

SDI ONLINE TUTORIAL

# File a Paid Family Leave Claim

# CONTENTS

File a Bonding Claim – New Mothers.....	<a href="#"><u>3</u></a>
For birth mothers transitioning from disability benefits.	
File a Bonding Claim.....	<a href="#"><u>22</u></a>
For new mothers (without a pregnancy-related disability claim), fathers, and foster or adoptive parents.	
Submit Supporting Bonding Claim Documents..	<a href="#"><u>44</u></a>
File a Care Claim.....	<a href="#"><u>50</u></a>
For individuals caring for a seriously ill family member.	
Submit Supporting Care Claim Documents.....	<a href="#"><u>69</u></a>
File a Military Assist Claim.....	<a href="#"><u>75</u></a>
For workers taking time off because of certain military-related events.	
Submit Supporting Military Assist Claim Documents.....	<a href="#"><u>94</u></a>
Complete Paper Claim Forms.....	<a href="#"><u>100</u></a>

# File a Bonding Claim - New Mothers

Learn more about how individuals apply for bonding benefits after a pregnancy-related disability claim.



[Get Started](#)

# Applying for bonding benefits after a pregnancy-related disability claim

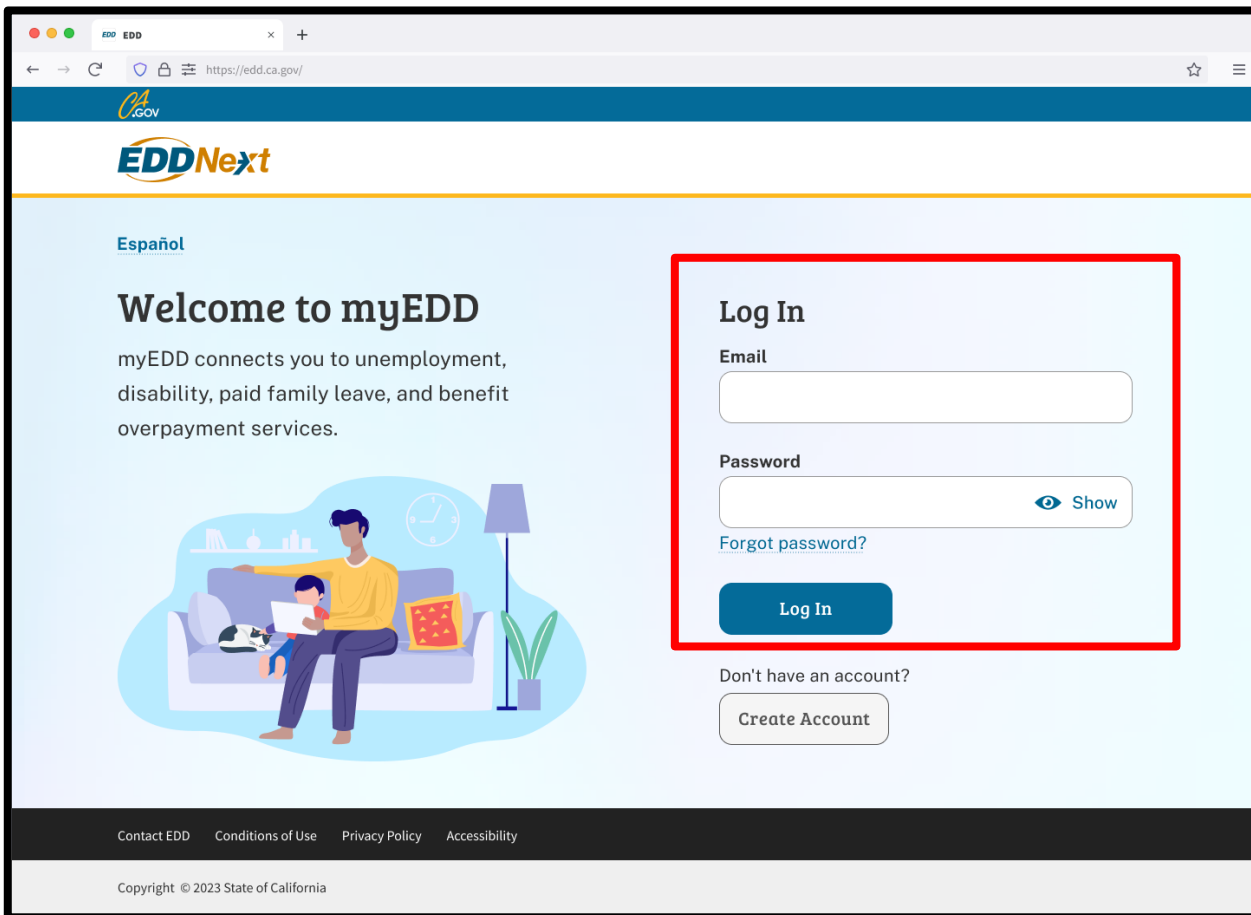
If you applied for a disability claim by:

- **Mail:** We automatically mail you a *Claim for Paid Family Leave (PFL) Benefits – New Mother* (DE 2501FP) form when your final disability payment is delivered.
- **Online:** We automatically send a link to the DE 2501FP form to your account inbox when your final disability payment is issued.

## Note

If you are a birth mother who did not have a pregnancy-related disability claim, or a new father, or a foster or adoptive parent, refer to [File a Bonding Claim for New Mothers \(without a pregnancy-related disability claim\), Fathers, and Foster or Adoptive Parents.](#)



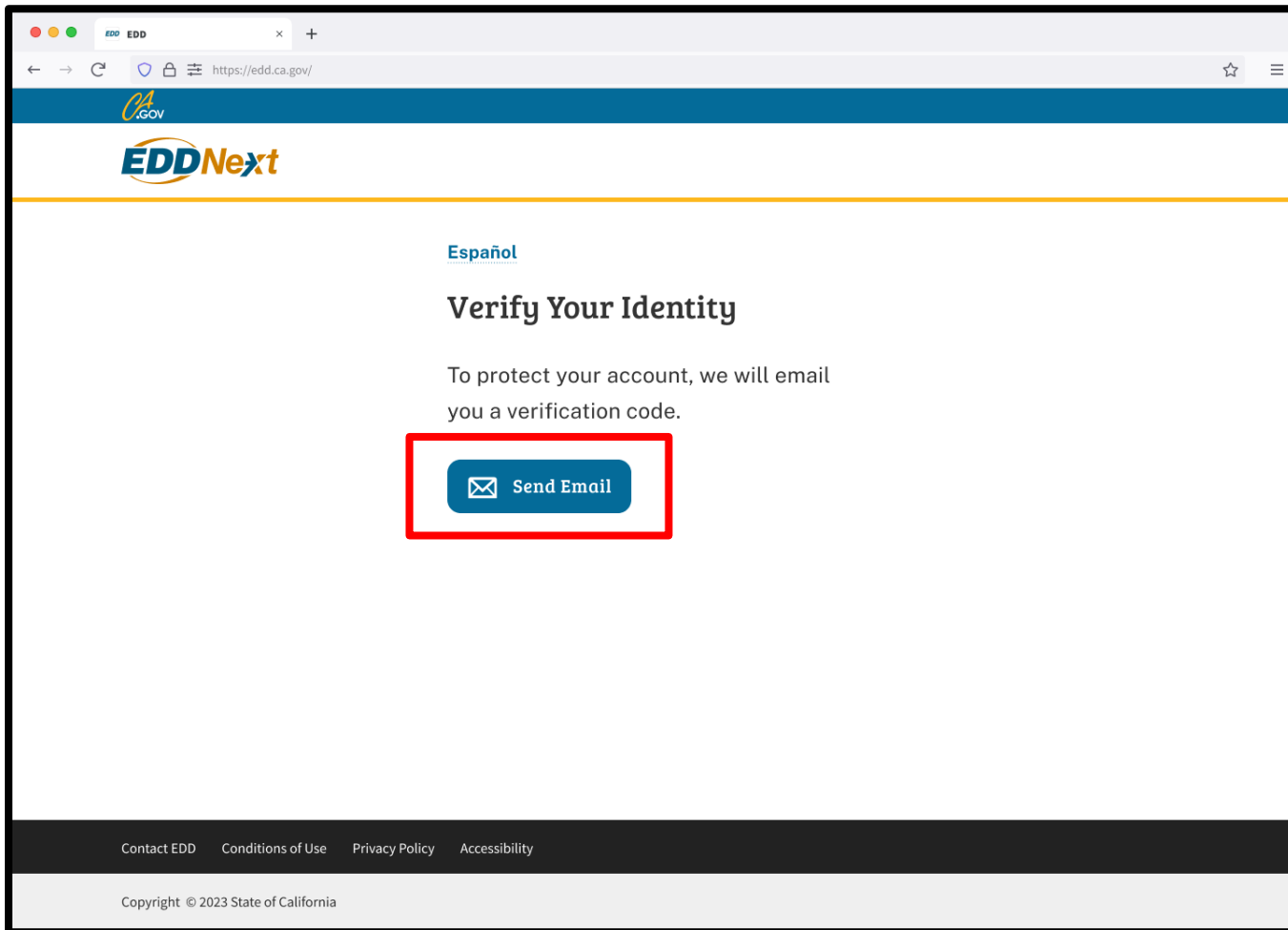


## Note

For Spanish, select **Español**.

Log in to myEDD to access SDI Online, update your email, password, security question, or verification option:

1. Visit [myEDD](#).
2. Enter the email and password used to create your 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/

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**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.](#)

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Gmail

Search mail

1-16 of 16

Compose

Inbox

myEDD Verification Code

California Employment Development Department to me

August 26, 2022, 3:26PM

**EDD** Employment Development Department State of California

Hello,

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

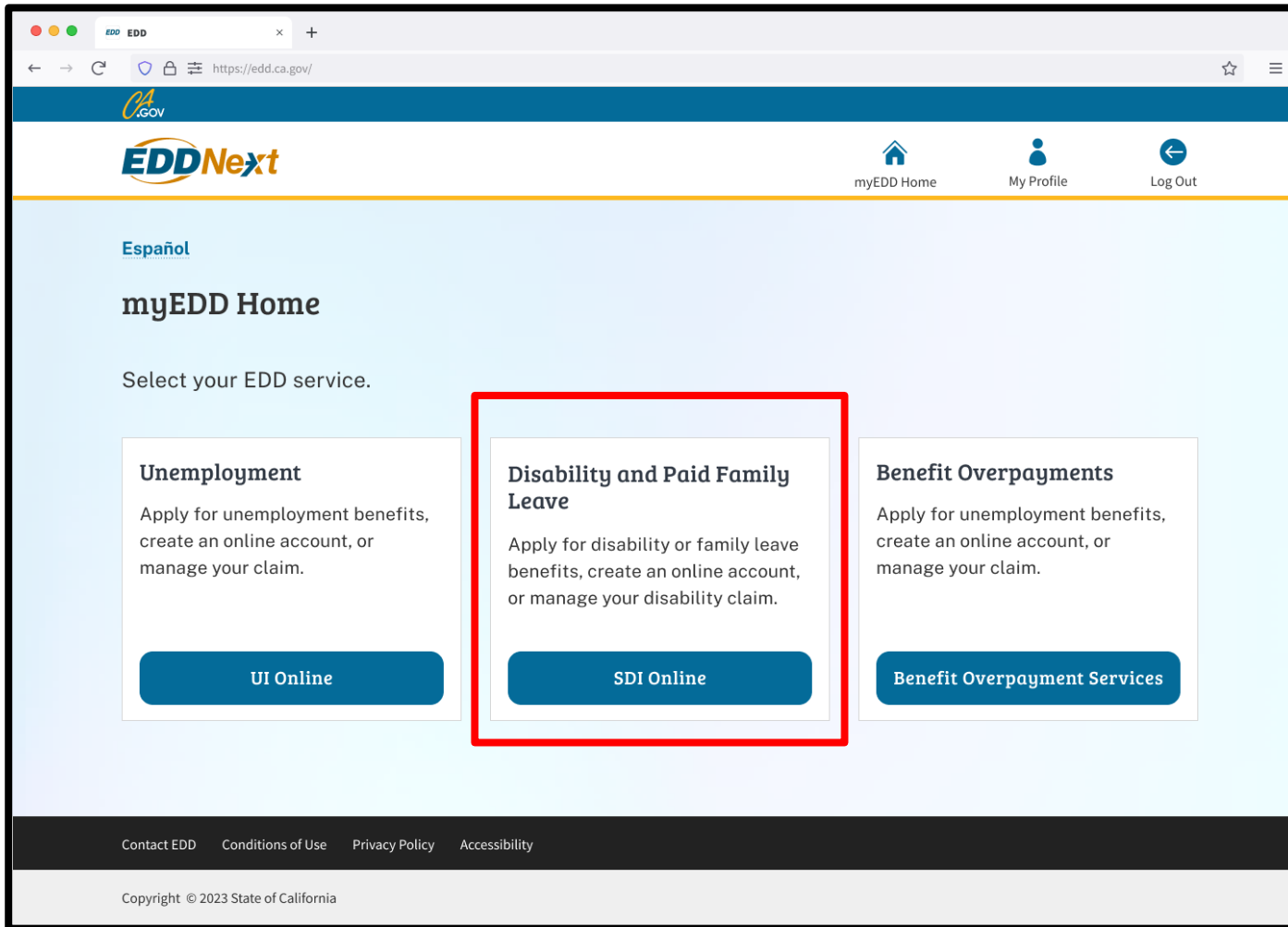
**012345**

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.



**Note**

Select **Log Out** in the top right corner of any screen to exit your account.

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.

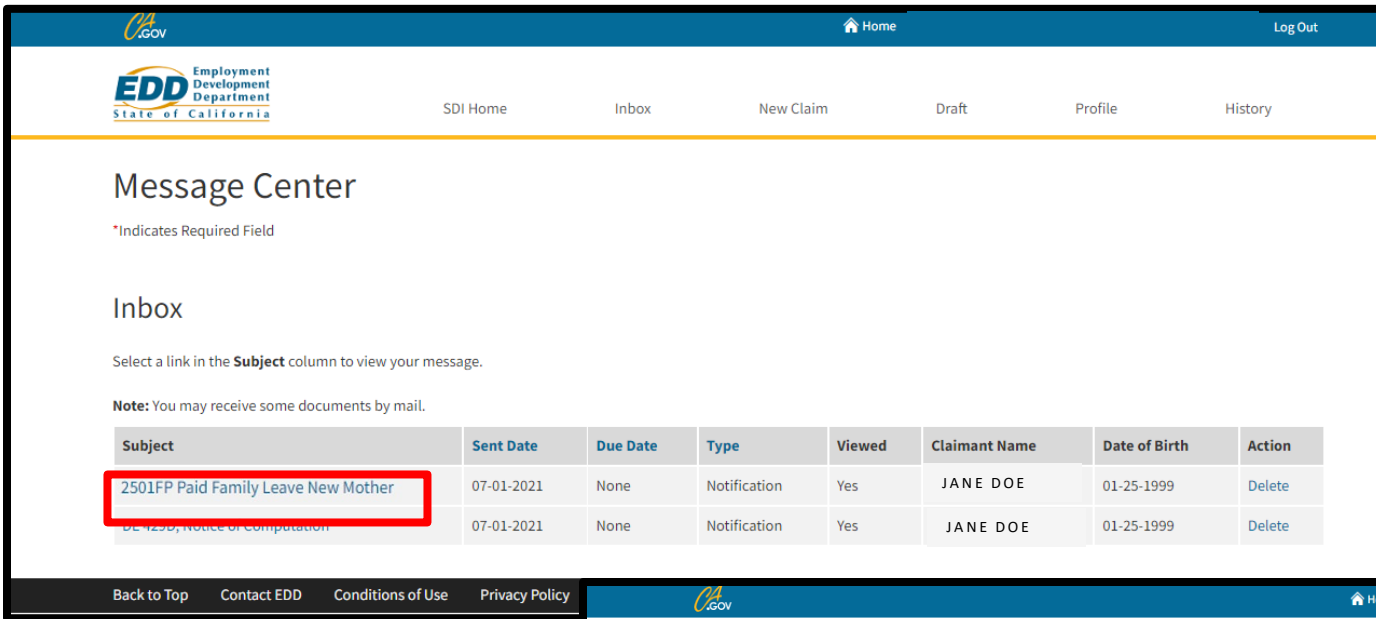
**Inbox** [ New: 0 , Total: 0 ]

## Personal Information

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

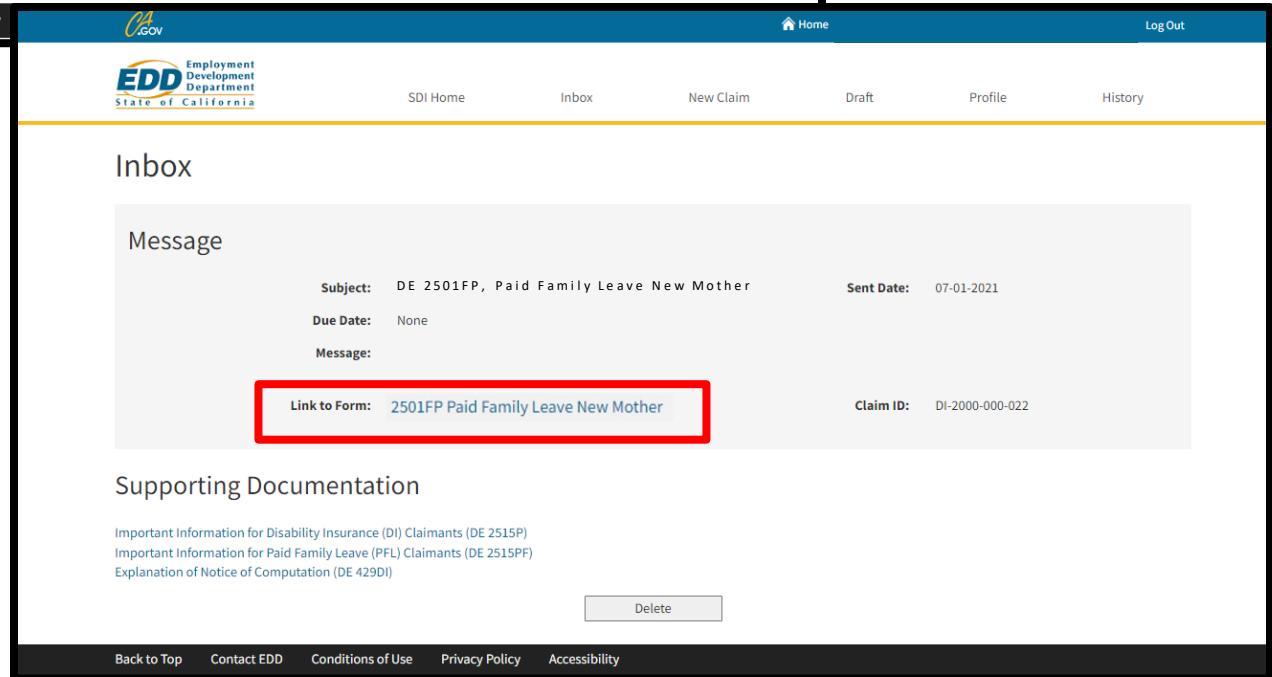
## Current Disability Insurance Claim(s)

Select **Inbox** from the main menu or the Message Center.



On the Message Center screen, select **DE 2501FP Paid Family Leave New Mother** to access the message.

Next, on the Inbox screen, select **DE 2501FP Paid Family Leave New Mother** to access the form.



## Forms Available to Submit Online

### Claim Information

Claimant Name: Jane Doe

Claim ID: DI-1000-XXX-XXX

Expected Return to Work Date: 03-05-2018

Claim Effective Date: 02-15-2018

### Forms Available to Submit

Below is a list of forms available to submit electronically. If you have received a form in the mail, return it by the due date listed on the form. Please allow 5-7 business days for your form to be processed.

If you have already submitted or mailed any of the forms listed below, do not submit a duplicate form. Submitting duplicate forms may delay the processing of your claim.

**Note:** "The DE 2587 Notice-Automatic Payment" will only apply to your Disability Insurance claim and should not be used if you are currently receiving Paid Family Leave benefits.

Note: It may be necessary to send some documents via US Postal Service.

[Paid Family Leave Bonding](#)

### Saved Drafts

To open and complete a form that you saved, select the Form Name. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the Delete button.

Form Name	Saved Date	Drafts will be saved until	Select
<a href="#">2500A Cert for Continued Benefits</a>	06-29-2018	07-29-2018	<input type="checkbox"/>

Delete

Select **Paid Family Leave Bonding** under Forms Available to Submit.

