Application for

Paid Family Leave Benefits

California's Paid Family Leave (PFL) program provides up to eight weeks of benefit payments to people who need to take time off work to:

- **Bond with a new child.**
- **Care for a seriously ill family member.**
- **Participate in a qualifying event because of a family member's military deployment to a foreign country.**

When to Apply

You can apply the first day you take time off for leave. You must apply within 41 days of this date to avoid losing benefits.

How to Complete Your Application

When completing your application:

- Use black ink only.
- Write clearly within the boxes provided.
- Enter the Social Security number used to obtain benefits on all pages of the application, including any attachments. If you do not have a Social Security number, you can leave the boxes blank.

Note: Do not complete this application if you're:

- Insured by a Voluntary Plan. Ask your employer for information on how to apply.
- A state government employee in bargaining unit 2, 5, 6, 7, 8, 9, 10, 12, 13, 16, 18, or 19. Use the *Claim for Nonindustrial Disability Insurance – Family Care Leave (NDI-FCL)* (DE 8501F).

Part A – Claimant's Statement

You must complete and sign Part A.

- For question A8, if you have a private mailbox, include "PMB" at the beginning of the address.
- For help with questions A11 and A12, see "Your Benefit Amounts" on page 2. Your claim can start the first day you take time off for PFL. You do not have to use all eight weeks of leave at once.

Part B – Bonding Certification

Complete and sign Part B if you're applying to bond with your child.

For question B10, you must submit a document that proves your relationship to your child. If you select "Other," the document must include your name, your child's name, and proof that you're providing care and financial support.

Part C – Statement of Family Member Receiving Care

Complete Part C if you're applying to care for a family member.

Your family member must sign Part C. If they're not able to sign or mark an "X," an authorized representative can sign.

Part D – Physician/Practitioner's Certification

Part D is for licensed health professionals. If you're applying to care for a family member, have their licensed health professional complete and sign the "Physician/Practitioner's Certification." They can do this using SDI Online or **Part D** of this application. If they use Part D, make sure you submit it with Part A and Part C.

If your family member is under the care of an accredited religious practitioner, the practitioner must complete and sign the *Practitioner's Certification for Paid Family Leave (PFL) Benefits* (DE 2502F). To get the DE 2502F, call 1-877-238-4373.

We do not accept rubber stamped signatures.

Part E – Military Assist Certification

Complete and sign Part E only if you're applying due to a family member's military deployment.

For questions E10 and E12, you must submit documentation that:

- Proves your family member is on covered active duty, call or order to covered duty, or military leave.
- Supports your need to take time off to participant in the qualifying event.

How to Submit Your Application

Mail your application to us using the envelope provided. If your application is late, has errors, or is missing information, it could delay your claim or you could be denied benefits.

For your application to be complete, we must receive:

- **Bonding claim:** Part A, Part B, and supporting documentation.
- **Care claim:** Part A, Part C, and Part D.
- **Military assist claim:** Part A, Part E, and supporting documentation.

After we've received your completed application, you'll receive information by mail in about two weeks. The time it takes to process an application can vary. For faster processing, you can apply using **SDI Online** at edd.ca.gov/SDI_Online.

If you cannot complete your application due to a disability, or if you're an authorized representative applying on behalf of an incapacitated or deceased person, call 1-877-238-4373 or send us a message using **Ask EDD** at askedd.edd.ca.gov.

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

Basic Eligibility

To be eligible for Paid Family Leave (PFL) benefits, you must:

- Be unable to do your regular or customary work due to the need to bond with your child, provide care, or participate in a qualifying event.
- Be employed or actively looking for work when your leave begins.
- Have lost wages (if working) due to your need to bond with your child, provide care, or participate in a qualifying event.
- Have earned at least $300 from which State Disability Insurance (SDI) deductions were withheld during the past 5 to 18 months. See "Your Benefit Amounts" in the next column.
- Submit your application within 41 days after the first day you take time off for leave or you may lose benefits.

If you're applying to bond:

- You must use PFL within 12 months of the birth, adoption, or foster care placement of the child.
- The child must be your own or your registered domestic partner's biological child, adopted child, or foster child.

