

SDI ONLINE TUTORIAL File a Disability Claim

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File a Disability Insurance Claim

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



Get Started

	☆ =	Note For Spanish, select Español.
<text><text></text></text>	Log In Password Password? Log In Don't have an account? Create Account	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.
Contact EDD Conditions of Use Privacy Policy Accessibility Copyright © 2023 State of California		

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

- 1. Visit <u>myEDD</u>.
- 2. Enter the email and password used to create you myEDD account.
- 3. Select Log In.

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Car		
EDDNext		
Es	spañol	
v	Verify Your Identity	
Тс	o protect your account, we will email	
ус	ou a verification code.	
	Send Email	
Contact EDD Conditions of Use Privacy Policy A	Accessibility	
Copyright © 2023 State of California		

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.

Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History	
Home							
Message Center							
Check the message center Inbox below to Inbox [New: 0 , Total: 0]	review messages and take req	uired actions as needed	L				
Personal Information							
Full Name	John Doe		EDD Customer	Account Numbe	123456789		
Mailing Addres:	123 Main St Sacramento, CA 95	814		Phone Numbe	916-555-1212		
Residence Addres	123 Main St Sacramento, CA 95	814	Cel	l Phone Numbe	916-555-1213		
E-mail Addres	Jdoe@gmail.com						
Current Disability Insur	rance Claim(s)						
No Results Found							
Pending Disability Insu	rance Claim App	olication(s)					
No Results Found							
Submitted Paid Family	Leave Claim Fo	rms					
Only forms you submitted online are listed b Leave claim is currently not available online.	elow. To submit an electronic o . For assistance with a Paid Fan	document for a previousl nily Leave claim, call 1-87	y submitted care or bon 7-238-4373.	ding claim, select	New Claim. The status of your Pa	aid Family	_
No Results Found							^

Select New Claim from the main menu.

04						
Cov Employment Development			A Hor	me		Log Out
State of California	SDI Home	Inbox	New Claim	Draft	Profile	History
Apply for Benef	its or Continu	e a Draft /	Application			
Select a link below to apply for Disab (DE 2501F), do not submit a duplicat claim.	ility Insurance or Paid Family Lea e form. It may take up to 14 days f	ve benefits. If you hav or your Initial Claim fo	e already submitted a <i>Claim</i> orm to be reviewed and proc	for Disability Insuran essed. Submitting du	<i>ce</i> (DE 2501) or a <i>Claim</i> plicate forms may dela	<i>for Paid Family Leave</i> y the processing of your
Note: It may be necessary to send so	me documents via US Postal Serv	ice.				
Apply for Disability	Insurance Benefi	ts				
Disability Insurance						
Apply for Paid Fam	ily Leave Benefits					
Paid Family Leave Bonding Submit Electronic Paid Family Leave Paid Family Leave Care Submit Electronic Paid Family Leave Paid Family Leave Military Assist Submit Electronic Paid Family Leave	Bonding Attachment Care Attachment Military Assist Attachment					
Saved Drafts						
To open and complete a form that yo a draft immediately, select the check	u saved, select the Form Name . box and then select the Delete bo	Saved drafts are store utton.	d for a limited number of day	ys and will be automa	tically deleted on the d	ate indicated. To delete
No Results Found						
						Delete
Back to Top Contact EDD Co	onditions of Use Privacy Polic	y Accessibility				
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.

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Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History	
Disability Insura	ance Claim Fil	ing Instruc	tions				
		0					
Before You Start an	d After You File						
Please have the following information	available while completing this	form:		(
 Most current employer(s) busin Last date you worked your regu 	ess name, telephone number, ar lar or customary duties and hou	rd mailing address as stat irs.	ted on your W2 form and	/or paycheck stub.			
 Date you began working at less Wages you received or expect to 	than full duty or modified duty. > receive from your employer: sid	ck leave, paid time off (PT	O), vacation pay, annual	leave, and wages ear	ned after you stopped w	orking.	
 Workers' Compensation claim i The name, address, and telephone 	nformation, if applicable. one number, if any, of the Alcohc	olic Recovery Home or Dru	ug-Free Facility where yo	u are currently receivi	ing in-patient treatment		
You are responsible for obtaining 30 days. Please note that your e	ig a Physician/Practitioner Certif	fication for your disability	. Your claim will be retur	ned if the Physician/P	ractitioner Certification	is not received within	
employer.	inproyer will be notified that you	a nave submitted a Di cla	in nowever, your detain		s connuclinational with	oc be shared with your	
		Car	icel			Next	

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

Select Next to continue.



