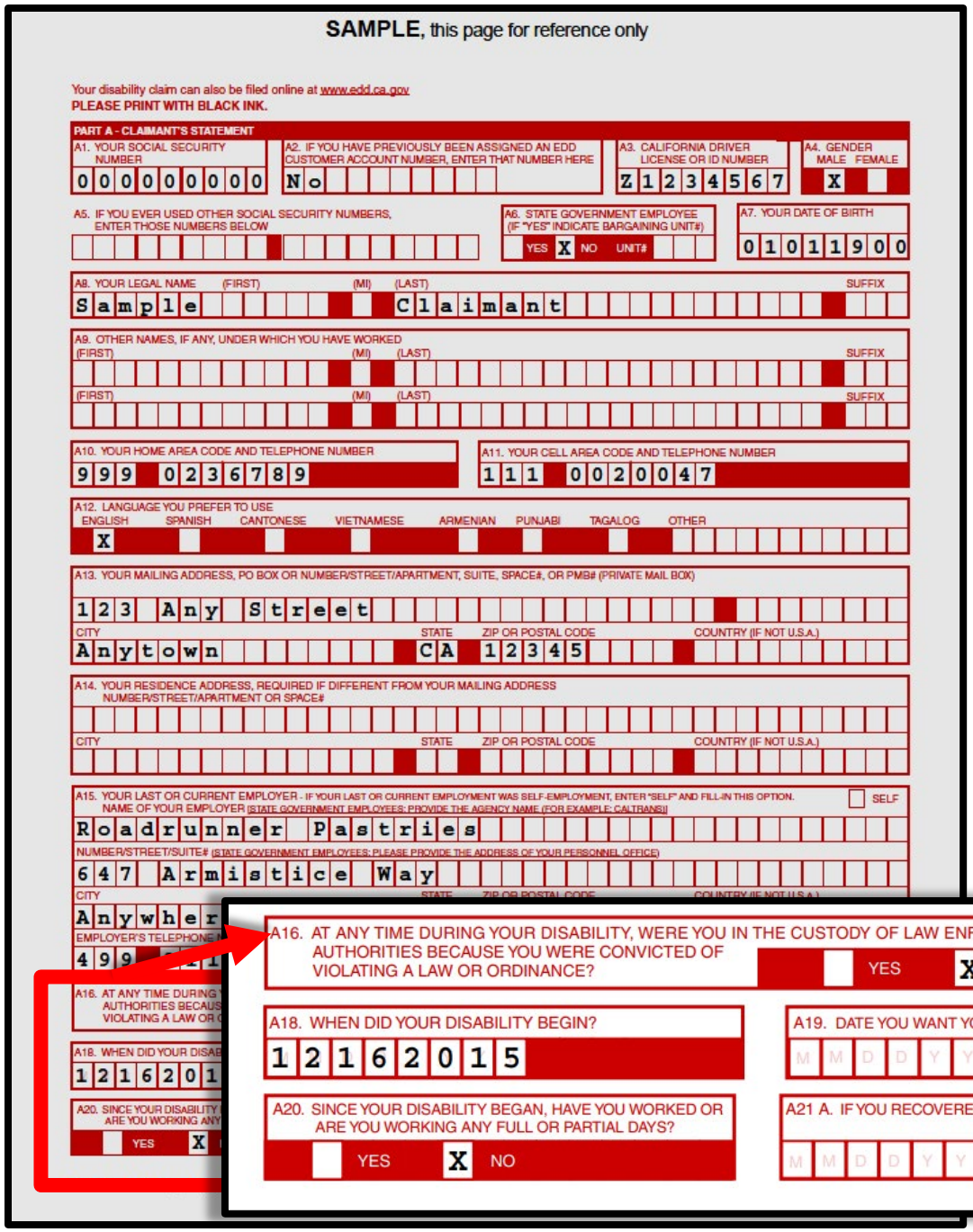


Claim for Disability Insurance (DI) Benefits (DE 2501) - Page 2

Part A - Claimant's Statement.