If you're applying to care:

- The family member must be your child, spouse, registered domestic partner, parent, parent-in-law, grandparent, grandchild, or sibling.
- The family member must be under the treatment or supervision of a licensed health professional while you're receiving benefits.
- The licensed health professional must complete a medical certification that shows your family member needs care. If your family member is under the care of an accredited religious practitioner, the practitioner must complete and sign the *Practitioner's Certification for Paid Family Leave (PFL) Benefits* (DE 2502F). To get the DE 2502F, call 1-877-238-4373.

If you're applying to support a military family member, you must provide documentation that:

- Proves your family member is on covered active duty, call or order to covered duty, or military leave.
- Supports your need to take time off to participant in the qualifying event.

Ineligibility

Apply for benefits even if you're not sure you're eligible. If we find you ineligible for all or part of your claim, we will let you know. You may not be eligible if:

- You're claiming or receiving unemployment or disability benefits.
- You're receiving Workers' Compensation benefits at a weekly rate equal to or greater than the PFL rate.
- You're in jail or prison.

Fraud

Making false statements or withholding information to receive benefit payments is a felony. Penalties may include fines, a loss of benefits, and criminal prosecution. To detect and discourage fraud, we monitor claims, investigate suspicious activity, and seek restitution and conviction through prosecution (CUIC, sections 1143, 2101, 2116, 2122, and 3305).

Your Responsibilities

- Submit your completed application within 41 days after the first day you take time off for leave. If your application is late, include a written explanation of why.
- Read the instructions on all forms you receive from us. If you're not sure about what you need to do, contact a PFL office (edd.ca.gov/Office_Locator).
- You must let us know in writing, through SDI Online, or by phone if you:
  - Change your address or phone number.
  - Return to part-time or full-time work.
  - Receive any type of income.
- **Include your name and the Social Security number used to obtain benefits on all correspondence.**

Your Rights

Information about your claim is confidential, except for the purposes allowed by law. You have the right to inspect any personal records we have about you and ask that we correct our records if you believe they are not accurate, relevant, timely, or complete (California Civil Code, sections 1798.34 and 1798.35).

Certain types of information are exempt from disclosure to you:

- Medical or psychological records where knowledge of the contents might be harmful to the subject.
- Records of active criminal, civil, or administrative investigation.
- Copies of your family member's medical information.

If you're denied access to records that you believe you have a right to inspect, or if your request to amend your records is refused, you may file an appeal with the PFL office. You may request a copy of your file by calling the number on your *Notice of Computation* (DE 429D) (Civil Code, section 1798.40).

You also have the right to appeal any disqualification, overpayment, or penalty. Instructions on how to appeal are provided on documents that can be appealed.

Your Benefit Amounts

Your claim can begin the first day you take time off for leave. We calculate your **weekly benefit amount** using your base period. The date your claim begins determines your base period. You cannot change the start date of your claim or adjust your base period after you've established a valid claim.

Your base period covers 12 months and is divided into four consecutive quarters. It includes wages subject to SDI tax that you were paid about 5 to 18 months before your PFL claim began. Your base period does not include wages being paid at the time your family leave began. Use the following information to determine your base period.

- If your claim begins in January, February, or March, your base period is the 12 months ending last September 30.
- If your claim begins in April, May, or June, your base period is the 12 months ending last December 31.
- If your claim begins in July, August, or September, your base period is the 12 months ending last March 31.
- If your claim begins in October, November, or December, your base period is the 12 months ending last June 30.

Your highest-earning quarter determines your weekly benefit amount. For more information, visit edd.ca.gov/Disability/Calculating_PFL_Benefit_Payment_Amounts.htm.

Contact the PFL office (edd.ca.gov/Office_Locator) for more information if:

- You do not have sufficient base period wages. You may be able to use a later start date on your claim.
- You do not have enough base period wages and you were actively seeking work for 60 days or more in any quarter of the base period. You may be able to substitute wages paid in prior quarters.
- During your base period, you served in the military, received Workers' Compensation benefits, or did not work because of a labor dispute.

How Benefits Are Paid

When we receive your completed application, we will mail you a *Notice of Computation* (DE 429D), which lets you know what your weekly payments could be. We may ask for more information to determine your eligibility.

