

SDI ONLINE TUTORIAL

File a Disability Claim

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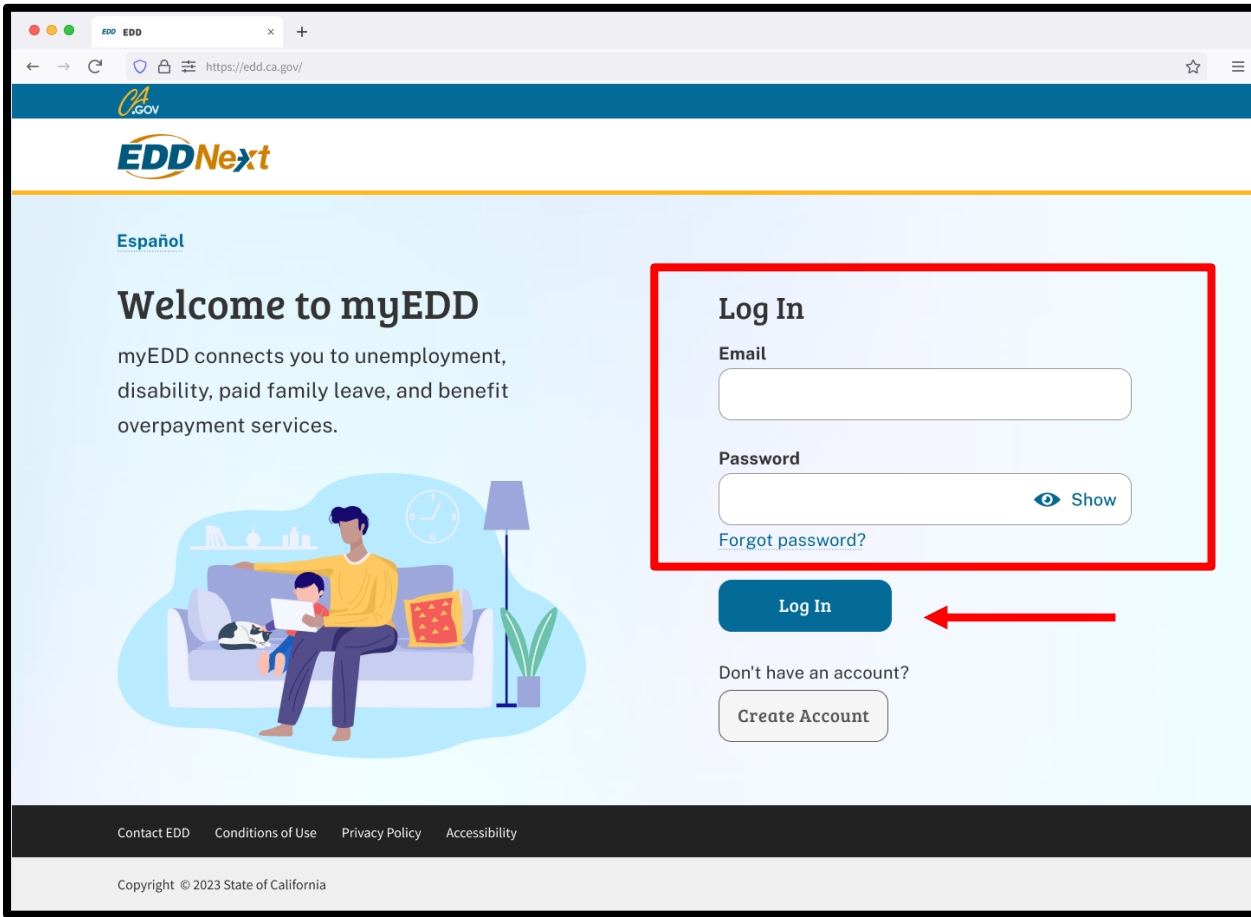
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File a Disability Insurance Claim

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



[Get Started](#)



