EDD "Notice to Employer of Disability Insurance Claim Form Instructions

Question 1: Verify if employee is still employed or has been separated.

Question 2: Verify reported last day worked.

Question 3: Verify if the employee has returned to work, if so indicate date and full-time or part-time status.

Question 4: The answer is always **NO**, we do not coordinate with state disability insurance benefits.

Question 5: Verify if the employee received or will receive any pay such as sick, vacation, holiday, cat leave, etc. Indicate dates and amounts.* (Only two wage lines are provided please combine forms of pay if needed.)

Question 6: The answer is always **NO**, we do not have a state-approved voluntary plan for disability insurance benefits.

Question 7: Verify if the employee reported a workers' comp claim, contact Nini Furst at extension 24207 for assistance.

Questions 8: Provide DBR signature, date, telephone number then return in envelope provided. Keep a copy for your records.

***Question 5. Calculating Wages**

- When calculating wages use part-month payments. Take into consideration the hours per month (e.g., 160, 168, 176, 184) and number of days and or hours worked in any month such pay was received.

Example

- Employee went out on disability on 12/1/10 and received sick pay through 1/8/11.
- December 2010 was a 184 hour month and January 2011 was a 168 hour month.
- December 1 through December 31 is 22 working days. 3 of these days were holidays
- January 1 through January 8 includes 5 working days.
- So we have 3 days of holiday in a 184 hour month, 19 days of sick leave in a 184 hour month and 5 days of sick leave in a 168 hour month
- The employee's salary is $3453 per month.
- Now we determine the factors by which to multiply the salary to determine amount paid. According to the part-month payments chart this equates to:

3 X 8 = 24 hours divided by 184 = .1304
19 X 8 = 152 hours divided by 184 = .8261
5 X 8 = 40 hours divided by 168 = .2381

- Wage type: Holiday from 12/24/10 to 12/31/10. Amount $450.27
- Wage type: Sick from 12/1/10 to 1/8/11. Amount $3674.68

DISABILITY INSURANCE
PO BOX 781
SAN BERNARDINO CA 92402-0781

(800) 480-3287

EDD Employment Development Department
State of California

RETURN TO ----->

DISABILITY INSURANCE
PO BOX 781
SAN BERNARDINO CA 92402-0781

UNIVERSITY OF RIVERSIDE
3333 WATKINS DR
RIVERSIDE CA 92507-3052

If employer name and/or address differs from that shown at left, please correct here:

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.

Section 2707.1 of the California Unemployment Insurance Code requires that you complete and return this form within **two working days.**

EMPLOYEE'S NAME	BADGE NO.	SSN	REPORTED LAST DAY AT WORK	CED	ECN	MAILING DATE
EXAMPLE, ANNA		123-45-6666	11-29-10			

1. If the claimant shown above was **EVER** your employee, please check the appropriate box below:
   - [X] Still employed
     Please provide employee's REGULAR WEEKLY RATE of pay or earnings prior to disability (excluding overtime):
     Hours worked per week: 40 at $ 3453 per ~~hour~~ month
   - [ ] Termination/laid off, date: _____ [ ] Quit, effective date: _____ [ ] Other: (please explain) _____

2. Do your records show a different ACTUAL last day of work than shown above? ..... [X] Yes [ ] No
   If **YES**, provide the correct last day worked: 11-30-10. Was this day a:
   [X] Full day or [ ] Partial day, number of hours worked _____ at $_____ per hour

3. Has the employee returned to work? ..... [X] Yes [ ] No
   If **YES**, date returned to work: 1-29-11
   [ ] Full-time, regular or customary duties [ ] Part-time, regular or customary duties
   [ ] Other (please explain) _____

4. Will the employee's wages be **coordinated/integrated** with the State Disability Insurance benefits? (Less State Disability Insurance) ..... ***If yes, please skip question #5*** ..... [ ] Yes [X] No

5. Has the employee received or will the employee receive wages in the form of paid sick leave, vacation, personal time off, holiday, bonus, commission, or other type of payment while disabled? ..... [X] Yes [ ] No
   If **YES:** Wage type: Holiday from 12/24/10 to 12/31/10. Amount $ 450.27
   Wage type: Sick from 12/1/10 to 1/8/11. Amount $ 3674.68

6. At the time the employee's disability began, did you have a state-approved voluntary plan for disability insurance benefits instead of the state plan? ..... [ ] Yes [X] No
   If **YES:** a. Enter the plan number: 99- _____
   b. If the employee is not covered, give reason: _____

7. Has the employee reported a work-incurred injury or occupational illness? ..... [ ] Yes [X] No
   If **YES:** Provide workers' compensation carrier name, address, and telephone number:
   _____
   _____
   "Date of injury": _____ Claim number: _____ Adjuster: _____
   Name & Phone Number
   WC Status: [ ] Delayed [ ] Denied [ ] Accepted

