

DISABILITY INSURANCE  
 PO BOX 469  
 LONG BEACH CA 90801-0469



250303121



RETURN TO: ----->



DISABILITY INSURANCE  
 PO BOX 989745  
 WEST SACRAMENTO CA 95798-9745

Mailing Date

10162017

CORPORATE MANAGEMENT GROUP  
 12000 WASHINGTON ST  
 DENVER CO 80241-3140



**NOTICE TO EMPLOYER OF DISABILITY INSURANCE CLAIM FILED**

Information is required to determine the employee's eligibility for Disability Insurance benefits, a worker-financed program. California Unemployment Insurance Code, section 2707.1, requires that you complete and return this form within two working days from the day you receive it if the person named below is still your employee and within five working days if not. For faster processing, complete and submit this form online at [www.edd.ca.gov](http://www.edd.ca.gov). If you submit online, you do not have to mail this form back to EDD. When completing this form, **PLEASE PRINT WITH BLACK INK**. To report fraud, call 1-800-229-6297.

EDD Customer Account Number (EDDCAN)	CLAIM ID	SSN/ECN	CED
6541694166	DI-1004-359-932	567-41-3341	10-12-2017

<b>EMPLOYEE'S NAME</b>		<b>LAST REPORTED DAY WORKED</b>	
JERRY DEAN EDWARDS		10-11-2017	
1. EMPLOYEE'S DATE OF BIRTH <input type="text"/>			
2. Fill in the box(es) below that describe the above named claimant's employment status:			
<input type="checkbox"/> <b>Has Never Worked Here - skip to #9; return form to EDD</b>			
<input type="checkbox"/> <b>CURRENT EMPLOYEE</b> ..... Hours worked per week <input type="text"/> <input type="text"/> at \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> per hour <small>(Please enter the employee's hours per week and rate of pay prior to disability)</small> <span style="float: right;"><small>(Prior to disability) (Exclude Overtime Pay)</small></span>			
<input type="checkbox"/> <b>FORMER EMPLOYEE</b> ..... Hours worked per week <input type="text"/> <input type="text"/> at \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> per hour <small>(Please enter the employee's hours per week and rate of pay prior to separation)</small> <span style="float: right;"><small>(Exclude Overtime Pay)</small></span>			
<input type="checkbox"/> Termination <input type="checkbox"/> Quit <input type="checkbox"/> Lay-off <input type="checkbox"/> Other _____ Separation Date: <input type="text"/>			
3. Do your records show a different ACTUAL last day of work than shown above? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
If <b>YES</b> , provide the correct last day worked: <input type="text"/>			
Was this day a: <input type="checkbox"/> Full day, or <input type="checkbox"/> Partial day Number of hours worked <input type="text"/> <input type="text"/> at \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> per hour			
4. Has the employee returned to work? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
If <b>YES</b> , date returned to work: <input type="text"/> <input type="checkbox"/> Regular schedule, duties and wages			
<input type="checkbox"/> Part-time, modified schedule, duties, or wages <input type="checkbox"/> Other/Explain _____			
5. Will this employee's <b>wages</b> be <b>coordinated/integrated</b> with State Disability benefits? <small>(Less State Disability Insurance) ..... If yes, skip question #7</small> ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			

**CONTINUED ON OTHER SIDE**



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6. At the time the employee's disability began, did your company have a state-approved voluntary plan for disability insurance benefits instead of the state plan?  Yes  No

If YES: a. Enter the plan number:

b. If this employee is not covered check here  Provide non-coverage explanation on a separate sheet

7. Has or will the employee receive wages in the form of paid sick leave, vacation, personal time off, holiday, bonus, commission, or other payment while disabled?  Yes  No

If YES, indicate type(s) of pay, period and amount:

Sick  Paid Time Off (PTO) Period  to

Vacation  Annual Leave  Other/Explain \_\_\_\_\_ Amount \$

Sick  Paid Time Off (PTO) Period  to

Vacation  Annual Leave  Other/Explain \_\_\_\_\_ Amount \$

Please attach a separate paper if you have additional periods or wages to report.

8. Has the employee reported a work-related injury or occupational illness?  Yes  No

If YES: Enter Workers' Compensation (WC) carrier name Area Code and Phone # Extension

NUMBER/STREET/SUITE #

CITY

STATE ZIP CODE

Date of Injury  Claim Number  Adjuster's Name

WC Status:  Delayed  Denied  Accepted

9. Completed by (Print name)

Area Code and Direct Phone #

Extension

Date

10. Do you wish to change the employer's address?  Yes  No

Is this a Centralized/HR address for processing forms for multiple locations?  Yes  No

Enter your new address below

NUMBER/STREET/SUITE OR UNIT #

CITY

STATE ZIP CODE

COUNTRY (IF NOT U.S.A.)