Note

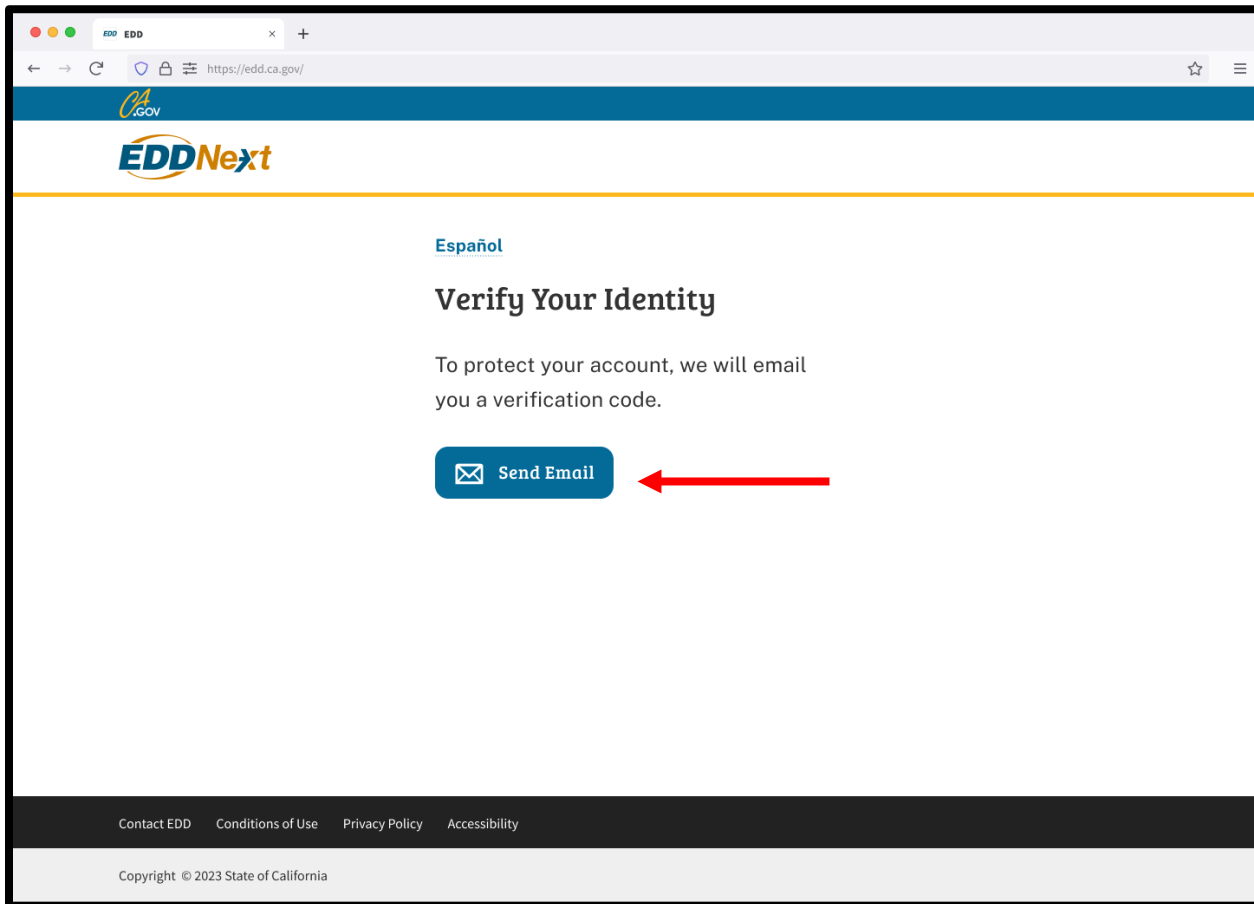
For Spanish, select **Español**.

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.

EDD EDD

https://edd.ca.gov/

CA.GOV

EDDNext

[Español](#)

Enter Verification Code

Enter the verification code you received at {J*****@gmail.com}. This code expires in 5 minutes.

*Required Field

*Verification Code

Submit

Didn't get the email? Check your spam folder or [resend the email.](#)

Contact EDD Conditions of Use Privacy Policy Accessibility

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Gmail

Search mail

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Meet

myEDD Verification Code

California Employment Development Department to me

August 26, 2022, 3:28PM

EDD Employment Development Department State of California

Hello,

Enter the following verification code in myEDD. This code will expire in 5 minutes.