### Note

Submit your claim no earlier than the first day your family leave begins, but no later than 41 days after your family leave begins, or you may lose benefits.

### Important

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

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EDD Employment Development Department State of California

SDI Home Inbox New Claim Draft Profile History

## Prescreening Questions

\*Indicates Required Field

### Prescreening Questions

\*Are you a mother bonding with your newborn?  Yes  No

\*Did you receive California State Disability Insurance benefits for your pregnancy with this newborn?  Yes  No

Cancel Next

Back to Top Contact EDD Conditions of Use Privacy Policy Accessibility

Next, answer the prescreening questions.

New mothers applying for bonding benefits who are transitioning from a pregnancy-related disability claim will select **Yes** for both questions and select **Next**.

### Note

Select **Cancel** at any time to cancel the claim and return to your homepage.

## Information for Before You Start and After You File

### Before you Start: Information you need to submit a *Claim for Paid Family Leave (PFL) Benefits – New Mother* (DE 2501FP)

When your pregnancy-related disability claim ends, we have identified critical items you should have immediately available when you select to file your DE 2501 FP.

- The last date you worked for any employer.
- Whether you returned to work for any period or will continue to work during your period of paid family leave.
- Information concerning the newborn with whom you are bonding, including: name, date of birth, and gender.
- Information as to whether you are receiving, or expect to receive any payment from your former employer (Failure to report your income could result in an overpayment, penalties, and a false statement disqualification)
- Whether you have claimed or plan to claim workers' compensation benefits for any portion of the period covered by this claim.
- Whether you were you in custody of law enforcement authorities because you were convicted of a violation of law or ordinance at any time during your family leave.
- The date you want your DE 2501FP to begin if other than the day your Disability Insurance benefits ended.

## After You Have Filed Your Application

### WHEN YOUR CLAIM IS SUCCESSFULLY SUBMITTED

The PFL office will notify you of your weekly benefit amount and request any additional information needed to determine your eligibility. If you meet all requirements, a payment will be issued to you. The majority of claims are processed and payments issued within 14 days of receipt of a correctly completed claim.

Note: It may be necessary to send some documents via US Postal Service. This includes Paid Family Leave (PFL) payments and PFL claim-related forms.

### YOUR RIGHTS

Information about your claim will be kept confidential, except for the purposes allowed by law. California Civil Code, section 1798.34, gives you the right to inspect any personal records maintained about you by EDD. Section 1798.35 permits you to request that the record be corrected if you believe it is not accurate, relevant, timely, or complete. Certain types of information that would generally be considered personal are exempt from disclosure to you: medical or psychological records where knowledge of the contents might be harmful to the subject (Civil Code, section 1798.40); records of active criminal, civil or administrative investigations (Civil Code, section 1798.40).

If you are denied access to records which you believe you have a right to inspect or if you request to amend your records is refused, you may file an appeal with the PFL office. You may

### SPECIAL CIRCUMSTANCE RELATING TO YOUR PAID FAMILY LEAVE CLAIM

Child Support Obligations. Questions should be directed to the Department of Child Support Services at 1-866-249-0773.

Spousal or Parental Support Obligations. Questions should be directed to the District Attorney's office administering the court order.

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

Death of Care or Bonding Recipient. If the child with whom you are bonding dies, report the death to PFL. Benefits are payable through the date of death, if otherwise eligible.

Job Benefits and Protection Programs. Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) offer job protected leave to "eligible" employees for certain family and medical reasons. Contact FMLA at 866-487-9243 or the Department of Labor Web site: <https://www.dol.gov/whd/fmla> or CFRA at 800-884-1684 or the Department of Fair Employment and Housing Web site: <https://www.dfeh.ca.gov> for additional information on these programs.

Phone Number Link

[https://www.edd.ca.gov/Disability/Contact\\_SDI.htm#byphone](https://www.edd.ca.gov/Disability/Contact_SDI.htm#byphone)

Frequently Asked Questions Link

<https://www.edd.ca.gov/Disability/FAQs.htm#pfl>

Carefully review the Information for Before You Start and After You File. It has important information you need to file a bonding claim.

Select **Next**.

CA.GOV Home Benefit Programs Online Log Out

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

## Applying for Claim for Paid Family Leave (PFL) Benefits - New Mother

\*Indicates Required Field

### Applying for Claim for Paid Family Leave (PFL) Benefits - New Mother

Read the information below and check the box if you agree. A check in the box indicates an electronic signature executed by you, and is a legally binding equivalent of traditional hand-written signatures.

I have read and understand the instructions above. I understand that failure to supply any or all information may cause delay in issuing benefit checks or may cause a denial of benefits. If I make any false statement or misrepresentation or knowingly withhold of a material fact to obtain or increase any benefit or payment, EDD will disqualify me from receiving benefits and/or services and may initiate criminal prosecution against me.

Previous Cancel Next

Back to Top Contact EDD Conditions of Use Privacy Policy Accessibility

Select the box to authorize an electronic signature.

Select **Next**.

## Initial Questions

1 Initial Questions

2 DI Claim Information

3 Claim Information

4 Declaration

You are currently on Step 1 Initial Questions

\* Indicates Required Field

### Section 1 - Contact Information

Claimant Name: Jane Doe

EDD Customer Account Number: 123456789

Mailing Address: 123 Main St  
Sacramento, CA 95814

Phone Number: 916-555-1212

If your personal information has changed, select Save as Draft. To update your personal information before completing this form, select Profile. Submission of the Claim for Paid Family Leave (PFL) Benefits - New Mother, DE2501FP, is available Monday - Saturday, 6 a.m. to 6 p.m. and Sunday, 6 a.m. to 5:30 p.m.

Is this address different from the address where you received your last payment for your Disability Insurance claim?  Yes  No

\* Have you stopped claiming Disability Insurance benefits?  Yes  No

Previous

Cancel

Save as Draft

Next

## Note

Select **Save as Draft** at any time to complete the form later.

Select **Previous** to return to the previous screen.

The system automatically fills certain portions of the claim form.

- Make sure the information is correct. If your personal information has changed, select **Save as Draft** and update your SDI Online profile.
- Select **Next** to continue.

## Important

If you are still claiming disability benefits, you cannot submit this claim form. Complete this form after your final disability payment is issued.

# DI Claim Information

Initial Questions **2 DI Claim Information** 3 Claim Information 4 Declaration

You are currently on Step 2 DI Claim Information

## Section 2 - DI Claim Information

Social Security Number: xxx-xx-xxxx

\* Disability Insurance Claim Effective Date: (MMDDYYYY)

\* Final Date of Disability Insurance Benefits: (MMDDYYYY)

Do not submit this form unless you have stopped claiming Disability Insurance benefits and you are ready to claim PFL benefits to bond with your baby/babies.

Previous

Cancel

Save as Draft

Next

As a reminder, do not file for bonding benefits until you have fully recovered from childbirth and received your final disability payment.

- If you're still claiming disability benefits, select **Save as Draft** and complete the form later.
- To continue, make sure the prefilled information is correct. Next, enter the dates your disability claim started and ended to ensure your bonding claim is processed correctly.
- Select **Next** to continue.



## Paid Family Leave Claim Information

Initial Questions

DI Claim Information

3 Claim Information

4 Declaration

You are currently on Step 3 Claim Information

\*Indicates Required Field

### Section 3 - Baby Information

If you had a multiple birth, provide information for only one baby.

\*Baby's First Name:

Baby's Middle Initial:

\*Baby's Last Name:

Baby's Suffix:

\*Baby's Date of Birth:

\*Baby's Gender:  Male  Female

### Section 4 - Paid Family Leave Claim Information

Any overlapping period between Disability Insurance and Paid Family Leave will result in a disqualification of benefits from one of the programs.

\*Last Day Worked:

\*Do you want your Paid Family Leave claim to begin on the day after you stop claiming disability insurance benefits?  Yes  No

If "No," enter the date you want your Paid Family Leave claim to begin:

\*Do you want to claim the maximum amount of benefit weeks now?  Yes  No

If "No," enter the date you want to be paid through:

### Section 5 - Employer Information

\*Will you work at any time during your family leave?  Yes  No

If "Yes," enter the date you returned to work:

\*Will you continue to receive wages from your employer(s) during the period you are claiming Paid Family Leave benefits?  Yes  No

If "Yes," indicate type of pay:

Beginning Payment Date:

Ending Payment Date:

\*Do you have more than one employer?  Yes  No

\*Have you filed or do you intend to file for workers' compensation benefits?  Yes  No

Previous

Cancel

Save as Draft

Next

You must complete the following sections:

- Section 3 - Baby Information
- Section 4 - Paid Family Leave Claim Information
- Section 5 - Employer Information

Confirm the information and dates you enter are correct to avoid a possible delay of benefits.

You must complete all required fields marked with a red asterisk (\*).

Select **Next** to continue.

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SDI Home Inbox New Claim Draft Profile History

## Declaration

Initial Questions ✓ DI Claim Information ✓ Claim Information ✓ 4 Declaration

You are currently on Step 4 Declaration

\*Indicates Required Field

### Section 6 - 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 6 - Payment Choice by selecting how you want to get benefit payments from the options listed.

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

## Section 7 - Declaration

Read the information below and check the box if you agree. A check in the box indicates an electronic signature executed by you, and is a legally binding equivalent of traditional hand-written signatures.

\*  By my electronic signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was bonding with the bonding recipient named above; (2) authorize EDD to release my personal information as shown on this claim to the bonding recipient; (3) authorize my employer(s) to disclose to EDD all facts concerning my employment that are within their knowledge; and (4) authorize release and use of information as stated in the Information Collection and Access section of the [Important Paid Family Leave Program Information](#) page. 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 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. 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 electronic signature or the effective date of the claim, whichever is later.

Previous

Cancel

Save as Draft

Submit

Next, select the box to authorize an electronic signature and the release of your information.

**Note:** You cannot modify the form after you select Submit.

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

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 Questions

\*Indicates Required Field

### Paid Family Leave (PFL) Survey

The EDD has received your portion of your claim for Paid Family Leave benefits. There is one more step to complete before you receive your claim receipt number. Please answer the questions below and then select the "Submit" button for your receipt number.

**\*Before you filed your Paid Family Leave (PFL) claim, how did you learn about the Paid Family Leave (PFL) benefit program? Please select the response that best applies:**

- From a brochure I received by U.S. mail.
- From a friend or family member.
- From an SDI Online Notification.
- From my employer.
- From a social worker or hospital employee.
- None of these.

Back to Top Contact EDD Conditions of Use Privacy Policy Accessibility

Complete the survey and select **Submit**.

## Confirmation

Print this page for your records. If a printer is unavailable at this time, record the Form Receipt Number below. The Form Receipt Number is required to retrieve a copy of the *Claim for Paid Family Leave (PFL) – New Mother (DE 2501FP)* application. You will not be able to access your confirmation page and Form Receipt Number after this window is closed.

Most claims are processed and a decision is made within two weeks of the date the claim was submitted. If you have not received anything from PFL within 10 days or if you have any questions you may call 1-877-238-4373.

### Confirmation Information

Claimant Name: Jane Doe

Social Security Number: XXX-XX-XXXX

You requested to have your PFL claim begin on this date. If this field is blank, your PFL claim will begin on the day after you stop claiming Disability Insurance benefits:

Receipt Number: R10000000032192

### Warning

You will receive a paper version of the *Claim for Paid Family Leave (PFL) – New Mother (DE 2501FP)* in the mail. Do NOT return the paper form for the benefit period you just successfully submitted online.

On the Confirmation screen we assign your claim a **Receipt Number**. Save your Receipt Number for future reference. We will ask for it when you contact us.

Most claims are processed within 14 days. Do not submit another claim because it can delay your benefits.

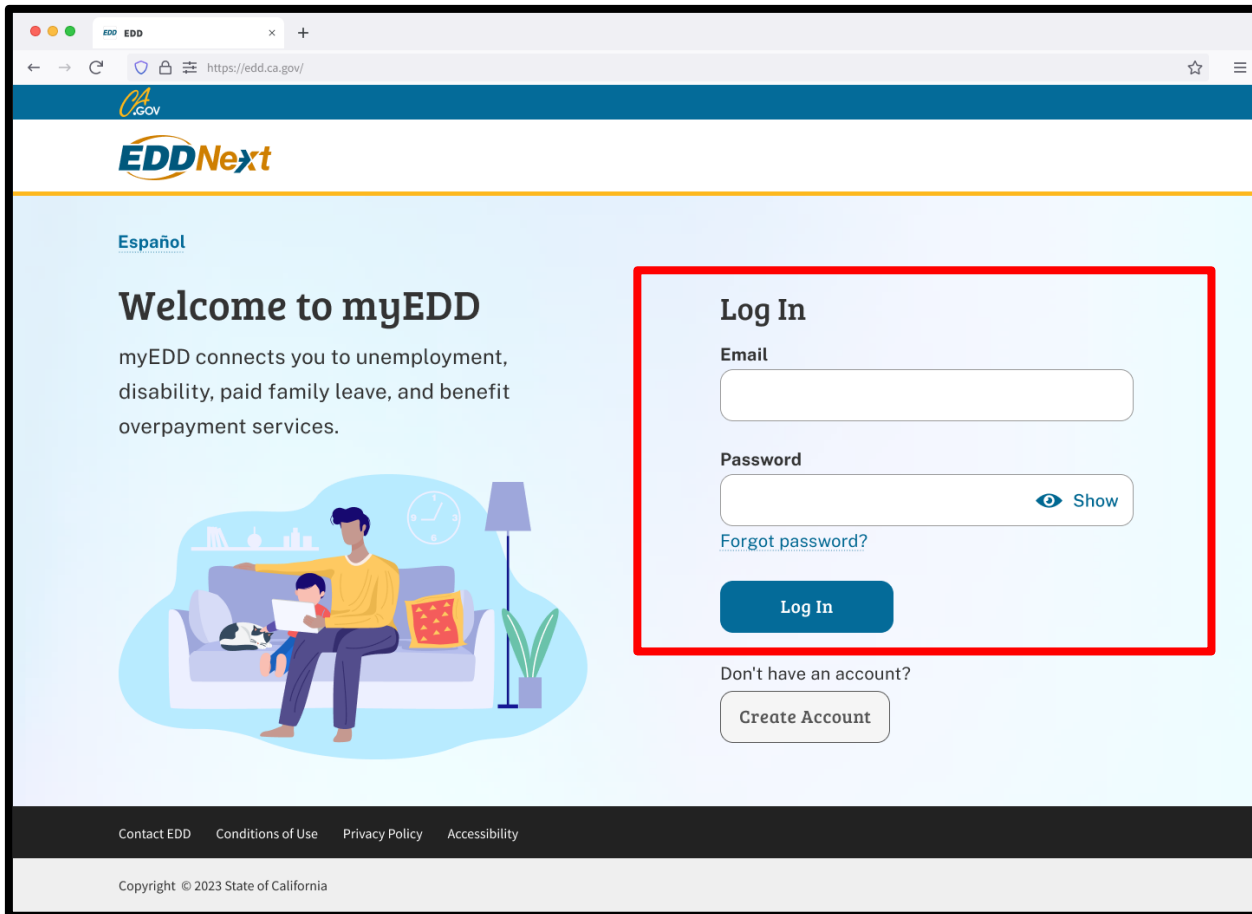
# File a Bonding Claim

New Mothers (without a pregnancy-related disability claim), Fathers, and Foster or Adoptive Parents

Learn more about how new mothers (without a pregnancy-related disability claim), fathers, and foster care or adoptive parents file for bonding benefits.



[Get Started](#)

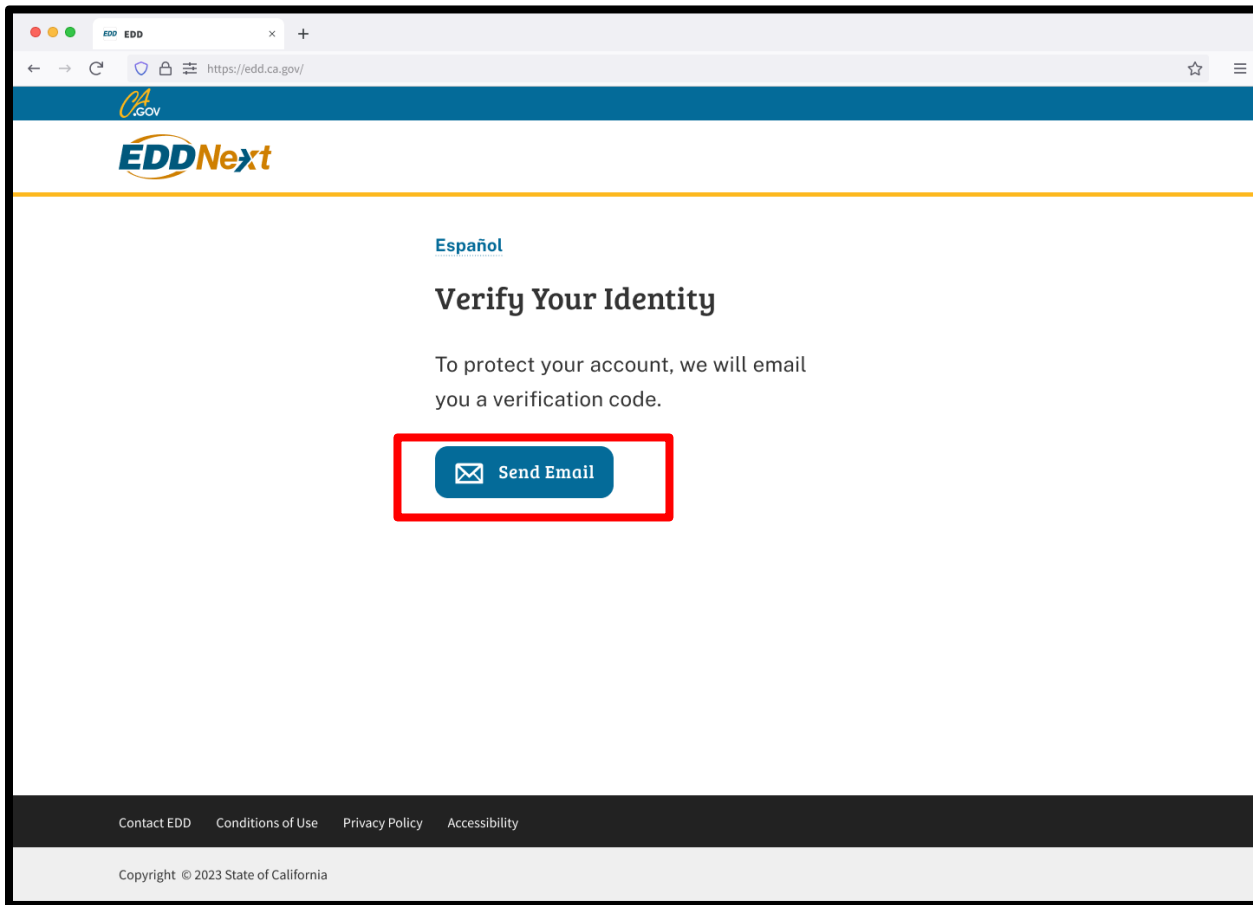


## Note

For Spanish, select **Español**.

Log in to myEDD to access SDI Online, update your email, password, security question, or verification option:

1. Visit [myEDD](#).
2. Enter the email and password used to create your 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.

