

## First Claim for Nonindustrial Disability Insurance (NDI)

**NOTE TO NDI APPLICANTS: KEEP THIS INSTRUCTION & INFORMATION JACKET FOR REFERENCE**

### To qualify for NDI benefits, you must be:

1. A California State government employee  
and
2. Unable to perform your job duties because of a non-work-related disability.  
(See "Nonindustrial Disability Insurance Provisions," DE 8502, for details.)

### How to complete the NDI claim form, DE 8501:

1. Have your Attendance Clerk or Payroll Officer complete Part A.
2. Complete all items in Part B when you have stopped working due to a disability.
3. Give this claim form to your doctor for completion of Part C. (If you are under the care of an accredited religious practitioner, ask your practitioner to complete and sign a "Practitioner's Certificate," DE 2502, available from any State Disability Insurance office.)
4. Advise your doctor that upon completion of the medical certificate the claim form should be forwarded **ONLY** to the NDI office indicated below.

**Note:** It is the employee's responsibility to see that this Claim and the Doctor's Certificate are filled out **COMPLETELY** and mailed to the Employment Development Department address listed below. If you do not understand this form, you may call the NDI office at **866-758-9768**. If any item is not completed on this form, it may be returned for completion and your benefit payment may be delayed.

If an authorized agent is filing for benefits for a **PHYSICALLY INCAPACITATED, MENTALLY INCAPACITATED, or DECEASED** claimant, contact any State Disability Insurance office or call 1-800-480-3287 for the required forms and instructions.

**MAIL COMPLETED FORM TO:** State of California  
Employment Development Department  
NDI  
P.O. Box 2168  
Stockton CA 95201-2168

## Information Collection and Access

State law requires the following information to be provided when collecting information from individuals:

<b>Agency Name:</b> Employment Development Department (EDD)	<b>Title of Official Responsible for Information Maintenance:</b> Manager, EDD Disability Insurance Office
<b>Local Contact Person:</b> Manager, EDD Disability Insurance Office	<b>Address and Telephone Number:</b> 528 North Madison, Stockton, CA 95202-1917 866-758-9768
<b>Maintenance of the information is authorized by:</b> California Unemployment Insurance Code, sections 2601 through 3272. California Code of Regulations, title 22, sections 2706-1, 2706-3, 2708.1-1, 2710-1. California Government Code, sections 19878 through 19886.2.	
<b>All information requested is mandatory. Consequences of not providing all or any part of the requested information:</b> <ul style="list-style-type: none"><li>• Failure to supply any or all information may cause delay in issuing benefit checks or may cause you to be denied benefits to which you are entitled.</li><li>• If you willfully make a false statement or representation or knowingly withhold a material fact to obtain or increase any benefit or payment, EDD will disqualify you from receiving benefits any/or services and may initiate criminal prosecution against you.</li><li>• EDD may require an independent medical examination to determine your initial or continuing eligibility.</li></ul>	
<b>Principal purpose(s) for which the information is to be used:</b> <ul style="list-style-type: none"><li>• To determine eligibility for nonindustrial disability insurance benefits.</li><li>• To be summarized and published in statistical form for the use and information of government agencies and the public. (Your name and identification will not appear in publications.)</li><li>• To be used to locate persons who are being sought for failure to provide child or spousal support.</li><li>• To be used by other governmental agencies to determine eligibility for public social services under the provisions of California Welfare and Institutions Code, division 9.</li><li>• To be used by EDD to carry out its responsibilities under the California Unemployment Insurance Code.</li><li>• To be exchanged pursuant to California Unemployment Insurance Code, section 322, and California Civil Code, section 1798.24, with other governmental departments and agencies, both federal and state, which are concerned with any of the following:<ol style="list-style-type: none"><li>(1) administration of an unemployment insurance program;</li><li>(2) collection of taxes which may be used to finance unemployment insurance or disability insurance;</li><li>(3) relief of unemployed or destitute individuals;</li><li>(4) investigation of labor law violations or allegations of unlawful employment discrimination;</li><li>(5) the hearing of workers' compensation appeals;</li><li>(6) whenever necessary to permit a state agency to carry out its mandated responsibilities where the use to which the information will be put is compatible with the purpose for which it was gathered; or</li><li>(7) when mandated by state or federal law. Disclosures under California Unemployment Insurance Code, section 322, will be made only in those instances in which it furthers the administration of the programs mandated by that Code.</li></ol></li><li>• Pursuant to California Unemployment insurance Code, sections 1095 2714:<ol style="list-style-type: none"><li>(1) Information may be revealed to the extent necessary for the administration of public social services or to the Director of Social Services or his/her representatives;</li><li>(2) Claimant identity may be released to the Department of Rehabilitation.</li></ol></li><li>• Information shall be disclosed to authorized agencies in accordance with California Unemployment Insurance Code, sections 1095 and 2714.</li></ul>	
<b>Under California Civil Code, section 1798.34, you have the right to inspect records maintained on you by the agency unless exempted as described on page C.</b>	