Employment Development Department State of California	SDI Home	Inbox New Claim	Draft	Profile	History	The system auto
Personal Informatio	on	Employment				fills certain field application.
1 Personal Information 2 You are currently on Step 1 Personal Inform	2 Initial Questions Nation	³ Information	4 Additional Inform	nation 5 Certificat	tion	Verify the inform
Section 1 - Personal In Social Security Number: Legal Name:	formation XXX-XX-XXXX John Doe	EDD Custon California Driver L	ner Account Number: icense or ID Number:	1234567890 X1234567		any open fields 2, as appropriat
Date of Birth: Preferred Language: Mailing Address:	01-01-XXXX English 123 Main St Sacramento, CA 95814		Gender: Residence Address:	Male 123 Main St Sacramento, CA 95814		If your personal information has
Home Phone Number: Section 2 - Other Names	s and Social Secu	irity Numbers Used	Cell Phone Number:	555-123-4567		select Save as l update your SDI profile.
Please enter any other names or other Social S section blank. First Name:	Security Numbers under which y	ou have worked. It you have never work	ed under another name Middle Initial:	or Social Security Number ple	ease leave this	Select Next to n
Last Name: Social Security Number:			Suffix:			the next step.
First Name:			Middle Initial:			
Last Name:			Suffix:			
Social Security Number:			_			
Previous		Cancel Save as Draft			Next	<
Not	е					
Select Save a return to the p	as Draft at previous s	t any time to creen. Do n o	comple ot use y	ete the for your brow	m later sers "b	. Select Previous to ack" button.

tem automatically ain fields of the ion.

e information in 1 and complete n fields in Section propriate.

personal tion has changed, ave as Draft and your SDI Online

lext to move to step.

Employment Development Department	SDI Home	Inbox	New Claim	Draft	Profile	History
Section 3 - Empl	oyment Informatior	ı				
	*Ar	e you self employed?	🔿 Yes 🔵 No			
	*Are you a State Go	vernment employee?	Yes No			
	If "Yes," indicate Barg	gaining Unit Number:				
*At any time during yo authorities b	ur disability, were you in the custod ecause you were convicted of violati	y of law enforcement ing law or ordinance?	🔾 Yes 🔵 No			
*Before	your disability began, what was the	last day you worked?	(MMDDYYYY)			
	tWhen did y	our disability bogin?				
	-when did y	your disability begin:	(MMDDYYYY)			
Date you want your Disabilit	ty Insurance claim to begin if differe	nt than the date your disability began:	(MMDDYYYY)			
*Since your disability bega	n, have you worked or are you work	ing any full or partial days?	🔵 Yes 🔵 No			
		Have you recovered?	🔿 Yes 🔵 No			
		If "Yes," enter date:	(MMDDYYYY)			
	*Have y	ou returned to work?	🔿 Yes 🔵 No			
		If "Yes," enter date:	(MMDDYYYY)			
	*What is your regular or cu	stomary occupation?				
	*Why d	id you stop working?	Select	~		
 How would you describe or cl. Mostly sitting; occasionally si Walking/standing most of the Constantly lift, carry, push, p Constantly lift, carry, push, p Constantly lift, carry, push, p 	assify your job? tanding and walking; occasionally lift, e time; occasionally lift, carry, push, pu ull or otherwise move objects that wei ull or otherwise move objects that wei ull or otherwise move objects that wei	carry, push, pull or othe ill or otherwise move of gh up to 10 lbs.; frequer gh up to 20 lbs.; frequer gh up to 20 lbs.; frequer	rwise move objects that we ojects that weigh up to 20 lbs ttly up to 20 lbs.; occasional ttly up to 50 lbs.; occasional ttly over 50 lbs.; occasional	igh 10 lbs. or less s. ly up to 50 lbs. ly up to 100 lbs. y over 100 lbs.		
*Has or will your em	nployer continue to pay you during y	our disability leave?	🔿 Yes 🔵 No			
	lf "Yes," ind	iicate type(s) of pay:	Sick Vacation Paid Time Off Annual Leave Other Type of Pay			
		Other Type of Pay:				
*May we dis	close benefit payment information t	o your employer(s)?	🔿 Yes 🔵 No			
*Have you filed or de	o you intend to file for Workers' Com	pensation benefits?	🔿 Yes 🔵 No			
	*Was this disability	caused by your job?	🔿 Yes 🔵 No			
*Are you a re	sident of an alcohol recovery home o	or drug-free facility?	🔿 Yes 🔵 No			
Previous		Cancel	Save as Draft			Next

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.