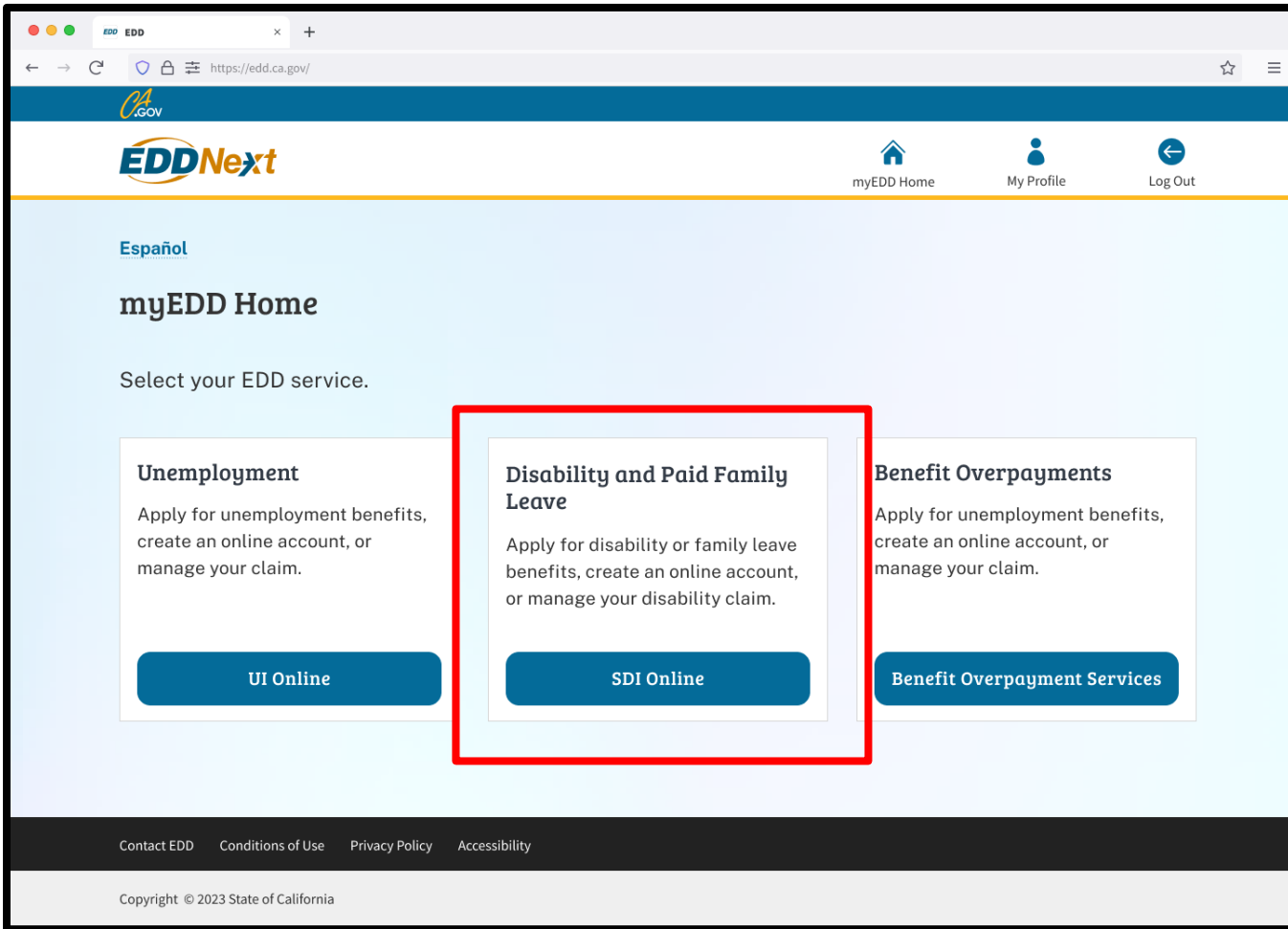
012345

Do not reply to this auto-generated message.

Thank you,
Employment Development Department
State of California

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**.

Home

Message Center

Check the message center inbox below to review messages and take required actions as needed.

Inbox [New: 0, Total: 0]

Personal Information

Full Name:	John Doe	EDD Customer Account Number:	123456789
Mailing Address:	123 Main St Sacramento, CA 95814	Phone Number:	916-555-1212
Residence Address:	123 Main St Sacramento, CA 95814	Cell Phone Number:	916-555-1213
E-mail Address:	Jdoe@gmail.com		

Current Disability Insurance Claim(s)

No Results Found

Pending Disability Insurance Claim Application(s)

No Results Found

Submitted Paid Family Leave Claim Forms

Only forms you submitted online are listed below. To submit an electronic document for a previously submitted care or bonding claim, select New Claim. The status of your Paid Family Leave claim is currently not available online. For assistance with a Paid Family Leave claim, call 1-877-238-4373.