# 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.

<b>Part A - Employer Information</b>					
<b>1. NAME OF EMPLOYEE (EE)</b>		<b>2. SOCIAL SECURITY NUMBER</b>		<b>3. POSITION NUMBER</b>	
FIRST                      INITIAL                      LAST				AGENCY      UNIT      CLASS      SERIAL	
<b>3. GENDER</b> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<b>4. OCCUPATION</b>	<b>5. CEID #</b>	<b>6. GROSS MONTHLY SALARY</b> \$	<b>7. LAST DAY PHYSICALLY WORKED</b> / /	
<b>8. PERSONNEL TRANSACTIONS UNIT (PTU) OR SECTION RESPONSIBLE FOR EMPLOYEE'S PAYROLL DOCUMENTS</b>		<b>9. APPOINTMENT / TIME BASE STATUS (CHECK ALL THAT APPLY)</b>			
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 ( )		<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			
EXTENSION		<input type="checkbox"/> TAL - DOES EE HAVE THE RIGHT TO RETURN TO A PRIOR PERMANENT, FULL-TIME POSITION? <input type="checkbox"/> YES <input type="checkbox"/> NO			
FAX ( )		<input type="checkbox"/> GEA - DOES EE HAVE THE RIGHT TO RETURN TO A PRIOR PERMANENT, FULL-TIME POSITION? <input type="checkbox"/> YES <input type="checkbox"/> NO			
<b>10. DID EE LEAVE WORK BECAUSE OF SICKNESS, INJURY, SURGERY, OR PREGNANCY?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> LEAP - HAS EE SUCCESSFULLY COMPLETED THE TEMPORARY JOB EXAMINATION PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO			
<b>11. EXEMPT EE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> SEASONAL			
<b>12. IS EE REQUIRED TO EXHAUST SICK LEAVE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> ANNUITANT			
<b>13. ADDRESS OR LOCATION WHERE EMPLOYEE ACTUALLY WORKS</b>		<input type="checkbox"/> EMERGENCY			
<b>14. FOR ANNUAL LEAVE PROGRAM (ALP) EMPLOYEES:</b>		<b>12. IS EE ENROLLED IN THE ANNUAL LEAVE PROGRAM?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			
		IS EE SUPPLEMENTING NDI WITH ANNUAL 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			
		IF "YES," LEAVE CREDITS ARE TO BE PAID THROUGH _____ (DATE)			
<b>15. COMPLETED BY (PLEASE PRINT NAME)</b>		<b>16. FOR NON-ALP EMPLOYEES:</b>			
DATE COMPLETED		DID EE ELECT TO USE FULL LEAVE CREDITS, INCLUDING CATASTROPHIC LEAVE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
		IF "YES," LEAVE CREDITS ARE TO BE PAID THROUGH _____			
<b>16. COMPLETED BY (PLEASE PRINT NAME)</b>		LAST DATE PAID                      HOURS PAID ON THAT DAY			
SIGNATURE		<b>17. WORKERS' COMPENSATION INFORMATION</b>			
PUBLIC PHONE ( )		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			
EXTENSION		IF YES, PROVIDE PERIODS PAID FROM _____ TO _____			
FAX ( )		FOR WHAT BODY PARTS? _____			
		FOR WHAT DATE OF INJURY? _____			
<b>18. CSUS EMPLOYEES ONLY</b>		HAS EE RETURNED TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO			
		IF YES: <input type="checkbox"/> PART TIME <input type="checkbox"/> FULL TIME    GIVE DATE(S) _____			
<b>NOTE TO EMPLOYER:</b>		<b>18. CSUS EMPLOYEES ONLY</b>			
While the NDI office determines the period of eligibility and authorizes payment on claims, your personnel office has the responsibility for requesting a claim.		EE APPOINTED FOR ONE YEAR OF SERVICE (ACADEMIC YEAR OR FISCAL YEAR)? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Your date of claim determination is _____.		ACADEMIC EMPLOYEE? <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			
		AND THE DESIGNATED SUMMER PERIOD OR QUARTER DATES: _____			
		IF EE IS RECEIVING CATASTROPHIC LEAVE, IS IT SUPPLEMENTING NDI? <input type="checkbox"/> YES <input type="checkbox"/> NO			

