Employment Development Department
State of California

Claim for Nonindustrial Disability Insurance – Family Care Leave (NDI-FCL)

NOTE TO NDI-FCL APPLICANTS: KEEP THIS INSTRUCTION AND INFORMATION JACKET FOR REFERENCE

Nonindustrial Disability Insurance – Family Care Leave (NDI-FCL) Benefits, an employer-funded program, provides benefits to eligible workers who have 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 to participate in a qualifying event as a result of a family member's military deployment to a foreign country.

To qualify for NDI-FCL benefits, you must be:

1. An Excluded California State Government Employee
   and
2. A participant in the Annual Leave Program.

NOTE: See Nonindustrial Disability Insurance – Family Care Leave Provisions, DE 8502F, for details.

Instructions for completing the NDI-FCL claim form, DE 8501F

While completing the NDI-FCL claim form, write clearly using only upper case. Enter your Social Security number on all pages of the claim form, including attachments. **Mail** the completed form to the Employment Development Department (EDD) in the envelope provided. Submit you claim no earlier than the first day your family leave begins.

How to complete the DE 8501F:

1. Part A-Employee Information to be complete by your Attendance Clerk or Payroll Officer.
2. Part B-Claim Statement of Employee to be completed when you have stopped working.
   NOTE: For box 3, the United States Postal Service will not deliver mail to a private mail box unless it is preceded by the initials "PMB."
   a. Sign and date box 15-Declaration and Signature on Part B-Claim Statement of Employee.
3. **BONDING:** Part C-Bonding Certification only completed for bonding claims. Enclose a copy of one of the documents listed in box 10. **Do not** complete Part C if you are filing to care for a family member, or to participate in a qualifying event.
4. **CARE:**
   a. Part D-Statement of Care Recipient to be completed by the care recipient. If the care recipient is a minor or incapacitated, an authorized representative may complete this part.
   b. Part E-Physician/Practitioner's Certification to be completed by the treating physician/practitioner. Certification may be made by a licensed physician or practitioner authorized to certify to a patient's disability or serious health condition pursuant to California Unemployment Insurance Code, Section 2708. If the care recipient is under the care of an accredited religious practitioner, obtain a *Practitioner's Certification for Nonindustrial Disability Insurance – Family Care Leave* (DE 2502FF), by calling 1-866-758-9768. **Rubber stamp signatures are not accepted.**
5. **MILITARY ASSIST**: Complete Part F-Military Assist Certification and enclose a copy of one of the documents listed in Box 10.
6. Place the completed, signed form(s) in the envelope provided. Claims are generally processed within 14 days after the EDD receives a completed claim.
   - For **bonding**, a claim is complete when parts A, B, C and supporting documents are received.
   - For **care**, a claim is complete when parts A, B, D and E are received.
   - For **military assist**, a claim is complete when Parts A, B, F, and supporting documents are received.
7. Keep these instructions and information pages for future reference.

NOTE: It is the employee's responsibility to see that this claim form and all sections that apply are filled out COMPLETELY and mailed to the EDD address listed below. If you do not understand this form you may call Nonindustrial Disability Insurance at 1-866-758-9768.

MAIL COMPLETED FORM TO:
State of California
Employment Development Department
NDI-FCL
PO Box 2168
Stockton, CA 95201-2168

Information Collection and Access

State law requires the following information to be provided when collecting information from individuals:

Agency Name: Employment Development Department (EDD)	**Title of Official Responsible for Information Maintenance:** Manager, EDD Disability Insurance Office
Local Contact Person: Manager, EDD Disability Insurance Office	**Address and Telephone Number:** PO Box 2168, Stockton, CA 95201-2168 1-866-758-9768

Maintenance of the Information is authorized by:
California Unemployment Insurance Code, sections 2601 through 3272.
California Code of Regulations, title 22, sections 2706-1, 2706-3, 2708.1-1, 2710-1.
California Government Code, sections 19878 through 19886.2.

Basic Eligibility:
Nonindustrial Disability Insurance – Family Care Leave can be paid only after you meet all the following requirements:

- You must be **unable** to do your regular or customary work **due to the need to provide care, to bond with a new child, or to participate in a qualifying event.**
- You must be an **Excluded Government Employee of the State of California** at the time your Nonindustrial Disability Insurance – Family Care Leave begins.
- If working, you must have **lost wages** because you were caring for a seriously ill family member, bonding with a new child, or participating in a qualifying event.
- Must be a participant in the Annual Leave Program.

