

First Claim for Nonindustrial Disability Insurance (NDI)

Attendance Clerk or Payroll Officer:

Please complete Part A before giving or sending this form to the employee.

Part A - Employer Information			
1. NAME OF EMPLOYEE (EE)		2. SOCIAL SECURITY NUMBER	
FIRST INITIAL LAST		AGENCY UNIT CLASS SERIAL	
3. GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	4. OCCUPATION	5. CBID #	6. GROSS MONTHLY SALARY \$ / /
8. PERSONNEL TRANSACTIONS UNIT (PTU) OR SECTION RESPONSIBLE FOR EMPLOYEE'S PAYROLL DOCUMENTS		9. APPOINTMENT / TIME BASE STATUS (CHECK ALL THAT APPLY)	
DEPARTMENT OR CAMPUS		<input type="checkbox"/> PERMANENT/PROBATIONARY	
PTU OR SECTION		<input type="checkbox"/> FULL TIME	
MAILING ADDRESS		<input type="checkbox"/> PT/INT - DID EE HAVE EQUIVALENT OF 6 MONTHLY COMPENSATED PPS IN THE PAST 18 PPS? .. <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME OF PAYROLL SPECIALIST (PLEASE PRINT)		<input type="checkbox"/> PERS/STRS MEMBER	
PUBLIC PHONE EXTENSION FAX		<input type="checkbox"/> LT - DOES EE HAVE THE RIGHT TO RETURN TO A PRIOR PERMANENT, FULL-TIME POSITION? ... <input type="checkbox"/> YES <input type="checkbox"/> NO	
() () ()		<input type="checkbox"/> TAU - DOES EE HAVE THE RIGHT TO RETURN TO A PRIOR PERMANENT, FULL-TIME POSITION? .. <input type="checkbox"/> YES <input type="checkbox"/> NO	
13. ADDRESS OR LOCATION WHERE EMPLOYEE ACTUALLY WORKS		<input type="checkbox"/> CEA - DOES EE HAVE THE RIGHT TO RETURN TO A PRIOR PERMANENT, FULL-TIME POSITION? .. <input type="checkbox"/> YES <input type="checkbox"/> NO	
15. COMPLETED BY (PLEASE PRINT NAME) DATE COMPLETED		<input type="checkbox"/> LEAP - HAS EE SUCCESSFULLY COMPLETED THE TEMPORARY JOB EXAMINATION PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO	
SIGNATURE		<input type="checkbox"/> SEASONAL	
PUBLIC PHONE EXTENSION FAX		<input type="checkbox"/> ANNUITANT	
() () ()		<input type="checkbox"/> EMERGENCY	
14. FOR ANNUAL LEAVE PROGRAM (ALP) EMPLOYEES:		10. DID EE LEAVE WORK BECAUSE OF SICKNESS, INJURY, SURGERY, OR PREGNANCY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IS EE SUPPLEMENTING NDI WITH ANNUAL LEAVE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF "NO," PLEASE GIVE REASON (SEPARATION, LAYOFF, RETIREMENT, LOA, SUSPENSION, ETC.)	
IF "NO," LEAVE CREDITS ARE TO BE PAID THROUGH _____ (DATE)		11. EXEMPT EE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
16. FOR NON-ALP EMPLOYEES:		12. IS EE REQUIRED TO EXHAUST SICK LEAVE? .. <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID EE ELECT TO USE FULL LEAVE CREDITS, INCLUDING CATASTROPHIC LEAVE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS EE ENROLLED IN THE ANNUAL LEAVE PROGRAM? ... <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF "YES," LEAVE CREDITS ARE TO BE PAID THROUGH _____		LAST DATE PAID HOURS PAID ON THAT DAY	
17. WORKERS' COMPENSATION INFORMATION		18. HAS EE RETURNED TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IS EE ENTITLED TO RECEIVE OR HAS THE EE RECEIVED WORKERS' COMPENSATION TEMPORARY DISABILITY OR IDL FOR ANY DAY AFTER THE LAST DAY PHYSICALLY WORKED SHOWN ABOVE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING		IF YES: <input type="checkbox"/> PART TIME <input type="checkbox"/> FULL TIME GIVE DATE(S) _____	
IF YES, PROVIDE PERIODS PAID FROM _____ TO _____.		19. CSUS EMPLOYEES ONLY	
FOR WHAT BODY PARTS? _____		EE APPOINTED FOR ONE YEAR OF SERVICE OR ONE ACADEMIC YEAR OR MORE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
FOR WHAT DATE OF INJURY? _____		ACADEMIC EMPLOYEE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
18. HAS EE RETURNED TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF "YES," SHOW <input type="checkbox"/> 10/10 <input type="checkbox"/> 10/12 <input type="checkbox"/> 12/12	
IF YES: <input type="checkbox"/> PART TIME <input type="checkbox"/> FULL TIME GIVE DATE(S) _____		AND THE DESIGNATED SUMMER PERIOD OR QUARTER OFF DATES: _____	
NOTE TO EMPLOYER: While the NDI office determines the period of eligibility and authorizes payment on claims, your personnel office has the responsibility for requesting payment from the State Controller.		IF EE IS RECEIVING CATASTROPHIC LEAVE, IS IT SUPPLEMENTING NDI? <input type="checkbox"/> YES <input type="checkbox"/> NO	