If you're eligible to receive benefits, you have the option to receive payments by direct deposit, debit card, or by check. **Direct deposit is a fast and secure way to automatically receive payments into your personal bank account.** *To receive your payments by direct deposit, you must apply using* **SDI Online** (edd.ca.gov/sdi_online).

You do not have to accept benefits by direct deposit or debit card. To receive your payments by check, allow 7 to 10 days for delivery by US mail. Select your preferred payment method in question A16.

Most claims are processed and issued payments within 14 days of receiving a correctly completed application.

Payments will be issued automatically. You will be paid 1/7 of your weekly benefit amount for each calendar day you're eligible unless benefits are reduced. See "Benefit Reductions" below.

Benefit Reductions

Under certain circumstances, you may not be eligible for benefits for a period of your claim or you may be entitled only to partial benefits. We will determine if benefits must be reduced. The following types of income should be reported to us even though they may not always affect your benefits:

- Sick leave pay
- Vacation pay
- Self-employment income
- Military pay
- Commissions
- Wages, including modified duty wages
- Residuals
- Bonuses
- Workers' Compensation benefits
- Holiday pay
- Paid time off
- Part-time work income
- Insurance settlements

Failure to report your income could result in an overpayment, penalties, and a false statement disqualification. In addition, your benefits may be reduced because of a prior unemployment, disability, or PFL overpayment, or for delinquent court-ordered support payments.

Benefit Interruption and Termination

We will send an *Electronic Benefit Payment (EBP) Notification* (DE 2500E) with a section titled "Notice of Exhaustion of Paid Family Leave Benefits" when:

- You have been paid to the date your family member no longer needs care, as estimated by their licensed health professional. If they still need care, complete and sign the "PFL Claimant's Certification" section and have the licensed health professional complete and mail the *Physician/Practitioner's Supplementary Certificate* (DE 2525XFA).
- Your family member has recovered. If you return to work and your family member requires care again, submit a new application and report the dates you worked.

We will send you a *Notice of Exhaustion of Paid Family Leave Benefits* (DE 2525AF) when you have been paid the maximum amount of PFL benefits.

Taxability of Benefits

PFL benefits are subject to federal income taxes and will be reported to the IRS.

If you receive PFL benefits, you will receive a 1099G form to include with your federal income tax return. PFL benefits are not subject to California income taxes. For more information about 1099G, call 1-800-795-0193.

Overpayment

An overpayment results when you receive PFL benefit payments you were not eligible to receive. Once we determine that you were overpaid, we will contact you to explain the reason. It's important that you complete and return all information requests, as there are instances when an overpayment can be waived.

If we determine that you were overpaid and the overpayment cannot be waived, you must repay the money. Payments issued after an overpayment is established may be reduced by 25 to 100 percent to collect your overpayment. We will send you a *Notice of Overpayment Offset* (DE 826) if your weekly benefit amount is reduced due to a disability, unemployment, or PFL overpayment.

Disqualification

We will consider all available information before paying or disqualifying your claim. Benefits will be paid only for the days you're eligible. If payment is denied or reduced, we will send you a *Notice of Determination* (DE 2517) explaining the reason and the time period.

If you knowingly report incorrect information or willfully withhold information, we will assess false statement disqualifications of up to 92 days. This can apply if you receive a payment that you know includes days you should not be paid, such as days after you returned to work. In addition, any overpayment will be increased by a 30 percent penalty.

Special Circumstances

- For pregnancy, mothers who are receiving disability benefits for a pregnancy-related disability and have delivered their child may be eligible for PFL benefits to bond with their child. An *Application for Paid Family Leave Benefits – Bonding for New Mother* (DE 2501FP) will automatically be sent to these mothers at the end of their pregnancy-related disability claim.
- For child support obligations, contact the District Attorney's office administering the court order.
- For spousal or parental support obligations, questions should be directed to the District Attorney's office administering the court order.
- If a person receiving PFL benefits dies, an heir or legal representative should report the death to PFL. Benefits are payable through the date of death, if otherwise eligible.
- If the person you're caring for or the child you're bonding with dies, report the death to PFL at 1-877-238-4373. Benefits are payable through the date of death, if otherwise eligible.
- For 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. For more information about FMLA, call 1-866-487-9293 or visit dol.gov/whd/fmla. For more information on CFRA, call 1-800-884-1684 or visit dfeh.ca.gov.