**NDI Applicant:** Please complete all items below after you have stopped working due to disability.

**Part B - Claim Statement of Employee**

<b>1. YOUR MAILING ADDRESS</b>  STREET, P.O. BOX, OR RFD                      APT. NO.                      CITY                      STATE                      ZIP CODE	<b>2. DATE OF BIRTH</b>  _____
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<b>3. YOUR HOME ADDRESS (IF DIFFERENT FROM MAILING ADDRESS)</b>  _____	<b>4. OTHER NAME(S) USED</b>  _____	<b>5. OCCUPATION</b>  _____
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<b>6. WHAT WAS THE FIRST DAY YOU WERE TOO SICK TO WORK, EVEN IF IT WAS A SATURDAY, SUNDAY, HOLIDAY, OR NORMAL DAY OFF?</b>  _____ MONTH      _____ DAY      _____ YEAR	<b>7. WHAT WAS THE LAST DAY YOU WORKED BEFORE THIS DISABILITY?</b>  _____ MONTH      _____ DAY      _____ YEAR
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**8. DID YOU STOP WORK BECAUSE OF SICKNESS, INJURY, SURGERY, OR PREGNANCY?** .....  YES  NO  
 IF "NO," PLEASE EXPLAIN: \_\_\_\_\_

**9. WAS THIS DISABILITY OR ANY OTHER DISABILITY DURING THIS CLAIM PERIOD CAUSED BY YOUR WORK?** .....  YES  NO  
 HAVE YOU FILED A CLAIM FOR WORKERS' COMPENSATION? .....  YES  NO  
 IF "YES," PLEASE PROVIDE THE FOLLOWING INFORMATION:

NAME OF WORKERS' COMPENSATION INSURANCE CARRIER		CARRIER'S TELEPHONE NUMBER	
ADDRESS OF CARRIER			
NAME OF ADJUSTER	DATE OF INJURY	CLAIM NUMBER	
BODY PART(S)			
ARE YOU RECEIVING WORKER'S COMPENSATION BENEFITS?		IF "YES," BENEFITS PAID	
<input type="checkbox"/> YES <input type="checkbox"/> NO		FROM _____ TO _____	

**10. IF ANNUAL LEAVE PARTICIPANT, INDICATE YOUR DESIRE TO SUPPLEMENT NDI WITH LEAVE** .....  NO SUPPLEMENT  75%  100%

**11. HAVE YOU RECOVERED FROM YOUR DISABILITY?** .....  YES  NO  
 IF "YES," PLEASE ENTER DATE: \_\_\_\_\_

**12. HAVE YOU RETURNED TO WORK AFTER THE DATE SHOWN ABOVE IN ITEM 6?** .....  YES  NO  
 IF "YES," PLEASE ENTER DATE(S) \_\_\_\_\_  FULL-TIME  PART-TIME

PLEASE REVIEW, SIGN, AND DATE BOTH No. 13 AND No. 14.

**13. 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. (A large-print version of this text is contained on page 4 of this form.)

YOUR SIGNATURE (DO NOT PRINT)	DATE SIGNED
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**14. Declaration and Signature.** I hereby claim benefits and certify that for the period covered by this claim I was unemployed and disabled and that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize my employer to furnish and disclose all facts concerning my disability and wages or earnings that are within his/her knowledge. I understand this authorization is granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later. I agree that a photocopy of this authorization shall be as valid as the original.