No Results Found

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

The screenshot shows the EDD website interface. At the top, there is a blue navigation bar with the CA.GOV logo, a Home icon, and a Log Out link. Below this is a white header with the EDD logo and navigation links: SDI Home, Inbox, New Claim, Draft, Profile, and History. The main content area is titled 'Apply for Benefits or Continue a Draft Application'. It contains a paragraph of instructions, a note about postal service, and a section for 'Apply for Disability Insurance Benefits'. In this section, the 'Disability Insurance' link is highlighted with a red rectangular box, and a red arrow points to it from the right. Below this are links for 'Apply for Paid Family Leave Benefits' and a 'Saved Drafts' section which currently shows 'No Results Found' and a 'Delete' button.

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.

The screenshot shows the top navigation bar with 'CA.GOV', 'Home', and 'Log Out'. Below it is the EDD logo and a menu with 'SDI Home', 'Inbox', 'New Claim', 'Draft', 'Profile', and 'History'. The main heading is 'Disability Insurance Claim Filing Instructions'. Underneath is the sub-heading 'Before You Start and After You File'. A list of instructions follows, including details about employer information, work dates, leave types, and certification requirements. At the bottom of the content area are two buttons: 'Cancel' (highlighted with a red box) and 'Next' (pointed to by a red arrow). The footer contains links for 'Back to Top', 'Contact EDD', 'Conditions of Use', 'Privacy Policy', and 'Accessibility'.

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.

Personal Information



You are currently on Step 1 Personal Information

Section 1 - Personal Information

Social Security Number:	XXX-XX-XXXX	EDD Customer Account Number:	1234567890
Legal Name:	John Doe	California Driver License or ID Number:	X1234567
Date of Birth:	01-01-XXXX	Gender:	Male
Preferred Language:	English	Residence Address:	123 Main St Sacramento, CA 95814
Mailing Address:	123 Main St Sacramento, CA 95814	Cell Phone Number:	555-123-4567
Home Phone Number:			

Section 2 - Other Names and Social Security Numbers Used

Please enter any other names or other Social Security Numbers under which you have worked. If you have never worked under another name or Social Security Number please leave this section blank.

First Name:	<input type="text"/>	Middle Initial:	<input type="text"/>
Last Name:	<input type="text"/>	Suffix:	<input type="text"/>
Social Security Number:	<input type="text"/>		
First Name:	<input type="text"/>	Middle Initial:	<input type="text"/>
Last Name:	<input type="text"/>	Suffix:	<input type="text"/>
Social Security Number:	<input type="text"/>		

Previous

Cancel

Save as Draft

Next

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.

Section 3 - Employment Information

*Are you self employed? Yes No

*Are you a State Government employee? Yes No

If "Yes," indicate Bargaining Unit Number:

*At any time during your disability, were you in the custody of law enforcement authorities because you were convicted of violating law or ordinance? Yes No

*Before your disability began, what was the last day you worked?

*When did your disability begin?

Date you want your Disability Insurance claim to begin if different than the date your disability began:

*Since your disability began, have you worked or are you working any full or partial days? Yes No

*Have you recovered? Yes No

If "Yes," enter date:

*Have you returned to work? Yes No

If "Yes," enter date:

*What is your regular or customary occupation?

*Why did you stop working?

***How would you describe or classify your job?**

- Mostly sitting; occasionally standing and walking; occasionally lift, carry, push, pull or otherwise move objects that weigh 10 lbs. or less
- Walking/standing most of the time; 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.
- 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 up to 20 lbs.; frequently over 50 lbs.; occasionally over 100 lbs.

*Has or will your employer continue to pay you during your disability leave? Yes No

- If "Yes," indicate type(s) of pay:
- Sick
 - Vacation
 - Paid Time Off
 - Annual Leave
 - Other Type of Pay

Other Type of Pay:

*May we disclose benefit payment information to your employer(s)? Yes No

*Have you filed or do you intend to file for Workers' Compensation benefits? Yes No

*Was this disability caused by your job? Yes No

*Are you a resident of an alcohol recovery home 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**.