Prepaid Debit Card Disclosures

Money Network® State Government Disbursement Program Short Form

You do not have to accept this benefits card. Ask about other ways to receive your benefits.			
Monthly fee **$0**	**Per purchase** **$0**	**ATM withdrawal** **$0** in-network **$1.00** out-of-network	**Cash reload** **N/A**
ATM balance inquiry (in-network or out-of-network)			**$0**
Customer service			**$0** per call
Inactivity			**$0**
We charge 5 other types of fees. Here are two of them:			
ATM Withdrawal Int. — $1.00 | Priority Shipping — $8.00			
No overdraft/credit feature: Your funds are eligible for FDIC insurance. For general information about prepaid accounts, visit cfpb.gov/prepaid. Find details and conditions for all fees and services in the Cardholder Agreement.			

Money Network State Government Disbursement Program. The Mastercard Card is issued by My Banking Direct, a service of Flagstar Bank, N.A., Member FDIC, pursuant to a license from Mastercard U.S.A. Inc. Incorporated. Card is serviced by Money Network Financial, LLC.

List of all fees (Long Form) for the Money Network® State Government Disbursement Program

All Fees	Program Fees	Details
Monthly Usage		
Account Opening and Card Receipt	**$0.00**	No fee for Account Opening and initial Card.
Monthly Maintenance Fee	**$0.00**	We do not assess a monthly maintenance fee.
Add Money		
Payer Deposit	**$0.00**	Funds are loaded only by your Payer.
Spend Money		
Signature Debit Transactions	**$0.00**	Select “Credit” or sign at point-of-sale (POS). International Service Assessment or Cross Border Assessment may also apply to International Transactions.
PIN Debit Transactions	**$0.00**	Select “Debit” and enter PIN at POS; cash back option at participating merchants. International Service Assessment or Cross Border Assessment may also apply to International Transactions.
Get Cash or Send Cash		
ATM Withdrawal Fee or ATM Decline Fee | In-Network	**$0.00**	Withdrawal or Decline from ATM that is a part of our network. To find in-network ATMs, use the locator on our Mobile App (data rates may apply) or on our Website, or call Customer Service.
ATM Withdrawal Fee | Out-of-Network	**$1.00**	This is our fee. You will receive two (2) free withdrawals after each deposit made to your account. You may also be charged a fee by the ATM operator, even if you do not complete a transaction. “Out-of-Network” means ATMs that are not in-network ATMs. To find in-network ATMs, use the locator on our Mobile App (data rates may apply) or on our Website, or call Customer Service.
ATM Decline Fee | Out-of-Network	**$0.00**	We do not charge a fee for this service. You may be charged a fee by the ATM operator.
Bank Teller Over the Counter Cash Withdrawal	**$1.00**	At banks displaying the card association logo on your Card’s front side. This is our fee. You will receive one (1) free per deposit made to your account. International Service Assessment or Cross Border Assessment may also apply to International Transactions.
Transfer to Customer Bank Fee	**$0.00**	Domestic ACH transactions are subject to additional terms that are disclosed when transaction is initiated.
International ACH Withdrawal Fee	**Not Applicable**	ACH funds transfers to international bank accounts are not available.

List of all fees (Long Form) for the Money Network® State Government Disbursement Program *(continued)*