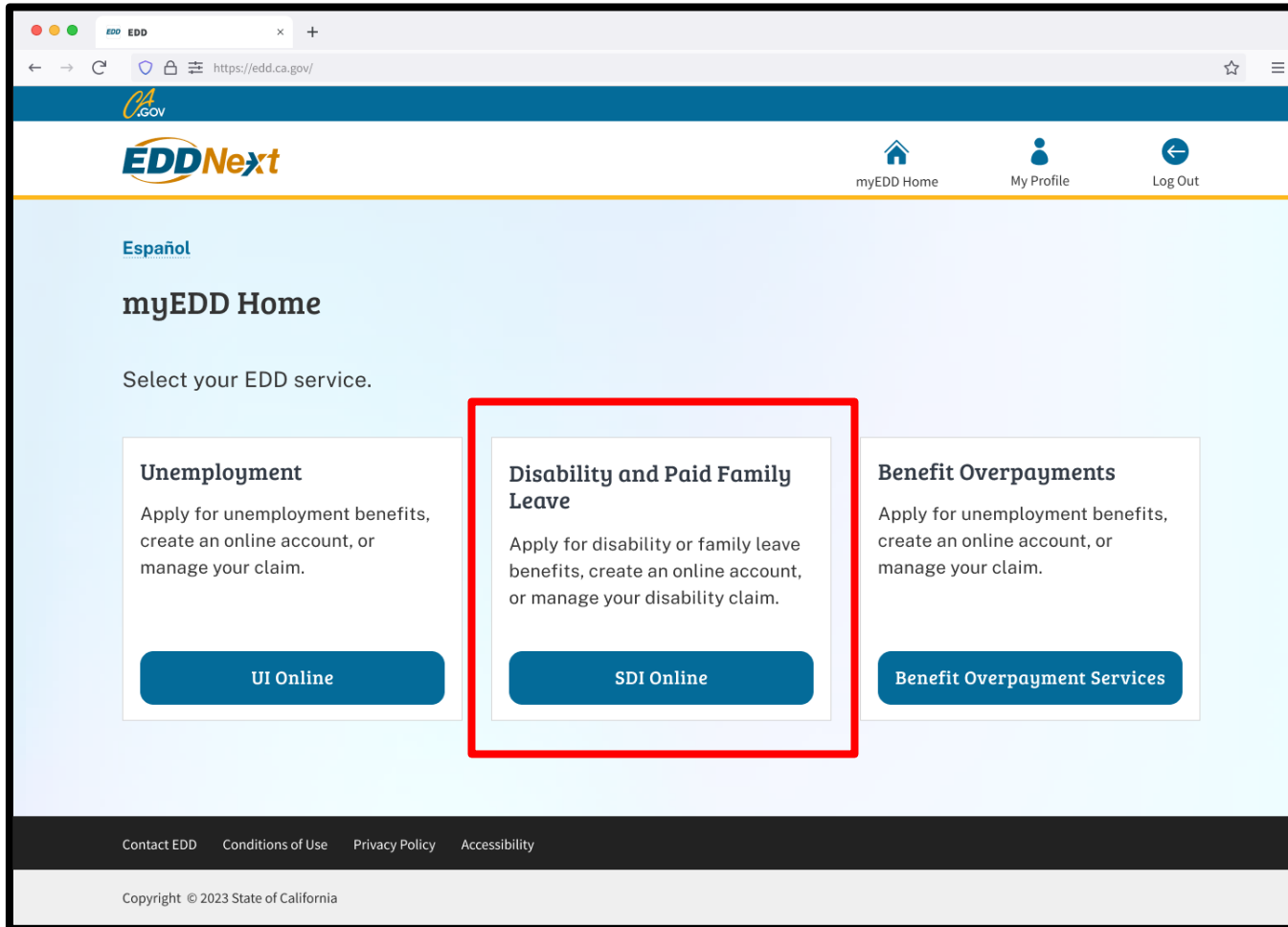


The screenshot shows the EDD Next website interface. At the top, there is a navigation bar with the EDD logo and the text "EDDNext". Below the navigation bar, there is a link for "Español". The main heading is "Enter Verification Code". The text below the heading reads: "Enter the verification code you received at {J\*\*\*\*\*@gmail.com}. This code expires in 5 minutes." There is a red box around the text "\*Required Field" and another red box around the text "\*Verification Code" above a text input field. Below the input field is a blue "Submit" button. At the bottom of the form, there is a link that says "Didn't get the email? Check your spam folder or [resend the email.](#)". The footer contains links for "Contact EDD", "Conditions of Use", "Privacy Policy", and "Accessibility", along with the copyright notice "Copyright © 2023 State of California".

The screenshot shows a Gmail inbox. The selected email is titled "myEDD Verification Code" and is from the "California Employment Development Department". The email content includes the EDD logo and the text: "Hello, Enter the following verification code in myEDD. This code will expire in 5 minutes." Below this text, the verification code "012345" is displayed in a red box. The email also includes the text "Do not reply to this auto-generated message." and "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.



**Note**  
Select **Log Out** in the top right corner of any screen to exit your account.

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](mailto:Jdoe@gmail.com)

### Current Disability Insurance Claim(s)

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

## Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

Note: It may be necessary to send some documents via US Postal Service.

### Apply for Disability Insurance Benefits

Disability Insurance

### Apply for Paid Family Leave Benefits

Paid Family Leave Bonding

Submit Electronic Paid Family Leave Bonding Attachment

Paid Family Leave Care

Submit Electronic Paid Family Leave Care Attachment

Paid Family Leave Military Assist

Submit Electronic Paid Family Leave Military Assist Attachment

### Saved Drafts

To open and complete a form that you saved, select the **Form Name**. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the **Delete** button.

To apply for bonding benefits, select **Paid Family Leave Bonding** under Apply for Paid Family Leave Benefits.

If you are unsure which application to complete, review [Types of Claims](#).

### Note

Submit your claim no earlier than the first day your family leave begins, but no later than 41 days after your family leave begins, or you may lose benefits.

### Important

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

## Prescreening Questions

\* Indicates Required Field

### Prescreening Questions

\* Are you a mother bonding with your newborn?  Yes  No

\* Did you receive California State Disability Insurance benefits for your pregnancy with this newborn?  Yes  No

Cancel

Next

You must answer the prescreening questions:

- If you are a new mother applying for bonding benefits and **did not** file a pregnancy-related disability claim, select **Yes** for the first question and **No** for the second question.
- If you are a new father, or an adoptive, or foster parent applying for bonding benefits, select **No** for both questions.

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

### Note

Selecting **Cancel** will cancel the claim and return you to your homepage.

## Information for Before You Start and After You File

### Before you Start: Information you need to apply for Paid Family Leave (PFL) Initial Claim Form for Bonding (DE 2501F)

PFL will use information provided in your EDD online profile, including:

- Your name (including other names under which you have worked), date of birth, gender, preferred language, and Social Security account number.
- Your mailing address (including ZIP code) and telephone number (including area code).
- The last date you worked for any employer.
- Your occupation.
- The name, mailing address and telephone number of your last employer or employers. (Be specific about the spelling of the employer's name and make sure the mailing address is correct. An incorrect address may delay benefit payments.)
- Any period you returned to work or will continue to work during your period of PFL.
- The reason why you have reduced work hours or stopped working.

#### PROOF OF RELATIONSHIP FOR BONDING

To be eligible for PFL benefits to bond with a new minor child you will also need to submit one of the documents listed below to provide proof of your relationship to the child. ONLY send copies of these documents:

- Child's Birth Certificate
- Official letter from foster care agency
- Child's Hospital Birth Certificate
- Adoptive Placement Agreement, AD-907
- Declaration of Paternity, CS 909

### After You Have Filed Your Application

#### WHEN YOUR CLAIM IS RECEIVED

When you have successfully transmitted an electronic bonding claim, the PFL office will notify you of your weekly benefit amount and request any additional information needed to determine your eligibility. If you meet all eligible requirements, a payment will be issued to you from a central payment center. The majority of claims are processed and payments issued within fourteen (14) days of receipt of a correctly completed claim.

#### SPECIAL CIRCUMSTANCES RELATING TO YOUR PAID FAMILY LEAVE CLAIM

Child Support Obligations: Questions should be directed to the Department of Child Support Services at 1-866-249-0773.

Spousal or Parental Support Obligations: Questions should be directed to the District Attorney's office administering the court order.

Death of Claimant: If a person receiving PFL benefits dies, an heir or legal representative should report the death to PFL. Benefits are payable through date of death, if otherwise eligible.

Death of Care or Bonding Recipient: If the child with whom you are bonding dies, report the death to PFL. Benefits are payable through the date of death, if otherwise eligible.

Job Benefits and Protection Programs: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) offer job protected leave to "eligible" employees for certain family and medical reasons. Contact FMLA at 1-866-487-9243 or the Department of Labor Web site:

<https://www.dol.gov/whd/fmla> or CFRA at 1-800-884-1684 or the Department of Fair Employment and Housing Web site:

<https://www.dfeh.ca.gov> for additional information on these programs.

Phone Number Link

[http://www.edd.ca.gov/Disability/Contact\\_SDI.htm#byphone](http://www.edd.ca.gov/Disability/Contact_SDI.htm#byphone)

Frequently Asked Questions Link

<http://www.edd.ca.gov/Disability/FAQs.htm#pfl>

Cancel

Next

Review the Information for Before You Start and After You File. It has important information you need to file a bonding claim.

Select **Next**.

# Applying for Paid Family Leave (PFL) Initial Claim Form for Bonding

\*Indicates Required Field

Window Snip

## Applying for Paid Family Leave (PFL) Initial Claim Form for Bonding (DE 2501F)

Please read these instructions and information before completing the electronic Claim for Paid Family Leave (PFL) Benefits (DE 2501F). Do not complete this claim form if you are insured by a Voluntary Plan maintained by your employer. (Ask your employer for the proper forms.)

The Paid Family Leave (PFL) program provides affordable, worker-funded benefits to eligible workers suffering a full or partial loss of wages due to the need to care for a seriously ill family member, to bond with a new child or assist with matters related to a family member's military deployment to a foreign country.

- (B) Call 1-877-238-4373 for required forms and instructions if:
1. A disability prevents you from completing the claim form and you need to designate a representative to sign for you.
  2. You are an authorized representative filing for benefits on behalf of a physically or mentally incapacitated care provider/care recipient or a deceased care provider/care recipient.

Do NOT submit an electronic PFL Claim for bonding if the purpose of your family leave is to care for a seriously ill family member. Follow these instructions to file for a Paid Family Leave Care application.

1. Select New Claim.
2. Choose Paid Family Leave Care.

### INELIGIBILITY:

You may apply for benefits even if you are not sure you are eligible. If you are found to be ineligible for all or part of a period claimed, you will be notified of the ineligible period and the reason(s) why you were not eligible. Below are some reasons why you may not be eligible for benefits:

- If you are claiming or receiving Unemployment Insurance or Disability Insurance (DI) benefits.
- If you are receiving workers' compensation benefits at a weekly rate equal to or greater than the PFL rate.
- If you are in custody of law enforcement authorities because you were convicted of violating law or ordinance.

### FRAUD:

If you are eligible for further benefits, additional payments will either be sent automatically or in response to your submitted certification, whichever is appropriate to your claim. You will be paid 1/7 of your weekly benefit amount for each calendar day you are eligible unless benefits are reduced for some reason. (See [Calculating Paid Family Leave Benefit Payment Amounts](#) for more information.)

**TAXABILITY OF BENEFITS:** Paid Family Leave benefits are subject to federal income taxes and will be reported to the Internal Revenue Service. Each person receiving PFL benefits will receive a 1099G form to include with his/her federal income tax return. PFL benefits are not subject to California income taxes.

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

**DISQUALIFICATION:** All available information will be considered before paying or disqualifying your claim. Benefits will be paid only for the days for which you are eligible. If payment of benefits is denied or reduced for any period, you will receive a written notice stating the reason for the disqualification or reduction.

If you deliberately report incorrect information, willfully omit or withhold information, a false statement disqualification of up to 92 days may be assessed. In addition, any resulting overpayment may be increased by a 30 percent penalty. This penalty can apply to benefits you received but were not entitled to, even if the payment has not been cashed.

I have read and understand the instructions above. I understand that failure to supply any or all information may cause delay in issuing benefit payments or may cause a denial of benefits. If I make any false statement or misrepresentation or knowingly withhold of a material fact to obtain or increase any benefit or payment, EDD will disqualify me from receiving benefits and/or services and may initiate criminal prosecution against me.

Previous

Cancel

Next

Continue to review the information on the next screen. It has more information about filing a bonding claim.

Select the box to agree to the terms.

Select **Next** to proceed.

### Note

Select **Cancel** at any time to cancel your claim.

Select **Previous** to return to the previous screen.

# Personal Information

- 1 Personal Information
- 2 Employment Information
- 3 Additional Questions
- 4 Certification
- 5 Qualifying Events
- 6 Declaration

You are currently on Step 1 Personal Information

## Verify Your Personal Information

If your personal information has changed, select **Save as Draft**, then select **Profile** from the main menu to update your information before completing this form.

**Social Security Number:** XXX-XX-XXXX

**EDD Customer Account Number:** 123456789

**Full Name:** John Doe

**Other Names (if any, under which you have worked):**

**Date of Birth:** XX-XX-XXXX

**Gender:** Male

**Mailing Address:** 123 Main St  
Sacramento, CA 95814  
United States

**Phone Number:** 916-555-1213

**Preferred Language:** English

Previous

Cancel

Save as Draft

Next

The system automatically fills certain portions of the claim form.

Make sure the information is correct. If your personal information has changed, select **Save as Draft** and update your SDI Online profile.

Select **Next** to continue.



EDD Employment Development Department State of California

SDI Home    Inbox    New Claim    Draft    Profile    History

## Employment Information

1 Personal Information    2 **Employment Information**    3 Additional Questions    4 Certification    5 Qualifying Events    6 Declaration

You are currently on Step 2 Employment Information

\*Indicates Required Field

### Your Employment Details

\*Occupation:

\*Are you a state government employee?  Yes  No

If "Yes," indicate bargaining unit number:

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

\*Do you have more than one employer?  Yes  No

\*Reason for reducing work hours or stopping work:  Participating in a qualifying event  Other

Other Reason:

### Employer Information

Enter your current or most recent employer information.

Note: An incorrect employer name or address can delay benefit payments.

\*Name of Employer:

US  International

\*Address Line 1:

Address Line 2:

\*City:

\*State: CA

Employer Phone Number:  9161234567 Ext:

Check here if the phone number is international

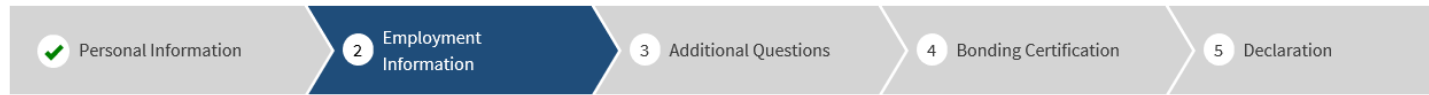
Previous    Cancel    Save as Draft    **Next**

On the Employment Information screen add your current employer's business name, phone number, and mailing address as shown on your W-2 or paystub. Ask your employer if you are unsure what address to enter.

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

Select **Next** to continue.

# Employment Details



You are currently on Step 2 Employment Information

\*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

414 k st  
sacramento CA 95834

### Updated Address

414 K St  
Sacramento CA 95814 - 3335

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 is correct.
- Select **No** to go back to the previous screen and re-enter the address.

## Additional Questions

Personal Information   Employment Information   **3 Additional Questions**   4 Bonding Certification   5 Declaration

You are currently on Step 3 Additional Questions

\*Indicates Required Field

### Section 7 - Additional Questions

\*Date you last worked:

The date you want your Paid Family Leave claim to begin should not be before the child's date of birth (or the Date of foster care or adoption placement).

\*Date you want your Paid Family Leave claim to begin:

\*Do you want to claim the maximum amount of benefit weeks now?  Yes  No

If "No," enter the date you want to be paid through:

Date you returned to work:

Or date you plan to return to work:

\*Will you work at any time during your family leave?  Yes  No

If you will receive any type of pay from your employer(s) during your family leave, indicate type of pay:  
 Sick  
 Employer Required Vacation  
 Other Type of Pay

Specify if "Other type of pay":

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

\*Have you claimed or do you plan to claim Workers' Compensation Benefits for any portion of the period covered by this claim?  Yes  No

Previous

Cancel

Save as Draft

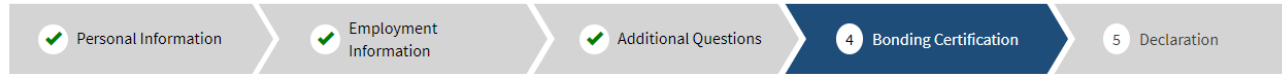
Next

Complete Section 7 - Additional Questions and confirm the dates are correct to avoid a delay or incorrect payment of benefits.

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

Select **Next** to continue.

# Bonding Certification



You are currently on Step 4 Bonding Certification

\* Indicates Required Field

## Section 3 - Personal Information

\* Child relationship:

If you select foster care, adoption or guardianship, please provide the date of placement:

## Section 4 - Child's Legal Name and Information

Child's Social Security Number (if available):

\* Child's First Name:

Middle Initial:

\* Last Name:

Suffix:

\* Date of Birth:

\* Child's Gender:  Male  Female

\* Is child's residence address different from your residence address?  Yes  No

In the Section 3 - Personal Information, select your relationship to the child you are bonding.

Complete Section 4 - Child's Legal Name and Information with the child's information.

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

### Note

If the child's legal residence is different than yours, select **Yes** to enter the child's legal address on another screen.

## Section 5 - Proof of Relationship

To be eligible for Paid Family Leave benefits to bond with a new child, you must submit an approved "Proof of Relationship" document. The "Proof of Relationship" must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online bonding claim.

*Proof of Relationship document includes:*

- Child's Birth Certificate
- Official letter from foster care agency
- Child's Hospital Birth Certificate
- Adoptive Placement Agreement, AD-907
- Declaration of Paternity, CS-909
- Independent Adoption Placement Agreement, AD-924
- Approval of Family Caregiver Home, SOC-815
- Other evidence of relationship

\* Please indicate the type of "Proof of Relationship" you plan on providing from the list of approved "Proof of Relationship" documents:

Select

*Failure to submit the "Proof of Relationship" will result in claim disqualification and no payment will be issued. Further instructions for submitting "Proof of Relationship" will be provided on the confirmation page.*

Previous

Cancel

Save as Draft

Next

## Note

The accepted "Proof of Relationship" document options are:

- Child's birth certificate
- Official letter from foster care agency
- Child's hospital birth certificate
- Adoptive Placement Agreement, AD-907
- Declaration of Paternity, CS-909
- Independent Adoption Placement Agreement, AD-924
- Approval of Family Caregiver Home, SOC-815
- Other evidence of relationship

To be eligible for bonding benefits, you must provide an approved Proof of Relationship document after you submit your claim. Upload or mail one of the accepted documents within 10 days from the date you send us your online bonding claim.

Select the type of Proof of Relationship document you plan on giving us after completing the online claim.

Instructions to upload or mail your proof of relationship documents are available on the Confirmation screen.

Select **Next** to continue.

## Child's Residence Address



Personal Information



Employment Information



Additional Questions

4

Bonding Certification

5

Declaration

You are currently on Step 4 Bonding Certification

\*Indicates Required Field

### Section 6 - Residence Address

US  International

\*Address Line 1:

Address Line 2:

\*City:

\*State:

\*ZIP Code:

Previous

Cancel

Save as Draft

Next

If you selected **Yes** to “Is the child’s residence address different from your resident address?” you must enter the child’s residential address in Section 6 – Residence Address.

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

If you selected **No** to the above question, skip to the next page.

Select **Next** to continue.

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EDD Employment Development Department State of California

SDI Home Inbox New Claim Draft Profile History

## Declaration

Personal Information Employment Information Additional Questions Bonding Certification 5 Declaration

You are currently on Step 5 Declaration

\*Indicates Required Field

### Section 8 - 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 8 - 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.

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EDD Employment Development Department State of California

SDI Home Inbox New Claim Draft Profile History

## Section 9 - Declaration

Read the information below and check the box if you agree. A check in the box indicates an electronic signature executed by you, and is a legally binding equivalent of traditional handwritten signatures.

\*  By my signature on this bonding certification, I authorize the medical provider, adoption agency, adoption party(ies), or foster care placement agency to disclose to the Employment Development Department all facts concerning the birth, adoption, or foster care placement of the above-named child. 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 punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements or documents, is to the best of my knowledge and belief true, correct, and complete. 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.

\*  By my electronic signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was bonding with the bonding recipient named above; (2) authorize EDD to release my personal information as shown on this claim to the bonding recipient; (3) authorize my employer(s) to disclose to EDD all facts concerning my employment that are within their knowledge; and (4) authorize release and use of information as stated in the Information Collection and Access section of the [Important Paid Family Leave Program Information](#) page. 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 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. 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 electronic signature or the effective date of the claim, whichever is later.

Previous Cancel Save as Draft Submit

Back to Top Contact EDD Conditions of Use Privacy Policy Accessibility

Select both check boxes to authorize an electronic signature and the release of your information.

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

**Note:** You cannot modify the form after you select Submit.

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



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SDI Home Inbox New Claim Draft Profile History

## Paid Family Leave (PFL) Survey Questions

\*Indicates Required Field

### Paid Family Leave (PFL) Survey

The EDD has received your portion of your claim for Paid Family Leave benefits. There is one more step to complete before you receive your claim receipt number. Please answer the questions below and then select the "Submit" button for your receipt number.

