EDD Employment Development Department State of California

Claim for Disability Insurance (DI) Benefits

250110161

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Claimant Social Security Number

Claimant Name (First) (MI) (Last)

I authorize

(Person/Organization providing the information) to furnish and disclose all my health information and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability for which this claim is filed that are within their knowledge to the following employees of the California Employment Development Department (EDD): Disability Insurance Branch examiners, their direct supervisors/managers and any other EDD employee who may have a need to access this information in order to process my claim and/or determine eligibility for State Disability Insurance benefits.

I understand that EDD is not a health plan or health care provider, so the information released to EDD may no longer be protected by federal privacy regulations. (45 CFR Section 164.508(c)(2)(iii)). EDD may disclose information as authorized by the California Unemployment Insurance Code.

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

I understand I have the right to revoke this authorization by sending written notification stopping this authorization to EDD, DI Branch MIC 29, PO Box 826880, Sacramento, CA 94280. The authorization will stop on the date my request is received. I understand that the consequences for my revoking this authorization may result in denial of further State Disability Insurance benefits.

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.

I understand that I am signing this authorization voluntarily and that payment or eligibility for my benefits will be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization may result in an incomplete claim form that cannot be processed for payment of State Disability Insurance benefits.

I understand I have the right to receive a copy of this authorization.

Claimant Signature (Do Not Print)	Date Signed M M D D Y Y Y Y

Your disability claim can also be filed online at www.edd.ca.gov/

PLEASE PRINT WITH BLACK INK.

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PART A - CLAIMANT'S STATEMENT

A1. YOUR SOCIAL SECURITY NUMBER

A2. IF YOU HAVE PREVIOUSLY BEEN ASSIGNED AN EDD CUSTOMER ACCOUNT NUMBER, ENTER THAT NUMBER HERE

A3. CALIFORNIA DRIVER LICENSE OR ID NUMBER

A4. GENDER MALE FEMALE

A5. IF YOU EVER USED OTHER SOCIAL SECURITY NUMBERS, ENTER THOSE NUMBERS BELOW

A6. STATE GOVERNMENT EMPLOYEE (IF "YES" INDICATE BARGAINING UNIT#) YES NO UNIT#

A7. YOUR DATE OF BIRTH M M D D Y Y Y Y

A8. YOUR LEGAL NAME (FIRST) (MI) (LAST) SUFFIX

A9. OTHER NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED
(FIRST) (MI) (LAST) SUFFIX
(FIRST) (MI) (LAST) SUFFIX

A10. YOUR HOME AREA CODE AND TELEPHONE NUMBER

A11. YOUR CELL AREA CODE AND TELEPHONE NUMBER

A12. LANGUAGE YOU PREFER TO USE
ENGLISH SPANISH CANTONESE VIETNAMESE ARMENIAN PUNJABI TAGALOG OTHER

A13. YOUR MAILING ADDRESS, PO BOX OR NUMBER/STREET/APARTMENT, SUITE, SPACE#, OR PMB# (PRIVATE MAIL BOX)
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)

A14. YOUR RESIDENCE ADDRESS, REQUIRED IF DIFFERENT FROM YOUR MAILING ADDRESS
NUMBER/STREET/APARTMENT OR SPACE#
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)

A15. YOUR LAST OR CURRENT EMPLOYER - IF YOUR LAST OR CURRENT EMPLOYMENT WAS SELF-EMPLOYMENT, ENTER "SELF" AND FILL-IN THIS OPTION. SELF
NAME OF YOUR EMPLOYER [STATE GOVERNMENT EMPLOYEES: PROVIDE THE AGENCY NAME (FOR EXAMPLE: CALTRANS)]
NUMBER/STREET/SUITE# (STATE GOVERNMENT EMPLOYEES: PLEASE PROVIDE THE ADDRESS OF YOUR PERSONNEL OFFICE)
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)
EMPLOYER'S TELEPHONE NUMBER

A16. 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

A17. BEFORE YOUR DISABILITY BEGAN, WHAT WAS THE LAST DAY YOU WORKED? M M D D Y Y Y Y

A18. WHEN DID YOUR DISABILITY BEGIN? M M D D Y Y Y Y

A19. DATE YOU WANT YOUR CLAIM TO BEGIN IF DIFFERENT THAN THE DATE ENTERED IN A18 M M D D Y Y Y Y

A20. SINCE YOUR DISABILITY BEGAN, HAVE YOU WORKED OR ARE YOU WORKING ANY FULL OR PARTIAL DAYS? YES NO

A21 A. IF YOU RECOVERED, ENTER DATE: M M D D Y Y Y Y

A21 B. IF YOU RETURNED TO WORK, ENTER DATE: M M D D Y Y Y Y

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PART A - CLAIMANT'S STATEMENT - CONTINUED

A22. PLEASE RE-ENTER YOUR SOCIAL SECURITY NUMBER

A23. WHAT IS YOUR REGULAR OR CUSTOMARY OCCUPATION?