YOUR SIGNATURE (DO NOT PRINT)	DATE SIGNED	WORK TELEPHONE NUMBER	HOME TELEPHONE NUMBER
		(      )	(      )

**15. Personal Representative signing on behalf of claimant must complete the following:** I \_\_\_\_\_, represent the claimant in this matter as authorized by  power of attorney (attach copy)  Declaration of Individual Claiming Disability Insurance Benefits Due an Incapacitated or Deceased Claimant, DE 2522 (see pg. A,14)

Personal Representative's Signature (DO NOT PRINT)	Date Signed
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**IT IS A VIOLATION OF THE CALIFORNIA UNEMPLOYMENT INSURANCE CODE TO WILLFULLY MAKE A FALSE STATEMENT OR TO KNOWINGLY CONCEAL A MATERIAL FACT IN ORDER TO OBTAIN THE BENEFITS OF ANY BENEFITS.**

**NOTE TO EMPLOYER:** The NDI office determines the period of disability and the estimated payment amount. However, your employer's personnel office has the responsibility for requesting payment from the State Controller. Please contact your employer's personnel office if you have any questions regarding payments.

### 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
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16. I ATTENDED THIS PATIENT FOR THE PRESENT MEDICAL PROBLEM

FROM  TO  AT INTERVALS OF  DAILY  WEEKLY  MONTHLY  AS NEEDED

MM DD YY                      MM DD YY

17. HISTORY:	18. OBJECTIVE FINDINGS / DETAILED STATEMENT OF SYMPTOMS:
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18. DIAGNOSIS:	19. ICD CODE, SECONDARY:
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20. ICD CODE PRIMARY (REQUIRED):	21. ICD CODE, SECONDARY:
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22. TYPE OF TREATMENT AND/OR MEDICATION RENDERED TO PATIENT:	23. REFERRED TO (E.G., SPECIALIST, PT, COUNSELING):
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24a. IF THIS PATIENT IS NOW OR WAS PREGNANT SINCE THE DATE OF TREATMENT REPORTED ABOVE, PLEASE PROVIDE FUTURE EDC OR DATE PREGNANCY TERMINATED:	24b. IF PREGNANCY IS/WAS ABNORMAL, STATE THE ABNORMAL AND INVOLUNTARY COMPLICATION CAUSING MATERNAL DISABILITY:
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25a. IF HOSPITALIZED, IN WHAT HOSPITAL WAS OR IS PATIENT CONFINED AS A REGISTERED BED PATIENT? NAME OF FACILITY ADDRESS DATE ENTERED: / /      DATE DISCHARGED: / /	25b. IF TREATED IN A SURGICAL CLINIC, IN WHAT SURGICAL CLINIC WAS PATIENT TREATED? NAME DATE ENTERED: / /      DATE DISCHARGED: / /
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26. WAS ABOVE HOSPITALIZATION FOR A SURGICAL PROCEDURE?  YES  NO

IF "YES," PLEASE DESCRIBE TYPE: \_\_\_\_\_ DATE PERFORMED/TO BE PERFORMED: / / ICD CODE \_\_\_\_\_ CPT PROCEDURE CODE \_\_\_\_\_

IF "NO," STATE THE PURPOSE FOR CONFINEMENT: \_\_\_\_\_

27. 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)

28. 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.

/ /

29. 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: \_\_\_\_\_

30. 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

31. FURTHER COMMENTS (IF INDICATED)

32. 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) \_\_\_\_\_ (Specify, if any) licensed to practice by the State of \_\_\_\_\_

Under sections 210 through 217.5 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 13.  
Please sign and date the smaller print version on page 2 of this claim form.

**13. 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.

**What is Nonindustrial Disability Insurance?** Nonindustrial Disability Insurance (NDI) is a program funded by state government employers to provide partial wages to most state government employees who experience a loss of wages due to a non-work-related disability.

### Coverage

No employee contributions, enrollment fees, or medical examinations are required in order to be covered.

NDI benefits are available to permanent or probationary full-time, part-time, or intermittent employees in "compensated employment" (in pay status and not separated by a formal leave of absence) who are members of the Public Employees' Retirement System (PERS) or the State Teachers' Retirement System (STRS).

Permanent part-time and intermittent employees must have the equivalent of six monthly compensated pay periods of service in the 18 months immediately preceding the pay period in which the disability begins. Such employees are eligible on a prorated basis.

Employees of the California State University appointed half-time or more for one year of service or one academic year or more are also covered.

NDI coverage is also provided to employees who are excluded from collective bargaining and to full-time, permanent part-time, or intermittent officers or employees of the State Legislature who are not members of the civil service.