**\*Before you filed your Paid Family Leave (PFL) claim, how did you learn about the Paid Family Leave (PFL) benefit program? Please select the response that best applies:**

- From a brochure I received by U.S. mail.
- From a friend or family member.
- From an SDI Online Notification.
- From my employer.
- From a social worker or hospital employee.
- None of these.

Submit

Back to Top Contact EDD Conditions of Use Privacy Policy Accessibility

Complete the survey and select **Submit** to proceed to the next step.

CA.GOV Home Log Out

EDD Employment Development Department State of California

SDI Home Inbox New Claim Draft Profile History

## Confirmation

IMPORTANT: Print this page for your records. If a printer is unavailable at this time, record the Form Receipt Number below. The Form Receipt Number is required to retrieve a copy of the *Paid Family Leave Claim Bonding* (DE 2501F) application. You will not be able to access your confirmation page and Form Receipt Number after this window is closed.

Most claims are processed and a decision is made within two weeks of the date the claim was submitted. If you have not received anything from PFL within 10 days or if you have any questions you may call 1-877-238-4373.

### Confirmation Information

Claimant Name:	John Doe	Social Security Number:	XXX-XX-XXXX
Date you requested to have your Paid Family Leave claim begin:	01-21-2021	Receipt Number:	R10000000032193

### Instructions for Submitting Proof of Relationship

To be eligible for Paid Family Leave benefits to bond with a new child you must submit an approved "Proof of Relationship" document. The "Proof of Relationship" must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online bonding claim.

We assign your claim a Receipt Number on the Confirmation screen.

## Note

Save the Receipt Number. You need this number to upload your supporting documentation to the correct online claim.

## Important

**Your claim is not complete.** The Confirmation screen provides instructions to upload the other documentation for your bonding claim.

## Instructions for Submitting Proof of Relationship

To be eligible for Paid Family Leave benefits to bond with a new child you must submit an approved "Proof of Relationship" document. The "Proof of Relationship" must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online bonding claim.

*Failure to submit the "Proof of Relationship" will result in claim disqualification and no payment will be issued.*

### Electronically

You may attach your electronic "Proof of Relationship" now:

[Attach my Proof of Relationship](#)

You may also submit your electronic Proof of Relationship at a later date by following these navigation instructions:

1. Select New Claim on the Main Menu.
2. Choose Submit Electronic Paid Family Leave Bonding Attachment.

### Mail

If you are mailing a "Proof of Relationship" document it must be a photocopy. Do not mail originals. On each page include your 9-digit Social Security Number, receipt number and date you requested to have your Paid Family Leave claim begin. The receipt number can be found above.

Mail your document to:  
**EDD - Paid Family Leave**  
**PO BOX 997017**  
**SACRAMENTO CA 95799-7017**

To complete your bonding claim, you must submit your Proof of Relationship online or by mail.

- To submit it online, select **Attach my Proof of Relationship** and follow the instructions. Review [Submit Supporting Bonding Claim Documents](#) for instructions.
- To submit by mail, send copies of your proof of relationship documents to the address on the screen. Do not mail originals. On each page include your nine-digit Social Security number, Receipt Number, and your requested claim start date.

# Submit Supporting Bonding Claim Documents

Learn more about how to submit your proof of relationship documents to complete your claim for bonding benefits.



[Get Started](#)

## 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

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

### Current Disability Insurance Claim(s)

To submit your Proof of Relationship document or if you need to submit more than one document (e.g., birth certificates for twins or to resubmit a document):

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

# Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

Note: It may be necessary to send some documents via US Postal Service.

## Apply for Disability Insurance Benefits

[Disability Insurance](#)

## Apply for Paid Family Leave Benefits

[Paid Family Leave Bonding](#)

[Submit Electronic Paid Family Leave Bonding Attachment](#)

[Paid Family Leave Care](#)

[Submit Electronic Paid Family Leave Care Attachment](#)

[Paid Family Leave Military Assist](#)

[Submit Electronic Paid Family Leave Military Assist Attachment](#)

## Saved Drafts

To open and complete a form that you saved, select the **Form Name**. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the **Delete** button.

Select **Submit Electronic Paid Family Leave Bonding Attachment** under Apply for Paid Family Leave Benefits.

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## Form Attachment

To attach a file to your successfully submitted Paid Family Leave claim form, choose the 'Select' link under the Action field. Most claims are processed and a decision is made within two weeks of the date the claim was submitted.

*If you have not received anything from PFL within 10 days or if you have any questions you may call 1-877-238-4373.*

### Select Claim to Attach Document

Form Name	Submitted Date	Receipt Number	Action
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Bond with Child	07-01-2021	R100000000032193	Select

Cancel

Back to Top Contact EDD Conditions of Use Privacy Policy Accessibility

Make sure the Receipt Number matches the number you got when you submitted the online claim.

If it matches your claim, choose **Select** from the Action column to attach a document to your claim.

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Employment Development Department State of California

SDI Home Inbox New Claim Draft Profile History

## Attachment

\*Indicates Required Field

### Identifying Information for Previously Submitted Paid Family Leave Initial Bonding Claim

Your Social Security Number:	XXX-XX-0001	Date you requested to have your Paid Family Leave claim begin:	01-21-2021
Form Receipt Number:	R100000000032193		

### Previously Submitted Attachments for Paid Family Leave Initial Bonding Claim

No Results Found

## Attachment

To attach a document, select the **Browse** button below.

- File size: less than 5MB
- File type: PDF, JPG, JPEG, TIF or TIFF

\*Please click the "Browse" button to browse for the document:

No file chosen **Browse**

\*Do you want to attach more documents?  Yes  No

Previous Cancel **Submit**

Back to Top Contact EDD Conditions of Use Privacy Policy Accessibility

To upload a document, select **Browse**.

To upload more than one document, select **Yes** and then select **Browse**. After uploading one document, the system sends you back to the Attachment screen to continue uploading documents.

When you are done uploading, select **No** and then **Submit**.



CA.GOV Home Out

EDD Employment Development Department State of California

SDI Home Inbox New Claim Draft Profile History

## Attachment

\*Indicates Required Field

### Identifying Information for Previously Submitted Paid Family Leave Initial Bonding Claim

Your Social Security Number: XXX-XX-0001 Date you requested to have your Paid Family Leave claim begin: 01-21-2021

Form Receipt Number: R100000000032193

### Previously Submitted Attachments for Paid Family Leave Initial Bonding Claim

File Name	Receipt Number
Birth Certificate.jpg	R100000000032195

## Attachment

To attach a document, select the **Browse** button below.

- File size: less than 5MB
- File type: PDF, JPG, JPEG, TIF or TIFF

\*Please click the "Browse" button to browse for the document:

No file chosen **Browse**

\*Do you want to attach more documents?  Yes  No

Previous Cancel **Submit**

Back to Top Contact EDD Conditions of Use Privacy Policy Accessibility

The Attachment screen confirms that the attachment was uploaded.

Save the **Receipt Number** for future reference. Select **Submit**.

Your bonding claim is now complete. It can take up to 14 days to process your claim.

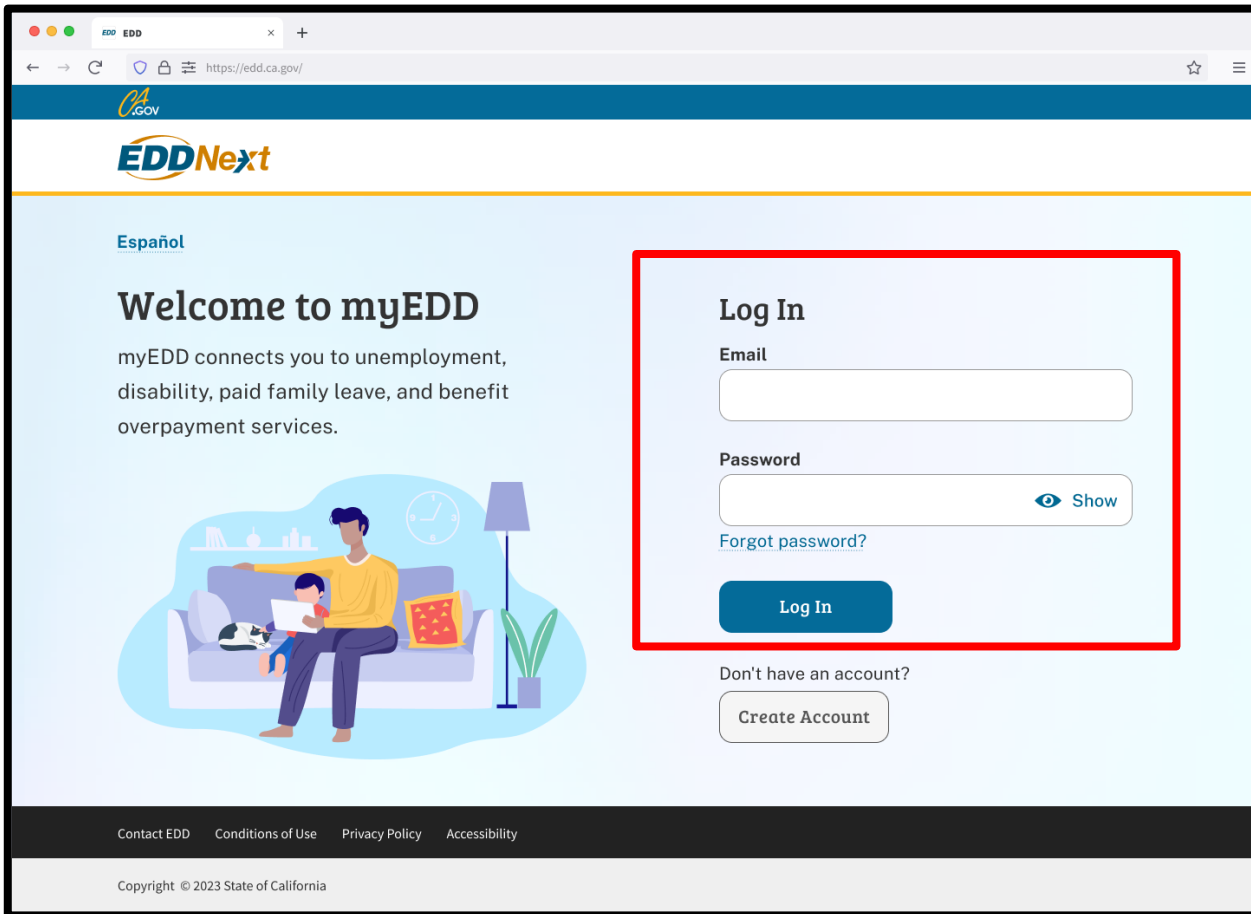


# File a Care Claim

Learn more about how individuals providing care to a seriously ill or injured family member apply for care benefits.



[Get Started](#)

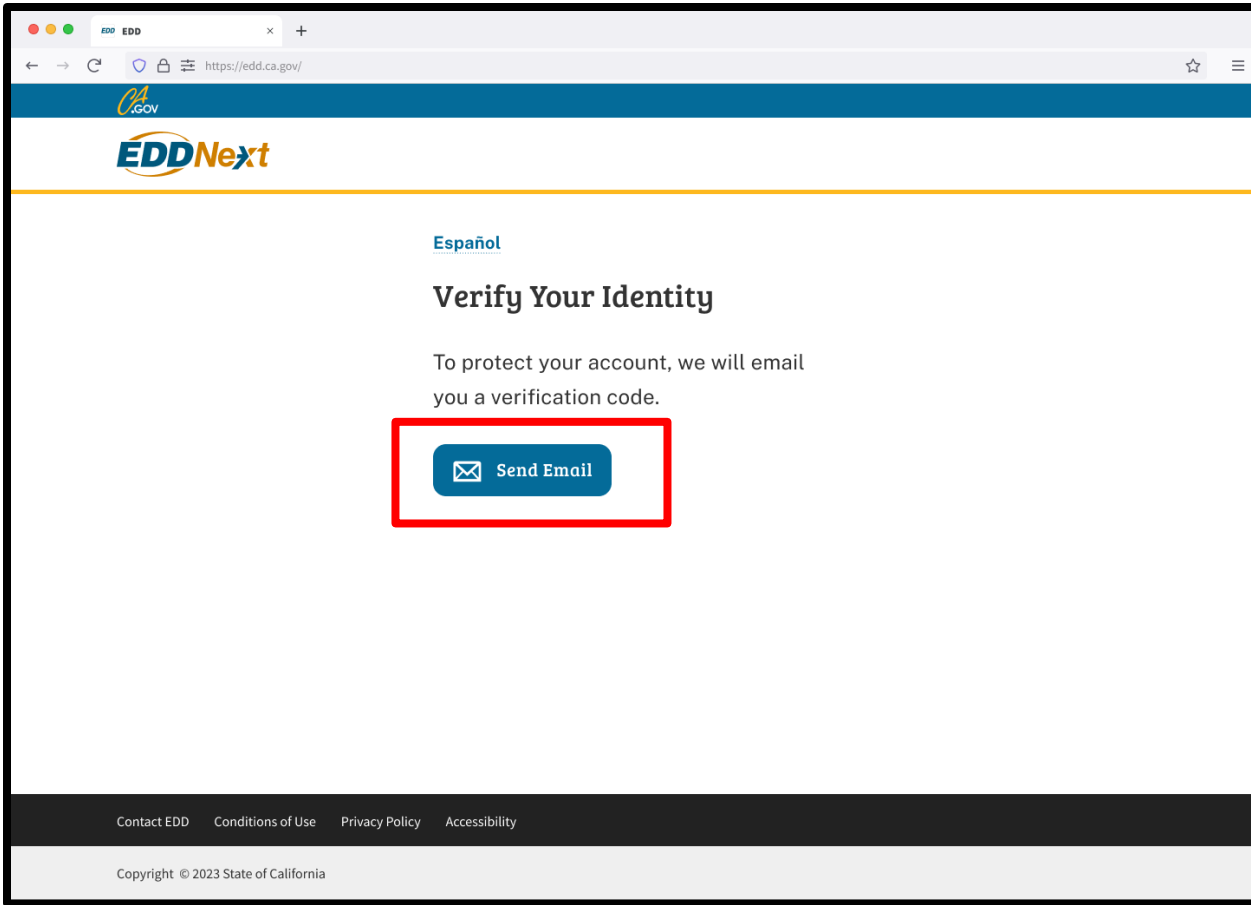


## Note

For Spanish, select **Español**.

Log in to myEDD to access SDI Online, update your email, password, security question, or login verification option:

1. Visit [myEDD](#).
2. Enter the email and password used to create your myEDD account.
3. Select **Log In**.



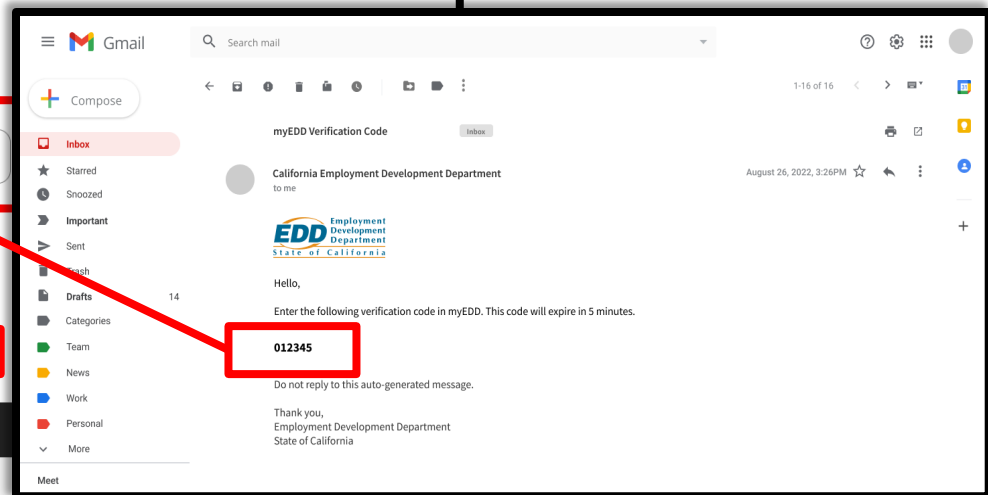
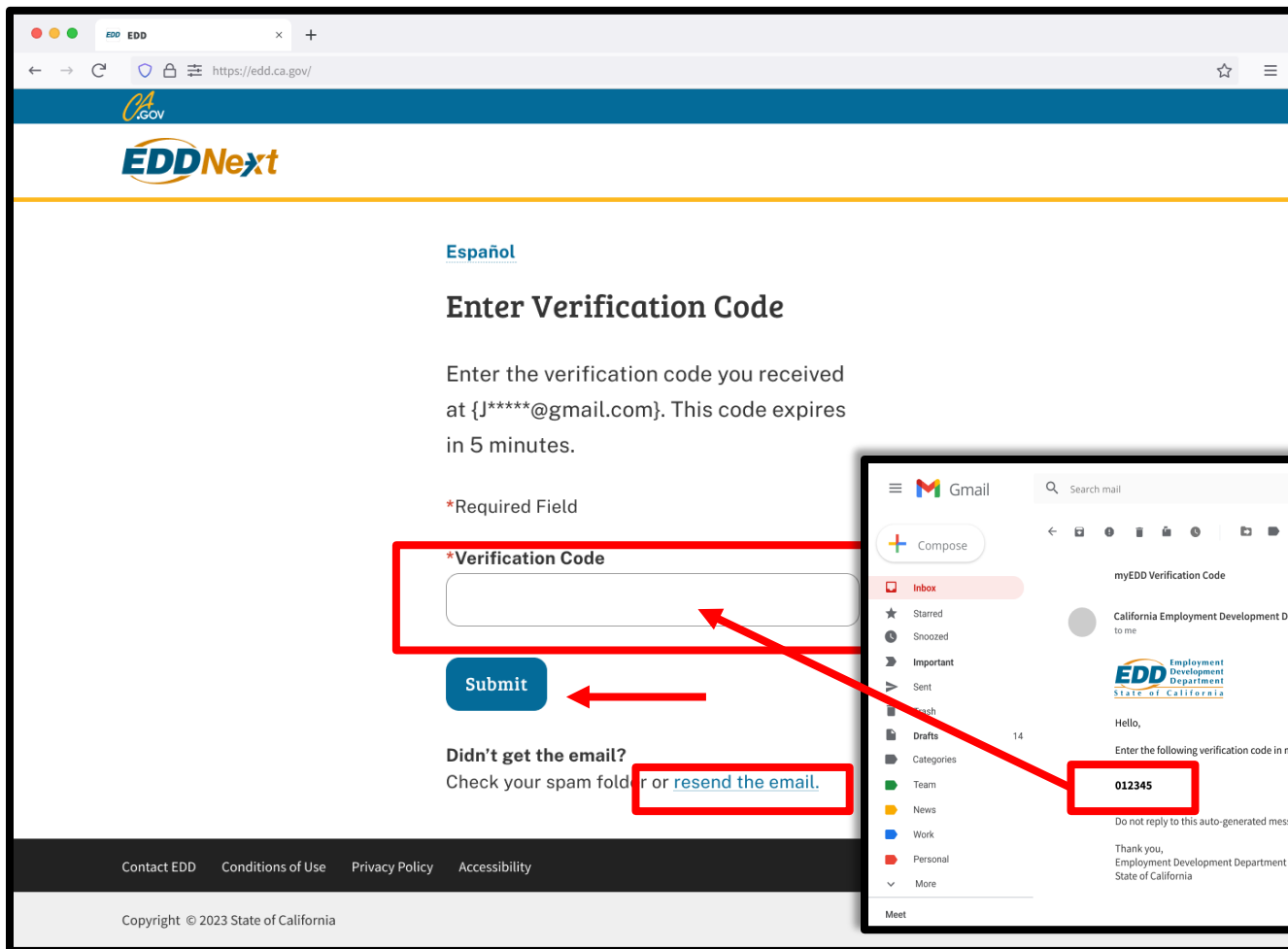
## Note

You can verify your identity through email even if your preferred verification option is text or voice.

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.