A24. WHY DID YOU STOP WORKING? (SELECT ONLY ONE BOX)

☐ ILLNESS, INJURY, OR PREGNANCY
☐ LAYOFF ☐ UNPAID LEAVE OF ABSENCE ☐ VOLUNTARILY QUIT OR RETIRED ☐ TERMINATED ☐ OTHER REASON

A25. HOW WOULD YOU DESCRIBE OR CLASSIFY YOUR JOB?

☐ Mostly sit; occasionally stand or walk; occasionally lift, carry, push, pull, or otherwise move objects that weigh 10 lbs. or less.

☐ Mostly walk/stand; occasionally lift, carry, push, pull, or otherwise move objects that weigh up to 20 lbs.

☐ Constantly lift, carry, push, pull, or otherwise move objects that weigh up to 10 lbs.; frequently up to 20 lbs.; occasionally up to 50 lbs.

☐ Constantly lift, carry, push, pull, or otherwise move objects that weigh up to 20 lbs.; frequently up to 50 lbs.; occasionally up to 100 lbs.

☐ Constantly lift, carry, push, pull, or otherwise move objects that weigh over 20 lbs.; frequently over 50 lbs.; occasionally over 100 lbs.

A26. IF YOUR EMPLOYER(S) CONTINUED OR WILL CONTINUE TO PAY YOU DURING YOUR DISABILITY, INDICATE TYPE OF PAY:

SICK ☐ VACATION ☐ Paid Time Off (PTO) ☐ ANNUAL ☐ OTHER (EXPLAIN)

A27. MAY WE DISCLOSE BENEFIT PAYMENT INFORMATION TO YOUR EMPLOYER(S)?

YES ☐ NO ☐

A28. SECOND EMPLOYER NAME (IF YOU HAVE MORE THAN ONE EMPLOYER)

NUMBER/STREET/SUITE#

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

BEFORE YOUR DISABILITY BEGAN, WHAT WAS THE LAST DAY YOU WORKED FOR THIS EMPLOYER? (M M D D Y Y Y Y) EMPLOYER'S TELEPHONE NUMBER

A29. IF YOU HAVE MORE THAN 2 EMPLOYERS CHECK HERE. ☐

A30. IF YOU ARE A RESIDENT OF AN ALCOHOLIC RECOVERY HOME OR A DRUG-FREE RESIDENTIAL FACILITY, PROVIDE THE FOLLOWING:

NAME OF FACILITY

NUMBER/STREET/SUITE#

CITY STATE ZIP OR POSTAL CODE AREA CODE AND TELEPHONE NUMBER

A31. HAVE YOU FILED OR DO YOU INTEND TO FILE FOR WORKERS' COMPENSATION BENEFITS?

☐ YES - COMPLETE ITEMS A32 THROUGH A38 ☐ NO - SKIP ITEMS A33 THROUGH A38

A32. WAS THIS DISABILITY CAUSED BY YOUR JOB?

☐ YES ☐ NO

A33. DATE(S) OF INJURY SHOWN ON YOUR WORKERS' COMPENSATION CLAIM

(M M D D Y Y Y Y) (M M D D Y Y Y Y) (M M D D Y Y Y Y) (M M D D Y Y Y Y)

A34. WORKERS' COMPENSATION INSURANCE COMPANY NAME AREA CODE AND TELEPHONE NUMBER EXTENSION (IF ANY)

NUMBER/STREET/SUITE#

CITY STATE ZIP CODE WORKERS' COMPENSATION CLAIM NUMBER

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PART A - CLAIMANT'S STATEMENT - CONTINUED

A35. PLEASE RE-ENTER YOUR SOCIAL SECURITY NUMBER

A36. WORKERS' COMPENSATION ADJUSTER'S NAME | AREA CODE AND TELEPHONE NUMBER | EXTENSION (IF ANY)

A37. EMPLOYER'S NAME SHOWN ON YOUR WORKERS' COMPENSATION CLAIM | AREA CODE AND TELEPHONE NUMBER | EXTENSION (IF ANY)

A38. YOUR ATTORNEY'S NAME (IF ANY) FOR YOUR WORKERS' COMPENSATION CASE | AREA CODE AND TELEPHONE NUMBER | EXTENSION (IF ANY)

ATTORNEY'S ADDRESS NUMBER/STREET/SUITE#

CITY | STATE | ZIP CODE | WORKERS' COMPENSATION APPEALS BOARD/ADJ CASE NUMBER

PLEASE REVIEW, SIGN, AND DATE ITEM A39, AND IF APPLICABLE, ITEMS A40 AND A41

A39. 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 (see Informational Instructions, page D). 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) OR SIGNATURE MADE BY MARK (X) | DATE SIGNED M M D D Y Y Y Y

A40. IF YOUR SIGNATURE IS MADE BY MARK (X), CHECK THE BOX AND IT MUST BE ATTESTED BY TWO WITNESSES WITH THEIR ADDRESSES. ☐

1st WITNESS SIGNATURE (PRINT AND SIGN) | DATE SIGNED M M D D Y Y Y Y

NUMBER/STREET/APARTMENT OR SPACE#, PO BOX OR PRIVATE MAIL BOX ADDRESSES NOT ACCEPTABLE.