In addition, the following requirements must be met only if your NDI-FCL claim is to **care** for a seriously ill family member:

- The care recipient must be your child, parent, spouse, registered domestic partner, grandparent, grandchild, sibling, or parent-in-law.
- The care recipient must be **under the continuing treatment** or supervision of a licensed physician/practitioner or accredited religious practitioner while you are receiving benefits.
- The care recipient's **physician/practitioner must complete the certification** that he/she requires care. If the care recipient is under the care of an EDD accredited religious practitioner, obtain a *Practitioner's Certification for Nonindustrial Disability Insurance – Family Care Leave*, (DE 2502FF).

In addition to basic eligibility requirements, the following requirements must be met only if your NDI-FCL claim is to **bond** with a new child:

- Your leave must take place within 12 months of the birth, adoption, or foster care placement of your child.
- The new child must be either your or your registered domestic partner's biological child, adopted child, or foster child.

The following requirements must also be met only if your NDI-FCL claim is to participate in a qualifying event:

- The military assist recipient must be your spouse, registered domestic partner, parent or child.

Your Responsibilities:

- File your claim and other forms completely, accurately and in a timely manner.
- Carefully read the instructions on this and all other forms you receive from NDI-FCL.
- Call or report in writing to NDI-FCL any:
  - Change of address or telephone number.
  - Return to work.
  - Need for care or bonding to stop.
- **Include your name and Social Security number on all correspondence.**

All information requested on the claim form is required to process your claim. Please note the following:

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

Information Collection and Access

State law requires the following information to be provided when collecting information from individuals:

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

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

Under California Civil Code, section 1798.34, you have the right to inspect records maintained on you by the agency unless exempted.

California Civil Code, section 1798 (The Information Practices Act), imposes conditions on the gathering, maintenance, disclosure and correction of personal information by public agencies.

1. **Right to inspect and correct:** California Civil Code, section 1798.34, gives you the right to inspect any personal records maintained about you by the Employment Development Department. Section 1798.34 also gives you the right to obtain a hardcopy of your file. Section 1798.35 permits you to request that the record be corrected if you believe that it is not accurate, relevant, timely or complete.
2. **Exemptions:** Certain limited types of information that would generally be considered personal are exempt from disclosure to you:
   (a) Medical or psychological records where knowledge of the contents might be harmful to the subject (Civil Code, section 1798.40);
   (b) Records of active criminal, civil or administrative investigations (Civil Code, section 1798.40);
   (c) Names of individuals submitting letters of reference (Civil Code, section 1798.38).
   NOTE: EDD will not disclose or provide copies of care recipient's medical information to care providers.
3. **Appeal rights:** If you are denied access to records which you believe you have a right to inspect or if your request to amend your records is refused, you may file an appeal in writing with Nonindustrial Disability Insurance at PO Box 2168, Stockton, CA 95201-2168.

Federal Privacy Act

The Employment Development Department requires disclosure of Social Security account numbers on a mandatory basis to comply with California Unemployment Insurance Code, sections 1253 and 2627; with California Code of Regulations, Title 22, sections 1085, 1088 and 1326; with Code of Federal Regulations, Title 20, part 604; and with U.S. Code, Title 8, sections 1621, 1641 and 1642.

Benefit Amounts

Enhanced NDI benefits are provided to employees who participate under the State's Annual Leave Program (ALP) in the amount of 50% of gross pay that may be supplemented with leave credits at 75% or 100%.

State and federal taxes will be withheld from NDI-FCL benefits. Voluntary deductions such as health insurance premiums, credit union loans, savings accounts, bonds, parking fees, etc. will automatically be deducted from NDI-FCL benefits unless cancelled by the employee. If the employee continues health insurance premium deductions, the State's employer contribution will also continue.

Benefit Payment Process

The EDD determines eligibility and authorizes benefit payments. The employer's personnel office then must request the State Controller or paying agent to issue benefit payments to the employee. Benefits are paid by your employer's payment schedule.

Once benefits are authorized by the EDD, inquiries concerning payment status, weekly rates, payment amounts, deductions, etc. should be directed to the employee's attendance clerk or personnel office.

Questions concerning eligibility for benefits should be directed to NDI-FCL at 1-866-758-9768. Any determination of eligibility made by the EDD may be appealed before an administrative law judge by writing to NDI-FCL to request a hearing.