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Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History	
Employment Su	mmary						
Personal Information	Initial Questions	3 Employme	nt Information	Additional Informatio	on 5 Certi	ification	
You are currently on Step 3 Employn	nent Information						
Section 4A - List of E	mployers						
Please click the "Add" button to add in	formation about your last or curren	t employer. You must	add at least one employe	er.			
No Results Found							
Previous	Cancel	Ado	d Save a	s Draft	[Next	
Back to Top Contact EDD Con	ditions of Use Privacy Policy	Accessibility					

Select Add to enter information about your current employer.

• You must add at least one employer to continue.

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EDD Employn Developi Departm State of Califor	nent nent n i a	SDI Home	Inbox	New Claim	Draft	Profile	History
Employe	er Search						
Personal In	formation	Initial Questions	3 Employment	Information 4	Additional Information	5 Certificati	on
You are currently o	n Step 3 Employment Info	mation					
*Indicates Required	Field						
Section 4B	- Search Crite	ria					
Please search for you	ur current or most recent en	ployer. After clicking the "S	Search" button, if your e	mployer is not found, c	lick the "Not Found" butto	on to enter your employ	er information.
	*Employer Name:	Begins With	~				
			Reset	Search		-	
Back to Top Cor	ntact EDD Conditions of	Use Privacy Policy	Accessibility				

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.

Section 4B - Search Criteria								
Please search for your current or most recent employer. After clicking the "Search" button, if your employer is not found, click the "Not Found" button to enter your employer information.								
* Employer Name:	Begins With	~	B Dalton					
	[Reset	Search					
Search Results								
Employer Name				Actio	1			
B Dalton Bookseller				Select	·			
Previous	[Cancel	Not Found					

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.

Section 4C - Employer Contact Information						
Enter your current or most recent employer's contact information as found on your W2 and/or paycheck stub. If you are a State government employee, enter the agency name (for example, Caltrans). If you are self-employed, enter "Self."						
Last or Current Employer Name:	B Dalton Bookseller					
	US International					
Address Line 1:						
Address Line 2:						
City:						
State:	CA 🗹					
ZIP Code:						
Employer Phone Number:	(No dashes or spaces) Ext:					
	Check here if the phone number is international					
Employment Information						
* Before your disability began, what was the last day you worked for this employer:	(MMDDYYYY)					
* Do you currently have another employer that you have not yet reported	Yes No					
Previous Cancel	Save as Draft Next					

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.

Employment Details (Add Employer)				
* Indicates Required Field				
Section 4D - Employer Contact Information				
Enter your most recent employer first. If your employer has a PO Box, please use that as their me each additional employer. If you are a State government employee, enter the agency name (for	ailing address. If you have more than e example Caltrans). If you are self emp	one emp loyed, e	oloyer, you mu: nter "Self."	st provide the information for
* Last or Current Employer Name:	Bob Jones			
Please provide your most current employer's mailing address as found on your W2 form and/or	paycheck stubs. If your employer has	a PO Bo	x please use th	at as their mailing address.
	● US ◯ International			
* Address Line 1:	800 Capitol Mall			
Address Line 2:				
* Citv:	C			
	Sacramento			
* State:	CA 💌			
* ZIP Code:	95814			
Employer Phone Number:	9161234567	Ext:	123	
	Check here if the phone number is	internat	ional	
Employment Information				
* Before your disability began, what was the last day you worked for this employer?	07312018			
* Do you currently have another employer that you have not yet reported?	● Yes ○ No			
Previous Cancel	Save as Draft			Next

Employment Details (Add Employer)

* Indicates Required Field

Address Validation

The address you have provided has been updated to meet USPS standards. Please verify the address is correct.