A1 Tip: If you **do not** have a Social Security number you may leave question A1 blank. Send proof of your wages (such as copies of your W-2s and paystubs) that cover the last 18 months with your application.

A15 Tip: Enter your employer's name and address as shown on your W-2 or paystub. If you are unsure what address to enter, ask your employer.



Claim for Disability Insurance (DI) Benefits (DE 2501) - Page 2 continued

Part A - Claimant's Statement.

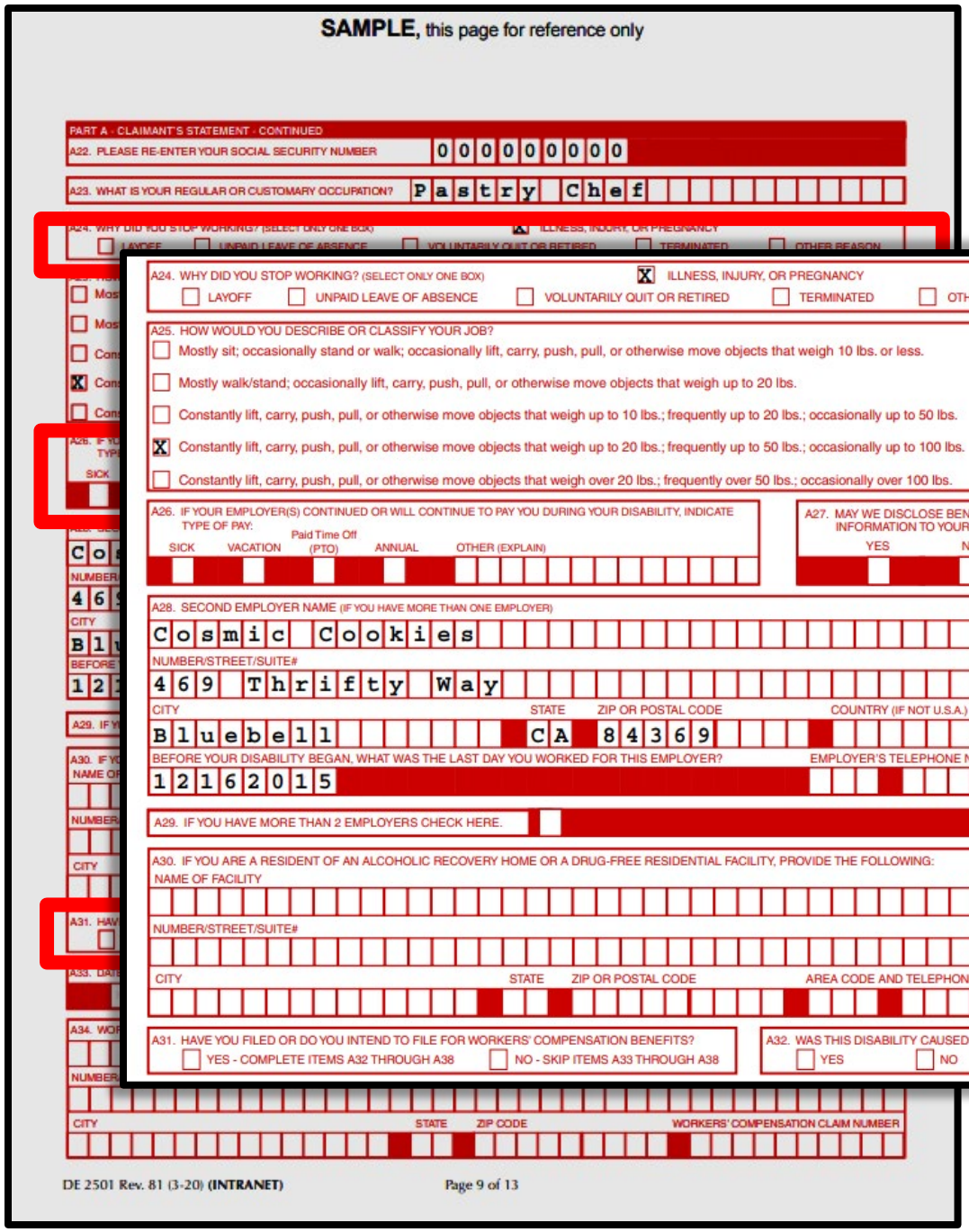
A17 Tip: Enter the last day you worked your regular schedule before your disability started.

