EDD Employment Development Department State of California

Claim for Disability Insurance Benefits – Claim Statement of Employee

TYPE or PRINT with BLACK INK.

1A. YOUR SOCIAL SECURITY NUMBER	1B. IF YOU HAVE EVER USED OTHER SOCIAL SECURITY NUMBERS, SHOW THOSE NUMBERS BELOW		2. STATE GOVERNMENT EMPLOYEE (IF YES, INDICATE BARGAINING UNIT #.)
			☐ YES (UNIT #) ☐ NO

3. DATE YOUR DISABILITY BEGAN	4. LAST DATE YOU WORKED	5. HAVE YOU WORKED ANY FULL OR PARTIAL DAYS SINCE YOUR DISABILITY BEGAN?	6. DATE YOU RECOVERED OR RETURNED TO WORK (IF ANY)
MM DD YY	MM DD YY	☐ YES ☐ NO	MM DD YY

7. GENDER	8. YOUR LEGAL NAME			9. YOUR DATE OF BIRTH
☐ MALE ☐ FEMALE	FIRST NAME	MIDDLE NAME OR INITIAL	LAST NAME	MM DD YY

10. OTHER NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED	11. LANGUAGE YOU PREFER TO USE
	☐ ENGLISH ☐ ESPAÑOL ☐ OTHER _____

12. YOUR MAILING ADDRESS (IF YOU WISH TO RECEIVE MAIL AT A PRIVATE MAIL BOX—NOT A US POSTAL SERVICE BOX—YOU MUST SHOW THE NUMBER IN THE "PMB#" SPACE.)

NUMBER / STREET / P.O. BOX / APARTMENT OR SPACE #	PMB # (PRIVATE MAIL BOX #)

CITY	STATE	COUNTRY (IF NOT UNITED STATES OF AMERICA)	ZIP CODE

13. YOUR AREA CODE AND TELEPHONE NUMBER	14. YOUR RESIDENCE ADDRESS, IF DIFFERENT FROM YOUR MAILING ADDRESS
( )	NUMBER / STREET / APARTMENT OR SPACE #

CITY	STATE	COUNTRY (IF NOT UNITED STATES OF AMERICA)	ZIP CODE

15. WHY DID YOU STOP WORKING?

16. YOUR LAST OR CURRENT EMPLOYER – IF YOUR LAST OR CURRENT EMPLOYMENT WAS SELF-EMPLOYMENT, ENTER "SELF"

EMPLOYER 'S AREA CODE AND TELEPHONE NUMBER	NAME OF EMPLOYER [STATE GOVERNMENT EMPLOYEES: PROVIDE THE AGENCY OR DEPARTMENT NAME (FOR EXAMPLE: CALTRANS)]
( )	

NUMBER / STREET / SUITE # (STATE GOVERNMENT EMPLOYEES: PLEASE PROVIDE THE ADDRESS OF YOUR PERSONNEL OFFICE)

CITY	STATE	COUNTRY (IF NOT UNITED STATES OF AMERICA)	ZIP CODE

17. YOUR REGULAR OCCUPATION	18. IF YOUR EMPLOYER CONTINUED TO PAY YOU, INDICATE TYPE OF PAY	19. MAY WE DISCLOSE BENEFIT PAYMENT INFORMATION TO YOUR EMPLOYER?
	☐ SICK ☐ VACATION ☐ OTHER _____	☐ YES ☐ NO

20. SECOND EMPLOYER (IF YOU HAVE MORE THAN ONE EMPLOYER)

EMPLOYER 'S AREA CODE AND TELEPHONE NUMBER	NAME OF EMPLOYER
( )	

NUMBER / STREET / SUITE #

CITY	STATE	COUNTRY (IF NOT UNITED STATES OF AMERICA)	ZIP CODE

21. AT ANY TIME DURING YOUR DISABILITY WERE YOU IN THE CUSTODY OF LAW ENFORCEMENT AUTHORITIES BECAUSE YOU WERE CONVICTED OF VIOLATING A LAW OR ORDINANCE?