Entered Address

800 Captiol Mall Sacramento CA 95814

Updated Address

800 Capitol Mall Sacramento CA 95814 - 4807

Would you like to proceed with the standardized address? Select 'Yes' to proceed or 'No' to return to correct the address.



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.

			<u>ሰ</u> ዘ	ome		Log Out	
Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History	
Employment Su	immary						
Personal Information	Initial Questions	3 Employme	ent Information	4 Additional Information	on 5 C	ertification	
You are currently on Step 3 Employr	nent Information						
Section 4A - List of E Please click the "Add" button to add in	Employers	nt employer. You mus	t add at least one emplo	yer.			
Section 4A - List of E Please click the "Add" button to add ir Employer Name	Employers nformation about your last or curren Employer Address	nt employer. You mus	t add at least one emplo	yer. ay Worked		Action	
Section 4A - List of E Please click the "Add" button to add in Employer Name Amazon	Employers formation about your last or current Employer Address 111 K st Sac, CA 95812 United States	nt employer. You mus	t add at least one emplo Last Di 01-01-2	yer. ay Worked 1021		Action Delete	
Section 4A - List of E Please click the "Add" button to add in Employer Name Amazon	Employers nformation about your last or current Employer Address 111 K st Sac, CA 95812 United States	nt employer. You mus	t add at least one emplo Last Da 01-01-2	yer. ay Worked 2021		Action Delete	
Section 4A - List of E Please click the "Add" button to add in Employer Name Amazon	Employers formation about your last or current Employer Address 111 K st Sac, CA 95812 United States Cancel	nt employer. You mus	t add at least one emplo Last Da 01-01-2 dd Save	iyer. ay Worked 2021 e as Draft		Action Delete Next	•

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.

<i>Cl</i> .gov						TORMY WEATHER Log Out	
Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History	
Benefit Paymen	t Options						
Personal Information	Initial Questions	Employm	ent Information	Additional Information	5 0	ertification	
You are currently on Step 5 Certificat *Indicates Required Field	tion						
If you're eligible for benefits, you have	three options to receive your benefit	t payments.					
	*Select your	payment option:	 Direct Deposit Debit Card Mailed Checks 				
Gather your bank routing and account	s and Disclosures. numbers and select Next to continu	e.					
Previous		Cancel	Save as Draft			Next	1

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.

Section 10 - Declaration

* If y 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 fillse 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 satted in the "Information Collection and Access" section of the Important Disability Insurance Program Information page. 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 of the effective date of the claim, whichever is later.

Health Insurance Portability and Accountability Act (HIPAA)

* I huthorize the below named Physician/Practitioner to furnish and disclose all my health information and to allow inspection of and provide copies of any medical, vocational thabilitation, 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 to the 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 form 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 funding may result in an incomplete claim form that cannot be processes for payment of State Disability Insurance benefits. I understand that the and signing this authorization no are received by EDD or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to rovoid prosecution or to prevent EDD's recovery of mon

Authorized Physician/Practitioner Name:	

To print or view your application in a new window, select <u>Claim for Disability Insurance (DI)</u> Benefits (DE 2501). To save and file your claim, select Submit. View Claim: Claim for Disability Insurance (DI) Benefits (DE 2501)

Cancel

Previous

Save as Draft

Important

You cannot modify the form after you select Submit.

Submit



Complete the survey and select Submit.