A18 Tip: Enter the day your disability started.

A19 Tip: Leave blank if you want your claim to start the same date entered in A18. Only enter a date if you want your claim to begin on a different day. For example, your disability is work related and worker's compensation payments ended, but you are still disabled.

A20 Tip: If you are working a reduced work schedule while disabled select **Yes**.

A21 A - A21 B Tip: Only enter a recover or return to work date if you have recovered or returned to work. **Do not** enter future dates.



Claim for Disability Insurance (DI) Benefits (DE 2501) - Page 3

Part A - Claimant's Statement (continued).

A24 Tip: Tell us why you stopped working. If it was because of your disability, select **illness, injury, or pregnancy**. If you left work for reasons other than your disability, select the appropriate box.

A26 Tip: If your employer continues to pay you while getting disability benefits, select the type of pay. If your employer will supplement benefits with your paid leave, select **other** and write in "**integrate**." If not, select the appropriate box.

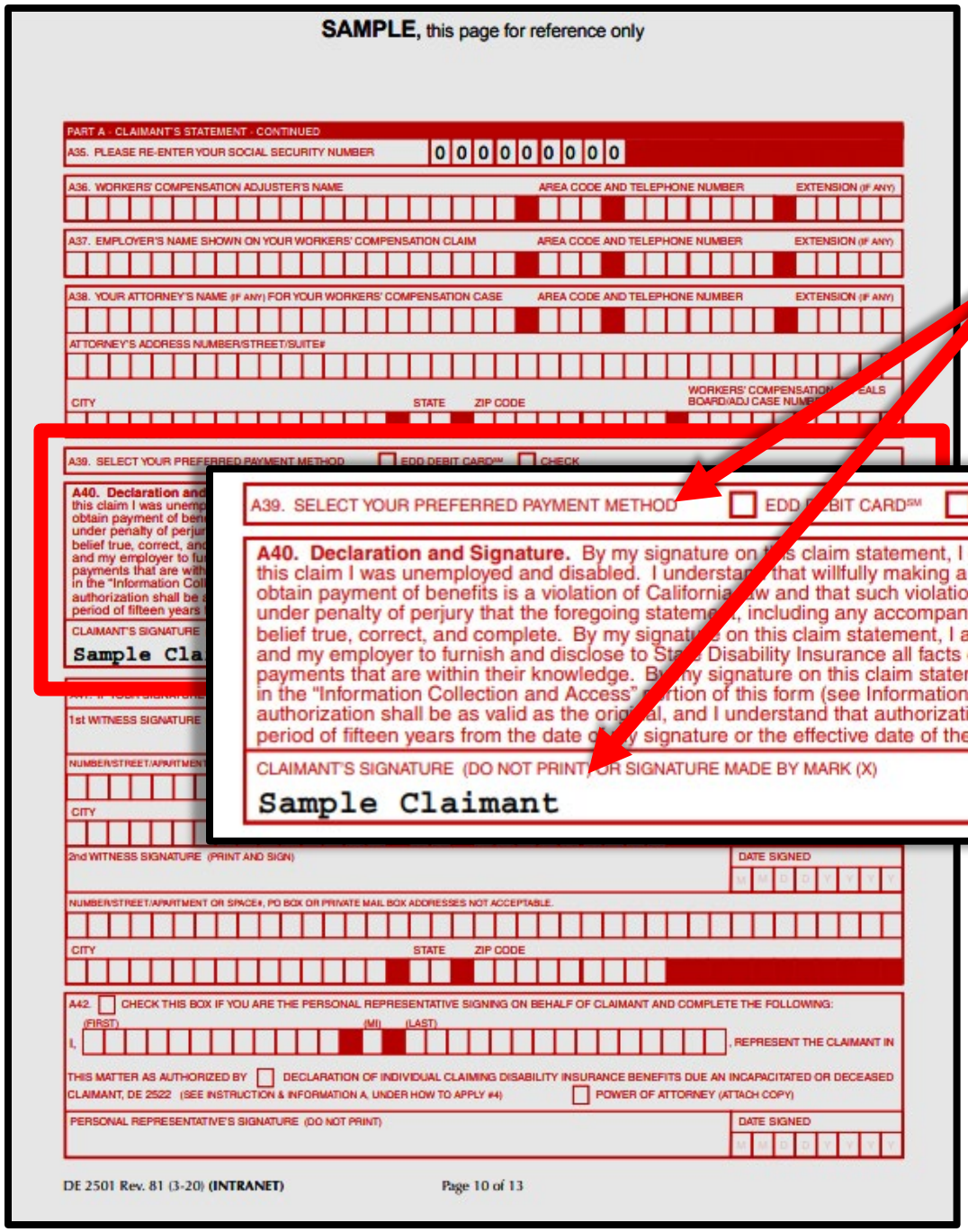
A27 Tip: If your employer supplements benefits with your paid leave, they can only get payment information from us if you select **Yes.** We will not release confidential claim information.