All Fees	Program Fees	Details
Information		
Monthly Paper Statement	**$0.00**	You may also obtain Account activity without a fee via Mobile App (data rates may apply), our Website, or by contacting Customer Service.
Customer Service	**$0.00**	24/7 toll free Account access, including account balance inquiries.
ATM Balance Inquiry Fee | In-Network	**$0.00**	To find in-network ATMs, use the locator on our Mobile App (data rates may apply) or at our Website, or call Customer Service.
ATM Balance Inquiry Fee | Out-of-Network	**$0.00**	This is our fee. You may also be charged a fee by the ATM operator, even if you do not complete a transaction.
Using Your Card Outside the U.S. (International Transactions)		
ATM Withdrawal INT Fee (Non-U.S.)	**$1.00**	This is our fee. You may also be charged a fee by the ATM operator, even if you do not complete a transaction. Currency Conversion Assessment Fee, International Service Assessment, and/or Cross Border Assessment may also apply to these transactions.
ATM Decline INT Fee (Non-U.S.)	**$0.00**	
ATM Balance Inquiry INT Fee (Non-U.S.)	**$0.00**	
Mastercard International Service Assessment	**2.0%**	This fee applies if a transaction is initiated in a currency other than U.S. dollars and a currency conversion rate applies. Fee is assessed as a percentage of the U.S. dollar amount of each International Transaction made with your Card. See the section labeled "International Transactions" in your Cardholder Agreement for additional information. If this fee applies to your transaction, it will be included in the transaction amount on your statement.
Mastercard Cross Border Assessment	**0.0%**	This fee applies if a transaction is initiated in U.S. dollars by a merchant with a non-U.S. country code. Fee is assessed as a percentage of the U.S. dollar amount of each International Transaction made with your Card. See the section labeled "International Transactions" in your Cardholder Agreement for additional information. If this fee applies to your transaction, it will be included in the transaction amount on your statement.
Other		
Reissuance of Lost/ Stolen Card	**$0.00**	We do not charge a fee for this service. Reissued Card shipped via U.S. mail 7-10 business days after order placed.
Emergency Funds	**$15.00**	This is our fee for you to obtain emergency funds, which must be initiated through customer service. See the section labeled "Accessing Funds and Limitations" in your Cardholder Agreement for additional information.
Priority Shipping Fee	**$8.00**	Additional fee to ship replacement Card 4-7 business days after order placed. Reissuance of Card Fee also applies.

Additional Disclosures

Your funds are eligible for deposit insurance up to the applicable limits by the Federal Deposit Insurance Corporation ("FDIC"). Your funds will be held at My Banking Direct, a service of Flagstar Bank, N.A., an FDIC-insured institution. Once there, your funds are insured up to $250,000 by the FDIC in the event Flagstar Bank, N.A. fails, if specific deposit insurance requirements are met and your card is registered. Money Network Financial, LLC is not a bank and is not FDIC-insured. See fdic.gov/deposit/deposits/prepaid.html for details.

No overdraft/credit feature.

Contact Customer Service by calling 1-800-684-7051, by mail at 2900 Westside Parkway, Alpharetta, GA 30004, or visit our Website at moneynetwork.com/EDD.

For general information about prepaid accounts, visit cfpb.gov/prepaid.

If you have a complaint about a prepaid account, call the Consumer Financial Protection Bureau at 1-855-411-2372 or visit cfpb.gov/complaint.

Federal Privacy Act

The EDD requires disclosure of Social Security numbers 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.

Information Collection and Access

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

Agency name: Employment Development Department (EDD)	**Title of official responsible for information maintenance:** Manager, EDD State Disability Insurance Office
Local contact person: Manager, EDD Paid Family Leave Office	**Contact information:** You may contact Paid Family Leave by calling 1-877-238-4373. A list of Paid Family Leave local office locations can be found by visiting edd.ca.gov/disability/Contact_DI.htm. The address and phone number of Paid Family Leave will also appear on the *Notice of Computation* (DE 429D) issued at the time your benefit determination is made.

Maintenance of the information is authorized by:

California Unemployment Insurance Code, sections 2601 through 3306.
California Code of Regulations, Title 22, sections 2706-2, 2706-3, and 2708-1.

Consequences of not providing all or any part of the requested information:

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

Principal purposes for which the information is to be used:

- To determine eligibility for Paid Family Leave benefits.
- To be summarized and published in statistical form for the use and information of government agencies and the public. (Neither your name and identification nor the name and identification of the family member receiving care, bonding, or military assist will 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 the 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 State 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 to which the information will be put is compatible with the purpose for which it was gathered.
  (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, information may be revealed to the extent necessary for the administration of public social services or to the Director of Social Services or their representatives.
- Information shall be disclosed to authorized agencies in accordance with California Unemployment Insurance Code, sections 1095 and 2714.