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	Employment Development Department State of California	SDI Home	Inbox	New Claim	Draft	Profile	History	
	Confirmation							
	Confirmation							
	You are responsible for providing your claim rec complete without the Physician/Practitioner's C	eipt number to your phys ertificate. For faster proc	sician/practitioner s essing, your physici	o they may complete and si ian/practitioner may complete	ubmit a medical certific ete and submit this forr	ation for your claim. Yo n online at www.edd.ca	ur claim form is not .gov.	
	Alternatively, your physician/practitioner may so EDD. Have your physician/practitioner complete to certify to a patient's disability or serious healt practitioner, obtain a "Claim for Disability Insura sign it. Rubber stamp signatures are not accepte	ubmit the Physician/Prac 2 and sign "Part B – PHYSI 2h condition pursuant to (2nce Benefits - Religious F 2d.	titioner's Certificate ICIAN/PRACTITIONE California Unemplo Practitioner's Certifi	e using the paper "Claim for :R'S CERTIFICATE." Certifica yment Insurance Code, Sec icate," DE 2502, by calling 1-	Disability Insurance (D tion may be made by a tion 2708. If you are un 800-480-3287 and ask y	 Benefits", DE 2501 for licensed physician or pr der the care of an accred your religious practition 	m and mailing it to the actitioner authorized dited religious er to complete and	
	Your completed claim form must be received no benefits. Most claims are processed within 14 da	earlier than 9 days, but r ays of receipt of a properly	no later than 49 days y completed claim f	s, after the first day you bec form, which includes your p	ame disabled. If your co ortion of the DE 2501 a	ompleted claim form is I nd the Physician/Practit	ate, you may lose cioner's Certificate.	
	If you are receiving temporary workers' compen CERTIFICATE" of this form is not required, howe	sation benefits and are fi ver after filing, contact SI	ling for reduced Dis DI by calling 1-800-4	ability Insurance benefits fo 80-3287.	or the same days, "PART	B – PHYSICIAN/PRACTI	TIONER'S	
		Form	n Receipt Number:	R10000000032191				
	Customer Satisfaction Su	irvey						
	Your opinion is important to us. Select the link b	elow to complete a surve	ey about your online	e experience.				
	Link to Survey							
	Back to Top Contact EDD Conditions of	Use Privacy Policy	Accessibility					
Your	claim is assigne	d a Forr	n Rec	eipt Num	ber on	the con	firmation scree	n.
	Note							
Sav subr	e this number and mit the medical ce	give it to rtificatior	your li ı.	icensed he	ealth pro	fessiona	l so they can	

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.

EDD 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.



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.

Claimant Social Security Number 0 0 0 0 0 0 0 0 0 0	
Claimant Name (First) (Mi) (Last) Sample Claimant	
I authorize Geolf E Bolokerz (Person/Organization providing the information) to fund information and to allow inspection of and provide co- rehabilitation, and billing records concerning my dis- that are within their knowledge to the following empt Development Department (EDD): Disability Insurano supervisors/managers and any other EDD employees this information in order to process my claim and/or Disability Insurance benefits.	urnish and disclose all my health opies of any medical, vocational ability for which this claim is filed yees of the California Employment ce Branch examiners, their direct a who may have a need to access determine eligibility for State
I understand that EDD is not a health plan or health released to EDD may no longer be protected by fedd (45 CFR Section 164.508(c)(2)(iii)). EDD may discle the California Unemployment Insurance Code.	care provider, so the information eral privacy regulations. ose information as authorized by
agree that photocopies of this authorization shall b	e as valid as the original.
I understand I have the right to revoke this authoriza stopping this authorization to EDD, DI Branch MIC 2 CA \$4280. The authorization will stop on the date m that the consequences for my revoking this authorizi State Disability Insurance benefits.	tion by sending written notification 19, PO Box 826880, Sacramento, y request is received. I understand ation may result in denial of further
I understand that, unless revoked by me in writing, ti years from the date received by EDD or the effective later. I understand that I may not revoke this authori prevent EDD's recovery of monies to which it is lega	his authorization is valid for fifteen a date of the claim, whichever is ization to avoid prosecution or to illy entitled.
I understand that I am signing this authorization volu eligibility for my benefits will be affected if I do not si consequences for my refusal to sign this authorizatio claim form that cannot be processed for payment of	Intarily and that payment or gn this authorization. The on may result in an incomplete State Disability Insurance benefits.
I understand I have the right to receive a copy of this	s authorization.
	Date Signed

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

How to get a paper DE 2501 form

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



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

To avoid delays when completing your paper claim form







SAMPLE, this page for reference only

Claim for Disability Insurance (DI) Benefits

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Claimant Social Security Number	0	0	0	0	0	0	0	0	0												
Claimant Name (First)	(N	1I)	(La	ist)	_	_		_	_		 _	_	 _	_	_	_	_	_	_		
Sample			С	1	a	i	n	ı a	n	t											

I authorize

(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)	Da	ate	Siç	gne	d			
Sample Claimant	1	2	2	5	2	0	1	5

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.



SAMPLE, this page for reference only



х

NO

YES

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

A18 Tip: Enter the day your disability

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.