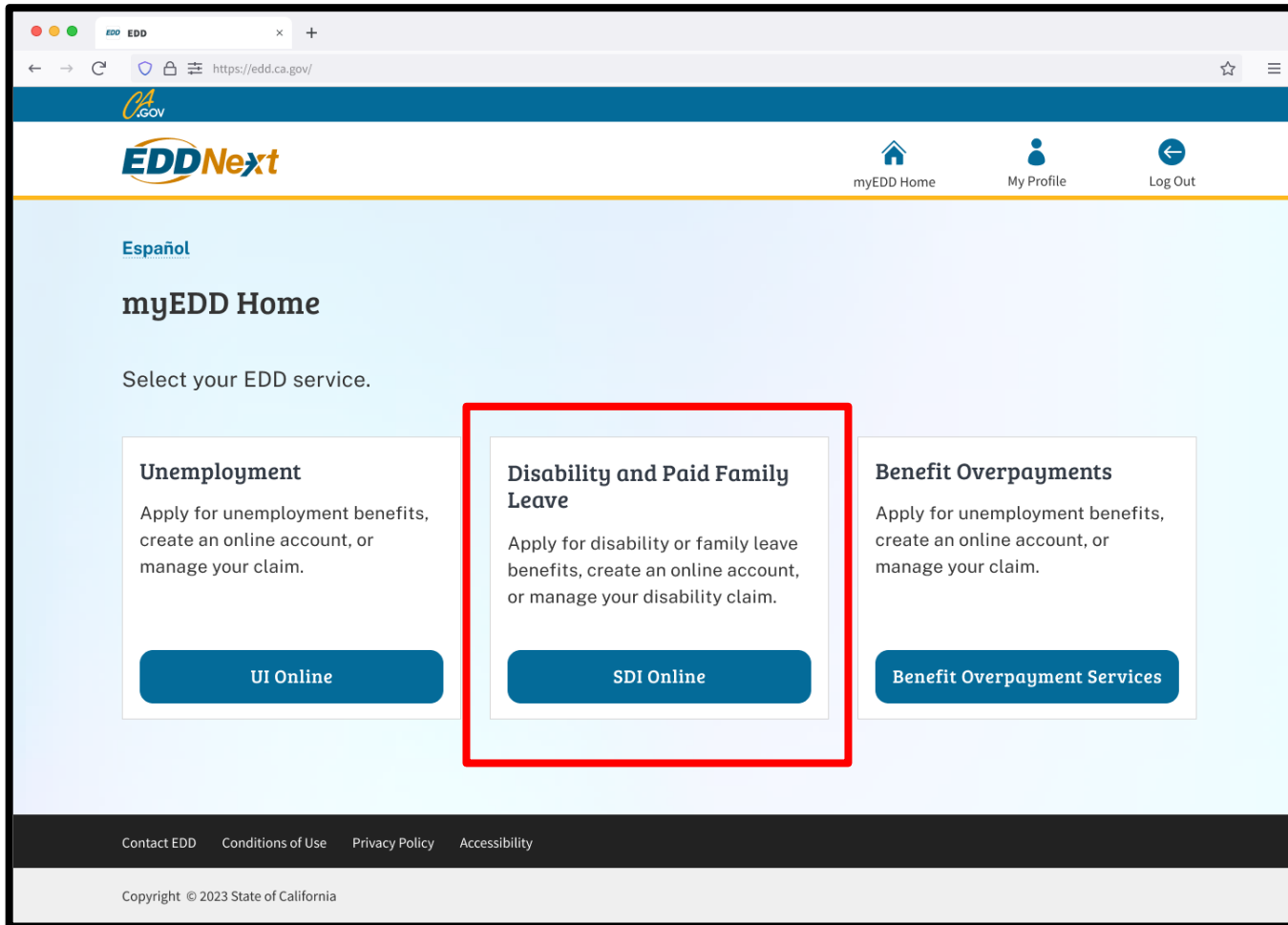
Select **Send Email**.

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.



**Note**

Select **Log Out** in the top right corner of any screen to exit your account.

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

<b>Full Name:</b>	John Doe	<b>EDD Customer Account Number:</b>	123456789
<b>Mailing Address:</b>	123 Main St Sacramento, CA 95814	<b>Phone Number:</b>	916-555-1212
<b>Residence Address:</b>	123 Main St Sacramento, CA 95814	<b>Cell Phone Number:</b>	916-555-1213
<b>E-mail Address:</b>	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.

## Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

Note: It may be necessary to send some documents via US Postal Service.

### Apply for Disability Insurance Benefits

Disability Insurance

### Apply for Paid Family Leave Benefits

Paid Family Leave Bonding

Submit Electronic Paid Family Leave Bonding Attachment

Paid Family Leave Care

Submit Electronic Paid Family Leave Care Attachment

Paid Family Leave Military Assist

Submit Electronic Paid Family Leave Military Assist Attachment

### Saved Drafts

To open and complete a form that you saved, select the **Form Name**. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the **Delete** button.

To apply for care benefits, select **Paid Family Leave Care** under Apply for Paid Family Leave Benefits.

If you are unsure which application to complete, review [Types of Claims](#).

### Note

Submit your claim no earlier than the first day your family leave begins, but no later than 41 days after your family leave begins, or you may lose benefits.

### Important

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



# Information for Before You Start and After You File

## Before You Start and After You File

Please have the following information available while completing this form:

- Most current employer(s) business name, telephone number, and mailing address as stated on your W2 form and/or paycheck stub.
- Last date you worked your regular or customary duties and hours.
- Wages you received or expect to receive from your employer: sick leave, paid time off (PTO), vacation pay, annual leave, and wages earned after you stopped working.
- You are responsible for obtaining a Physician/Practitioner Certification to verify care is needed. A disqualification will be sent to you if the Physician/Practitioner Certification is not received within 10 days.
- Please note that your employer will be notified that you have submitted a PFL claim. However, your detailed claim information is confidential and will not be shared with your employer.

Cancel

Next

Review the Information for Before You Start and After You File. It has important information you need to file a care claim.

Select **Next**.

1 Personal Information

2 Employment Information

3 Additional Questions

4 Care Certification

5 Declaration

You are currently on Step 1 Personal Information

## Section 1 - Personal Information

**Social Security Number:** XXX-XX-XXXX

**EDD Customer Account Number:** 123456789

**Full Name:** John Doe

**Other Names (if any, under which you have worked):**

**Date of Birth:** XX-XX-XXXX

**Gender:** Male

**Mailing Address:** 123 Main St  
Sacramento, CA 95814

**Phone Number:** 916-555-1212

**Preferred Language:**

If your personal information has changed, select Save as Draft. To update your personal information before completing this form, select Profile.

Previous

Cancel

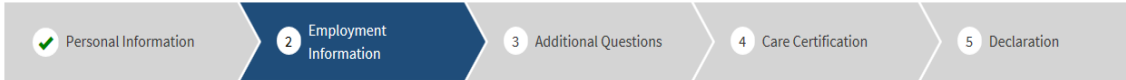
Save as Draft

Next

The system automatically fills certain portions of the claim form.

- Make sure the information is correct. If your personal information has changed, select **Save as Draft** and update your SDI Online profile.
- Select **Next** to continue.

# Employment Details



You are currently on Step 2 Employment Information

\* Indicates Required Field

## Section 2 - Employer Information

Enter your current employer. If unemployed, enter your most recent employer.

\* Name of Your Employer:

\* Occupation:

\* Are you a state government employee?  Yes  No

If "Yes", Indicate Bargaining Unit Number:

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

\* Do you have more than one employer?  Yes  No

\* Reason for reducing work hours or stopping work:  Care for Family Member  Other

## Employer Mailing Address

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

Previous

Cancel

Save as Draft

Next

Complete Section 2 - Employer Information with your current employer's business name, phone number, and mailing address as shown on your W-2 or paystub. If you're unsure what address to enter, ask your employer.

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

Select **Next** to continue.

## Additional Questions

✓ Personal Information    ✓ Employment Information    **3 Additional Questions**    4 Care Certification    5 Declaration

You are currently on Step 3 Additional Questions

\*Indicates Required Field

### Section 3 - Additional Questions

\*Date you last worked:

\*Date you want your Paid Family Leave claim to begin:

\*Do you want to claim the maximum amount of benefit weeks now?  Yes  No

If "No," enter the date you want to be paid through:

Date you returned to work:

Or date you plan to return to work:

\*Will you work at any time during your family leave?  Yes  No

If you will receive any type of pay from your employer(s) during your family leave, indicate type of pay:

- Sick
- Employer Required Vacation
- Other Type of Pay

Specify if "Other type of pay":

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

\*Have you claimed or do you plan to claim Workers' Compensation Benefits for any portion of the period covered by this claim?  Yes  No

Previous

Cancel

Save as Draft

Next

Complete Section 3 - Additional Questions and confirm all dates are correct to avoid a delay or incorrect payment of benefits.

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

Select **Next**.

# Care Recipient's Information

- Personal Information
- Employment Information
- Additional Questions
- 4 Care Certification**
- 5 Declaration

You are currently on Step 4 Care Certification

\* Indicates Required Field

## Section 4 - Care Recipient's Information

You must submit a signed "Care Recipient Authorization of Disclosure of Personal Health Information" form and a signed "Statement of Care Recipient" form. Details on how to submit these forms will be provided on the confirmation page.

These documents must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online care claim.

\* First Name:

Middle Initial:

\* Last Name:

Suffix:

\* Gender:  Male  Female

\* Date of Birth:

\* Is any other family member ready, willing, and able and available to provide care for the same period you are claiming Paid Family Leave benefits?  Yes  No

\* Person you are caring for is your:

Other Relationship:

US  International

\* Address Line 1:

Address Line 2:

\* City:

\* State:

\* ZIP Code:

Phone Number:  Ext:

Check here if the phone number is international

Previous

Cancel

Save as Draft

Next

Complete Section 4 - Care Recipient's Information and Residence Address with information about the person you are caring for.

Details on how to submit a signed Statement of Care Recipient form are available on the Confirmation screen.

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

Select **Next**.

CA .GOV Home Log Out

EDD Employment Development Department State of California

SDI Home Inbox New Claim Draft Profile History

## Declaration

Personal Information Employment Information Additional Questions Care Certification 5 Declaration

You are currently on Step 5 Declaration

\*Indicates Required Field

### Section 5 - 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 5 - 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.

## Section 6 - Declaration

Read the information below and check each box if you agree. A check in the box indicates an electronic signature executed by you, and is a legally binding equivalent of traditional handwritten signatures.

\*  By my electronic signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was providing care for the care recipient named above; (2) authorize EDD to release my personal information as shown on this claim to the care recipient and to the care recipient's treating physician/practitioner as they are listed on this claim; (3) authorize my employer(s) to disclose to EDD all facts concerning my employment that are within their knowledge; and (4) authorize release and use of information as stated in the EDD "Information Collection and Access" section of the [Important Paid Family Leave Program Information page](#). 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 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. I agree that photocopies of this authorization shall be 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 electronic signature or the effective date of the claim, whichever is later.

Previous

Cancel

Save as Draft

Submit

In Section 6 – Declaration, select the box to authorize an electronic signature. You must select this box to complete your claim.

**Note:** You cannot modify the form after you select Submit.

Select **Submit** to send the online portion of your claim to us.

### Important

**Your claim is not complete.** The Confirmation screen provides instructions to submit the Statement of Care Recipient and the Physician's/Practitioner's Certification sections of the *Claim for Paid Family Leave (PFL) Care Benefits (DE 2501FC)*.

## Paid Family Leave (PFL) Survey Questions

\* Indicates Required Field

### Paid Family Leave (PFL) Survey

The EDD has received your portion of your claim for Paid Family Leave benefits. There is one more step to complete before you receive your claim receipt number. Please answer the questions below and then select the "Submit" button for your receipt number.

**\* Before you filed your Paid Family Leave (PFL) claim, how did you learn about the Paid Family Leave (PFL) benefit program? Please select the response that best applies:**

- From a brochure I received by U.S. mail.
- From a friend or family member.
- From an SDI Online Notification.
- From my employer.
- From a social worker or hospital employee.
- None of these.

Submit

Complete the survey and select **Submit**.



# Confirmation

Print this page for your records. If a printer is unavailable at this time, record the Form Receipt Number below. The Form Receipt Number is required to retrieve a copy of the *Paid Family Leave Claim Care* (DE 2501F) application. You will not be able to access your confirmation page and Form Receipt Number after this window is closed.

Most claims are processed and a decision is made within two weeks of the date the claim was submitted. If you have not received anything from PFL within 10 days or if you have any questions you may call 1-877-238-4373.

## Confirmation Information

**Claimant Name:** Jane Doe

**Social Security Number:** XXX-XX-XXXX

**Date you requested to have your Paid Family Leave claim begin:** 08-01-2018

**Receipt Number:** R10000000033448

## Instructions for Submitting Physician/Practitioner's Certification for Care Recipient

To be eligible for Paid Family Leave benefits to care for a family member, you must submit a "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information". These documents must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online care claim.

*Failure to submit the "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information" will result in claim disqualification and no payment will be issued.*

A paper "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information" is available to print from [http://www.edd.ca.gov/pdf\\_pub\\_ctr/de2501fc.pdf](http://www.edd.ca.gov/pdf_pub_ctr/de2501fc.pdf). Follow the instructions below to submit the completed form electronically or through the mail.

### Electronically

You may attach your electronic Physician/Practitioner's Certification for Care Recipient and Care Recipient Authorization for Disclosure of Personal Health Information

[http://www.edd.ca.gov/pdf\\_pub\\_ctr/de2501fc.pdf](http://www.edd.ca.gov/pdf_pub_ctr/de2501fc.pdf)

You may also submit it at a later time by following these navigation instructions:

1. Select New Claim
2. Choose Submit Electronic Paid Family Leave Care Attachment.

### Mail

You may mail your "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information".

Mail your document to:

**EDD - Paid Family Leave  
PO BOX 997017  
SACRAMENTO CA 95799-7017**

We assign your claim a **Receipt Number** on the Confirmation screen.

Save the **Receipt Number** for future reference. You need this number to upload the supporting documentation to the correct online claim.

A paper "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information" is available to print from [http://www.edd.ca.gov/pdf\\_pub\\_ctr/de2501fc.pdf](http://www.edd.ca.gov/pdf_pub_ctr/de2501fc.pdf). Follow the instructions below to submit the completed form electronically or through the mail.

#### Electronically

You may attach your electronic Physician/Practitioner's Certification for Care Recipient and Care Recipient Authorization for Disclosure of Personal Health Information

[http://www.edd.ca.gov/pdf\\_pub\\_ctr/de2501fc.pdf](http://www.edd.ca.gov/pdf_pub_ctr/de2501fc.pdf)

You may also submit it at a later time by following these navigation instructions:

1. Select New Claim
2. Choose Submit Electronic Paid Family Leave Care Attachment.

#### Mail

You may mail your "Physician/Practitioner's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information".

Mail your document to:  
**EDD - Paid Family Leave**  
**PO BOX 997017**  
**SACRAMENTO CA 95799-7017**

On the Confirmation screen, select the link and print the *Claim for Paid Family Leave (PFL) Care Benefits (DE 2501FC)* form. It is your responsibility to make sure this form is completed and signed by all parties and sent to us within 10 days.

- To send the DE 2501FC online, save it to your computer as a PDF, JPG, JPEG, TIF, or TIFF file.
- Or you can mail it to the address on the screen.

#### Note

You can print the DE 2501FC in English and Spanish from [Paid Family Leave Forms and Publications](#).



# Claim for Paid Family Leave (PFL) Care Benefits

Enter your receipt number here.

R1

1

## PART C – INSTRUCTIONS FOR PFL CARE CLAIMS

The care recipient (the person for whom you are providing care) must do the following: Complete and sign “Part C – Statement of Care Recipient.” If the care recipient is physically or mentally unable to sign, call PFL at 1-877-238-4373 for instructions.

The care recipient’s physician/practitioner must complete “Part D – Physician/Practitioner’s Certification” either electronically in SDI Online, or by completing and signing page 3 of *Claim for Paid Family Leave (PFL) Care Benefits* (DE 2501FC). If the care recipient is under the care of an accredited religious practitioner, call PFL at 1-877-238-4373 for the proper form *Practitioner’s Certification for Paid Family Leave Benefits* (DE 2502F).

The easiest way to have your claim processed is to submit the completed forms electronically in SDI Online as an attachment. If submitting by mail, send to the following address: Paid Family Leave, PO Box 997017, Sacramento, CA 95899-7017. If submitting electronically, return to the Homepage of your SDI Online account. Select **New Claim** from the Menu, and select **Submit Electronic Paid Family Leave Care Attachment**.

PART C – STATEMENT OF CARE RECIPIENT			
<small>(MAY BE COMPLETED BY CLAIMANT IF CARE RECIPIENT IS MENTALLY OR PHYSICALLY UNABLE TO DO SO. MUST BE SIGNED BY CARE RECIPIENT OR CARE RECIPIENT'S AUTHORIZED REPRESENTATIVE.)</small>			
C1. CARE PROVIDER SSN	C2. RECIPIENT'S DATE OF BIRTH	C3. RECIPIENT'S PHONE NUMBER	C4. RECIPIENT'S GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
C5. LEGAL NAME OF CARE RECIPIENT (FIRST, MIDDLE INITIAL, LAST)			
C6. CARE RECIPIENT'S RESIDENCE ADDRESS			
CITY _____ STATE/PROV. _____ ZIP OR POSTAL CODE _____ COUNTRY (IF NOT U.S.A.) _____			
C7. CONFIRMATION OF MEDICAL DISCLOSURE AUTHORIZATION. I authorize my physician/practitioner to disclose my current personal-health information to my care provider and to the California Employment Development Department (EDD). I further understand that copies of my signature below are as valid as the original. Care Recipient's Signature (DO NOT PRINT) _____ Date Signed _____			
C8. Authorized Representative signing on behalf of care recipient must complete the following: I, _____, represent the care recipient in this manner as authorized by <input type="checkbox"/> parental right <input type="checkbox"/> power of attorney (attach copy) <input type="checkbox"/> court order (attach copy) (For spouse or domestic partner, contact EDD). Authorized Representative's Signature (DO NOT PRINT) _____ Date Signed _____			

2

3

## Claim for Paid Family Leave (PFL) Care Benefits (DE 2501FC)

Page 1 is the Statement of Care Recipient, Part C.

To avoid delays:

1. Enter the **Receipt Number** of your claim in the top right corner.
2. Make sure you answer all questions.
3. The care recipient or their authorized representative must sign and date the bottom of this page.

**Note**

Page 2 is left blank intentionally and not shown in this tutorial.

Medical certifications must be completed by a licensed physician or practitioner authorized to certify to a patient's disability/serious health condition pursuant to California Unemployment Insurance Code Section 2708.

Enter your receipt number here. **1**

R1 \_\_\_\_\_

**PART D – PHYSICIAN/PRACTITIONER'S CERTIFICATION**

D1. PFL CLAIMANT'S (CARE PROVIDER'S) SOCIAL SECURITY NUMBER	D2. PFL CLAIMANT'S NAME (FIRST, MIDDLE INITIAL, LAST)		
D3. PATIENT'S DATE OF BIRTH	D4. DOES YOUR PATIENT REQUIRE CARE BY THE CARE PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> NO (SKIP TO D15)		
D5. PATIENT'S NAME (FIRST, MIDDLE INITIAL, LAST)			
D6. DIAGNOSIS OR, IF NOT YET DETERMINED, A DETAILED STATEMENT OF SYMPTOMS			
D7. PRIMARY ICD CODE	D8. SECONDARY ICD CODES	D9. DATE PATIENT'S CONDITION COMMENCED	
D10. FIRST DATE CARE NEEDED	D11. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CARE PROVIDER <input type="checkbox"/> PERMANENT CARE REQUIRED	D12. DATE YOU EXPECT RECOVERY <input type="checkbox"/> NEVER	
D13. APPROXIMATELY HOW MANY TOTAL HOURS PER DAY WILL PATIENT REQUIRE CARE BY A CARE PROVIDER? HOURS _____ COMMENTS _____			
D14. WOULD DISCLOSURE OF THE MEDICAL INFORMATION ON THIS CERTIFICATE BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL TO YOUR PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	D15. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER	D16. STATE OR COUNTRY (IF NOT U.S.A.) IN WHICH PHYSICIAN/PRACTITIONER IS LICENSED TO PRACTICE	
D17. PHYSICIAN/PRACTITIONER'S NAME (FIRST, MIDDLE INITIAL, LAST)			
D18. PHYSICIAN/PRACTITIONER'S ADDRESS (POST OFFICE BOX IS NOT ACCEPTABLE AS THE SOLE ADDRESS)			
CITY _____ STATE/PROV. _____ ZIP OR POSTAL CODE _____ COUNTRY (IF NOT U.S.A.) _____			
D19. TYPE OF PHYSICIAN/PRACTITIONER		D20. SPECIALTY (IF ANY)	
D21. Physician/Practitioner's Certification: I certify under penalty of perjury that this patient has a serious health condition and requires a care provider. I have performed a physical examination and/or treated the patient. I am authorized to certify a patient disability or serious health condition pursuant to California Unemployment Insurance Code section 2708. Original Signature of physician/practitioner – RUBBER STAMP IS NOT ACCEPTABLE			
PHYSICIAN/PRACTITIONER'S PHONE NUMBER _____		DATE SIGNED _____	

**3**

Under sections 2116 and 2122 of the California Unemployment Insurance Code, it is a violation for any individual who, with intent to defraud, falsely certifies the medical condition of any person in order to obtain disability insurance benefits, whether for the maker or for any other person, and is punishable by imprisonment and/or a fine not exceeding \$20,000. Sections 1143 and 3305 require additional administrative penalties.