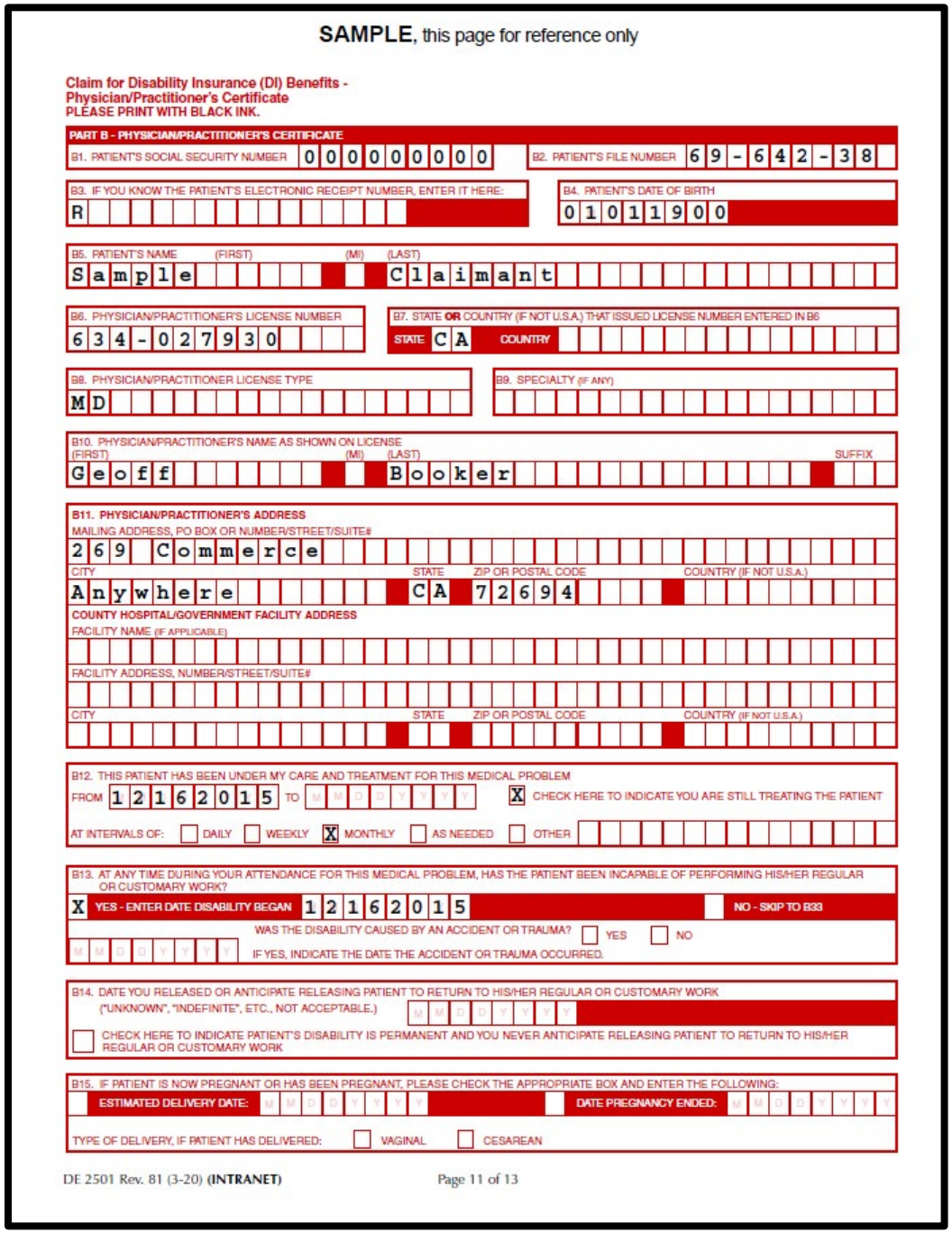
A31 – A 32 Tip: Do not forget to answer both questions. If the disability is not work related, select **No** to both.

