EDD Employment Development Department State of California

Claim for Disability Insurance Benefits – Claim Statement of Employee

TYPE or PRINT with BLACK INK.

1. YOUR SOCIAL SECURITY NUMBER

2. IF YOU HAVE EVER USED OTHER SOCIAL SECURITY NUMBERS, SHOW THOSE NUMBERS BELOW

3. DATE YOUR DISABILITY BEGAN MM DD YY

4. LAST DATE YOU WORKED MM DD YY

5. HAVE YOU WORKED ANY FULL OR PARTIAL DAYS SINCE YOUR DISABILITY BEGAN? ☐ YES ☐ NO

6. DATE YOU RECOVERED OR RETURNED TO WORK (IF ANY) MM DD YY

7. GENDER ☐ MALE ☐ FEMALE

8. YOUR LEGAL NAME FIRST NAME MIDDLE NAME OR INITIAL LAST NAME

9. YOUR DATE OF BIRTH 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

NUMBER / STREET / SUITE #

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 ☐ SICK ☐ VACATION ☐ OTHER _____

19. MAY WE DISCLOSE BENEFIT PAYMENT INFORMATION TO YOUR EMPLOYER? ☐ 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. WAS THIS DISABILITY CAUSED BY YOUR JOB?

☐ YES
☐ NO

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

☐ YES–COMPLETE ITEMS 26 THROUGH 32
☐ NO–SKIP TO ITEMS 31 AND 32

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

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

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 NO. ( )	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?

☐ NO – SKIP TO THE DOCTOR'S CERTIFICATION SECTION ☐ YES – ENTER DATE DISABILITY BEGAN: _____/_____/_____

43. DATE YOU RELEASED OR ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR / CUSTOMARY WORK

("UNKNOWN," "INDEFINITE," ETC., NOT ACCEPTED.) _____/_____/_____

44. ICD9 DISEASE CODE, PRIMARY (REQUIRED UNLESS DIAGNOSIS NOT YET OBTAINED)

_____ . _____

45. IDC9 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.)

☐ YES ☐ NO

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?

☐ YES ☐ NO

55. WOULD DISCLOSURE OF THIS INFORMATION TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL?

☐ 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.