SAMPLE, this page for reference only

Application for Paid Family Leave Benefits

Part A – Statement Of Claimant (Care, Bonding, Or Military Assist Provider)

A1. Your Social Security Number: 000000000

A2. Your date of birth: MM DD YYYY

A3. Language you prefer to use: [X] English [ ] Español [ ] Other (If Other, Print Below)

A4. Your Legal Name | First Name: Sample | MI: | Last Name: Claimant

A5. Gender Identity: [ ] Male [X] Female

A6. Phone Number: 123 4567890

A7. If you have worked under any other last names, enter them here (for example, a maiden name or chosen name):

A8. Mailing Address (to receive mail at a private mail box—not a U.S. Postal Service box—you must include the number in the "PMB#" space.): 123 Any Street

PMB# (if applicable):

City: Anytown | State/Prov.: CA | Zip or Postal Code: 12345 | Country (if not U.S.A.):

A9. Name of your Employer: Roadrunner Pastries

Mailing Address: 647 Armistice Way

City: Cityname | State/Prov.: CA | Zip or Postal Code: 12345 | Employer's Phone Number: 5551234567

A10. Last day you worked: MM DD YYYY

A11. Date you want your PFL claim to start: MM DD YYYY

A12. Date you returned or will return to work: MM DD YYYY

A13. Did you work or will you continue to work during your family leave period? [X] No [ ] Yes

A14. Why did you or will you reduce your work hours or stop working?

Care for family member	Bond with child	Military Assist	Other (explain)
	X		

A15. What is your usual occupation? Pastry Chef

A16. Select your preferred payment method: [X] Debit Card [ ] Check

A17. Family Member's Legal Name | First Name: Cookie | MI: | Last Name: Claimant (This is the person you are caring for or bonding with, or your military family member.)

A18. This family member is your:

Child	Spouse	Registered Domestic Partner	Parent	Parent In-Law	Grand Parent	Grand Child	Sibling	Other (Explain)
X								

A19. Is any other family member ready, willing, and able and available to provide care for the same period you are claiming PFL Benefits?

No	Yes
X	

A20. Have you claimed or do you plan to claim workers' compensation benefits for any portion of the period covered by this claim?

No	Yes

A21. Do you have more than one employer?

No	Yes
X	

A22. If your employer(s) continued or will continue to pay you during your family leave, indicate type of pay:

Sick	Vacation	Other (explain)

A23. May we disclose benefit payment information to your employer(s)?

No	Yes
	X

A24. At any time during your PFL leave, were you in the custody of law enforcement authorities because you were convicted of violating a law or ordinance? [X] No [ ] Yes

A25. **Declaration and signature.** By my signature on this application statement, I (1) claim Paid Family Leave Benefits and certify that throughout the period covered by this application I was providing care for, bonding with, or participating in a qualifying event with the recipient named above (2) authorize EDD to release my personal information as shown on this application to the care recipient's treating physician as they are respectively listed in Part C and Part D of this application (3) authorize my employer(s) to disclose 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 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, 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 application statement are granted for a period of 15 years from the date of my signature or the effective date of the application, whichever is later.

Claimant's Signature (do not print): Sample Claimant

If signature is made by mark (X), please place mark here.*

Date Signed: 01252025

*If your signature is made by mark (X), it must be attested by two witnesses with their addresses

1st Witness Signature and Address

2nd Witness Signature and Address

Part B – Bonding Certification (to be completed by person claiming PFL benefits to bond with a child)

B1. Your Social Security Number
000000000

B2. Date of foster care or adoption placement
MM DD YYYY

B3. Child named in B8 is my
Biological Child: X | Stepchild | Foster Child | Adopted Child | Other

B4. Your Legal Last Name (needed in case pages of this claim become separated)
Claimant

B5. Child's Social Security Number (if available)

B6. Child's date of birth
12012024

B7. Child's Gender Identity
Male | Female: X

B8. Legal Name of Child | First Name: Cookie | MI: A | Last Name: Claimant

B9. Address where the child lives (if different from claimant's)

City | State/Prov. | Zip or Postal Code | Country (if not U.S.A.)