Benefits Are Not Payable:

- For any day of entitlement to temporary workers' compensation benefits or industrial disability leave.
- For any day wages are received in the form of sick leave, vacation, compensatory time off, or catastrophic leave.
- For any day Unemployment Insurance benefits are received.
- For any day on and after separation or retirement from state service. It is permissible to delay the effective date of a disability retirement until NDI-FCL benefits are exhausted.

Retirement Credit

You will not earn Public Employees' Retirement System (PERS) or State Teachers Retirement System (STRS) service credit while you are receiving NDI-FCL. State employer contributions to your retirement account will not be made while you are receiving NDI-FCL. If supplementing or working while on NDI-FCL, contact CalPERS for information on retirement credit/contribution amounts.

Disqualification

All available information will be considered before issuing a benefit payment or disqualifying your claim. Benefits will be paid only for the days to which you are eligible. If payment of benefits is denied or reduced, you will receive a written notice stating the reason for the disqualification.

If you deliberately report incorrect information or if you willfully omit or withhold information, disqualifications will be assessed.

Fraud

Under the California Unemployment Insurance Code, sections 1143, 2101, 2116, 2122 and 3305, it is a violation to willfully make a false statement or knowingly conceal a material fact in order to obtain the payment of any benefits. Such violation is punishable by imprisonment, and/or by a fine not exceeding $20,000, or both. To detect and discourage fraud, the EDD continually monitors claims, vigorously investigates suspicious activity, and will seek restitution and conviction through prosecution.

EDD Employment Development Department State of California

Claim for Nonindustrial Disability Insurance – Family Care Leave (NDI-FCL)

Part A – Employee Information (To be completed by employer)

1. NAME OF EMPLOYEE (EE)
FIRST | INITIAL | LAST

2. SOCIAL SECURITY NUMBER

3. POSITION NUMBER
AGENCY | UNIT | CLASS | SERIAL

4. GENDER
☐ MALE ☐ FEMALE

5. OCCUPATION

6. CBID #

7. GROSS MONTHLY SALARY
$

8. LAST DAY PHYSICALLY AT WORK

9. PERSONNEL TRANSACTIONS OFFICE
DEPARTMENT OR CAMPUS
BRANCH OR DIVISION
MAILING ADDRESS
NAME OF PAYROLL SPECIALIST (PLEASE PRINT)
PUBLIC PHONE | EXTENSION | FAX

10. APPOINTMENT/TIME BASE STATUS (CHECK ALL THAT APPLY)
☐ PERMANENT/PROBATIONARY
☐ FULL TIME
☐ PT/INT – DID EE HAVE EQUIVALENT OF 6 MONTHLY COMPENSATED PPS IN THE PAST 18 PPS? ☐ YES ☐ NO
☐ PERS/STRS MEMBER
☐ LT – DOES EE HAVE THE RIGHT TO RETURN TO A PRIOR PERMANENT, FULL-TIME POSITION? ☐ YES ☐ NO
☐ TAU – DOES EE HAVE THE RIGHT TO RETURN TO A PRIOR PERMANENT, FULL-TIME POSITION? ☐ YES ☐ NO
☐ CEA – DOES EE HAVE THE RIGHT TO RETURN TO A PRIOR PERMANENT, FULL-TIME POSITION? ☐ YES ☐ NO
☐ LEAP – HAS EE SUCCESSFULLY COMPLETED THE TEMPORARY JOB EXAMINATION PERIOD? ☐ YES ☐ NO
☐ SEASONAL
☐ ANNUITANT
☐ EMERGENCY

11. ADDRESS OR LOCATION WHERE EMPLOYEE ACTUALLY WORKS.

12. COMPLETED BY (PLEASE PRINT NAME)
DATE COMPLETED
SIGNATURE
PUBLIC PHONE | EXTENSION | FAX

13. FOR ANNUAL LEAVE PROGRAM (ALP) EMPLOYEES
DID EE ELECT TO USE FULL LEAVE CREDITS, INCLUDING CATASTROPHIC LEAVE?
☐ YES ☐ NO

14. WORKERS' COMPENSATION INFORMATION
IS EE ENTITLED TO RECEIVE OR HAS THE EE RECEIVED WORKERS' COMPENSATION TEMPORARY DISABILITY OR IDL FOR ANY DAY AFTER THE LAST DAY PHYSICALLY WORKED SHOWN ABOVE?
☐ YES ☐ NO ☐ PENDING

IF YES, PROVIDE PERIODS PAID FROM TO .