BEFORE YOUR DISABILITY BEGAN, WHAT

15

WAS THE LAST DAY YOU WORKED?

20

A21 B. IF YOU RETURNED TO WORK.

ENTER DATE:

0 1

SAMPLE, this page for reference only	Cla (Dl) Part
PART A - CLAIMANT'S STATEMENT - CONTINUED A22. PLEASE RE-ENTER YOUR SOCIAL SECURITY NUMBER 000000000000000000000000000000000000	i art
A24. WHY DID YOU STOP WORKING? (SELECT ONLY ONE BOX)	
Mos LAYOFF UNPAID LEAVE OF ABSENCE VOLUNTARILY QUIT OR RETIRED TERMINATED 0	THER REASON
Mass A25. How would you describe on classify your Job?	
Com Mostly all, occasionally stand or waik, occasionally lift, carry, push, pull, or otherwise more objects that weight to be, of ress.	
Cont Contains and, occasionally int, carry push, pull, or otherwise move objects that weigh up to 20 lbs.	
All. FX	
TYPE Constantly lift, carry, push, pull, or otherwise move dojects that weigh up to 20 los.; trequently up to 50 los.; occasionally up to 100 los	5.
Constantly lift, carry, push, pull, or otherwise move objects that weigh over 20 lbs.; trequently over 50 lbs.; occasionally over 100 lbs.	
A26. IF YOUR EMPLOYER(S) CONTINUED OR WILL CONTINUE TO PAY YOU DURING YOUR DISABILITY, INDICATE A27. MAY WE DISCLOSE BI TYPE OF PAY: Paid Time Off Pay: Paid Time Off	INEFIT PAYMENT
C O SICK VACATION (PTO) ANNUAL OTHER (EXPLAIN) YES	NO
A28. SECOND EMPLOYER NAME (IF YOU HAVE MORE THAN ONE EMPLOYER)	
121 469 Thrifty Way	
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.)	A.)
A22. FY Bluebell CA 84369	
A30. IF YO BEFORE YOUR DISABILITY BEGAN, WHAT WAS THE LAST DAY YOU WORKED FOR THIS EMPLOYER? EMPLOYER'S TELEPHONE	NUMBER
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:	
A31. HAV NUMBER/STREET/SUITE#	
AGS. LAWE CITY STATE ZIP OR POSTAL CODE AREA CODE AND TELEPHO	INE NUMBER
A31. HAVE YOU FILED OR DO YOU INTEND TO FILE FOR WORKERS' COMPENSATION BENEFITS? A32. WAS THIS DISABILITY CAUSE YES - COMPLETE ITEMS A32 THROUGH A38 VICE - COMPLETE - COMPL	D BY YOUR JOB?
CITY STATE ZIP CODE WORKERS'COMPENSATION CLAIM NUMBER	
DE 2501 Rev. 81 (3-20) (INTRANET) Page 9 of 13	

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.