8. Completed by (Print name): DBR NAME Date: 2-9-11 Direct Number & Extension: 951-827-####

PART-MONTH PAYMENTS

DAYS WORKED	DAYS PER MONTH 20 HOURS PER MONTH 160	21 168	22 176	23 184	DAYS WORKED	DAYS PER MONTH 20 HOURS PER MONTH 160	21 168	22 176	23 184
1 Hour	.0063	.0060	.0057	.0055					
3 Hours	.0188	.0179	.0171	.0164	8	.4000	.3810	.3636	.3478
1/4	.0125	.0119	.0114	.0109	1/4	.4125	.3929	.3750	.3587
1/2	.0250	.0238	.0227	.0217	1/2	.4250	.4048	.3864	.3696
3/4	.0375	.0357	.0341	.0326	3/4	.4375	.4167	.3977	.3804
1	.0500	.0476	.0455	.0435	9	.4500	.4286	.4091	.3913
1/4	.0625	.0595	.0568	.0543	1/4	.4625	.4405	.4205	.4022
1/2	.0750	.0714	.0682	.0652	1/2	.4750	.4524	.4318	.4130
3/4	.0875	.0833	.0795	.0761	3/4	.4875	.4643	.4432	.4239
2	.1000	.0952	.0909	.0870	10	.5000	.4762	.4545	.4348
1/4	.1125	.1071	.1023	.0978	1/4	.5125	.4881	.4659	.4457
1/2	.1250	.1190	.1136	.1087	1/2	.5250	.5000	.4773	.4565
3/4	.1375	.1310	.1250	.1196	3/4	.5375	.5119	.4886	.4674
3	.1500	.1429	.1364	.1304	11	.5500	.5238	.5000	.4783
1/4	.1625	.1548	.1477	.1413	1/4	.5625	.5357	.5114	.4891
1/2	.1750	.1667	.1591	.1522	1/2	.5750	.5476	.5227	.5000
3/4	.1875	.1786	.1705	.1630	3/4	.5875	.5595	.5341	.5109
4	.2000	.1905	.1818	.1739	12	.6000	.5714	.5455	.5217
1/4	.2125	.2024	.1932	.1848	1/4	.6125	.5833	.5568	.5326
1/2	.2250	.2143	.2045	.1957	1/2	.6250	.5952	.5682	.5435
3/4	.2375	.2262	.2159	.2065	3/4	.6375	.6071	.5795	.5543
5	.2500	.2381	.2273	.2174	13	.6500	.6190	.5909	.5652
1/4	.2625	.2500	.2386	.2283	1/4	.6625	.6310	.6023	.5761
1/2	.2750	.2619	.2500	.2391	1/2	.6750	.6429	.6136	.5870
3/4	.2875	.2738	.2614	.2500	3/4	.6875	.6548	.6250	.5978
6	.3000	.2857	.2727	.2609	14	.7000	.6667	.6364	.6087
1/4	.3125	.2976	.2841	.2717	1/4	.7125	.6786	.6477	.6196
1/2	.3250	.3095	.2955	.2826	1/2	.7250	.6905	.6591	.6304
3/4	.3375	.3214	.3068	.2935	3/4	.7375	.7024	.6705	.6413
7	.3500	.3333	.3182	.3043	15	.7500	.7143	.6818	.6522
1/4	.3625	.3452	.3295	.3152	1/4	.7625	.7262	.6932	.6630
1/2	.3750	.3571	.3409	.3261	1/2	.7750	.7381	.7045	.6739
3/4	.3875	.3690	.3523	.3370	3/4	.7875	.7500	.7159	.6848

PART-MONTH PAYMENTS (continued)

	DAYS PER MONTH			
	20	21	22	23
DAYS WORKED	HOURS PER MONTH 160	168	176	184
16	.8000	.7619	.7273	.6957
1/4	.8125	.7738	.7386	.7065
1/2	.8250	.7857	.7500	.7174
3/4	.8375	.7976	.7614	.7283
17	.8500	.8095	.7727	.7391
1/4	.8625	.8214	.7841	.7500
1/2	.8750	.8333	.7955	.7609
3/4	.8875	.8452	.8068	.7717
18	.9000	.8571	.8182	.7826
1/4	.9125	.8690	.8295	.7935
1/2	.9250	.8810	.8409	.8043
3/4	.9375	.8929	.8523	.8152
19	.9500	.9048	.8636	.8261
1/4	.9625	.9167	.8750	.8370
1/2	.9750	.9286	.8864	.8478
3/4	.9875	.9405	.8977	.8587
20	1.0000	.9524	.9091	.8696
1/4		.9643	.9205	.8804
1/2		.9762	.9318	.8913
3/4		.9881	.9432	.9022
21		1.0000	.9545	.9130
1/4			.9659	.9239
1/2			.9773	.9348
3/4			.9886	.9457
22			1.0000	.9565
1/4				.9674
1/2				.9783
3/4				.9891
23				1.0000