DISABILITY INSURANCE
PO BOX 60006
CITY OF INDUSTRY CA 91716-0006

250303121

RETURN TO: ----->

DISABILITY INSURANCE
PO BOX 989745
WEST SACRAMENTO CA 95798-9745

Mailing Date

11212017

CORPORATE MANAGEMENT
12000 WASHINGTON ST
DENVER CO 80241-3140

Employment Development Department
State of California
(800) 480-3287

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. 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
	DI-1004-447-434	573-17-9668	11-07-2017

EMPLOYEE'S NAME	LAST REPORTED DAY WORKED
VERONICA SCOTT	08-08-2017

1. EMPLOYEE'S DATE OF BIRTH (M M D D Y Y Y Y)

2. Fill in the box(es) below that describe the above named claimant's employment status:

☐ **Has Never Worked Here - *skip to #9; return form to EDD***

☐ CURRENT EMPLOYEE ..... Hours worked per week ☐☐ at $ ☐☐☐.☐☐ per hour
(Please enter the employee's hours per week and rate of pay prior to disability)
(Prior to disability) *(Exclude Overtime Pay)*

☐ FORMER EMPLOYEE ..... Hours worked per week ☐☐ at $ ☐☐☐.☐☐ per hour
(Please enter the employee's hours per week and rate of pay prior to separation)
(Exclude Overtime Pay)

☐ Termination ☐ Quit ☐ Lay-off ☐ Other_____ Separation Date: (M M D D Y Y Y Y)

3. Do your records show a different ACTUAL last day of work than shown above? ..... ☐ Yes ☐ No

If **YES,** provide the correct last day worked: (M M D D Y Y Y Y)

Was this day a: ☐ Full day, or ☐ Partial day Number of hours worked ☐☐ at $ ☐☐☐.☐☐ per hour

4. Has the employee returned to work? ..... ☐ Yes ☐ No

If **YES,** date returned to work: (M M D D Y Y Y Y) ☐ Regular schedule, duties and wages

☐ Part-time, modified schedule, duties, or wages ☐ Other/Explain_____

5. Will this employee's **wages** be **coordinated/integrated** with State Disability benefits?
(Less State Disability Insurance) ..... **If yes, skip question #7** ..... ☐ Yes ☐ No

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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** M M D D Y Y Y Y to M M D D Y Y Y Y

☐ Vacation ☐ Annual Leave ☐ Other/Explain _____ Amount $

☐ Sick ☐ Paid Time Off (PTO) **Period** M M D D Y Y Y Y to M M D D Y Y Y Y

☐ 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 M M D D Y Y Y Y

Claim Number

Adjuster's Name

WC Status: ☐ Delayed ☐ Denied ☐ Accepted

9. Completed by (Print name)

Area Code and Direct Phone # Extension Date M M D D Y Y Y Y

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.)

OSP 12 127857