Claim for Disability Insurance (DI) Benefits (DE 2501) - Page 4

Part A - Claimant's Statement (continued).

A39 – A40 Tip: Make sure to select how you want to get payment and sign the form. We cannot process your claim without a signature.





SAMPLE, this page for reference only

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 [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
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.)
[ ] 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: [ ] DATE PREGNANCY ENDED:
TYPE OF DELIVERY, IF PATIENT HAS DELIVERED: [ ] VAGINAL [ ] CESAREAN

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Claim for Disability Insurance (DI) Benefits (DE 2501) – Pages 5-7

Part B - Physician/Practitioner's Certificate.

Your licensed health professional must complete all relevant information including treatment dates, diagnosis, and medical codes. The licensed health professional must also sign the form.

- **If you complete your portion online,** enter the Receipt Number provided on the Confirmation screen in question B3 and give the form to your doctor.
- **If your doctor will complete their portion online,** send your claim form to us first and allow 5 business days for mailing. Then, contact your doctor and they can complete their medical certificate through SDI Online.

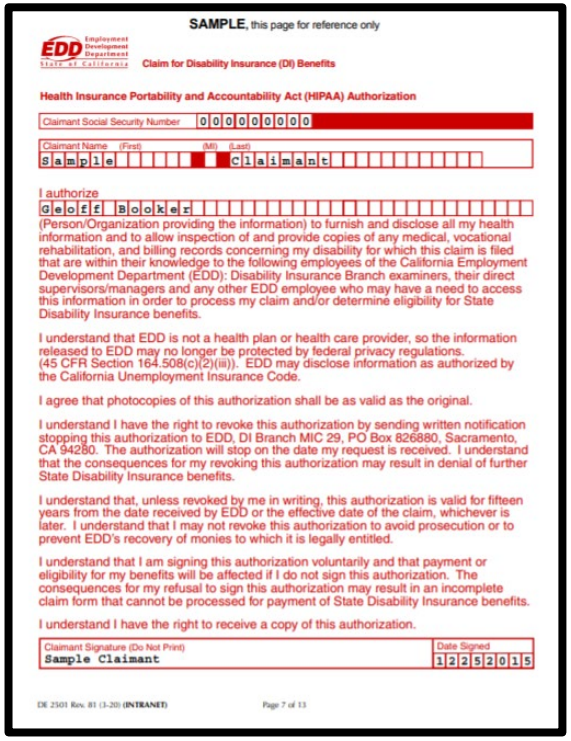
Mail in your completed claim form

Use the pre-addressed envelope to mail to:

State of California
Employment Development Department
PO Box 989777
West Sacramento, CA 95798-9777

Do not submit the same claim more than once. This can delay your benefits.