### Eligibility

NDI benefits are payable to covered employees who cannot perform their regular or customary work and suffer a wage loss because of a non-work-related mental or physical disability, including disability due to pregnancy.

There is a waiting period of either seven or ten days according to employment status and/or provisions of collective bargaining agreements. All or part of the waiting period may be waived under certain circumstances. Such circumstances include being confined in a hospital or nursing home or any circumstance specified in an applicable collective bargaining agreement.

Benefits are not payable:

- For any day of entitlement to temporary workers' compensation benefits or industrial disability leave. EXCEPTION: If the weekly rate for such benefits is less than the weekly NDI rate, the difference can be paid.
- For any day wages are received in the form of sick leave, vacation, compensatory time off, or catastrophic leave.
- For any day Unemployment Insurance benefits are received.
- For any day on and after separation or retirement from state service. It is permissible to delay the effective date of a disability retirement until NDI benefits are exhausted.

**Retirement Credit.** You will not earn PERS or STRS service credit while you are receiving NDI. State employer contributions to your retirement account will not be made while you are receiving NDI.

### Benefit Amounts

NDI provides up to \$250.00 per week for 26 weeks (182 days). The weekly benefit amount and rules regarding use of leave credits vary according to employment status and/or collective bargaining agreement. Enhanced NDI benefits are provided to employees who participate under the State's Annual Leave Program (ALP) in the amount of 50% of gross pay that may be supplemented with leave credits up to 100%.

State and federal taxes will be withheld from NDI benefits. Voluntary deductions such as health insurance premiums, credit union loans, savings accounts, bonds, parking fees, health insurance premiums, etc., will automatically be deducted from NDI benefits unless cancelled by the employee. If the employee continues health insurance premium deductions, the State's employer contribution will also continue.

### Benefit Payment Process

The NDI office within the Employment Development Department (EDD) determines eligibility and authorizes benefit payments. The employer's personnel office then must request the State Controller or paying agent to issue benefit payments to the disabled employee. Benefits are paid monthly.

Once benefits are authorized by NDI/EDD, inquiries concerning payment status, weekly rates, payment amounts, deductions, etc., should be directed to the employee's attendance clerk or personnel office.

Questions concerning eligibility for benefits should be directed to the NDI office at 866-758-9768. Any determination of eligibility made by the NDI office may be appealed before an administrative law judge by writing to the NDI office to request a hearing.

### Requirements and Responsibilities

NDI claimants may be required to submit to an examination in order to determine physical or mental disability. Fees for such examinations are paid the

NDI claimants are responsible for filing claims promptly and accurately. It is a violation of the Department's Unemployment Insurance Code to willfully make a false statement or to knowingly conceal a material fact in order to obtain benefits.

California Civil Code, section 1798 (The Information Practices Act), imposes conditions on the gathering, maintenance, disclosure, and correction of personal information by public agencies.

1. **Right to inspect and correct:** California Civil Code, section 1798.34, gives you the right to inspect any personal records maintained about you by the Employment Development Department. Section 1798.34 also gives you the right to obtain a hardcopy of your file. Section 1798.35 permits you to request that the record be corrected if you believe that it is not accurate, relevant, timely, or complete.
2. **Exemptions:** Certain limited types of information that would generally be considered personal are exempt from disclosure to you:
  - (a) Medical or psychological records where knowledge of the contents might be harmful to the subject (Civil Code, § 1798.40);
  - (b) Records of active criminal, civil, or administrative investigations (Civil Code, § 1798.40);
  - (c) Names of individuals submitting letters of reference (Civil Code, § 1798.38).
3. **Appeal rights:** If you are denied access to records which you believe you have a right to inspect or if your request to amend your records is refused, you may file an appeal in writing with the EDD Disability Insurance Office whose address is shown on page B.

**Federal Privacy Act.** The Employment Development Department requires disclosure of Social Security account numbers on a mandatory basis to comply with California Unemployment Insurance Code, sections 1253 and 2627; with California Code of Regulations, title 22, sections 1085, 1088, and 1326; with Code of Federal Regulations, title 20, part 604; and with U.S. Code, title 8, §§ 1621, 1641, and 1642.

**Health Insurance Portability and Accountability Act.** Federal law requires that we obtain a separate authorization and signature that permits your doctor to provide medical information regarding your claim. EDD collects medical and health information in accordance with Code of Federal Regulations, title 45, part 164.