Part C - Doctor's Certificate

Certification may be made by a licensed medical or osteopathic physician and surgeon, chiropractor, dentist, podiatrist, optometrist, designated psychologist, or an authorized medical officer of a United States Government facility. Certification may also be made by a licensed nurse-midwife, nurse practitioner, or licensed midwife for disabilities related to normal pregnancy or childbirth. **All items on this sheet must be completed legibly.**

PATIENT FILE OR ID NO.	PATIENT'S NAME	PATIENT'S SOCIAL SECURITY NUMBER
------------------------	----------------	----------------------------------

17. I ATTENDED THIS PATIENT FOR THE PRESENT MEDICAL PROBLEM

FROM / / TO / / AT INTERVALS OF DAILY WEEKLY MONTHLY AS NEEDED

18. HISTORY:	19. OBJECTIVE FINDINGS / DETAILED STATEMENT OF SYMPTOMS:
---------------------	---

20. DIAGNOSIS:	22. ICD CODE, SECONDARY:
-----------------------	---------------------------------

21. ICD CODE PRIMARY (REQUIRED):	22. ICD CODE, SECONDARY:
---	---------------------------------

23. TYPE OF TREATMENT AND/OR MEDICATION RENDERED TO PATIENT:	24. REFERRED TO (E.G., SPECIALIST, PT, COUNSELING):
---	--

25A. IF THIS PATIENT IS NOW OR WAS PREGNANT SINCE THE DATE OF TREATMENT REPORTED ABOVE, PLEASE PROVIDE FUTURE EDC OR DATE PREGNANCY TERMINATED:	25B. IF PREGNANCY IS/WAS ABNORMAL, STATE THE ABNORMAL AND INVOLUNTARY COMPLICATION CAUSING MATERNAL DISABILITY:
--	--

26A. IF HOSPITALIZED, IN WHAT HOSPITAL WAS OR IS PATIENT CONFINED AS A REGISTERED BED PATIENT?	26B. IF TREATED IN A SURGICAL CLINIC, IN WHAT SURGICAL CLINIC WAS PATIENT TREATED?
NAME OF FACILITY	NAME
ADDRESS	DATE ENTERED / / DATE DISCHARGED / /
DATE ENTERED / / DATE DISCHARGED / /	DATE ENTERED / / DATE DISCHARGED / /