SAMPLE, this page for reference only	<i>Claim for Disability Insurance</i> <i>(DI) Benefits</i> (DE 2501) - Page 4
PART A - CLAIMANT'S STATEMENT - CONTINUED	
AS6. WORKERS' COMPENSATION ADJUSTER'S NAME AREA CODE AND TELEPHONE NUMBER EXTENSION (# ANY)	Part A - Claimant's Statement (continued).
AS8. YOUR ATTORNEY'S NAME (# ANY) FOR YOUR WORKERS' COMPENSATION CASE AREA CODE AND TELEPHONE NJIMBER EXTENSION (# ANY) ATTORNEY'S ADDRESS NUMBER/STREET/SUITE# CITY STATE ZIP CODE WORKERS' COMPENSATION' EALS	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.
A30. SELECT YOUR PREFERED BAYMENT METHOD IF EDD DEBIT CARDIN IT CHECK	
A40. Declaration and Signature. By my signature on this claim statement, I claim and my employer to fur payments that are within the "Information of Denefits is a violation of California aw and that such violation is under penalty of perjury that the foregoing statement, including any accompanying belief true, correct, and complete. By my signature on this claim statement, I author and my employer to furnish and disclose to State Disability Insurance all facts comparents that are within their knowledge. By my signature on this claim statement, I author and my employer to furnish and disclose to State Disability Insurance all facts comparents that are within their knowledge. By my signature on this claim statement in the "Information Collection and Access" of the of this form (see Informational Ir authorizations shall be as valid as the original, and I understand that authorizations period of fifteen years from the date of the signature or the effective date of the claim statement of the claim statement is a signature or the effective date of the claim statement is a signature or the effective date of the claim statement is a signature or the effective date of the claim statement is a signature or the effective date of the claim statement is a signature or the effective date of the claim statement is a signature or the effective date of the claim statement is a signature or the effective date of the claim statement is a signature or the effective date of the claim statement is a signature or the effective date of the claim statement is a signature or the effective date of the claim statement is a signature or the effective date of the claim statement is a signature or the effective date of the claim statement is a signature or the effective date of the claim statement is a signature or the effective date of the claim statement is a signature or the effective date of the claim statement is a signature or the effective date of the claim statement is a signature or the effective date of the claim statement is a sig	m benefits and certify that for the period covered by se statement or concealing a material fact in order to punishable by imprisonment or fine or both. I declare g statements, is to the best of my knowledge and orize the California Department of Industrial Relations cerning my disability, wages or earnings, and benefit ti, I authorize release and use of information as stated instructions, page D). I agree that photocopies of this is contained in this claim statement are granted for a aim, whichever is later.
NUMBERSTREET/APM/TMENT CLAIMANT'S SIGNATURE (DO NOT PRINT) OR SIGNATURE MADE BY MARK (X)	DATE SIGNED
Sample Claimant	12162015
and WITNESS BIGNATURE (PRINT AND SIGN) DATE SIGNED NUMBERINSTREET/AVAILITMENT ON SPACEA, PO BOX ON PRINTE MAIL BOX ADDRESSES NOT ACCEPTABLE. CITY STATE ZIP CODE CITY STATE A42 CHECK THIS BOX IF YOU ARE THE PERSONAL REPRESENTATIVE SIGNING ON BEHALF OF CLAIMANT AND COMPLETE THE FOLLOWING: (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 (ATACH COPY) PERSONAL REPRESENTATIVE'S SIGNATURE (DO NOT PRINT) DATE SIGNED DATE SIGNATURE	

SAMPLE, this page for reference only
Claim for Disability Insurance (DI) Benefits - Physician/Practitioner's Certificate PLEASE PRINT WITH BLACK INK.
R 0 1 0 1 1 9 0 0
B5. PATIENT'S NAME (FIRST) (MI) (LAST)
Sample
B8. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER 6 3 4 - 0 2 7 9 3 0 B7. STATE OR COUNTRY (F NOT U.S.A) THAT ISSUED LICENSE NUMBER ENTERED IN B8 STATE C A COUNTRY
B8. PHYSICIAN/PRACTITIONER LICENSE TYPE B9. SPECIALTY ((F ANY)
B10. PHYSICIANFRACTITIONER'S NAME AS SHOWN ON LICENSE (FIRST) (MI) (LAST) SUFFIX
Geoff
811. PHYSICIAN/PRACTITIONER'S ADDRESS MAILING ADDRESS, PO BOX OR NUMBER/STREET/SUITE#
Anywhere CA 72694
COUNTY HOSPITAL/GOVERNMENT FACILITY ADDRESS FACILITY NAME (# APPLICABLE)
HAULIT AUDRESS, NUMBERSTREET/SUITEF
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)
D10 THIS DATIENT HAS DEEN LINDED MY PADE AND TREATMENT FOR THIS MEDICAL DRIVEL
FROM 1 2 1 6 2 0 1 5 TO M C
B13. AT ANY TIME DURING YOUR ATTENDANCE FOR THIS MEDICAL PROBLEM, HAS THE PATIENT BEEN INCAPABLE OF PERFORMING HIS/HER REGULAR
CHC CUSTOMARY WORK? X YES - ENTER DATE DISABILITY BEGAN 1 2 1 6 2 0 1 5 NO - SKIP TO B33
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: M M 0 D V Y Y Y Y DELIVERY DATE: M V 0 D V Y Y Y Y
TYPE OF DELIVERY, IF PATIENT HAS DELIVERED: VAGINAL CESAREAN
DE 2501 Rev. 81 (3-20) (INTRANET) Page 11 of 13

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

CONTACT US 1-800-480-3287





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.