☐ YES ☐ NO IF "YES," INDICATE NAME OF FACILITY: _____

22. PLEASE RE-ENTER YOUR SOCIAL SECURITY NUMBER.....

23. IF YOU ARE A RESIDENT OF AN ALCOHOLIC RECOVERY HOME OR A DRUG-FREE RESIDENTIAL FACILITY, SHOW THE NAME, TELEPHONE NUMBER, AND ADDRESS

NAME OF FACILITY	FACILITY AREA CODE AND TELEPHONE NUMBER
	( )

ADDRESS OF FACILITY (NUMBER AND STREET / CITY / STATE / ZIP CODE)

24. HAVE YOU FILED OR DO YOU INTEND TO FILE FOR WORKERS' COMPENSATION BENEFITS?

☐ YES–COMPLETE ITEMS 25 THROUGH 32

☐ NO– COMPLETE ITEMS 25, 31 AND 32

25. WAS THIS DISABILITY CAUSED BY YOUR JOB?

☐ YES

☐ NO

26. DATE(S) OF INJURY SHOWN ON YOUR WORKERS' COMPENSATION CLAIM

27. WORKERS' COMPENSATION INSURANCE COMPANY

COMPANY NAME			COMPANY AREA CODE AND TELEPHONE NUMBER
			( )

NUMBER / STREET / SUITE #

CITY	STATE	ZIP CODE	YOUR WORKERS' COMPENSATION CLAIM NUMBER

28. WORKERS' COMPENSATION ADJUSTER

ADJUSTER NAME	ADJUSTER AREA CODE AND TELEPHONE NUMBER
	( )

29. EMPLOYER SHOWN ON YOUR WORKERS' COMPENSATION CLAIM

EMPLOYER NAME	EMPLOYER AREA CODE AND TELEPHONE NUMBER
	( )

30. YOUR ATTORNEY (IF ANY) FOR YOUR WORKERS' COMPENSATION CASE

ATTORNEY NAME	ATTORNEY AREA CODE AND TELEPHONE NUMBER
	( )

NUMBER / STREET / SUITE #

CITY	STATE	ZIP CODE	WORKERS' COMPENSATION APPEALS BOARD CASE NUMBER

PLEASE REVIEW, SIGN, AND DATE BOTH NO. 31 AND NO. 32.

31. Health Insurance Portability and Accountability Act Authorization. I authorize any physician, practitioner, hospital, vocational rehabilitation counselor, or workers' compensation insurance carrier to furnish and disclose to employees of California Employment Development Department (EDD) all facts concerning my disability that are within their knowledge and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability that are under their control. I understand that EDD may disclose information as authorized by the California Unemployment Insurance Code and that such redisclosed information may no longer be protected by this rule. I agree that photocopies of this authorization shall be as valid as the original. I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by EDD or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

Claimant's Signature (DO NOT PRINT)	**Date Signed**

32. Declaration and Signature. By my signature on this claim statement, I claim benefits and certify that for the period covered by this claim I was unemployed and disabled. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law and that such violation is punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to the best of my knowledge and belief true, correct, and complete. By my signature on this claim statement, I authorize the California Department of Industrial Relations and my employer to furnish and disclose to State Disability Insurance all facts concerning my disability, wages or earnings, and benefit payments that are within their knowledge. By my signature on this claim statement, I authorize release and use of information as stated in the "Information Collection and Access" portion of this form. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.

Claimant's Signature (DO NOT PRINT)	**Date Signed**

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

33. Personal Representative signing on behalf of claimant must complete the following: I,_____ , represent the claimant in this matter as authorized by ☐ power of attorney (attach copy) ☐ Declaration of Individual Claiming Disability Insurance Benefits Due an Incapacitated or Deceased Claimant, DE 2522 (see pg. A,#4)

Personal Representative's Signature (DO NOT PRINT)	**Date Signed**

Employment Development Department
State of California

Claim for Disability Insurance Benefits – Doctor's Certificate

TYPE or PRINT with BLACK INK.

34. PATIENT'S FILE NUMBER	35. PATIENT'S SOCIAL SECURITY NO.	36. PATIENT'S LAST NAME	
37. DOCTOR'S NAME AS SHOWN ON LICENSE		38. DOCTOR'S TELEPHONE NUMBER ( )	39. DOCTOR'S STATE LICENSE NO.