FOR WHAT BODY PARTS?

FOR WHAT DATE OF INJURY?

15. HAS EE RETURNED TO WORK? ☐ YES ☐ NO

IF YES: ☐ PART TIME ☐ FULL TIME GIVE DATE(S)

NOTE TO EMPLOYER:
While the NDI office determines the period of eligibility and authorizes payment on claims, your personnel office has the responsibility for requesting payment from the State Controller.

Part B – Claim Statement of Employee

1. PLEASE RE-ENTER YOUR SOCIAL SECURITY NUMBER

2. DATE OF BIRTH

3. YOUR MAILING ADDRESS

STREET, PO BOX, OR RFD | APT. NO. | CITY | STATE | ZIP CODE

4. YOUR HOME ADDRESS (IF DIFFERENT FROM MAILING ADDRESS)

5. OTHER NAME(S) USED

6. OCCUPATION

7. INDICATE YOUR DESIRE TO SUPPLEMENT NDI-FCL WITH LEAVE

☐ NO SUPPLEMENT ☐ 75% ☐ 100%

8. DATE YOU WANT YOUR NDI-FCL CLAIM TO BEGIN

9. LAST DAY PHYSICALLY WORKED

10. REASON YOU REDUCED YOUR WORK HOURS OR STOPPED WORKING

☐ CARE FOR FAMILY MEMBER ☐ BOND WITH CHILD ☐ MILITARY ASSIST ☐ OTHER (EXPLAIN)

11. LEGAL NAME OF CARE, BONDING, OR MILITARY ASSIST RECIPIENT

12. THE ABOVE NAMED CARE, BONDING, OR MILITARY ASSIST RECIPIENT IS YOUR ☐ CHILD ☐ SPOUSE ☐ REGISTERED DOMESTIC PARTNER

☐ PARENT ☐ PARENT IN-LAW ☐ GRANDPARENT ☐ GRANDCHILD ☐ SIBLING ☐ OTHER (EXPLAIN)

13. IS ANY OTHER FAMILY MEMBER READY, WILLING, AND ABLE AND AVAILABLE TO PROVIDE CARE FOR THE SAME PERIOD YOU ARE CLAIMING NONINDUSTRIAL DISABILITY INSURANCE - FAMILY CARE LEAVE? ☐ YES ☐ NO

14. HAVE YOU FILED A CLAIM FOR WORKERS' COMPENSATION? ☐ YES ☐ NO

IF "YES", PLEASE PROVIDE THE FOLLOWING INFORMATION

NAME OF WORKERS' COMPENSATION INSURANCE CARRIER

CARRIER'S PHONE NUMBER

ADDRESS OF CARRIER

NAME OF ADJUSTER

DATE OF INJURY

CLAIM NUMBER

BODY PARTS

ARE YOU RECEIVING WORKERS' COMPENSATION BENEFITS? ☐ YES ☐ NO

IF "YES", DATES BENEFITS PAID

FROM TO

15. DECLARATION AND SIGNATURE. By my signature on this claim statement for Nonindustrial Disability Insurance – Family Care Leave, I certify that (1) throughout the period covered by this claim, I was providing care for, bonding with, or participating in a qualifying event with the recipient named above; (2) authorize the Employment Development Department (EDD) to release my personal information as shown on this claim to the care recipient and to the care recipient's treating physician as they are respectively listed in Part D and Part E of this claim; (3) authorize my employer(s) to disclose to the 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 Access" portion of this form. 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 and 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 15 years from the date of my signature or the effective date of the claim, whichever is later.

YOUR SIGNATURE | DATE | WORK PHONE NUMBER | HOME PHONE NUMBER

Part C – Bonding Certification (To be completed by person claiming NDI-FCL to bond with a child)

1. YOUR SOCIAL SECURITY NUMBER	2. YOUR LEGAL LAST NAME (NEEDED IN CASE PAGES OF THIS CLAIM BECOME SEPARATED)	3. CHILD'S SOCIAL SECURITY NUMBER (IF AVAILABLE)

4. LEGAL NAME OF CHILD

5. CHILD'S DATE OF BIRTH	6. CHILD'S GENDER	7. DATE OF FOSTER CARE OR ADOPTION PLACEMENT
	☐ MALE ☐ FEMALE	

8. CHILD'S RESIDENCE ADDRESS (IF DIFFERENT FROM CLAIMANT'S)

ADDRESS | CITY | STATE | ZIP CODE | COUNTRY (IF NOT U.S.A.)