B10. As evidence of the relationship in B3, check one of the following and attach a copy of the document checked.
(Do not send original document. It will not be returned.)

- [X] Child's birth certificate
- [ ] Declaration of paternity, CS-909
- [ ] Adoptive placement agreement, AD-907
- [ ] Independent adoption placement agreement, AD-924
- [ ] Other

B11. Declaration and signature. 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 15 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
Sample Claimant

Date Signed
01252025

Part C – Statement of Family Member Receiving Care

May be completed by claimant if the family member receiving care is mentally or physically unable to do so.
Must be signed by the family member receiving care or their authorized representative.

C1. Date of Birth of Family Member Receiving Care
MM DD YYYY

C2. Phone Number of Family Member Receiving Care

C3. Gender Identity of Family Member Receiving Care
Male | Female

C4. Legal Name of Family Member Receiving Care | First Name | MI | Last Name

C5. Address of Family Member Receiving Care

City | State/Prov. | Zip or Postal Code | Country (if not U.S.A.)

C6. 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.

Signature of Family Member Receiving Care (Do Not Print)

Date Signed
MM DD YYYY

C7. Authorized Representative signing on behalf of family member receiving care must complete the following I, _____ , represent the family member receiving care or bonding in this matter as authorized by ☐ parental right ☐ power of attorney (attach copy) ☐ court order (attach copy) (for spouse or domestic partner, contact EDD).

Authorized Representative's Signature (Do Not Print)

Date Signed
MM DD YYYY

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

Instructions for completing this form:

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.)

D1. PFL claimant's (care provider's) Social Security Number

D2. PFL claimant's name
First Name MI Last Name

D3. Patient's date of birth
M M D D Y Y Y Y

D4. Does your patient require care by the claimant?
No (skip to D15) Yes

D5. Patient's Name | First Name MI Last Name

D6. Diagnosis or, if not yet determined, a detailed statement of symptoms

D7. Primary ICD Code

D8. Secondary ICD Codes

D9. Date when the patient's condition started
M M D D Y Y Y Y

D10. First date patient needed care
M M D D Y Y Y Y

D11. Date you expect patient to recover
NEVER
M M D D Y Y Y Y

D12. Date you estimate patient will no longer need care by the claimant
PERMANENT
M M D D Y Y Y Y

D13. Approximately how many total hours per day will the patient need the claimant for care?
Hours Comments

D14. Would disclosure of this certificate to your patient be medically or psychologically detrimental? ..... No Yes

D15. Physician/Practitioner's license number

D16. State or Country Physician/Practitioner is licensed

D17. Physician/Practitioner's Name | First Name MI Last Name

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 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
M M D D Y Y Y Y

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.

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

E1. Your Social Security Number

E2. Your Legal Name
First Name | MI | Last Name

E3. Name of military member on covered active duty or impending call to covered active duty status (First Name | MI | Last Name)

E4. Military Member's Date of Birth
M M D D Y Y Y Y

E5. Military Member's Gender Identity
☐ Male ☐ Female

E6. Military Member's Mailing Address
City | State/Prov. | Zip or Postal Code | Country (if not U.S.A.)

E7. Last four digits of military member's Social Security Number

E8. Period of military member's covered active duty
M M D D Y Y Y Y TO M M D D Y Y Y Y

E9. Date military member was notified of covered active duty
M M D D Y Y Y Y

E10. 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

E11. The qualifying event for the PFL claim is to: (One or more reasons may be selected)

☐ Provide or arrange childcare for military member's child
☐ Provide or arrange care for military member's parent
☐ Attend counseling
☐ Make financial or 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:

E12. 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 PFL 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).

E13. 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 15 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)

Date Signed
M M D D Y Y Y Y

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	MI	Last Name

Name of individual with whom claimant is meeting: _____

Title: _____

Organization: _____

Phone Number (provide area or country code)**:** _____

Fax Number (provide area or country code)**:** _____

Email Address: _____

Mailing Address

City	State/Prov.	Zip or Postal Code	Country (if not U.S.A.)

Describe nature of meeting, include dates, if known: