EDD Employment Development Department State of California

Claim for Paid Family Leave (PFL) Benefits

2501F12031

PART A – STATEMENT OF CLAIMANT (CARE OR BONDING PROVIDER)

A1. YOUR SOCIAL SECURITY NO.
123456789

A2. YOUR DATE OF BIRTH (M M D D Y Y Y Y)
05211959

A3. LANGUAGE YOU PREFER TO USE
ENGLISH: X | ESPAÑOL: | OTHER (PRINT BELOW):

A4. YOUR LEGAL NAME
FIRST NAME: JANE | MI: D | LAST NAME: JONES

A5. YOUR GENDER
MALE: | FEMALE: X

A6. YOUR TELEPHONE NUMBER
916 5551212

A7. OTHER LAST NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED
SMITH

A8. YOUR MAILING ADDRESS (TO RECEIVE MAIL AT A PRIVATE MAIL BOX—NOT A US POSTAL SERVICE BOX—YOU MUST SHOW THE NUMBER IN THE "PMB#" SPACE.) **PMB# (IF APPLICABLE)**
321 SPRING STREET
CITY: ANYTOWN | STATE/PROV.: CA | ZIP OR POSTAL CODE: 999999999 | COUNTRY (IF NOT U.S.A.):

A9. NAME OF YOUR EMPLOYER
ABC CORPORATION
MAILING ADDRESS: 987 BUSINESS BLVD
CITY: ANYTOWN | STATE/PROV.: CA | ZIP OR POSTAL CODE: 999997777 | EMPLOYER'S TELEPHONE NUMBER: 9165559999

A10. DATE YOU LAST WORKED (M M D D Y Y Y Y)
09102004

A11. DATE YOU WANT YOUR PFL CLAIM TO BEGIN (M M D D Y Y Y Y)
09202004

A12. DATE YOU RETURNED OR WILL RETURN TO WORK (M M D D Y Y Y Y)
11082004

A13. DID YOU WORK OR WILL YOU CONTINUE TO WORK DURING YOUR FAMILY LEAVE PERIOD?
NO: X | YES:

A14. WHY DID YOU OR WILL YOU REDUCE YOUR WORK HOURS OR STOP WORKING?
CARE FOR FAMILY MEMBER: X | BOND WITH CHILD: | OTHER (EXPLAIN):

A15. WHAT IS YOUR OCCUPATION?
RESEARCH ANALYST

A16. LEGAL NAME OF PERSON FOR WHOM YOU ARE CARING (FIRST | MIDDLE INITIAL | LAST) **OR WITH WHOM YOU ARE BONDING (CARE OR BONDING RECIPIENT)**
MARY | J | SMITH

A17. THE ABOVE-NAMED CARE OR BONDING RECIPIENT IS YOUR:
CHILD: | SPOUSE: | REGISTERED DOMESTIC PARTNER: | PARENT: X | OTHER (EXPLAIN):

A18. IS ANY OTHER FAMILY MEMBER READY, WILLING, AND ABLE AND AVAILABLE TO PROVIDE CARE FOR THE SAME PERIOD YOU ARE CLAIMING PFL BENEFITS?
NO: X | YES:

A19. HAVE YOU CLAIMED OR DO YOU PLAN TO CLAIM WORKERS' COMPENSATION BENEFITS FOR ANY PORTION OF THE PERIOD COVERED BY THIS CLAIM?
NO: X | YES:

A20. DO YOU HAVE MORE THAN ONE EMPLOYER?
NO: X | YES:

A21. IF YOUR EMPLOYER(S) CONTINUED OR WILL CONTINUE TO PAY YOU DURING YOUR FAMILY LEAVE, INDICATE TYPE OF PAY:
SICK: | VACATION: | OTHER (EXPLAIN):

A22. MAY WE DISCLOSE BENEFIT PAYMENT INFORMATION TO YOUR EMPLOYER(S)?
NO: | YES: X

A23. 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:

A24. Declaration and Signature. By my signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was providing care for or bonding with the care recipient named above; (2) authorize EDD to release my personal information as shown on this claim to the care recipient and to the care recipient's treating physician as they are respectively listed in Part C and Part D of this claim; (3) authorize my employer(s) to disclose to EDD all facts concerning my employment that are within their knowledge; and (4) authorize release and use of information as stated in the "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 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)
Jane D. Jones

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

Date Signed (MM | DD | YYYY)
09222004

***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

CARE RECIPIENT'S AUTHORIZATION FOR DISCLOSURE OF PERSONAL-HEALTH INFORMATION

I authorize my physician or practitioner, as identified on Part D of this claim, to disclose my current personal-health information to my care provider, as identified on Part A of this claim, and to the California Employment Development Department (EDD).

I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and an estimation of the amount of care that I require from my care provider as a result of my current condition. I further understand that disclosure of my personal-health information may include my AIDS/HIV status, drug or alcohol addiction, or any other physical or mental condition.

I understand that EDD may disclose this information as authorized by the California Unemployment Insurance Code and that such re-disclosed information may no longer be protected. I agree that photocopies of the authorization form in conjunction with my signature on Page 3 in Item 6 of Part C shall be as valid as the original.

I understand that unless I inform EDD in writing at P.O. Box 997017, Sacramento, CA 95799-7017, that I wish to revoke this authorization, it will be valid for 10 years from the date EDD receives it or the effective date of this claim, whichever is later. I understand that I have the right to receive a copy of an authorization form from EDD if I request one in writing.

I make this authorization to support my care provider's claim for Paid Family Leave benefits. I understand that I may not revoke my authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

WE CANNOT PROCESS THIS CLAIM UNLESS YOU SIGN BOTH THIS PAGE AND PAGE 3 IN ITEM C6 OF PART C.

MARY J. SMITH

Care recipient's name (Print your name)

Sept. 23, 2004

Date signed

Mary J. Smith

Care recipient's signature (Sign your name)

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

B1. YOUR SOCIAL SECURITY NUMBER: 123456789

B2. DATE OF FOSTER CARE OR ADOPTION PLACEMENT (M M D D Y Y Y Y):

B3. CHILD NAMED IN B8 IS MY: BIOLOGICAL CHILD / STEPCHILD / FOSTER CHILD / ADOPTED CHILD / OTHER

B4. YOUR LEGAL LAST NAME (NEEDED IN CASE PAGES OF THIS CLAIM BECOME SEPARATED): JONES

B5. CHILD'S SOCIAL SECURITY NUMBER (IF AVAILABLE):

B6. CHILD'S DATE OF BIRTH (M M D D Y Y Y Y):

B7. CHILD'S GENDER: MALE / FEMALE

B8. LEGAL NAME OF CHILD (FIRST / MIDDLE INITIAL / LAST):

B9. CHILD'S RESIDENCE ADDRESS (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.)

- ☐ CHILD'S BIRTH CERTIFICATE
- ☐ CHILD'S HOSPITAL DISCHARGE RECORD
- ☐ DECLARATION OF PATERNITY, CS-909
- ☐ FOSTER CARE PLACEMENT RECORD, SOC-815
- ☐ CERTIFICATE OF PLACEMENT, AD-907
- ☐ CHILD'S PASSPORT SHOWING IMMIGRATION AND NATURALIZATION SERVICE STAMP I-551
- ☐ 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 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 (M M | D D | Y Y Y Y)

PART C – 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.)

C1. RECIPIENT'S DATE OF BIRTH (M M D D Y Y Y Y): 02091928

C2. RECIPIENT'S TELEPHONE NUMBER: 530 555 7777

C3. RECIPIENT'S GENDER: MALE / FEMALE: X

C4. LEGAL NAME OF CARE RECIPIENT (FIRST / MIDDLE INITIAL / LAST): MARY J SMITH

C5. CARE RECIPIENT'S RESIDENCE ADDRESS: 345 PINE STREET

CITY: SOME CITY | STATE/PROV.: CA | ZIP OR POSTAL CODE: 97777 0000 | COUNTRY (IF NOT U.S.A.)

C6. CONFIRMATION OF MEDICAL DISCLOSURE AUTHORIZATION. I have read and signed the Care Recipient's Authorization for Disclosure of Personal-Health Information on page 2 of this claim. I understand that by signing it I have agreed to all its provisions and terms. I further understand that copies of my signature below are as valid as the original.