40. DOCTOR'S ADDRESS – NUMBER AND STREET, CITY, STATE, COUNTRY (IF NOT USA), ZIP CODE. **POST OFFICE BOX NUMBER IS NOT ACCEPTED AS THE SOLE ADDRESS**

41. THIS PATIENT HAS BEEN UNDER MY CARE AND TREATMENT FOR THIS MEDICAL PROBLEM

FROM _____/_____/_____ TO _____/_____/_____ AT INTERVALS OF ☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ AS NEEDED

42. AT ANY TIME DURING YOUR ATTENDANCE FOR THIS MEDICAL PROBLEM, HAS THE PATIENT BEEN INCAPABLE OF PERFORMING HIS/HER REGULAR OR CUSTOMARY WORK?	43. DATE YOU RELEASED OR ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR / CUSTOMARY WORK ("UNKNOWN," "INDEFINITE," ETC., NOT ACCEPTED.)
☐ NO – SKIP TO THE DOCTOR'S CERTIFICATION SECTION ☐ YES – ENTER DATE DISABILITY BEGAN: _____/_____/_____	_____/_____/_____
44. ICD9 DISEASE CODE, PRIMARY (REQUIRED UNLESS DIAGNOSIS NOT YET OBTAINED)	**45. ICD9 DISEASE CODE(S), SECONDARY**
_____ . ____	_____ . ____, _____ . ____, _____ . ____

46. DIAGNOSIS (REQUIRED) – IF NO DIAGNOSIS HAS BEEN DETERMINED, ENTER OBJECTIVE FINDINGS OR A DETAILED STATEMENT OF SYMPTOMS

47. FINDINGS – STATE NATURE, SEVERITY, AND EXTENT OF THE INCAPACITATING DISEASE OR INJURY. INCLUDE ANY OTHER DISABLING CONDITIONS

48. TYPE OF TREATMENT / MEDICATION RENDERED TO PATIENT	49. IF PATIENT WAS HOSPITALIZED, PROVIDE DATES OF ENTRY AND DISCHARGE
	_____/_____/_____ TO _____/_____/_____
50. DATE AND TYPE OF SURGERY / PROCEDURE PERFORMED OR TO BE PERFORMED	**ICD9 PROCEDURE CODE(S)**
_____/_____/_____	

51. IF PATIENT IS NOW PREGNANT OR HAS BEEN PREGNANT, WHAT DATE DID PREGNANCY TERMINATE OR WHAT DATE DO YOU EXPECT DELIVERY?	52. IF PREGNANCY IS / WAS ABNORMAL, STATE THE ABNORMAL AND INVOLUNTARY COMPLICATION CAUSING MATERNAL DISABILITY
_____/_____/_____	

53. BASED ON YOUR EXAMINATION OF PATIENT, IS THIS DISABILITY THE RESULT OF "OCCUPATION," EITHER AS AN "INDUSTRIAL ACCIDENT" OR AS AN "OCCUPATIONAL DISEASE"? (INCLUDE SITUATIONS WHERE PATIENT'S OCCUPATION HAS AGGRAVATED PRE-EXISTING CONDITIONS.)	54. ARE YOU COMPLETING THIS FORM FOR THE SOLE PURPOSE OF REFERRAL / RECOMMENDATION TO AN ALCOHOLIC RECOVERY HOME OR DRUG-FREE RESIDENTIAL FACILITY AS INDICATED BY THE PATIENT IN QUESTION 23?	55. WOULD DISCLOSURE OF THIS INFORMATION TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL?
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Doctor's Certification and Signature (REQUIRED): Having considered the patient's regular or customary work, I certify under penalty of perjury that, based on my examination, this Doctor's Certificate truly describes the patient's disability (if any) and the estimated duration thereof.

I further certify that I am a _____ (TYPE OF DOCTOR) _____ (SPECIALTY, IF ANY) licensed to practice in the State of _____.

► _____
ORIGINAL SIGNATURE OF ATTENDING DOCTOR – RUBBER STAMP IS NOT ACCEPTABLE

► _____
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 requires additional administrative penalties.

Employment Development Department
State of California

Health Insurance Portability and Accountability Act (HIPAA) Authorization

State Disability Insurance Claimant:

1. Complete, sign, and date this form.
2. Take the completed signed form to your doctor.

CLAIMANT'S NAME (FIRST, MIDDLE INITIAL, LAST)	CLAIMANT'S SOCIAL SECURITY NUMBER

I authorize any physician, practitioner, hospital, vocational rehabilitation counselor, or workers' compensation insurance carrier to furnish and disclose to employees of California Employment Development Department (EDD) all facts concerning my disability that are within their knowledge and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability that are under their control.

I understand that EDD may disclose information as authorized by the California Unemployment Insurance Code and that such redisclosed information may no longer be protected by this rule.

I agree that photocopies of this authorization shall be as valid as the original.

I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by EDD or the effective date of the claim, whichever is later.

I understand that I may not revoke this authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

CLAIMANT'S SIGNATURE (DO NOT PRINT)	DATE SIGNED