

Application For Disability Insurance Elective Coverage (DIEC)

Complete this application only if you meet the requirements as set forth in the attached Information Concerning Elective Coverage.

NOTE: For assistance in completing this application, contact the nearest Employment Tax Office or call 888-745-3886.

Upon completion of this application, return to:

Attention: Analysis Resolution and Correspondence Organization
Employment Development Department
PO Box 2068
Rancho Cordova, CA 95741-2068

For Department Use Only									
DIEC Approved: ☒ 06(b) ☐ 06.5					DIEC Account #				
Effective Date:					Subject Quarter				
Send Forms DE 2515, DE 3816DI ☐ DE 301 Qtr(s)									
Date Forms Sent:					Approved By:			Approval Date:	
☐					Rev/Reg By:			Rev/Reg Date:	

Please type or print all information clearly.

1. Social Security Number*				2. Employer Account Number				4. Year of Birth			
Male ☐ Female ☐								☐ ☐			
5. First Name				Middle Initial				Last Name			
6. Have you applied for elective coverage before? ☒ Yes ☐ No								If yes, Mo. Yr.			
7. Mailing Address: Number and Street or PO Box								City ZIP Code			
8. Business Name: (if Any)								Business Phone			
9. Business Address: Number and Street or PO Box								City ZIP Code			
10. Email Address:											
11. Website:											
12. Do you have any employees?				If yes, and you are not registered with the Employment Development Department (EDD) as an employer, please explain:							
Yes ☐ No ☒											
13. Type of Organization: ☒ Corporation - Do not submit, corporate officers are employees and covered under the State Disability Insurance Program. General Partnership (includes husband and wife co-owners who are both active in the operation and management of the business). Individual Limited Partnership - only general partner may apply ☐ Limited Liability Partnership - only general partners may apply ☐ Limited Liability Company - Partnership ☐ Limited Liability Company - Sole Proprietorship Managing Member ☐											
14. Name(s) and Title of All Partners and Members (continue on another page if necessary)											
General Partners/Members Social Security Number*				Limited Partners/Managing Members Social Security Number*							
15. Nature of Business:											
☐ Contracting ☐ Manufacturing/Repairing ☐											
☐ Retail Trade ☐ Service Wholesale Trade ☐ Other (describe) ☐											
16. Your Occupation/Title						17. Describe the Type of Service, Type of Contracting, or Product Sold.					
18. Is a license or permit required in your trade, business, or occupation? ☒ Yes ☐ No If yes, indicate type of license or permit required:						Do you possess such a valid and active license? ☐ Yes ☒ No			Provide License/Permit Number		
19. Are you conducting a seasonal type of business? ☒ Yes ☐ No If yes, do not submit. You are not eligible for this coverage. See information sheet attached.						20. Do you expect to remain in business for the next eight (8) calendar quarters? Yes ☒ No ☐ If no, do not submit. You are not eligible for this coverage. See information sheet attached.					
21. Do you perform services in your trade, business, or occupation continuously throughout the year? (include time spent doing office work, soliciting customers, and maintaining machinery and equipment.) Yes ☐ No ☒						If no, explain.					

*The disclosure of your Social Security number is mandatory under the Federal Tax Reform Act of 1976.