9. CHILD NAMED IN #4 IS MY ☐ BIOLOGICAL CHILD ☐ FOSTER CHILD ☐ ADOPTED CHILD ☐ STEPCHILD ☐ OTHER

10. AS EVIDENCE OF RELATIONSHIP, CHECK ONE OF THE FOLLOWING AND ATTACH A COPY OF THE DOCUMENT CHECKED.
(DO NOT SEND ORIGINAL DOCUMENT. IT WILL NOT BE RETURNED)

☐ CHILD'S BIRTH CERTIFICATE
☐ ADOPTIVE PLACEMENT AGREEMENT, AD-907
☐ DECLARATION OF PATERNITY, CS-909
☐ INDEPENDENT ADOPTION PLACEMENT AGREEMENT, AD-924
☐ FOSTER CARE PLACEMENT RECORD, SOC-815
☐ OTHER

11. DECLARATION AND SIGNATURE. By my signature on this bonding certification, I authorize the medical provider, adoption agency, adoption party, 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 or 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.

ORIGINAL Signature of Bonding Claimant — RUBBER STAMP IS NOT ACCEPTABLE | DATE SIGNED

Part D – Statement of Care Recipient (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.)

1. CLAIMANT SOCIAL SECURITY NUMBER	2. YOUR LEGAL LAST NAME (NEEDED IN CASE PAGES OF THIS CLAIM BECOME SEPARATED)

3. LEGAL NAME OF CARE RECIPIENT

4. CARE RECIPIENT'S DATE OF BIRTH	5. CARE RECIPIENT'S GENDER	6. CARE RECIPIENT'S PHONE NUMBER
	☐ MALE ☐ FEMALE	

7. CARE RECIPIENT'S RESIDENCE ADDRESS

ADDRESS | CITY | STATE | ZIP CODE | COUNTRY (IF NOT U.S.A.)

8. CONFIRMATION OF MEDICAL DISCLOSURE AUTHORIZATION. I authorize my physician or practitioner to disclose my current personal-health information to my care provider and to the California Employment Development Department (EDD).

CARE RECIPIENT'S SIGNATURE (DO NOT PRINT) | DATE SIGNED

9. AUTHORIZED REPRESENTATIVE signing on behalf of care recipient must complete the following: I, , represent the care or bonding recipient in this matter as authorized by ☐ parental right ☐ power of attorney (attach copy) ☐ court order (attach copy)
(For spouse or domestic partner, contact the EDD.)

AUTHORIZED REPRESENTATIVE'S SIGNATURE (DO NOT PRINT) | DATE SIGNED

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

Part E – Physician/Practitioner's Certification (Do NOT complete this part if claim is for bonding.)

1. CLAIMANT'S (CARE PROVIDER'S) SOCIAL SECURITY NUMBER	2. CLAIMANT LAST NAME (NEEDED IN CASE PAGES OF THIS CLAIM BECOME SEPARATED)
3. PATIENT'S NAME	
4. PATIENT'S DATE OF BIRTH	5. DOES THE PATIENT REQUIRE CARE BY THE CLAIMANT? ☐ NO (SKIP TO #14) ☐ YES
6. DIAGNOSIS OR, IF NOT YET DETERMINED, A DETAILED STATEMENT OF SYMPTOMS	
7. PRIMARY ICD CODE	8. SECONDARY ICD CODES

9. FIRST DATE CARE NEEDED	10. DATE YOU EXPECT RECOVERY ☐ NEVER	11. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CLAIMANT ☐ PERMANENT

12. APPROXIMATELY HOW MANY TOTAL HOURS PER DAY WILL PATIENT REQUIRE CARE BY CLAIMANT?	
HOURS	COMMENTS

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

14. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER	15. STATE OR COUNTRY PHYSICIAN/PRACTITIONER IS LICENSED
16. PHYSICIAN/PRACTITIONER'S NAME	

17. PHYSICIAN/PRACTITIONER'S ADDRESS				
ADDRESS	CITY	STATE	ZIP CODE	COUNTRY (IF NOT U.S.A.)

18. TYPE OF PHYSICIAN/PRACTITIONER	19. SPECIALTY (IF ANY)

20. PHYSICIAN/PRACTITIONER'S Certification and Signature: 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 ATTENDING PHYSICIAN/PRACTITIONER – RUBBER STAMP IS NOT ACCEPTABLE	PHYSICIAN/PRACTITIONER'S PHONE NUMBER	DATE SIGNED