DE 2501FC Rev. 5 (12-20) Page 3 of 4

## Claim for Paid Family Leave (PFL) Care Benefits (DE 2501FC), cont'd

Page 3 is the Physician/Practitioner's Certification, Part D.

To avoid delays:

1. Enter the **Receipt Number** of your claim in the top right corner.
2. The care recipient's licensed health professional must complete all relevant information.
3. Get a signature from the care recipient's licensed health professional before you upload or mail the form.

### Note

You may also give your **Receipt Number** to your care recipient's licensed health professional so they can submit the medical certificate through SDI Online. Ask the licensed health professional about how they submit a claim. Some submit them differently than others.

# Submit Supporting Care Claim Documents

Learn more about how to submit supporting documents to complete your claim for care benefits.



[Get Started](#)

## 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)

To submit your completed and signed *Claim for Paid Family Leave (PFL) Care Benefits* (DE 2501FC) form, return to your SDI Online homepage.

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

### Note

Send this form within 10 days from the date you filed your claim.

# Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

Note: It may be necessary to send some documents via US Postal Service.

## Apply for Disability Insurance Benefits

[Disability Insurance](#)

## Apply for Paid Family Leave Benefits

[Paid Family Leave Bonding](#)

[Submit Electronic Paid Family Leave Bonding Attachment](#)

[Paid Family Leave Care](#)

[Submit Electronic Paid Family Leave Care Attachment](#)

[Paid Family Leave Military Assist](#)

[Submit Electronic Paid Family Leave Military Assist Attachment](#)

## Saved Drafts

To open and complete a form that you saved, select the **Form Name**. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the **Delete** button.

Select **Submit Electronic Paid Family Leave Care Attachment** under Apply for Paid Family Leave Benefits.

## Form Attachment

To attach a file to your successfully submitted Paid Family Leave claim form, choose the 'Select' link under the Action field. Most claims are processed and a decision is made within two weeks of the date the claim was submitted.

*If you have not received anything from PFL within 10 days or if you have any questions you may call 1-877-238-4373.*

### Select Claim to Attach Document

Form Name	Submitted Date	Receipt Number	Action
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Care for Sick	10-24-2018	R100000000033445	Select
DE 2501F, Claim for Paid Family Leave (PFL) Benefits - Care for Sick	10-24-2018	R100000000033448	Select

Cancel

Make sure the **Receipt Number** on the screen matches the number you got when you filed the online portion of the claim.

If it matches, click **Select** from the Action column to attach a document to your claim.



## Attachment

\* Indicates Required Field

### Identifying Information for Previously Submitted Paid Family Leave Initial Care Claim

Your Social Security Number: XXX-XX-XXXX

Date you requested to have your Paid Family Leave claim begin: 08-01-2018

Form Receipt Number: R100000000033448

### Previously Submitted Attachments for Paid Family Leave Initial Care Claim

No Results Found

## Attachment

To be eligible for Paid Family Leave benefits to care for a family member, you must submit a "Doctor's certification for care recipient" and "Care recipient authorization for disclosure of personal health information". These documents must be received by the Paid Family Leave Office no later than ten (10) days from the date you submit your online care claim.

A paper "Doctor's Certification for Care Recipient" and "Care Recipient Authorization for Disclosure of Personal Health Information" is available to print or download from [http://www.edd.ca.gov/pdf\\_pub\\_ctr/de2501fc.pdf](http://www.edd.ca.gov/pdf_pub_ctr/de2501fc.pdf). Follow the instructions below to attach the completed form electronically or through the mail.

To attach a document, select the Browse button below.

- File size: less than 5MB
- File type: PDF, JPG, JPEG, TIF or TIFF

\* Please click the "Browse" button to browse for the document:

No file chosen

Browse

\* Do you want to attach more documents?  Yes  No

Previous

Cancel

Submit

Select **Browse** to upload the document from your computer.

To upload more documents, select **Yes** to "Do you want to attach more documents" and then select **Submit**. This sends you back to the Attachment screen to continue uploading documents.

When you are done uploading, select **No** to "Do you want to attach more documents" and then select **Submit**.

## Note

To upload a document, you must have the document saved on your computer as a PDF, JPG, JPEG, TIF, or TIFF file. All file sizes must be 5MB or less.

## Attachment Confirmation

### Identifying Information for Previously Submitted Paid Family Leave Initial Care Claim

Your Social Security Number: XXX-XX-XXXX

Date you requested to have your Paid Family Leave claim begin: 08-01-2018

Form Receipt Number: R100000000033448

### Previously Submitted Attachments for Paid Family Leave Initial Care Claim

File Name	Receipt Number
Care Recipient Authorization.JPG	R100000000033449

The Attachment Confirmation screen confirms the attachment was submitted.

Save the **Receipt Number** for future reference.

Your care claim is complete after you upload the Statement of Care Recipient and Physician/Practitioner's Certification of the DE 2501FC.

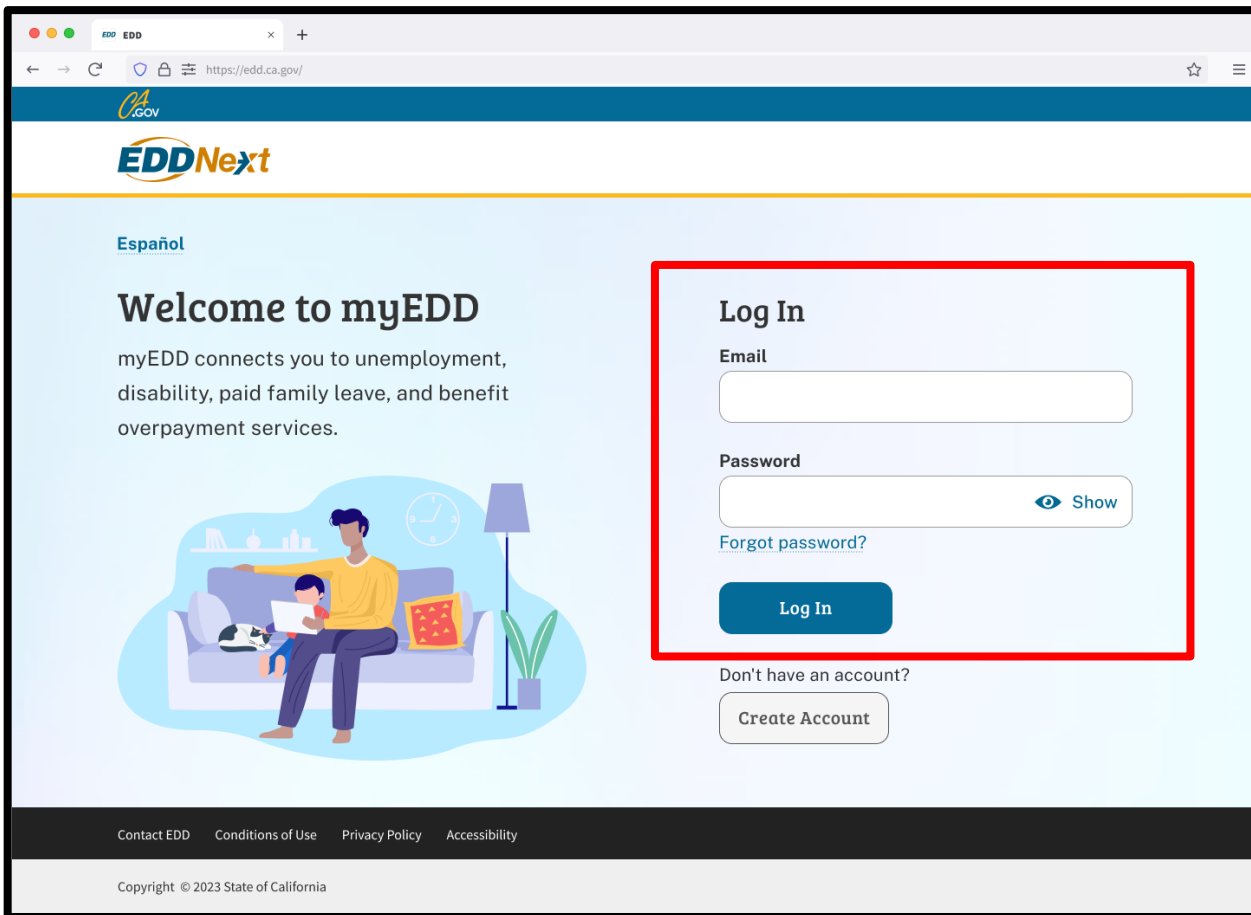
It can take up to 14 days to process your claim.

# File a Military Assist Claim

For individuals participating in a qualifying event because of a family member's military deployment to a foreign country.



[Get Started](#)

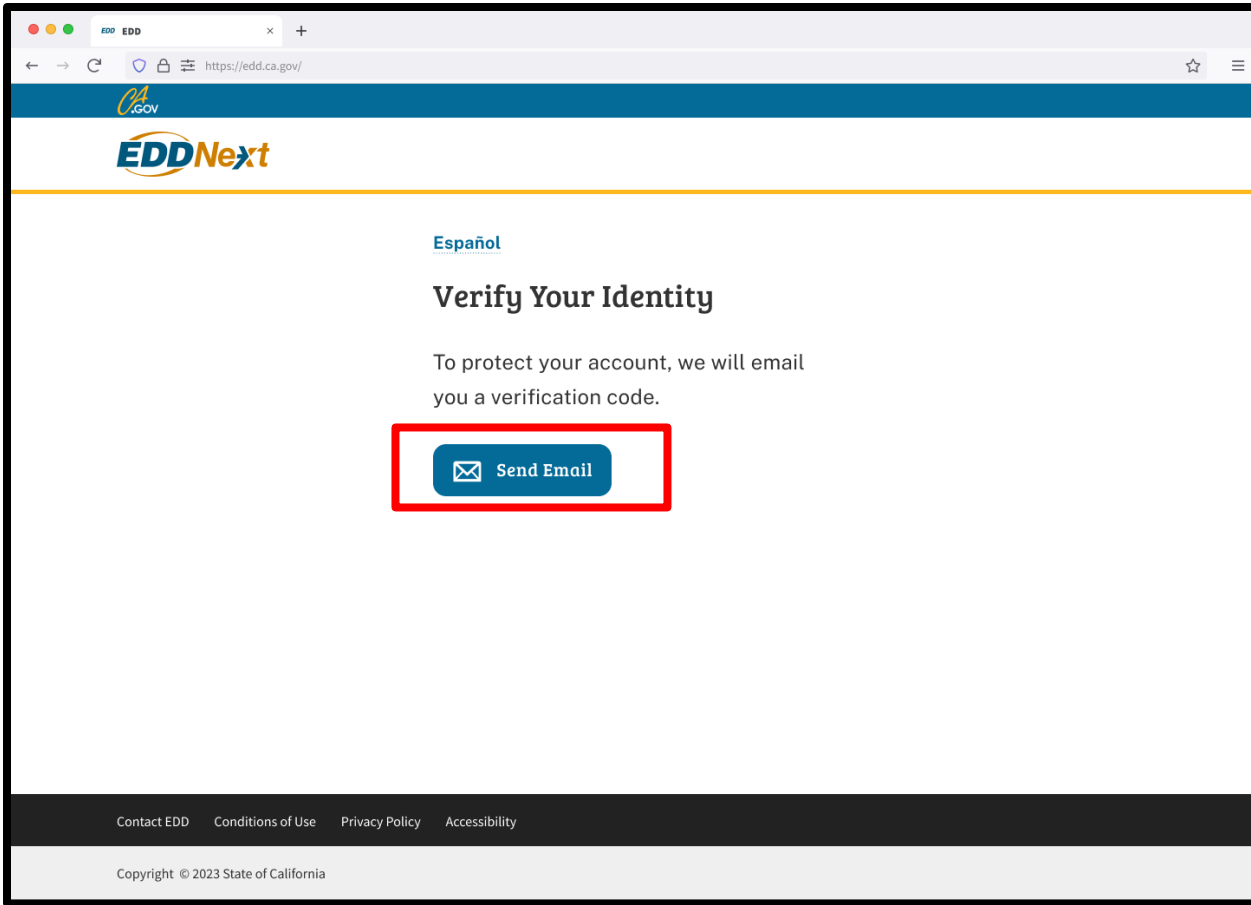


## Note

For Spanish, select **Español**.

Log in to myEDD to access SDI Online, update your email, password, security question, or verification option:

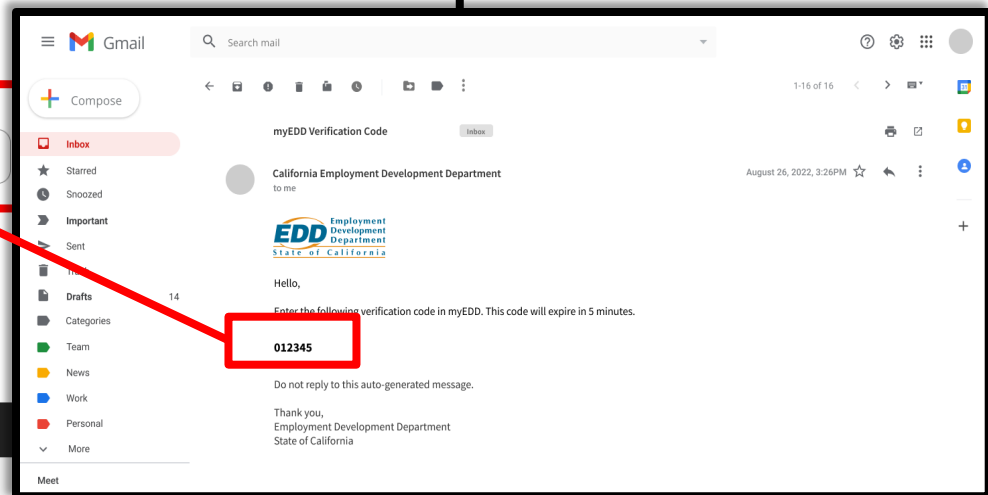
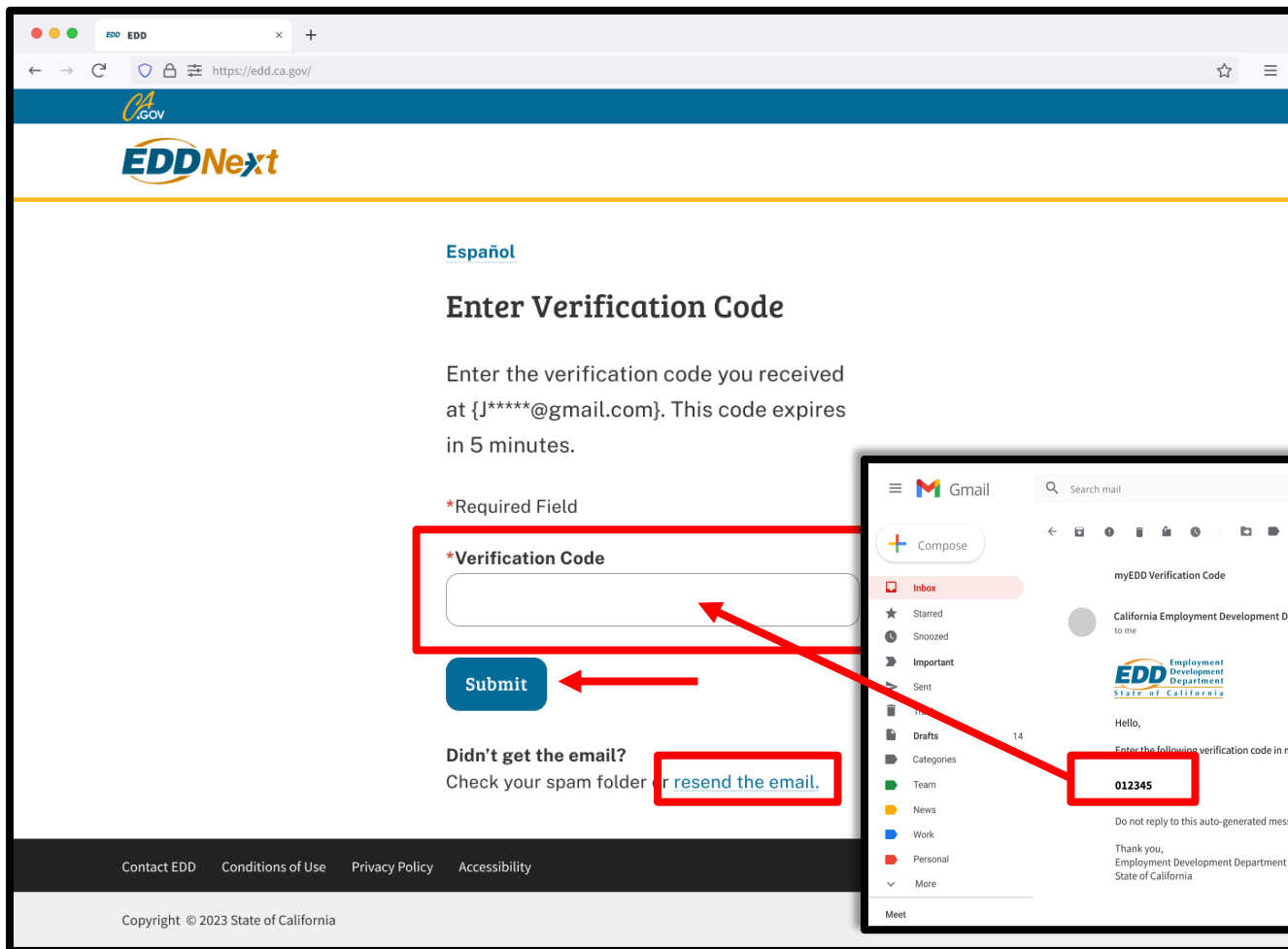
1. Visit [myEDD](#).
2. Enter the email and password used to create your myEDD account.
3. Select **Log In**.



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

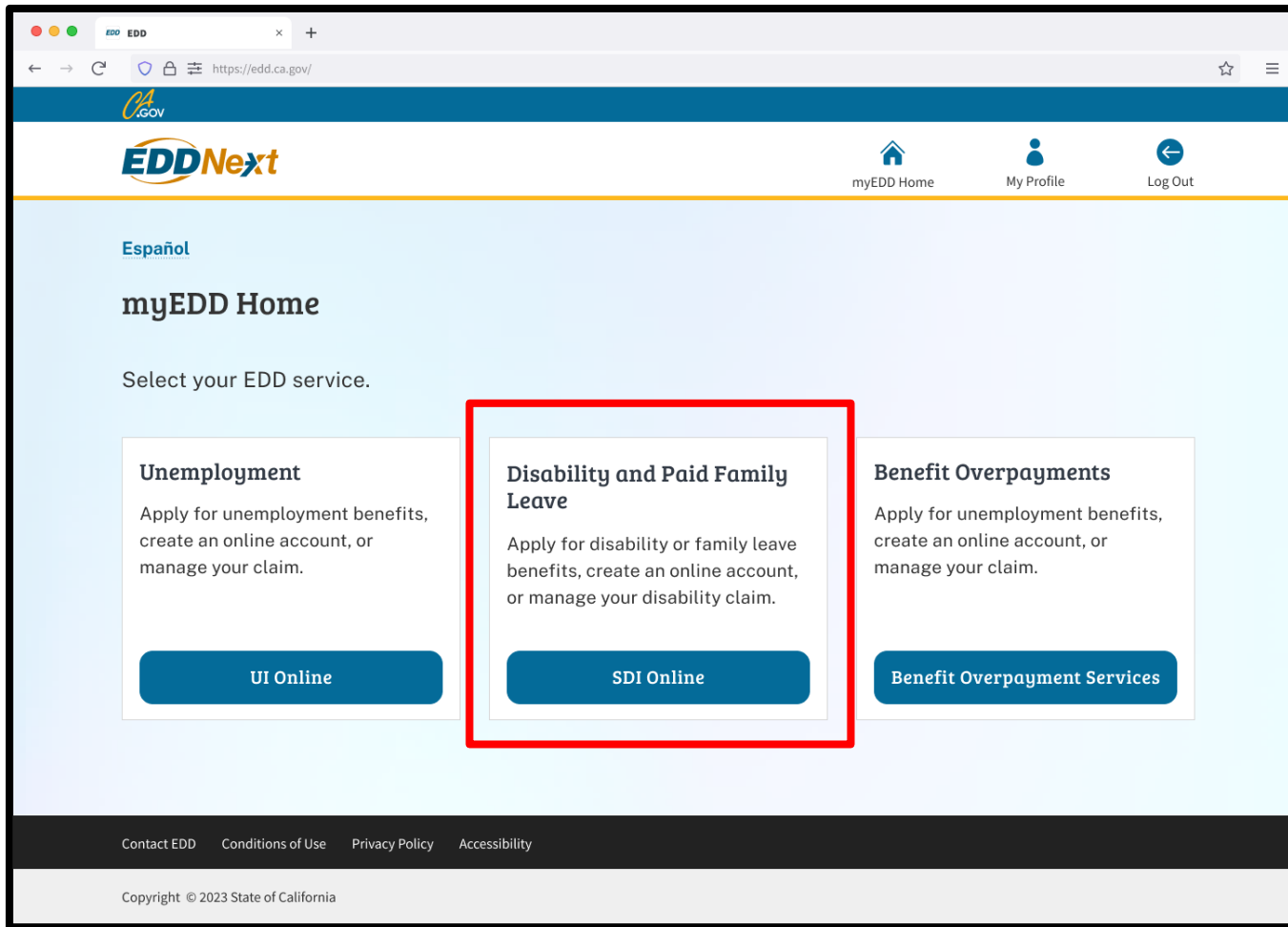
Select **Send Email**.