The screenshot shows the EDD State of California website interface. At the top, there is a navigation bar with 'CA.GOV', 'Home', and 'Log Out'. Below this is a secondary navigation bar with 'SDI Home', 'Inbox', 'New Claim', 'Draft', 'Profile', and 'History'. The main content area is titled 'Employment Summary' and features a progress bar with five steps: 1. Personal Information (checked), 2. Initial Questions (checked), 3. Employment Information (active), 4. Additional Information, and 5. Certification. Below the progress bar, it states 'You are currently on Step 3 Employment Information'. The section is titled 'Section 4A - List of Employers' and includes a message: 'Please click the "Add" button to add information about your last or current employer. You must add at least one employer.' Below this message is a grey box with the text 'No Results Found'. At the bottom of the section, there are five buttons: 'Previous', 'Cancel', 'Add', 'Save as Draft', and 'Next'. The 'Add' button is highlighted with a red rectangular box. The footer contains links for 'Back to Top', 'Contact EDD', 'Conditions of Use', 'Privacy Policy', and 'Accessibility'.

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

- You must add at least one employer to continue.

CA .GOV Home Log Out

EDD Employment Development Department State of California

SDI Home Inbox New Claim Draft Profile History

Employer Search

✓ Personal Information ✓ Initial Questions **3** Employment Information 4 Additional Information 5 Certification

You are currently on Step 3 Employment Information

*Indicates Required Field

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:

[Back to Top](#) [Contact 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	Action
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: **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?

* 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 mailing address. If you have more than one employer, you must provide the information for each additional employer. 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:

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 Box please use that as their mailing address.

US International

* Address Line 1:

Address Line 2:

* City:

* State:

* ZIP Code:


Employer Phone Number: 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?

* Do you currently have another employer that you have not yet reported? Yes No



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 Capitol 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.

No

Yes

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.

CA.GOV Home Log Out

EDD Employment Development Department State of California

SDI Home Inbox New Claim Draft Profile History

Employment Summary

Personal Information
 Initial Questions
 3 Employment Information
 4 Additional Information
 5 Certification

You are currently on Step 3 Employment Information

Section 4A - List of Employers

Please click the "Add" button to add information about your last or current employer. You must add at least one employer.

Employer Name	Employer Address	Last Day Worked	Action
Amazon	111 K st Sac, CA 95812 United States	01-01-2021	Delete

[Back to Top](#)
[Contact EDD](#)
[Conditions of Use](#)
[Privacy Policy](#)
[Accessibility](#)

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.

CA.GOV Home Log Out

EDD Employment Development Department State of California

SDI Home Inbox New Claim Draft Profile History

Declaration

Personal Information Initial Questions Employment Information Additional Information 5 Certification

You are currently on Step 5 Certification

*Indicates Required Field

Section 9 - Payment Choice

If you are eligible to receive benefits, you have two options to receive your benefit payments: by debit card, through Money Network, or by check, which is mailed to you from the Employment Development Department. You do not have to accept the debit card. Select your preferred payment method below.

*Preferred Payment Method: EDD Debit Card Check

Disclosures Agreement: [EDD Debit Card Fee Disclosures, DE 5617PD \(PDF\)](#)

I acknowledge that I have reviewed the EDD Debit Card Fee Disclosures.

Complete Section 9 - Payment Choice to select how you want to get benefit payments from the options listed.

Select the **I acknowledge** box to confirm you have reviewed the disclosures.

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

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" 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 authorize 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 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 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 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.

Authorized Physician/Practitioner Name:

To print or view your application in a new window, select [Claim for Disability Insurance \(DI\) Benefits \(DE 2501\)](#). To save and file your claim, select Submit.
[View Claim: Claim for Disability Insurance \(DI\) Benefits \(DE 2501\)](#)

Important

You cannot modify the form after you select Submit.

CA.GOV Home Log Out

EDD Employment Development Department State of California SDI Home Inbox New Claim Draft Profile History

Paid Family Leave (PFL) Survey Question

*Indicates Required Field

You're almost done

Answer the following question. Then, select **Submit** to complete your claim and receive your receipt number.

***Which PFL services are you aware of? Check all that apply:**

- PFL provides benefits to workers who need to care for a seriously ill family member.
- PFL provides benefits to qualifying workers whose military family members are being deployed.
- Parents can be eligible for PFL benefits to bond with a newborn, adopted, or foster child.
- New mothers can be eligible for PFL bonding benefits after their pregnancy-related disability claim.
- I am not familiar with the PFL benefit program.

Submit

Back to Top Contact EDD Conditions of Use Privacy Policy Accessibility

Complete the survey and select **Submit**.