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

Part F – Military Assist Certification (To be completed by the claimant)

1. YOUR SOCIAL SECURITY NUMBER

2. YOUR LEGAL NAME

FIRST NAME | INITIAL | LAST NAME

3. NAME OF MILITARY MEMBER ON COVERED ACTIVE DUTY OR IMPENDING CALL TO COVERED ACTIVE DUTY STATUS

FIRST NAME | INITIAL | LAST NAME

4. MILITARY MEMBER'S DATE OF BIRTH (MM/DD/YYYY)

5. MILITARY MEMBER'S GENDER

☐ MALE ☐ FEMALE

6. LAST 4 DIGITS OF MILITARY MEMBER'S SOCIAL SECURITY NUMBER

7. MILITARY MEMBER'S MAILING ADDRESS

ADDRESS | CITY | STATE | ZIP CODE | COUNTRY (IF NOT U.S.A.)

8. PERIOD OF MILITARY MEMBER'S COVERED ACTIVE DUTY (MM/DD/YYYY TO MM/DD/YYYY)

TO

9. DATE MILITARY MEMBER WAS NOTIFIED OF COVERED ACTIVE DUTY (MM/DD/YYYY)

10. 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:

☐ COVERED ACTIVE DUTY ORDERS

☐ LETTER OF IMPENDING CALL OR ORDER TO COVERED DUTY

☐ DOCUMENTATION OF MILITARY LEAVE SIGNED BY THE APPROVING AUTHORITY FOR MILITARY MEMBER'S REST AND RECUPERATION

11. THE QUALIFYING EVENT FOR THE NDI-FCL CLAIM IS TO: (ONE OR MORE REASONS MAY BE SELECTED)

☐ PROVIDE/ARRANGE CHILDCARE FOR MILITARY MEMBER'S CHILD

☐ PROVIDE/ARRANGE CARE FOR MILITARY MEMBER'S PARENT

☐ ATTEND COUNSELING

☐ MAKE FINANCIAL/LEGAL ARRANGEMENTS

☐ ASSIST MILITARY MEMBER DURING REST AND RECUPERATION LEAVE

☐ ATTEND MILITARY EVENT

☐ REPRESENT MILITARY MEMBER AT FEDERAL, STATE, OR LOCAL AGENCIES

☐ ADDRESS ISSUES DUE TO MILITARY MEMBER'S DEATH

☐ OTHER:

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

☐ YES ☐ NO ☐ NONE AVAILABLE

NOTE: A complete and sufficient certification to support a request for NDI-FCL leave due to a qualifying event includes any available written documentation that supports the need for leave. Documentation may include; a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming the military member's Rest and Recuperation leave, an appointment with a third party (i.e., a counselor, school official, or staff at a care facility), or a copy of a bill for services for the handling of legal or financial affairs. If leave is requested to meet with a third party, the employee must provide the 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 phone number, fax number, or email address of the individual or entity).

13. DECLARATION AND SIGNATURE. By my signature on this military assist certification, 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.

ORIGINAL Signature of Military Assist Claimant | DATE SIGNED (MM/DD/YYYY)

Qualifying Event for Leave - Documentation

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 parental care, counseling, making financial or legal arrangements, acting as the military member's representative before a federal, state or local agency for purposes of obtaining, arranging or appealing military service benefits, or attending any event sponsored by the military or military service organizations.

PLEASE SUBMIT SUPPORTING DOCUMENTATION, IF APPLICABLE (Attach an additional sheet if more space is required)

YOUR SOCIAL SECURITY NUMBER	**YOUR LEGAL NAME** FIRST NAME INITIAL LAST NAME

NAME OF INDIVIDUAL WITH WHOM CLAIMANT IS MEETING

FIRST NAME INITIAL LAST NAME

TITLE	**ORGANIZATION**

PHONE NUMBER (PROVIDE AREA OR COUNTRY CODE)	**FAX NUMBER** (PROVIDE AREA OR COUNTRY CODE)	**EMAIL ADDRESS**

MAILING ADDRESS

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

DESCRIBE NATURE OF MEETING. INCLUDE DATES, IF KNOWN: