EDD Employment Development Department State of California

Claim for Paid Family Leave (PFL) Benefits

2011PL2613

PART A—STATEMENT OF CLAIMANT (TO BE COMPLETED BY CLAIMANT)

#1. YOUR SOCIAL SECURITY NO.

#2. YOUR DATE OF BIRTH (M M D D Y Y Y Y)

#3. LANGUAGE YOU PREFER TO USE (ENGLISH SPAN. OTHER (PLEASE SPECIFY))

#4. YOUR LEGAL NAME (FIRST NAME, MI, LAST NAME)

#5. YOUR GENDER (MALE, FEMALE)

#6. YOUR TELEPHONE NUMBER

#7. OTHER LAST NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED

#8. YOUR MAILING ADDRESS (IF YOU DO NOT HAVE A STREET OR MAIL BOX—NOTIFY A DISPOSITION REPRESENTATIVE—PFL MAY BE DENIED THE BENEFITS YOU "PLEAD" WHILE) (PLEASE, IF APPLICABLE)

CITY | STATE/PROV. | ZIP OR POSTAL CODE | COUNTRY (IF NOT USA)

#9. NAME OF YOUR EMPLOYER (MAILING ADDRESS)

CITY | STATE/PROV. | ZIP OR POSTAL CODE | EMPLOYER'S TELEPHONE NUMBER

#10. DATE YOU LAST WORKED (M M D D Y Y Y Y)

#11. DATE YOU WANT YOUR PFL CLAIM TO BEGIN (M M D D Y Y Y Y)

#12. DATE YOU RETURNED OR WILL RETURN TO WORK (M M D D Y Y Y Y)

#13. DID YOU WORK OR WILL YOU CONTINUE TO WORK DURING YOUR FAMILY LEAVE PERIOD? (NO, YES)

#14. WHY DID YOU OR WILL YOU REDUCE YOUR WORK HOURS OR STOP WORKING? (CARE FOR FAMILY MEMBER, BONDING WITH CHILD, OTHER (EXPLAIN))

#15. WHAT IS YOUR OCCUPATION?

#16. LEGAL NAME OF PERSON FOR WHOM YOU ARE CARING (FIRST, MIDDLE INITIAL, LAST) OR WITH WHOM YOU ARE BONDING (CARE OR BONDING RECIPIENT)

#17. THE ABOVE-NAMED CARE OR BONDING RECIPIENT IS YOUR: (SPOUSE, DOMESTIC PARTNER, CHILD, PARENT, OTHER (EXPLAIN))

#18. IS ANY OTHER FAMILY MEMBER READY, WILLING, AND ABLE AND AVAILABLE TO PROVIDE CARE FOR THE SAME PERIOD YOU ARE CLAIMING PFL BENEFITS? (NO, YES)

#19. HAVE YOU CLAIMED OR DID YOU PLAN TO CLAIM WORKERS' COMPENSATION BENEFITS FOR ANY PORTION OF THE PERIOD COVERED BY THIS CLAIM? (NO, YES)

#20. DID YOU HAVE MORE THAN ONE EMPLOYER? (NO, YES)

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

#22. MAY WE DISCLOSE BENEFIT PAYMENT INFORMATION TO YOUR EMPLOYER? (NO, YES)

#23. AT ANY TIME DURING YOUR PFL LEAVE, WERE YOU IN THE CUSTODY OF LAW ENFORCEMENT AUTHORITIES BECAUSE YOU WERE CONVICTED OR VIOLATING A LAW OR ORDINANCE? (NO, YES)

#24. Declaration and Signature. By my signature on this claim statement, I declare that I have the right to receive benefits and certify that throughout the period covered by this claim I was not receiving, earning or benefiting with the type and amount noted above. I (or California EDD) is allowed to request additional information or there on this claim to the type recipient and to the type recipient's healthcare provider. I hereby authorize State and Federal agencies to release information to California EDD. 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 under the laws of the State of California, including any accompanying statements, documents, or information, 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 authorization contained in this form is valid for one year or for a period of fifteen years from the date of my signature on the information form or the claim, whichever is later.

Claimant's Signature (DO NOT PRINT) | If signature is made by mark (X), please place mark here.* | Date Signed (M M D D Y Y Y Y)

*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