Allow at least 14 days for processing once we get Part A and Part B of the DE 2501 form.



SAMPLE, this page for reference only

EDD 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): Sample Claimant

Date Signed: 12252015

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SAMPLE
Claim for Disability Insurance (DI) Benefits
(DE 2501)

CONTACT US

1-800-480-3287

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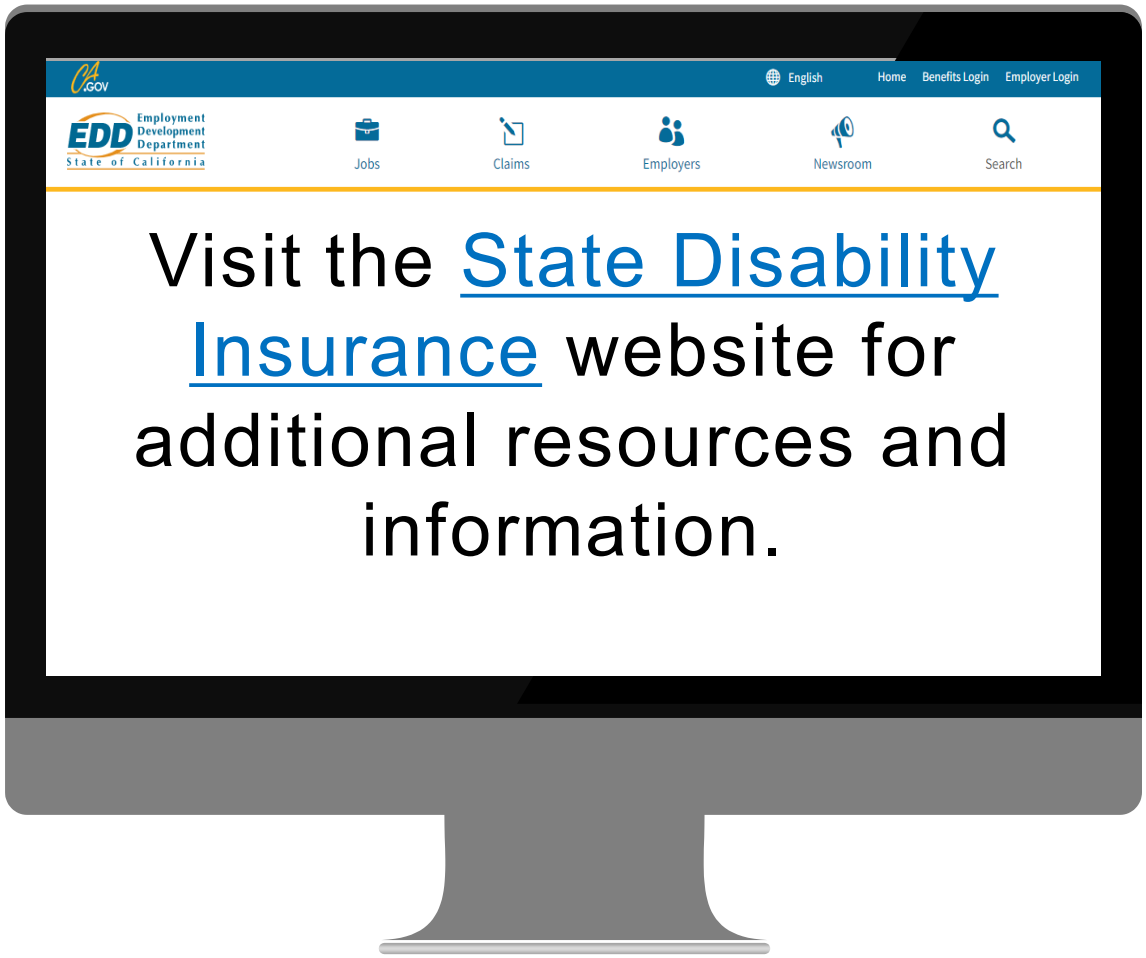

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and alternate formats need to be made by calling 1-866-490-8879 (voice), or through the California Relay Service at 711.