Employment Development Department
State of California

REPORT OF VOLUNTARY PLAN DISABILITY CLAIM

PLEASE READ INSTRUCTIONS BEFORE COMPLETING THIS FORM. TO REPORT A VOLUNTARY PLAN FAMILY LEAVE (VPFL) CLAIM, YOU MUST SUBMIT A COMPLETED REPORT OF VOLUNTARY PLAN FAMILY LEAVE CLAIM, DE 2523F.

CLAIMANT INFORMATION

COMPLETE ITEMS 1 – 10 AND 16 – 18. SUBMIT WITHIN 15 DAYS AFTER RECEIPT OF A FIRST CLAIM FOR DISABILITY BENEFITS.

1. SOCIAL SECURITY NUMBER	2. CLAIMANT'S NAME (FIRST, MIDDLE, LAST)	3. DATE DISABILITY BEGAN
___ – __ – _____		

4. CLAIMANT'S MAILING ADDRESS

STREET/PO BOX		
CITY	STATE	ZIP CODE

5. SEX ☐ MALE ☐ FEMALE

6. DATE OF BIRTH ___/___/_____ MM DD YYYY

7. VOLUNTARY PLAN NUMBER	8. VOLUNTARY PLAN EMPLOYER NAME
–	

9. DIAGNOSIS OR INTERNATIONAL CLASSIFICATION OF DISEASES (ICD) CODE

10. DO YOU WANT STATE AWARD INFORMATION? ☐ NO ☐ YES (**REMINDER**: IF YES, YOU MUST COMPLETE THE ADDRESS AREA AT THE BOTTOM OF THIS PAGE.)

FOR DEPARTMENT USE ONLY

CLAIM EFFECTIVE DATE	WEEKLY BENEFIT AMOUNT	MAXIMUM BENEFIT AMOUNT
	$	$

COMPLETE ITEMS 11 – 18 AND SUBMIT WITHIN 35 DAYS AFTER FINAL PAYMENT FOR EACH PERIOD OF DISABILITY.

11. NUMBER OF DAYS BENEFITS PAID	12. BENEFITS PAID THROUGH	13. TOTAL AMOUNT OF BENEFITS PAID	14. TOTAL AMOUNT DIVERTED TO SATISFY SUPPORT OBLIGATION
		$	$

15. CLAIM STATUS (CHECK ALL APPROPRIATE)

☐ BENEFITS EXHAUSTED ☐ BENEFITS NOT EXHAUSTED ☐ BENEFITS DENIED (ATTACH DENIAL LETTER)

☐ RECOVERED / RETURNED TO WORK ☐ ADJUSTMENT

16. **(REQUIRED)** TYPE OR PRINT NAME OF PERSON COMPLETING FORM	17. TELEPHONE NUMBER	18. DATE
	( )	

SUBMIT COMPLETED FORM AS FOLLOWS:

INTERNET OR HARDCOPY VERSION: PRINT AND MAIL TO: VOLUNTARY PLAN GROUP, MIC 29VP
P.O. BOX 826880
SACRAMENTO, CA 94280-0001

(PLEASE DO NOT ATTEMPT TO E-MAIL THE INTERNET VERSION.)

WORD VERSION: E-MAIL TO: VOLUNTARY PLAN GROUP, vp2523@edd.ca.gov

IN THE AREA BELOW, ENTER THE NAME AND ADDRESS (INCLUDING ZIP CODE) OF EMPLOYER OR PLAN ADMINISTRATOR IF REQUESTING STATE AWARD INFORMATION.

INSTRUCTIONS FOR COMPLETING THE REPORT OF VOLUNTARY PLAN DISABILITY CLAIM, DE 2523

Complete items 1-10 and 16-18 and return within 15 days after the receipt of a first claim for disability benefits (California Code of Regulations, title 22, section 3267-1).

1. Enter all digits of the claimant's social security number.
   (A claim cannot be processed without an accurate number. The use of an incorrect number can result in erroneous notices to the claimant and employer.)
2. Enter the claimant's full name.
3. Enter the date the disability began.
4. Enter the claimant's current mailing address.
5. Enter a check mark in the appropriate box.
6. Enter the month, day, and year of claimant's date of birth.
7. Enter the six digit voluntary plan number.
8. Enter the employer's name.
9. Enter the physician's diagnosis or International Classification of Diseases (ICD) Code.
10. Enter an "X" in the appropriate box. If yes is checked, the Department will mail the award information to the address provided.

Complete items 11-18 and return within 35 days after final payment for each period of disability (California Code of Regulations, title 22, section 3267-1).

11. Enter the number of days disability benefits were paid.
    (Includes days paid under a supplemental accident and sickness plan or salary continuance only if they are part of the Voluntary Plan.)
12. Enter the last date for which disability benefits were paid by the voluntary plan.
13. Enter the amount of disability benefits paid from the voluntary plan.
    (Enter the amount paid for the days entered in item 11. Include any amount withheld for support obligation.)
14. Enter the amount of disability benefits that were diverted to satisfy a support obligation.
    (Enter the amount of benefits withheld under the Support Intercept Program. This amount must be included in the total of item 13.)
15. Enter an "X" in the boxes that apply to the current claim status.

    Benefits Exhausted: The total maximum award has been paid.

    Benefits Not Exhausted: A balance of the maximum benefit amount remains.

    Benefits Denied: No benefits have been paid. A copy of the denial letter to the claimant must be electronically attached or submitted under separate cover.

    Recovered/Return to Work: The claimant has recovered from the disability and/or returned to work.
    Adjustment: Use if submitting an amended report.
16. Enter the printed name of the person completing the form.
17. Indicate the telephone number of the person completing the form.
18. Enter the current date.

In the space provided at the bottom of the page, type or print clearly the name and mailing address of the employer or the third party administrator.

SUBMIT COMPLETED FORM AS FOLLOWS:

INTERNET or HARDCOPY VERSION	**WORD VERSION**
PRINT and MAIL TO: Voluntary Plan Group, MIC 29VP P.O. Box 826880 Sacramento, CA 94280-0001 (Please do not attempt to e-mail the Internet version.)	E-MAIL TO: Voluntary Plan Group, vp2523@edd.ca.gov You may also print and mail your report to: Voluntary Plan Group, MIC 29VP P.O. Box 826880 Sacramento, CA 94280-0001