EDD Employment Development Department
State of California

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: Forassistance in completingthis application, contact the nearest Employment Tax Officeor call 888-745-3886.
Upon completion of thisapplication, return to:

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

Please type or print all information clearly.

For Department Use Only

DIEC Approved: ☐ 706(b) ☐ 3.5	DIEC Account #	– –
Effective Date:	Subject Quarter	–
Send Forms DE 2515, DE 3816DI	☐ DE 3DI Qtr(s)	
Date Forms Sent:	Approved By:	Approval Date:
☐	Revi/Reg By:	Revi/Reg Date:

1. Social Security Number* – – Male Female
2. Employer Account Number
4. Year of Birth ☐ ☐
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? Yes ☐ No ☐ If yes, and you are not registered with the Employment Development Department (EDD) as an employer, please explain:
13. Type of Organization: ☐ Corporation - **Do not** submit, corporate officers are employees and covered under the State Disability InsuranceProgram.
General Partnership (includes husband and wife co-owners who are both active in the operation and management ofthe 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 thiscoverage. See information sheet attached.
20. Do you expect to remain in business for the next eight (8) calendarquarters? Yes ☐ No If no ☐ do not submit. You are not eligible forthis coverage. See information sheet attached.
21. Do you perform services in your trade, business, or occupationcontinuously 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.