CITY | STATE | ZIP CODE

2nd WITNESS SIGNATURE (PRINT AND SIGN) | DATE SIGNED M M D D Y Y Y Y

NUMBER/STREET/APARTMENT OR SPACE#, PO BOX OR PRIVATE MAIL BOX ADDRESSES NOT ACCEPTABLE.

CITY | STATE | ZIP CODE

A41. ☐ CHECK THIS BOX IF YOU ARE THE PERSONAL REPRESENTATIVE SIGNING ON BEHALF OF CLAIMANT AND COMPLETE THE FOLLOWING:

I, (FIRST) (MI) (LAST), REPRESENT THE CLAIMANT IN

THIS MATTER AS AUTHORIZED BY ☐ DECLARATION OF INDIVIDUAL CLAIMING DISABILITY INSURANCE BENEFITS DUE AN INCAPACITATED OR DECEASED CLAIMANT, DE 2522 (SEE INSTRUCTION & INFORMATION A, UNDER HOW TO APPLY #4) ☐ POWER OF ATTORNEY (ATTACH COPY)

PERSONAL REPRESENTATIVE'S SIGNATURE (DO NOT PRINT) | DATE SIGNED M M D D Y Y Y Y

Claim for Disability Insurance (DI) Benefits - Physician/Practitioner's Certificate
PLEASE PRINT WITH BLACK INK.

250110165

PART B - PHYSICIAN/PRACTITIONER'S CERTIFICATE

B1. PATIENT'S SOCIAL SECURITY NUMBER

B2. PATIENT'S FILE NUMBER

B3. IF YOU KNOW THE PATIENT'S ELECTRONIC RECEIPT NUMBER, ENTER IT HERE:
R

B4. PATIENT'S DATE OF BIRTH
M M D D Y Y Y Y

B5. PATIENT'S NAME (FIRST) (MI) (LAST)

B6. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER

B7. STATE **OR** COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED IN B6
STATE COUNTRY

B8. PHYSICIAN/PRACTITIONER LICENSE TYPE

B9. SPECIALTY (IF ANY)

B10. PHYSICIAN/PRACTITIONER'S NAME AS SHOWN ON LICENSE
(FIRST) (MI) (LAST) SUFFIX

B11. PHYSICIAN/PRACTITIONER'S ADDRESS
MAILING ADDRESS, PO BOX OR NUMBER/STREET/SUITE#

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

COUNTY HOSPITAL/GOVERNMENT FACILITY ADDRESS
FACILITY NAME (IF APPLICABLE)

FACILITY ADDRESS, NUMBER/STREET/SUITE#

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

B12. THIS PATIENT HAS BEEN UNDER MY CARE AND TREATMENT FOR THIS MEDICAL PROBLEM
FROM M M D D Y Y Y Y TO M M D D Y Y Y Y ☐ CHECK HERE TO INDICATE YOU ARE STILL TREATING THE PATIENT

AT INTERVALS OF: ☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ AS NEEDED ☐ OTHER

B13. AT ANY TIME DURING YOUR ATTENDANCE FOR THIS MEDICAL PROBLEM, HAS THE PATIENT BEEN INCAPABLE OF PERFORMING HIS/HER REGULAR OR CUSTOMARY WORK?

☐ YES - ENTER DATE DISABILITY BEGAN M M D D Y Y Y Y ☐ NO - SKIP TO B33

WAS THE DISABILITY CAUSED BY AN ACCIDENT OR TRAUMA? ☐ YES ☐ NO

M M D D Y Y Y Y IF YES, INDICATE THE DATE THE ACCIDENT OR TRAUMA OCCURRED.

B14. DATE YOU RELEASED OR ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR OR CUSTOMARY WORK
("UNKNOWN", "INDEFINITE", ETC., NOT ACCEPTABLE.)
M M D D Y Y Y Y

☐ CHECK HERE TO INDICATE PATIENT'S DISABILITY IS PERMANENT AND YOU NEVER ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR OR CUSTOMARY WORK

B15. IF PATIENT IS NOW PREGNANT OR HAS BEEN PREGNANT, PLEASE CHECK THE APPROPRIATE BOX AND ENTER THE FOLLOWING:

☐ ESTIMATED DELIVERY DATE: M M D D Y Y Y Y ☐ DATE PREGNANCY ENDED: M M D D Y Y Y Y

TYPE OF DELIVERY, IF PATIENT HAS DELIVERED: ☐ VAGINAL ☐ CESAREAN

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PART B - PHYSICIAN/PRACTITIONER'S CERTIFICATE - CONTINUED

B16. PLEASE RE-ENTER PATIENT'S SOCIAL SECURITY NUMBER

B17. IF THE PATIENT HAS NOT DELIVERED AND YOU DO NOT ANTICIPATE RELEASING THE PATIENT TO RETURN TO REGULAR OR CUSTOMARY WORK PRIOR TO THE ESTIMATED DELIVERY DATE, ENTER THE **NUMBER OF DAYS** THAT THE PATIENT WILL BE DISABLED POSTPARTUM, FOR EACH DELIVERY TYPE:

VAGINAL DELIVERY CESAREAN DELIVERY

B18. IN CASE OF AN ABNORMAL PREGNANCY AND/OR DELIVERY, STATE THE COMPLICATION(S) CAUSING MATERNAL DISABILITY

B19. ICD DIAGNOSIS CODE(S) FOR DISABLING CONDITION THAT PREVENT THE PATIENT FROM PERFORMING HIS/HER REGULAR OR CUSTOMARY WORK (REQUIRED)

(Check only one box)

ICD-9

ICD-10

PRIMARY

SECONDARY

SECONDARY

SECONDARY

EXAMPLE OF HOW TO COMPLETE ICD CODES

ICD-9 3 2 0 . 1

ICD-10 G 0 0 . 1

B20. DIAGNOSIS (REQUIRED) - IF NO DIAGNOSIS HAS BEEN DETERMINED, ENTER A DETAILED STATEMENT OF SYMPTOMS

B21. FINDINGS - STATE NATURE, SEVERITY, AND EXTENT OF THE INCAPACITATING DISEASE OR INJURY, INCLUDE ANY OTHER DISABLING CONDITIONS

B22. TYPE OF TREATMENT/MEDICATION RENDERED TO PATIENT

B23. IF PATIENT WAS HOSPITALIZED, PROVIDE DATES OF ENTRY AND DISCHARGE M M D D Y Y Y Y TO M M D D Y Y Y Y

CHECK HERE TO INDICATE THE PATIENT IS STILL HOSPITALIZED

B24. CHECK HERE IF PATIENT IS DECEASED, PLEASE PROVIDE DATE OF DEATH M M D D Y Y Y Y

CITY COUNTY STATE

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PART B - PHYSICIAN/PRACTITIONER'S CERTIFICATE - CONTINUED

B25. PLEASE RE-ENTER PATIENT'S SOCIAL SECURITY NUMBER

B26. WAS THE PATIENT SEEN PREVIOUSLY BY ANOTHER PHYSICIAN/PRACTITIONER OR MEDICAL FACILITY FOR THE CURRENT DISABILITY/ILLNESS/INJURY?

YES NO UNKNOWN IF YES, WHAT WAS THE DATE OF FIRST TREATMENT? M M D D Y Y Y Y

B27. DATE AND TYPE OF SURGERY/PROCEDURE MOST RECENTLY PERFORMED OR TO BE PERFORMED

M M D D Y Y Y Y

M M D D Y Y Y Y

WAS THE PATIENT UNABLE TO WORK IMMEDIATELY PRIOR TO THE SURGERY OR PROCEDURE? YES NO

IF YES, PLEASE PROVIDE THE FIRST DATE THE PATIENT WAS UNABLE TO WORK BEFORE THE SURGERY OR PROCEDURE

B28. ICD PROCEDURE CODE(S) ICD-9 ICD-10

CPT CODE(S) (DO NOT INCLUDE MODIFIERS)

B29. WAS THIS DISABLING CONDITION CAUSED AND/OR AGGRAVATED BY THE PATIENT'S REGULAR OR CUSTOMARY WORK? YES NO

B30. 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 A30? YES NO

B31. DATE YOUR PATIENT BECAME A RESIDENT OF A DRUG OR ALCOHOL FACILITY (IF KNOWN) M M D D Y Y Y Y

B32. WOULD DISCLOSURE OF THE INFORMATION ON THIS FORM BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL TO YOUR PATIENT? YES NO

B33. **PHYSICIAN/PRACTITIONER'S:** I CERTIFY UNDER PENALTY OF PERJURY THAT THE PATIENT IS UNABLE TO PERFORM HIS/HER REGULAR OR CUSTOMARY WORK BECAUSE OF THE LISTED DISABLING CONDITION(S). 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.

PHYSICIAN/PRACTITIONER'S ORIGINAL SIGNATURE - **RUBBER STAMP IS NOT ACCEPTABLE**

DATE SIGNED M M D D Y Y Y Y

AREA CODE/PHONE NUMBER

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.