Confirmation

Confirmation

You are responsible for providing your claim receipt number to your physician/practitioner so they may complete and submit a medical certification for your claim. Your claim form is not complete without the Physician/Practitioner's Certificate. For faster processing, your physician/practitioner may complete and submit this form online at www.edd.ca.gov.

Alternatively, your physician/practitioner may submit the Physician/Practitioner's Certificate using the paper "Claim for Disability Insurance (DI) Benefits", DE 2501 form and mailing it to the EDD. 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 California Unemployment Insurance Code, 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.

Your completed claim form must be received no earlier than 9 days, but no later than 49 days, after the first day you became disabled. If your completed claim form is late, you may lose benefits. Most claims are processed within 14 days of receipt of a properly completed claim form, which includes your portion of the DE 2501 and the Physician/Practitioner's Certificate.

If you are receiving temporary workers' compensation benefits and are filing for reduced Disability Insurance benefits for the same days, "PART B - PHYSICIAN/PRACTITIONER'S CERTIFICATE" of this form is not required, however after filing, contact SDI by calling 1-800-480-3287.

Form Receipt Number: R10000000032191

Customer Satisfaction Survey

Your opinion is important to us. Select the link below to complete a survey about your online experience.

[Link to Survey](#)

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.

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 0000000000

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

I authorize
Geoff Blocker

(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)(ii)). 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
1/2/2015

DE 2501 Rev. 01 (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.

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: 0000000000

Claimant Name (First) (MI) (Last)
SAMPLE CLAIMANT

I authorize
GEOFF BLOKER
(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.

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

Claimant Signature (Do Not Print) Date Signed
SAMPLE CLAIMANT 1/2/2015

DE 2501 Rev. 01 (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.

SAMPLE, this page for reference only



Claim for Disability Insurance (DI) Benefits

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Claimant Social Security Number 0000000000

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

I authorize Geoffrey Blocker

(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 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

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.

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
0 0 0 0 0 0 0 0

A2. IF YOU HAVE PREVIOUSLY BEEN ASSIGNED AN EDD CUSTOMER ACCOUNT NUMBER, ENTER THAT NUMBER HERE
N o

A3. CALIFORNIA DRIVER LICENSE OR ID NUMBER
Z 1 2 3 4 5 6 7

A4. GENDER
MALE FEMALE
X

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

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

A7. YOUR DATE OF BIRTH
0 1 0 1 1 9 0 0

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.

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
0 0 0 0 0 0 0 0

A2. IF YOU HAVE PREVIOUSLY BEEN ASSIGNED AN EDD CUSTOMER ACCOUNT NUMBER, ENTER THAT NUMBER HERE
N o

A3. CALIFORNIA DRIVER LICENSE OR ID NUMBER
Z 1 2 3 4 5 6 7

A4. GENDER
MALE FEMALE
X

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

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

A7. YOUR DATE OF BIRTH
0 1 0 1 1 9 0 0

A8. YOUR LEGAL NAME (FIRST, MIDDLE, LAST, SUFFIX)
Sample Claimant

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

A10. YOUR HOME AREA CODE AND TELEPHONE NUMBER
9 9 9 0 2 3 6 7 8 9

A11. YOUR CELL AREA CODE AND TELEPHONE NUMBER
1 1 1 0 0 2 0 0 4 7

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

A13. YOUR MAILING ADDRESS, PO BOX OR NUMBER/STREET/APARTMENT, SUITE, SPACE#, OR PMB# (PRIVATE MAIL BOX)
1 2 3 Any Street
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)
Anytown CA 1 2 3 4 5

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)
6 4 7 Armistice Way

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)
6 4 7 Armistice Way

CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)
Anywhere CA 6 6 2 2 2

A16. EMPLOYER'S TELEPHONE NUMBER
4 9 9 3 1 1 1 1 1 1

SAMPLE, this page for reference only

Your disability claim can also be filed online at www.eddi.ca.gov
PLEASE PRINT WITH BLACK INK.