Care Recipient's Signature (DO NOT PRINT): Mary J. Smith | Date Signed (M M | D D | Y Y Y Y): 09232004

C7. **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 EDD.)

Authorized Representative's Signature (DO NOT PRINT) | Date Signed (M M | D D | Y Y Y Y)

Doctor's Certification may be made by a licensed medical or osteopathic physician and surgeon, chiropractor, dentist, podiatrist, optometrist, designated psychologist, or an authorized medical officer of a United States Government facility

2501F12033

If using **typewriter/printer**, type across boxes in UPPER CASE as shown.

If **hand printing**, place each letter/number in a separate box as shown.

PATIENT'S DATE OF BIRTH (M M D D Y Y Y Y)	TYPE OF DOCTOR	PATIENT'S DATE OF BIRTH (M M D D Y Y Y Y)	TYPE OF DOCTOR
07 26 1930	PODIATRIST	07261930	PODIATRIST

PART D – DOCTOR'S CERTIFICATION (DO NOT COMPLETE THIS PART IF REASON FOR PFL LEAVE IS BONDING WITH CHILD)

D1. PFL CLAIMANT'S (CARE PROVIDER'S) SOCIAL SECURITY NUMBER: 123456789

D2. PFL CLAIMANT'S NAME (FIRST | MIDDLE INITIAL | LAST): JANE | D | JONES

D3. PATIENT'S DATE OF BIRTH (M M D D Y Y Y Y): 02 09 1928

D4. DOES YOUR PATIENT REQUIRE CARE BY THE CARE PROVIDER? NO (SKIP TO D15) | YES: X

D5. PATIENT'S NAME (FIRST | MIDDLE INITIAL | LAST): MARY | J | SMITH

D6. DIAGNOSIS OR, IF NOT YET DETERMINED, A DETAILED STATEMENT OF SYMPTOMS: FRACTURED FEMUR

D7. PRIMARY ICD CODE: 820 • 09

D8. SECONDARY ICD CODES: • • •

D9. DATE PATIENT'S CONDITION COMMENCED (M M D D Y Y Y Y): 09 13 2004

D10. FIRST DATE CARE NEEDED (M M D D Y Y Y Y): 09 20 2004

D11. DATE YOU EXPECT RECOVERY (M M D D Y Y Y Y) TERMINAL: 02 15 2005

D12. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CARE PROVIDER (M M D D Y Y Y Y): 12 31 2004

D13. APPROXIMATELY HOW MANY TOTAL HOURS PER DAY WILL PATIENT REQUIRE CARE BY A CARE PROVIDER?

HOURS: 24 COMMENTS:

D14. WOULD DISCLOSURE OF THIS CERTIFICATE TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL? ..... NO: X | YES:

D15. DOCTOR'S LICENSE NUMBER: A987654

D16. STATE OR COUNTRY (IF NOT U.S.A.) IN WHICH DOCTOR IS LICENSED TO PRACTICE: CALIFORNIA

D17. DOCTOR'S NAME (FIRST | MIDDLE INITIAL | LAST): DONALD | R | BROWN

D18. DOCTOR'S ADDRESS (POST OFFICE BOX IS NOT ACCEPTABLE AS THE SOLE ADDRESS): 678 CENTRAL BLVD

CITY	STATE/PROV.	ZIP OR POSTAL CODE		COUNTRY (IF NOT U.S.A.)
SOME CITY	CA	97777	9999	

D19. TYPE OF DOCTOR: MEDICAL DOCTOR

D20. SPECIALTY (IF ANY): ORTHOPEDICS

D21. Doctor's Certification and Signature (REQUIRED): I certify under penalty of perjury that, based on my examination, this Doctor's Certificate truly describes the patient's condition and need for care and the estimated duration thereof.

Original Signature of Attending Doctor – RUBBER STAMP IS NOT ACCEPTABLE	DOCTOR'S TELEPHONE NO.	Date Signed (MM | DD | YYYY)
Donald R. Brown, M.D.	530 5554444	09 27 2004

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.