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



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

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



**Note**

Select **Log Out** in the top right corner of any screen to exit your account.

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.



# Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

Note: It may be necessary to send some documents via US Postal Service.

## Apply for Disability Insurance Benefits

[Disability Insurance](#)

## Apply for Paid Family Leave Benefits

[Paid Family Leave Bonding](#)

[Submit Electronic Paid Family Leave Bonding Attachment](#)

[Paid Family Leave Care](#)

[Submit Electronic Paid Family Leave Care Attachment](#)

[Paid Family Leave Military Assist](#)

[Submit Electronic Paid Family Leave Military Assist Attachment](#)

## Saved Drafts

To open and complete a form that you saved, select the **Form Name**. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the **Delete** button.

Select **Paid Family Leave Military Assist** under Apply for Paid Family Leave Benefits.

If unsure which application to complete, review the [Types of Claims](#).

## Paid Family Leave – Military Assist Claim Information

Complete this form if you had or will have a loss of wages while assisting with matters related to a family member's military deployment to a foreign country.

**Note:** Do not complete this form if you are insured by a Voluntary Plan maintained by your employer. Ask your employer for the proper forms.

### Gather Your Information

Have the following available while completing this form:

#### Personal Information

- Full name (and other names)
- Date of birth
- Gender
- Preferred language
- Social Security number
- Mailing address
- Phone number
- Your relation to the member

#### Wage Information

- If you are receiving, or expect to receive, any payments from your employer(s)
  - Type of payment received, such as (but not limited to):
    - Sick leave
    - Employer-required vacation
    - Wage continuation
    - Military pay
    - Commissions
    - Earnings from part-time or modified duty
    - Residuals
    - Bonuses
    - Holiday pay

**Note:** Failure to report any payment can result in an overpayment, penalties, and disqualification.

#### Additional Information

- If you claimed or plan to claim Workers' Compensation
- If you were convicted of a crime and held in custody
- If you want to use all your benefit weeks
- When you want your military assist claim

**Note:** The date you want your military assist claim

#### Military Member's Information

- Full name
- Date of birth
- Gender
- Last four digits of their Social Security number
- Date they were notified of covered active duty
- Covered active duty start date and end date
- Mailing address

#### Supporting Military Documentation

After you file your PFL claim, you must send a copy of the following:

- Covered active duty orders
- Letter of impending call or order to cover
- Documentation approving rest and recuperation leave

#### Qualifying Events

You can request PFL benefits for multiple qualifying events. You must provide the following for each event:

- Type of qualifying event, such as (but not limited to):
  - Provide/arrange childcare for the military member's child
  - Provide/arrange care for the military member's parent
  - Attend counseling
  - Make financial/legal arrangements
  - Assist the military member during rest and recuperation leave
  - Attend a military event
  - Represent the military member at federal, state, or local events
  - Address issues due to the military member's death
- Event start and end dates
- Contact information for the person or organization you are assisting
- Description of the event

#### Reasonable Accommodations

Call 1-877-238-4373 for required forms and instructions if you:

- Need this form in an alternate format (e.g., braille).
- Do not understand this form or any form provided by the PFL office.
- Are prevented from completing the form due to a disability.
- Need to choose a representative to sign for you.
- Are an authorized representative filing on behalf of a person.

For individuals with disabilities requesting auxiliary aids and services:

Review the Military Assist Claim Information. It has important information you need to file a military assist claim.

Select **Next**.

#### Resources for Special Circumstances

##### Child Support Obligations

Direct your questions to the Department of Child Support Services at 1-866-249-0773.

##### Spousal or Parental Support Obligations

Direct your questions to the District Attorney's Office administering the court order.

##### Death of Claimant

If a person receiving PFL benefits dies, an heir or legal representative should report the death to the PFL office. Benefits are payable through date of death, if otherwise eligible.

##### Death of Military Member

If the military member dies, report the death to the PFL office. You are eligible to receive benefits to take care of any business related to their death.

##### Job Benefits and Protection Programs

The Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) offer job-protected leave to eligible employees for certain family and medical reasons.

- To contact FMLA, call 1-866-487-9243 or visit the Department of Labor.
- To contact CFRA, call 1-800-884-1684 or visit the Department of Fair Employment and Housing.

For more information about Paid Family Leave, visit the EDD website.

Cancel

Next

# Military Assist Claim Instructions

\*Indicates Required Field

Read and understand the following information before completing this form.

## Requirements

### Your Responsibilities

You must:

- Read these instructions
- Include your military service records
- File your claim within 90 days of your discharge
- Report in writing if you are not sure you are eligible
- If you are not sure you are eligible, you must check the box to agree to our terms and conditions.

If you are not sure you are eligible, you must check the box to agree to our terms and conditions.

### Basic Eligibility

You must:

- Have a family notification card
- Have had one or more periods of unemployment
- Be employed for at least 90 days
- Have earned at least \$1,000
- Have submitted your claim within 90 days of your discharge
- Be the spouse of a military member
- Certify the information you provide is true and correct

### Ineligibility

You must not be:

- Claiming or receiving Unemployment Insurance (UI) or Disability Insurance (DI) benefits.
- Receiving Workers' Compensation benefits at a weekly rate equal to or greater than the PFL benefit rate.
- In custody of law enforcement authorities because you were convicted of a crime.

You can apply for benefits even if you are not sure you are eligible. If you are ineligible for all or part of a period claimed, the EDD will notify you of the ineligible period and the reason(s) why.

### Disqualification

The PFL office will consider all available information before disqualifying your claim. If the PFL office denies your claim, you will receive a written notice stating the reason(s) why.

Do not deliberately report incorrect information to collect or increase your benefits. Reporting incorrect or incomplete information to collect or increase your benefits violates the California Unemployment Insurance Code and is punishable by imprisonment, a fine up to \$20,000, or both. The EDD actively prosecutes fraud, and claimants who are caught will face criminal prosecution to the fullest extent of the law.

### Benefits

#### Benefit Amount

Carefully decide the date you were laid off. You will be paid one-seventh of your weekly wage for up to 26 weeks. The start date of your claim can impact your benefit amount.

#### How Benefits Are Paid

After your claim is processed, you will receive your benefits by direct deposit. If you do not have a direct deposit, a payment will be mailed to you. Continued benefits, if payment is not received, will be mailed to you.

**Note:** The majority of claims are processed within 10 business days.

#### Taxability of Benefits

PFL benefits are subject to federal income tax. PFL benefits are not subject to state income tax.

#### Overpayment

If you receive PFL benefits you are not entitled to, you must repay them. If you do not repay, you must pay from 25 to 100 percent until the debt is paid in full.

#### Fraud

Reporting incorrect or incomplete information to collect or increase your benefits violates the California Unemployment Insurance Code and is punishable by imprisonment, a fine up to \$20,000, or both. The EDD actively prosecutes fraud, and claimants who are caught will face criminal prosecution to the fullest extent of the law.

### Your Rights

#### Confidentiality

Information about your claim will be kept confidential, except for the purposes allowed by law. The EDD will not disclose or provide copies of medical information to medical providers.

#### Inspection

You have the right to inspect any of your personal records maintained by the EDD, except for:

- Medical or psychological records where knowledge of the contents might be harmful to the subject.
- Records of active criminal, civil, or administrative investigations.

Call 1-877-238-4373 to request a copy of your records. If the EDD denies you access, you can mail a request to review the denial to:

Employment Development Department  
Information Security Office, MIC 33  
PO Box 826880  
Sacramento, CA 94280-0001

#### Correction

Call 1-877-238-4373 to correct your records if you believe they are not accurate, relevant, timely, or complete. If the EDD refuses your request, you can mail a request to review the denial to:

Employment Development Department  
Information Security Office, MIC 33  
PO Box 826880  
Sacramento, CA 94280-0001

#### Appeal

You have the right to appeal any overpayment, penalty, or disqualification. Instructions on how to appeal will be provided on any appealable document you receive.

### Agree Before Continuing

I understand these instructions for submitting a military assist claim. If I don't provide complete and accurate information, my benefits can be delayed or denied. If I deliberately report incorrect or incomplete information to collect or increase my benefits, the EDD will disqualify my claim and I can face criminal prosecution.

Previous

Cancel

Next

Continue to review the instructions on how to file a military assist claim.

You must check the box to agree to our terms and conditions. Select **Next** to continue.

1

Personal Information

2

Employment Information

3

Additional Questions

4

Certification

5

Qualifying Events

6

Declaration

You are currently on Step 1 Personal Information

## Section 1 - Personal Information

**Social Security Number:** XXX-XX-XXXX

**EDD Customer Account Number:** 123456789

**Full Name:** John Doe

**Other Names (if any, under which you have worked):**

**Date of Birth:** XX-XX-XXXX

**Gender:** Male

**Mailing Address:** 123 Main St  
Sacramento, CA 95814

**Phone Number:** 916-555-1212

**Preferred Language:**

If your personal information has changed, select Save as Draft. To update your personal information before completing this form, select Profile.

Previous

Cancel

Save as Draft

Next

The system automatically fills certain portions of the claim form.

Make sure the information is correct. If your personal information has changed, select **Save as Draft** and update your SDI Online profile.

Select **Next** to continue.

# Employment Details



You are currently on Step 2 Employment Information

\* Indicates Required Field

## Section 2 - Employer Information

Enter your current employer. If unemployed, enter your most recent employer.

\* Name of Your Employer:

\* Occupation:

\* Are you a state government employee?  Yes  No

If "Yes", Indicate Bargaining Unit Number:

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

\* Do you have more than one employer?  Yes  No

\* Reason for reducing work hours or stopping work:  Care for Family Member  Other

## Employer 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

Complete Section 2 - Employer Information with your current employer's business name, phone number, and mailing address as shown on your W-2 or paystub. If you are unsure what address to enter, ask your employer.

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

Select **Next**.

## Additional Questions

Personal Information   Employment Information   **3 Additional Questions**   4 Certification   5 Qualifying Events   6 Declaration

You are currently on Step 3 Additional Questions

\*Indicates Required Field

### Paid Family Leave Information

\*Date you last worked:

The date you want your Paid Family Leave (PFL) benefits to begin cannot be before the date the military member was notified of covered active duty status.

\*Date you want your PFL claim to begin:

\*Do you want to claim the maximum amount of benefit weeks now?  Yes  No

If "No," enter the date you want to be paid through:

Date you returned to work:

Or date you plan to return to work:

\*Did you or will you work at any time during your family leave period?  Yes  No

If you have or will receive any type of pay from your employer(s) during your family leave period, select the type of pay:  
 Sick  
 Employer Required Vacation  
 Other Type of Pay

If "Other Type of Pay," specify the type:

\*Have you claimed or do you plan to claim Workers' Compensation during your family leave period?  Yes  No

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

Previous

Cancel

Save as Draft

Next

Complete the Paid Family Leave Information section and make sure all dates are correct to avoid a delay or incorrect payment of benefits.

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

Select **Next**.

## Military Assist Certification

Personal Information
  Employment Information
  Additional Questions
 **4 Certification**
 5 Qualifying Events
  6 Declaration

You are currently on Step 4 Certification

\*Indicates Required Field

### Your Information

\*The Military Member is your:

If "Other," please specify:

### Military Member's Information

\*Military Member's First Name:

Military Member's Middle Initial:

\*Military Member's Last Name:

Military Member's Suffix:

\*Military Member's Date of Birth:

\*Military Member's Gender:  Male  Female

\*Last four digits of Military Member's Social Security Number:

\*Date Military Member was notified of covered active duty status:

\*Covered active duty start date:

Covered active duty end date (if known):

### Military Member's Mailing Address

US  International

\*Address Line 1:

Address Line 2:

\*City:

\*State:

\*ZIP Code:

### Supporting Military Documentation

After you file this claim, you must submit an approved supporting military document to receive PFL benefits.

\*Select the type of military document you will submit:  Covered active duty orders  Letter of impending call or order to covered active duty  Documentation approving rest and recuperation leave

Instructions for submitting a supporting military document will be provided on the Confirmation page.

Complete the following sections:

- Your Information
- Military Member's Information
- Military Member's Mailing Address
- Supporting Military Documentation

Make sure the information you enter is about the military member you are assisting.

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

Instructions on how to submit supporting military documentation are available on the Confirmation screen.

Select **Next**.

## Qualifying Events



You are currently on Step 5 Qualifying Events

\*Indicates Required Field

### Add Event

Enter a qualifying event. If you are requesting PFL benefits for multiple events, enter each event separately. You can add up to eight events.

- \*What is your qualifying event?
- Provide/arrange childcare for the military member's child
  - Provide/arrange care for the military member's parent
  - Attend counseling
  - Make financial/legal arrangements
  - Assist the military member during rest and recuperation leave
  - Attend a military event
  - Represent the military member at federal, state, or local agencies
  - Address issues due to the military member's death
  - Other

If "Other," please specify:

\*Event Start Date:

\*Event End Date:

### Event Details

Provide the following information related to the qualifying event.

\*Name or Organization:

US    International

Address Line 1:

Address Line 2:

City:

State:

ZIP Code:

\*Phone Number:  Ext:

Check here if the phone number is international

Email Address:

\*Describe your qualifying event:

You can add more events on the next page.

Previous

Cancel

Save as Draft

Next

Complete the following sections:

- Add Event
- Event Details

Make sure you enter information about the qualifying event you attend.

If requesting military assist benefits for multiple events:

- Enter each event separately.
- You can add up to eight events.
- Instructions to add additional events are located on the next page.

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

Select **Next** to continue.



# List of Qualifying Events



You are currently on Step 5 Qualifying Events

\*Indicates Required Field

## Your Events

Select **Add** to enter another qualifying event. If you are finished adding events, select **Next** to continue.

Qualifying Event	Name or Organization	Event Start Date	Event End Date	Action
Provide/arrange care for the military member's parent	Mother Jones	MM-DD-YYYY	MM-DD-YYYY	Delete

Buttons: Previous, Cancel, Add, Save as Draft, Next

To add more than one event:

- Select **Add** and enter the event information.
- Select **Next** once all events have been added.

# Declaration



You are currently on Step 6 Declaration

\*Indicates Required Field

## 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.

## Digital Signature

Read the following information and check the box if you agree.

Note: A check in the box is a digital signature executed by you and is the legally binding equivalent to a traditional handwritten signature.

By my signature on this Military Assist Certification and claim statement, I:

- Claim Paid Family Leave benefits and certify that, throughout the period covered by this claim, I was assisting a military member during a qualifying event.
- Authorize the EDD to release my personal information as shown on this claim to the military member I am assisting.
- Authorize my employer(s) to disclose all facts concerning my employment that are within their knowledge to the EDD.
- Authorize the release and use of information as stated in the Information Collection and Access section on the *Claim for Paid Family Leave (PFL) Benefits (DE 2501F)*.
- 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 punishable by imprisonment or fine or both.
- Declare under penalty of perjury that the foregoing statement, including any accompanying statements or documents, is to the best of my knowledge and belief true, correct, and complete.
- Agree that photocopies of this authorization shall be as valid as the original.
- Understand that authorizations contained in this claim statement are granted for a period of 15 years from the date of my signature or the effective date of the claim, whichever is later.

Previous

Cancel

Save as Draft

Submit

On the Declaration screen, select how you want to get your benefit payments from the options listed.

Next, select both boxes to acknowledge you have reviewed the disclosures and to provide a digital signature.

Select **Submit** to continue.

# Paid Family Leave (PFL) Survey Questions

\* Indicates Required Field

## Paid Family Leave (PFL) Survey

The EDD has received your portion of your claim for Paid Family Leave benefits. There is one more step to complete before you receive your claim receipt number. Please answer the questions below and then select the "Submit" button for your receipt number.

**\* Before you filed your Paid Family Leave (PFL) claim, how did you learn about the Paid Family Leave (PFL) benefit program? Please select the response that best applies:**

- From a brochure I received by U.S. mail.
- From a friend or family member.
- From an SDI Online Notification.
- From my employer.
- From a social worker or hospital employee.
- None of these.

Submit

Complete the survey and select **Submit**.

# Confirmation

You have successfully submitted your PFL claim. Allow two weeks for it to be processed. If you have any questions, call 1-877-238-4373.

## Claim Information

**Claimant Name:** John Doe  
**Requested Claim Start Date:** 11-07-2021

**Social Security Number:** XXX-XX-XXXX

**Receipt Number:** R100001000032163

## Important Next Steps

Failure to submit your supporting document will result in disqualification, and you will not receive payment. You must send it within 10 business days electronically or by mail.

### Send Electronically

You can [attach your supporting document now](#) or at a later date by following these instructions:

1. Select New Claim from the main menu.
2. Select the corresponding attachment link.

### Send by Mail

Mail a photocopy of your supporting document to:

**EDD - Paid Family Leave**  
**PO Box 997017**  
**Sacramento, CA 95799-7017**

Do not mail the original document. Include your 9-digit Social Security number, receipt number, and requested claim start date on each page.

We assign your claim a **Receipt Number** on the Confirmation screen.

Save the **Receipt Number**. You need this number to upload your supporting documentation to the correct online claim.

The Confirmation screen also gives you instructions on how to upload your documentation to your military assist claim.

## Important Next Steps

Failure to submit your supporting document will result in disqualification, and you will not receive payment. You must send it within 10 business days electronically or by mail.

### Send Electronically

You can **attach your supporting document now** or at a later date by following these instructions:

1. Select New Claim from the main menu.
2. Select the corresponding attachment link.

### Send by Mail

Mail a photocopy of your supporting document to:

**EDD - Paid Family Leave  
PO Box 997017  
Sacramento, CA 95799-7017**

Do not mail the original document. Include your 9-digit Social Security number, receipt number, and requested claim start date on each page.

To complete your military assist claim, you must send us your supporting military documentation and documentation of the qualifying event within 10 days.

### To submit your documentation online:

- Select **attach your supporting document now**.
- Use the [Submit Supporting Military Assist Claim Documents](#) section of this tutorial for instructions.

### To submit your documentation by mail:

- Send copies of your supporting military documentation and documentation of the qualifying event to the address on the screen.
- Do not mail the original documents. Include your nine-digit Social Security number, Receipt Number, and the date you want your claim to start on each page.

# Submit Supporting Military Assist Claim Documents

Learn more about how to submit supporting documents to complete your claim for military assist benefits.



[Get Started](#)

## 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

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

Current Disability Insurance Claim(s)

To upload the military documentation and documentation of the qualifying event we need for your online claim:

- Return to your homepage.
- Select **New Claim** from the main menu.

### Important

You must send us these documents within 10 days from the date you filed your claim.

# Apply for Benefits or Continue a Draft Application

Select a link below to apply for Disability Insurance or Paid Family Leave benefits. If you have already submitted a *Claim for Disability Insurance* (DE 2501) or a *Claim for Paid Family Leave* (DE 2501F), do not submit a duplicate form. It may take up to 14 days for your Initial Claim form to be reviewed and processed. Submitting duplicate forms may delay the processing of your claim.

Note: It may be necessary to send some documents via US Postal Service.

## Apply for Disability Insurance Benefits

[Disability Insurance](#)

## Apply for Paid Family Leave Benefits

[Paid Family Leave Bonding](#)

[Submit Electronic Paid Family Leave Bonding Attachment](#)

[Paid Family Leave Care](#)

[Submit Electronic Paid Family Leave Care Attachment](#)

[Paid Family Leave Military Assist](#)

[Submit Electronic Paid Family Leave Military Assist Attachment](#)

## Saved Drafts

To open and complete a form that you saved, select the **Form Name**. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the checkbox and then select the **Delete** button.

Select **Submit Electronic Paid Family Leave Military Assist Attachment** under Apply for Paid Family Leave Benefits.



## Form Attachment

Allow two weeks for attachments to be processed. If you have any questions, call 1-877-238-4373.

### Select a Claim

Only claims you have successfully submitted will be listed.

Form Name	Date Submitted	Receipt Number	Action
<i>Claim for Paid Family Leave (PFL) Benefits - Military Assist (DE 2501F)</i>	MM-DD-YYYY	R100001000032163	<a href="#">Select</a>

Cancel

Make sure the **Receipt Number** on the screen matches the number you got when you filed the online portion of the claim.

If it matches, choose **Select** from the Action column to attach a document to your claim.

## Attach File

\*Indicates Required Field

### Claim Information

Social Security Number: XXX-XX-XXXX

Requested Claim Start Date: MM-DD-YYYY

Receipt Number: R100001000032163

### Current Attachments

No Results Found

### Select a File

Select **Browse** to attach a file to your claim.

- Files must be less than 5MB
- Allowed file types: PDF, JPG, JPEG, TIF or TIFF

\*Choose a file: No file chosen

Browse

\*Attach another document?  Yes  No

Previous

Cancel

Submit

## Note

To upload a document, save the document to your computer or phone as a PDF, JPG, JPEG, TIF, or TIFF file. All file sizes must be 5MB or less.

Select **Browse** to upload a document from your computer or phone.

To upload another document, select **Yes** to “Attach another document?” and then select **Submit**. This sends you back to the Attachment screen to continue uploading documents.

When you are done uploading your documents, select **No** to “Attach another document?” and then select **Submit**.

# Attachment Confirmation

Your file has been uploaded and attached to your claim.

## Claim Information

Social Security Number: XXX-XX-XXXX

Requested Claim Start Date: MM-DD-YYYY

Receipt Number: R100001000032163

## Attachments

File Name	Date Submitted	Attachment Receipt Number
covered active duty orders - provide care.JPG	MM-DD-YYYY	R100001000032167

The Attachment Confirmation screen confirms the attachment was submitted.

Save the **Receipt Number** for future reference.

Your military assist claim is complete when you send us the supporting military documentation and documentation of the qualifying event. Allow at least 14 days for the claim to process.

# Complete Paper Claim Forms

Learn more about how to complete your paper claim form for bonding, care, or military assist benefits.



[Get Started](#)

# How to file a PFL claim

**1.**  
Get the  
Paper  
Application  
DE 2501F

**2.**  
Pick a Claim  
Type

- Care
- Bonding
- Military Assist

**3.**  
Submit  
Supporting  
Documents

## Important

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

# Get the *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F)

- Order a [form online](#) to have it mailed to you.
- Visit an [SDI Office](#).
- Call 1-877-238-4373 to request a paper form be mailed to you.
- Get the form from your licensed health professional or employer.

It may take up to 10 days to get in the mail.

## Note

**New mothers applying for bonding after a pregnancy-related disability claim: A *Claim for Paid Family Leave (PFL) Benefits – New Mother* (DE 2501FP) form is automatically sent to you with your final disability payment.**

The image shows a sample of the 'Claim for Paid Family Leave (PFL) Benefits' form (DE 2501F). The form is from the Employment Development Department of the State of California. It includes a barcode and the form number 2501FP2201. The form is divided into several sections: PART A - STATEMENT OF CLAIMANT'S CARE, BONDING, OR MILITARY ADULT DEPENDENT; PART B - EMPLOYER INFORMATION; and various numbered questions (401-406) regarding the claimant's status, employer's policies, and other relevant details. The form is designed for internal review use only.

## SAMPLE Claim for Paid Family Leave (PFL) Benefits (DE 2501F)

# Complete and review your portion of the DE 2501F form



Bonding claims are complete when the following documents are received:

Part A: Statement of Claimant

Part B: Bonding Certification

Supporting Bonding Documentation



Care claims are complete when the following documents are received:

Part A: Statement of Claimant

Part C: Statement of Care Recipient

Part D: Physician/Practitioner's Certification



Military assist claims are complete when the following documents are received:

Part A: Statement of Claimant

Part E: Military Assist Certification

Supporting Military Documentation

# To avoid processing 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.





# Claim for Paid Family Leave (PFL) Benefits (DE 2501F) - Page 2

## Part B - Bonding Certification:

- If you are filing a bonding claim, you must complete this section and sign the form.

## Part C - Statement of Care Recipient:

- If you are filing a care claim, you or the care recipient must complete this section. The care recipient or their authorized representative must sign the form.

Complete either Part B or Part C – **but never both** sections for one claim.

### Note

Part B and Part C are not needed for military assist claims.

**PART B - BONDING CERTIFICATION** (TO BE COMPLETED BY PERSON CLAIMING PFL BENEFITS TO BOND WITH A CHILD)

01. YOUR SOCIAL SECURITY NUMBER  
02. DATE OF POSTER CARD OR ADOPTION PLACEMENT  
03. CHILD NAMED IN DE IS: BIOLOGICAL, FOSTER, ADOPTED  
04. YOUR LEGAL LAST NAME (ENTER IN CARE RECIPIENT'S SECTION)  
05. CHILD'S SOCIAL SECURITY NUMBER (IF AVAILABLE)  
06. CHILD'S DATE OF BIRTH  
07. CHILD'S GENDER (MALE, FEMALE)  
08. LEGAL NAME OF CHILD (FIRST, MIDDLE INITIAL, LAST)  
09. CHILD'S RESIDENCE ADDRESS (IF DIFFERENT FROM CLAIMANT'S)  
10. AS EVIDENCE OF THE RELATIONSHIP (IN DE), CHECK (ONE) OF THE FOLLOWING AND ATTACH A COPY OF THE DOCUMENT CHECKED:  
 CHILD'S BIRTH CERTIFICATE  
 ADOPTIVE PLACEMENT AGREEMENT, AD-907  
 DECLARATION OF PARENTY, CS-900  
 INDEPENDENT ADOPTION PLACEMENT AGREEMENT, AID-624  
 FOSTER CARE PLACEMENT RECORD, SOC-815  
 OTHER  
 11. Declaration and Signature: I authorize the medical provider, adoption agency, adoption parent(s), or foster care placement agency to disclose to the Employment Development Department all facts concerning the birth, adoption, or foster care placement of the above-named child. 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 punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statements, including any accompanying statements or documents, to the best of my knowledge and belief are true, correct, and complete. I agree that physicians of the information shall be as valid as the original, and I understand that authorizations contained in this claim application are granted for a period of three years from the date of my signature or the effective date of the claim, whichever is later.  
 Original Signature of Bonding Claimant - (DO NOT PRINT) Date Signed (M/M/YY)  
**PART C - STATEMENT OF CARE RECIPIENT** (TO BE COMPLETED BY CLAIMANT IF CARE RECIPIENT IS MINORALLY OR PHYSICALLY UNABLE TO COMPLY. (PLEASE CHECKED BY CARE RECIPIENT OR CARE RECIPIENT'S AUTHORIZED REPRESENTATIVE).  
 12. RECIPIENT'S DATE OF BIRTH  
 13. RECIPIENT'S TELEPHONE NUMBER  
 14. RECIPIENT'S GENDER (MALE, FEMALE)  
 15. LEGAL NAME OF CARE RECIPIENT (FIRST, MIDDLE INITIAL, LAST)  
 16. CARE RECIPIENT'S RESIDENCE ADDRESS  
 17. CONFIRMATION OF MEDICAL DISCLOSURE AUTHORIZATION. I authorize my physician/practitioner to disclose my current personal health information to my care provider and to the California Employment Development Department (EDD). I further understand that copies of my signature below are as valid as the original.  
 Care Recipient's Signature (DO NOT PRINT) Date Signed (M/M/YY)  
 18. Authorized Representative's Signature (DO NOT PRINT) Date Signed (M/M/YY)  
 Page 2 of 6

# Claim for Paid Family Leave (PFL) Benefits (DE 2501F) - Page 3

## Part D - Physician/Practitioner's Certification:


- Your care recipient's licensed health professional must complete all patient information including dates, diagnosis codes, and signing the bottom of the form.

Page 4 is left blank intentionally and not shown in this tutorial. Do not remove this page.

### Note

Part D is not needed for bonding or military assist claims. It is only for care claims.

Medical certification must be completed by a licensed physician or practitioner authorized to certify to a patient's disability/serious health condition pursuant to California Unemployment Insurance Code Section 2700.



5501F12203

**INSTRUCTIONS FOR COMPLETING THIS FORM:**  
Please complete the information in the spaces provided in UPPER CASE using black ink. Do not use special characters ( -, . / \* ). If handwritten, print each letter or number in a separate box. Ignore the boxes provided if using a typewriter or printer.

**PART D - PHYSICIAN/PRACTITIONER'S CERTIFICATION (DO NOT COMPLETE THIS PART IF YOU ARE BONDING OR PARTICIPATING IN A QUALIFYING EVENT)**

021. PFL CLAIMANT'S CARE PROVIDER'S SOCIAL SECURITY NUMBER

022. PFL CLAIMANT'S NAME (FIRST MIDDLE INITIAL LAST)

023. PATIENT'S DATE OF BIRTH (M M D D Y Y T T T T)

024. DOES YOUR PATIENT REQUIRE CARE BY THE CLAIMANT? (NO OR YES)

025. PATIENT'S NAME (FIRST MIDDLE INITIAL LAST)

026. DIAGNOSIS OR, IF NOT YET DETERMINED, A DETAILED STATEMENT OF SYMPTOMS

027. PRIMARY ICD CODE

028. SECONDARY ICD CODES

029. DATE PATIENT'S CONDITION COMMENCED (M M D D Y Y T T T T)

030. FIRST DATE CARE NEEDED (M M D D Y Y T T T T)

031. DATE YOU EXPECT RECOVERY (M M D D Y Y T T T T) NEVER PERMANENT

032. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CLAIMANT (M M D D Y Y T T T T) PERMANENT

033. APPROXIMATELY HOW MANY TOTAL HOURS PER DAY WILL PATIENT REQUIRE CLAIMANT?

034. WOULD DISCLOSURE OF THIS CERTIFICATE TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL? NO YES

035. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER

036. STATE OR COUNTRY PHYSICIAN/PRACTITIONER IS LICENSED

037. PHYSICIAN/PRACTITIONER'S NAME (FIRST MIDDLE INITIAL LAST)

038. PHYSICIAN/PRACTITIONER'S ADDRESS (PLEASE PRINT OR TYPE AND NOT ACCEPTABLE AS THE BELOW ADDRESS)

CITY STATE/PRIN. ZIP OR POSTAL CODE COUNTRY OF RES. (USA)

039. TYPE OF PHYSICIAN/PRACTITIONER

040. SPECIALTY (IF ANY)

041. PHYSICIAN/PRACTITIONER'S Certification and Signature: I certify under penalty of perjury that this patient has a serious health condition and require a care provider. I have performed a physical examination and/or treated the patient. I am authorized to certify a patient's disability or serious health condition pursuant to California Unemployment Insurance Code Section 2700.

Original Signature of Attending Physician/Practitioner - (A RED INK SIGNATURE IS NOT ACCEPTABLE) PHYSICIAN/PRACTITIONER'S PHONE NO. SIGN SIGNATURE (M M D D Y Y T T T T)

Under sections 2714 and 2722 of the California Unemployment Insurance Code, it is a violation for any individual who, with intent to defraud, falsely certifies the medical condition of any person in order to obtain disability insurance benefits, whether for the mother or for any other person, and is punishable by imprisonment and/or a fine not exceeding \$20,000. Sections 11413 and 1305 require additional administrative penalties.

Page 4 of 6

# Claim for Paid Family Leave (PFL) Benefits (DE 2501F) - Page 5

## Part E – Military Assist Certification:

You must complete all information under Part E, including:

- The military member’s personal information
- Dates of covered duty
- Qualifying event information
- Your signature

### Note

Part E is not needed for bonding or care claims. It is only for military assist claims.

**PART E – MILITARY ASSIST CERTIFICATION (TO BE COMPLETED BY THE CLAIMANT)**

13. YOUR SOCIAL SECURITY NUMBER

14. YOUR LEGAL NAME (FIRST / MIDDLE INITIAL / LAST)

15. NAME OF MILITARY MEMBER ON COVERED ACTIVE DUTY OR IMPENDING CALL TO COVERED ACTIVE DUTY STATUS (FIRST / MIDDLE INITIAL / LAST)

16. MILITARY MEMBER'S DATE OF BIRTH

17. MILITARY MEMBER'S GENDER

18. MILITARY MEMBER'S MAILING ADDRESS

19. LAST FOUR DIGITS OF MILITARY MEMBER'S SOCIAL SECURITY NUMBER

20. PERIOD OF MILITARY MEMBER'S COVERED ACTIVE DUTY

21. DATE MILITARY MEMBER WAS NOTIFIED OF COVERED ACTIVE DUTY

22. PLEASE SELECT ONE OF THE FOLLOWING AND ATTACH THE INDICATED DOCUMENT TO SUPPORT THAT THE MILITARY MEMBER IS ON COVERED ACTIVE DUTY OR IMPENDING CALL OR ORDER TO COVERED ACTIVE DUTY STATUS.

23. THE QUALIFYING EVENT FOR THE PFL CLAIM IS TO: (One or more reasons may be selected)

24. WRITTEN DOCUMENTATION SUPPORTING THIS REQUEST FOR LEAVE IS AVAILABLE AND ATTACHED

25. Declaration and Signature. By my signature on this military assist certification, I understand that I will be making a false statement or certification if I submit this in order to obtain payment of benefits in a violation of California law, and I understand that I will be liable for any civil or criminal penalties of perjury that law regarding statements, including any accompanying statements or documents, to the best of my knowledge and belief true, correct, and complete. I agree that photographs of this certification shall be as valid as the original, and I understand that a false statement constitutes a crime under the law for a period of three years from the date of my signature or the effective date of the claim, whichever is later.

Original Signature of Military Assist Claimant (DO NOT PRINT)

Print Name (LAST / FIRST / MIDDLE INITIAL)

Page 5 of 6

# Claim for Paid Family Leave (PFL) Benefits (DE 2501F) - Page 6

## Part E - Qualifying Event for Leave Documentation:

If you're requesting leave to meet with a third party, you must include:

- Third party contact information.
- Description of the event, including dates.

Make sure to complete all pages needed and sign the claim form before mailing to us.

### Note

The Qualifying Event for Leave Documentation is not needed for bonding or care claims.

The form is titled "QUALIFYING EVENT FOR LEAVE - DOCUMENTATION" and includes a barcode at the top right with the number 2501F12205. Below the title is a red box with white text: "If leave is requested to meet with a third party, the employee must provide supporting documentation of the meeting that includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the phone number, fax number or email address of the individual or entity). The reason for a meeting can include arranging for child or personal care, counseling, making financial or legal arrangements, acting as the military member's representative before a tribunal, issue of local agency for purposes of obtaining, arranging or appealing military service benefits, or attending any event sponsored by the military or military service organized entities." Below this is a red box with white text: "PLEASE SUBMIT SUPPORTING DOCUMENTATION, IF APPLICABLE (Attach an additional sheet if more space is required)". The form has several sections: "YOUR SOCIAL SECURITY NUMBER" (a grid of boxes), "YOUR LEGAL NAME (first, middle, last, suffix)" (a grid of boxes), "NAME OF INDIVIDUAL WITH WHOM CLAIMANT IS MEETING:" (a line), "TITLE:" (a line), "ORGANIZATION:" (a line), "PHONE NUMBER (provide area or country code):" (a line), "FAX NUMBER (provide area or country code):" (a line), "EMAIL ADDRESS:" (a line), "MAILING ADDRESS:" (a section with "Mailing Address:" and a line), "City" (a line), "State/Prov" (a line), "ZIP or Postal Code" (a line), "Country (if not USA)" (a line), and "DESCRIBE NATURE OF MEETING, INCLUDE DATES, IF KNOWN:" (a large text area). At the bottom right, it says "Page 6 of 6".

# Mail in your completed claim form

Use the pre-addressed envelope to mail to:

State of California  
Employment Development Department  
P.O. Box 989315  
West Sacramento, CA 95798-9315

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



# CONTACT US

1-877-238-4373

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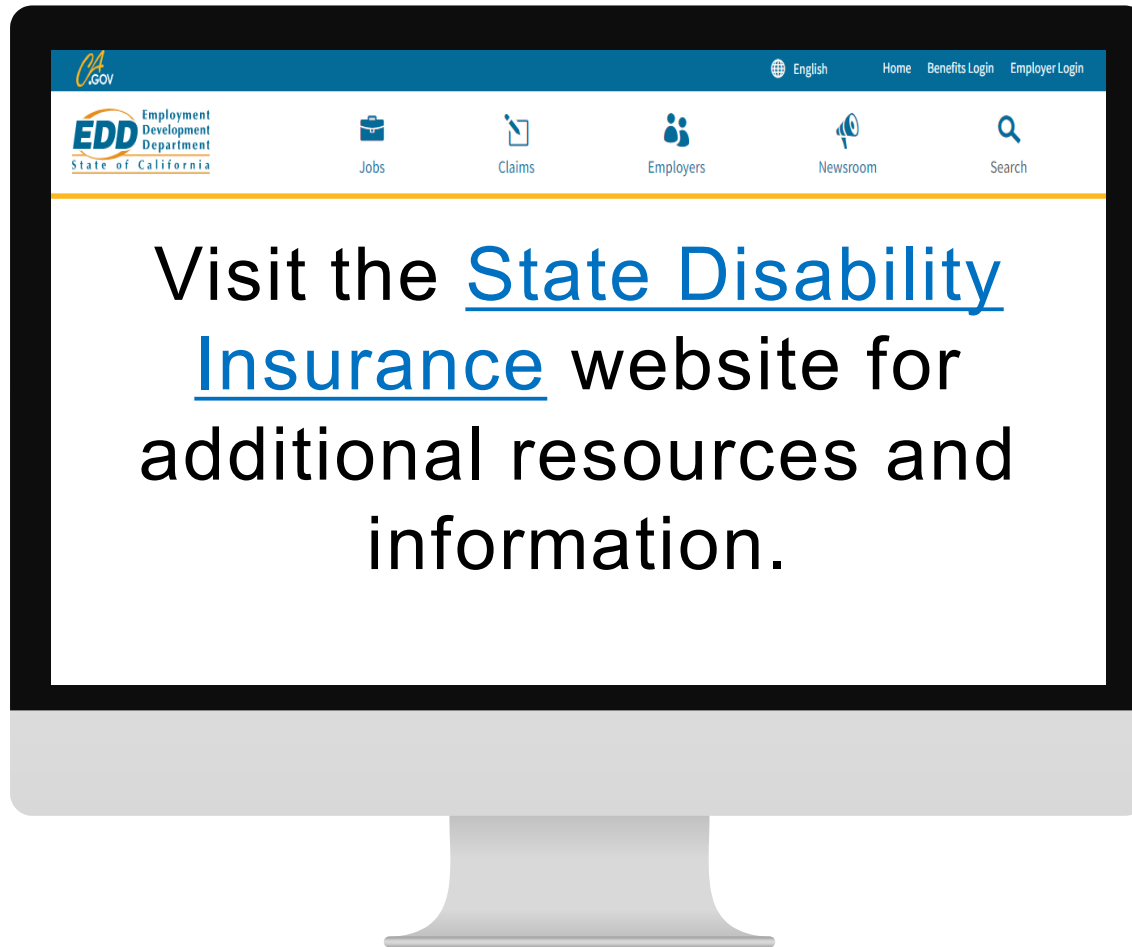
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