PART A - CLAIMANT'S STATEMENT

A1. YOUR SOCIAL SECURITY NUMBER
0 0 0 0 0 0 0 0 0 0

A2. IF YOU HAVE PREVIOUSLY BEEN ASSIGNED AN EDD CUSTOMER ACCOUNT NUMBER, ENTER THAT NUMBER HERE
N o

A3. CALIFORNIA DRIVER LICENSE OR ID NUMBER
Z 1 2 3 4 5 6 7

A4. GENDER
MALE FEMALE

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

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

A7. YOUR DATE OF BIRTH
0 1 0 1 1 9 0 0

A8. YOUR LEGAL NAME (FIRST) (M) (LAST) SUFFIX
S a m p l e C l a i m a n t

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

A10. YOUR HOME AREA CODE AND TELEPHONE NUMBER
9 9 9 0 2 3 6 7 8 9

A11. YOUR CELL AREA CODE AND TELEPHONE NUMBER
1 1 1 0 0 2 0 0 4 7

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

A13. YOUR MAILING ADDRESS, PO BOX OR NUMBER/STREET/APARTMENT, SUITE, SPACE#, OR PMB# (PRIVATE MAIL BOX)
1 2 3 A n y S t r e e t
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)
A n y t o w n C A 1 2 3 4 5

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))
R o a d r u n n e r P a s t r i e s

NUMBER/STREET/SUITE# (STATE GOVERNMENT EMPLOYEES: PLEASE PROVIDE THE ADDRESS OF YOUR PERSONNEL OFFICE)
6 4 7 A r m i s t i c e W a y
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)
A n y w h e r e

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.

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 NO

A17. BEFORE YOUR DISABILITY BEGAN, WHAT WAS THE LAST DAY YOU WORKED?
1 2 0 1 2 0 1 5

A18. WHEN DID YOUR DISABILITY BEGIN?
1 2 1 6 2 0 1 5

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 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

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

PART A - CLAIMANT'S STATEMENT - CONTINUED

A22. PLEASE RE-ENTER YOUR SOCIAL SECURITY NUMBER 0000000000

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

A24. WHY DID YOU STOP WORKING? (SELECT ONLY ONE BOX) ILLNESS, INJURY, OR PREGNANCY
 LAYOFF UNPAID LEAVE OF ABSENCE VOLUNTARILY QUIT OR RETIRED TERMINATED OTHER REASON

A24. WHY DID YOU STOP WORKING? (SELECT ONLY ONE BOX) 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.
 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)
CITY: Cosmic Cookies
NUMBER/STREET/SUITE#: 469 Thrifty Way
CITY: Bluebell STATE: CA ZIP OR POSTAL CODE: 84369 COUNTRY (IF NOT U.S.A.):

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 A32 THROUGH A38

A32. WAS THIS DISABILITY CAUSED BY YOUR JOB?
 YES NO

SAMPLE, this page for reference only

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.

PART A - CLAIMANT'S STATEMENT - CONTINUED

A35. PLEASE RE-ENTER YOUR SOCIAL SECURITY NUMBER

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 BOARD/ADJ CASE NUMBER _____ SEALS _____

A39. SELECT YOUR PREFERRED PAYMENT METHOD EDD DEBIT CARDSM 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" section 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
Sample Claimant

DATE SIGNED

1st WITNESS SIGNATURE

NUMBER/STREET/APARTMENT _____

CITY _____

2nd WITNESS SIGNATURE (PRINT AND SIGN)

NUMBER/STREET/APARTMENT OR 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:
(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 _____

A39. SELECT YOUR PREFERRED PAYMENT METHOD EDD DEBIT CARDSM 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" section 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
1 2 1 6 2 0 1 5

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						B2. PATIENT'S FILE NUMBER					
0000000000						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						B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED IN B6					
634-027930						STATE CA COUNTRY					
B8. PHYSICIAN/PRACTITIONER LICENSE TYPE						B9. SPECIALTY (IF ANY)					
MD											
B10. PHYSICIAN/PRACTITIONER'S NAME AS SHOWN ON LICENSE (FIRST) (MI) (LAST) SUFFIX											
Geoff Bookner											
B11. PHYSICIAN/PRACTITIONER'S ADDRESS											
MAILING ADDRESS, PO BOX OR NUMBER/STREET/SUITE#											
269 Commerce											
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)											
Anywhere CA 72694											
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 MONTHLY											
<input checked="" type="checkbox"/> CHECK HERE TO INDICATE YOU ARE STILL TREATING THE PATIENT											
AT INTERVALS OF: <input type="checkbox"/> DAILY <input type="checkbox"/> WEEKLY <input checked="" type="checkbox"/> MONTHLY <input type="checkbox"/> AS NEEDED <input type="checkbox"/> 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?											
<input checked="" type="checkbox"/> YES - ENTER DATE DISABILITY BEGAN 12162015 <input type="checkbox"/> NO - SKIP TO B33											
WAS THE DISABILITY CAUSED BY AN ACCIDENT OR TRAUMA? <input type="checkbox"/> YES <input type="checkbox"/> 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.)											
MONTHLY											
<input type="checkbox"/> 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: MONTHLY DATE PREGNANCY ENDED: MONTHLY											
TYPE OF DELIVERY, IF PATIENT HAS DELIVERED: <input type="checkbox"/> VAGINAL <input type="checkbox"/> CESAREAN											

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.