27. WAS ABOVE HOSPITALIZATION FOR A SURGICAL PROCEDURE? YES NO **REQUIRED**

IF "YES," PLEASE DESCRIBE TYPE: _____ DATE PERFORMED/TO BE PERFORMED: / / ICD CODE _____

IF "NO," STATE THE PURPOSE FOR CONFINEMENT: _____ CPT PROCEDURE CODE **C**

28. AT ANY TIME DURING YOUR ATTENDANCE, HAS THIS PATIENT BEEN INCAPABLE OF PERFORMING HIS/HER REGULAR WORK? YES NO

IF "YES," ON WHAT DATE DID DISABILITY COMMENCE? / / (REQUIRED)

29. DATE YOU RELEASED OR ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR OR CUSTOMARY WORK. THIS IS A REQUIREMENT OF THE CALIFORNIA UNEMPLOYMENT INSURANCE CODE, AND THE CLAIM WILL BE DELAYED IF NO DATE IS ENTERED. ANSWERS SUCH AS "INDEFINITE" OR "UNKNOWN" ARE NOT ACCEPTABLE.

/ /

30. WORKERS' COMPENSATION INFORMATION

A. IN YOUR OPINION, IS THIS DISABILITY THE RESULT OF "OCCUPATION," EITHER AS AN "INDUSTRIAL ACCIDENT" OR AS AN OCCUPATIONAL DISEASE? YES NO
(THIS SHOULD INCLUDE AGGRAVATION OF PRE-EXISTING CONDITIONS BY OCCUPATION.)

B. HAVE YOU REPORTED THIS OR A CONCURRENT DISABILITY TO ANY INSURANCE CARRIER AS AN INDUSTRIAL DISABILITY LEAVE OR WORKERS' COMPENSATION CLAIM? YES NO

C. IF "YES," GIVE NAME OF CARRIER OR FIRM: _____

31. DRUG- AND ALCOHOL-RELATED CLAIMS

A. ARE YOU COMPLETING THIS FORM FOR THE SOLE PURPOSE OF REFERRAL OR RECOMMENDATION TO AN ALCOHOLIC RECOVERY HOME OR DRUG-FREE RESIDENTIAL FACILITY? YES NO

B. IF "YES," PLEASE PROVIDE: FACILITY NAME: _____ TELEPHONE NUMBER: () _____

ADDRESS: _____ DATE ENTERED: / / DATE DISCHARGED: / /

C. IS THIS PATIENT UNDER YOUR DIRECT MEDICAL CARE? YES NO

32. FURTHER COMMENTS (IF INDICATED)

33. WOULD DISCLOSURE OF THIS INFORMATION TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL?..... YES NO

Doctor's Certification and Signature (Required): Having considered the patient's regular or customary work, I certify under penalty of perjury that, based on my examination, the foregoing Doctor's Certificate truly describes the patient's disability (if any) and the estimated duration thereof.

I further certify that I am a _____ (Type of Doctor) _____ (Specialty, if any) licensed to practice by the State of _____

(Print or type Doctor's Name) (Original signature of Attending Doctor) **Rubber Stamp is Not Acceptable.**

No. and Street City State ZIP Code State License No. Telephone No. Date Signed

Under sections 2116 through 2117.5 of the California Unemployment Insurance Code, it is a violation for any individual who, with intent to defraud, falsely certifies the medical condition of any person in order to obtain disability insurance benefits, whether for the maker or for any other person, and is punishable by imprisonment and/or a fine not exceeding \$20,000.

Below is a large print version of the text of Part B, Question 14.
Please sign and date the smaller print version on page 2 of this claim form.

14. Health Insurance Portability and Accountability Act Authorization.

I authorize any physician, practitioner, hospital, vocational rehabilitation counselor, or workers' compensation insurance carrier to furnish and disclose to employees of California Employment Development Department (EDD) all facts concerning my disability that are under their control.

I understand that EDD may disclose information as authorized by the California Unemployment Insurance Code and that such redisclosed information may no longer be protected by this rule.

I agree that photocopies of this authorization shall be as valid as the original.

I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by EDD or the effective date of the claim, whichever is later.

I understand that I may not revoke this authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.