CONTACT US

1-800-480-3287

– Helpful Links –



[Order Forms](#)



[Schedule a Webinar](#)



[Help Fight Fraud](#)



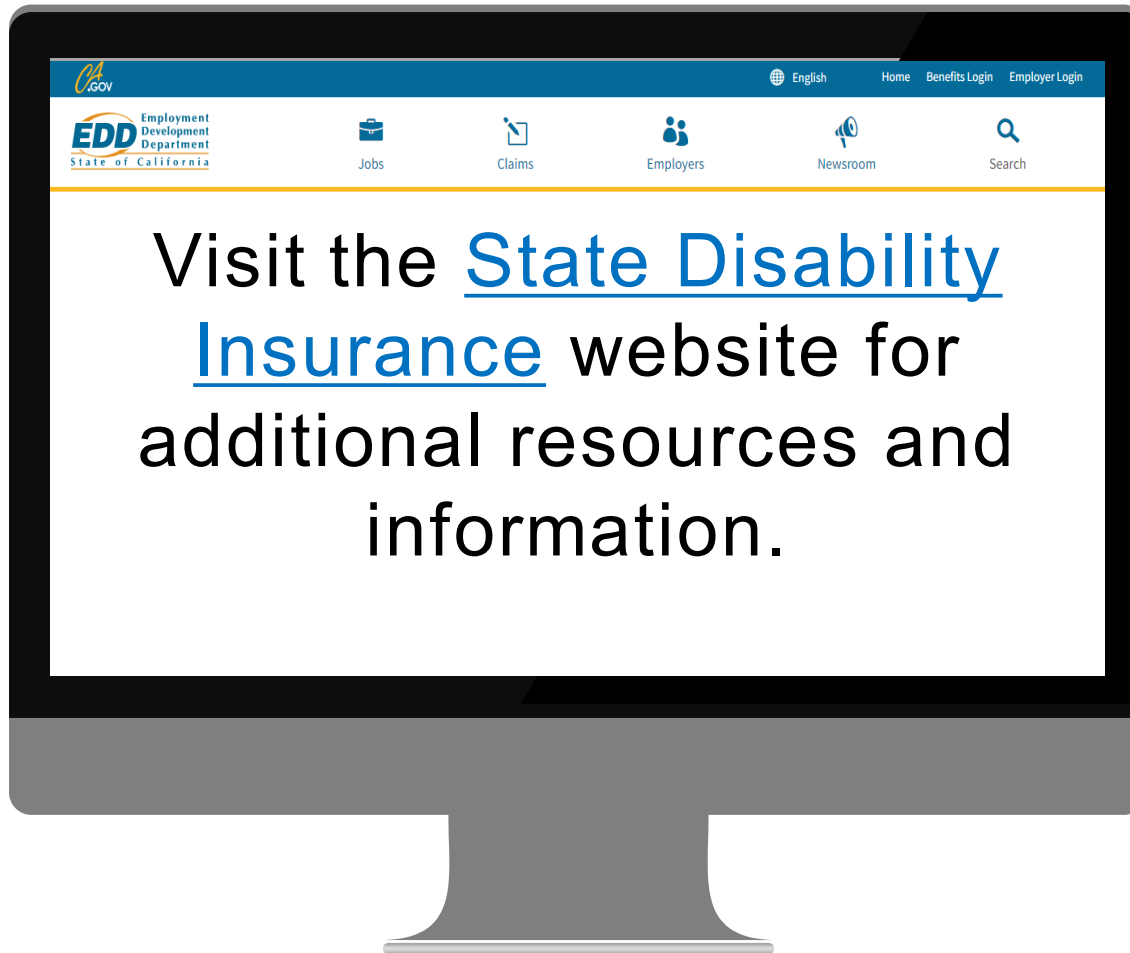
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The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and alternate formats need to be made by calling 1-866-490-8879 (voice), or through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