



250104123

PART A - CLAIMANT'S STATEMENT - CONTINUED

A22. PLEASE RE-ENTER YOUR SOCIAL SECURITY NUMBER

A23. WHAT IS YOUR REGULAR OR CUSTOMARY OCCUPATION?

A24. WHY DID YOU STOP WORKING? (SELECT ONLY ONE BOX)
LAYOFF UNPAID LEAVE OF ABSENCE VOLUNTARILY QUIT OR RETIRED ILLNESS, INJURY, OR PREGNANCY TERMINATED OTHER REASON

A25. HOW WOULD YOU DESCRIBE OR CLASSIFY YOUR JOB?
Mostly sit; occasionally stand or walk; occasionally lift, carry, push, pull, or otherwise move objects that weigh 10 lbs. or less.
Mostly walk/stand; occasionally lift, carry, push, pull, or otherwise move objects that weigh up to 20 lbs.
Constantly lift, carry, push, pull, or otherwise move objects that weigh up to 10 lbs.; frequently up to 20 lbs.; occasionally up to 50 lbs.
Constantly lift, carry, push, pull, or otherwise move objects that weigh up to 20 lbs.; frequently up to 50 lbs.; occasionally up to 100 lbs.
Constantly lift, carry, push, pull, or otherwise move objects that weigh over 20 lbs.; frequently over 50 lbs.; occasionally over 100 lbs.

A26. IF YOUR EMPLOYER(S) CONTINUED OR WILL CONTINUE TO PAY YOU DURING YOUR DISABILITY, INDICATE TYPE OF PAY:
SICK VACATION Paid Time Off (PTO) ANNUAL OTHER (EXPLAIN)

A27. MAY WE DISCLOSE BENEFIT PAYMENT INFORMATION TO YOUR EMPLOYER(S)?
YES NO

A28. SECOND EMPLOYER NAME (IF YOU HAVE MORE THAN ONE EMPLOYER)
NUMBER/STREET/SUITE#
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)
BEFORE YOUR DISABILITY BEGAN, WHAT WAS THE LAST DAY YOU WORKED FOR THIS EMPLOYER? EMPLOYER'S TELEPHONE NUMBER

A29. IF YOU HAVE MORE THAN 2 EMPLOYERS CHECK HERE.

A30. IF YOU ARE A RESIDENT OF AN ALCOHOLIC RECOVERY HOME OR A DRUG-FREE RESIDENTIAL FACILITY, PROVIDE THE FOLLOWING:
NAME OF FACILITY
NUMBER/STREET/SUITE#
CITY STATE ZIP OR POSTAL CODE AREA CODE AND TELEPHONE NUMBER

A31. HAVE YOU FILED OR DO YOU INTEND TO FILE FOR WORKERS' COMPENSATION BENEFITS?
YES - COMPLETE ITEMS A32 THROUGH A38 NO - SKIP ITEMS A33 THROUGH A38

A32. WAS THIS DISABILITY CAUSED BY YOUR JOB?
YES NO

A33. DATE(S) OF INJURY SHOWN ON YOUR WORKERS' COMPENSATION CLAIM

A34. WORKERS' COMPENSATION INSURANCE COMPANY NAME AREA CODE AND TELEPHONE NUMBER EXTENSION (IF ANY)
NUMBER/STREET/SUITE#
CITY STATE ZIP CODE WORKERS' COMPENSATION CLAIM NUMBER





250104124

PART A - CLAIMANT'S STATEMENT - CONTINUED

A35. PLEASE RE-ENTER YOUR SOCIAL SECURITY NUMBER

A36. WORKERS' COMPENSATION ADJUSTER'S NAME AREA CODE AND TELEPHONE NUMBER EXTENSION (IF ANY)

A37. EMPLOYER'S NAME SHOWN ON YOUR WORKERS' COMPENSATION CLAIM AREA CODE AND TELEPHONE NUMBER EXTENSION (IF ANY)

A39. YOUR ATTORNEY'S NAME (IF ANY) FOR YOUR WORKERS' COMPENSATION CASE AREA CODE AND TELEPHONE NUMBER EXTENSION (IF ANY)

ATTORNEY'S ADDRESS NUMBER/STREET/SUITE#

CITY STATE ZIP CODE WORKERS' COMPENSATION APPEALS BOARD/ADJ CASE NUMBER

PLEASE REVIEW, SIGN, AND DATE ITEM A39, AND IF APPLICABLE, ITEMS A40 AND A41

A39. Declaration and Signature. By my signature on this claim statement, I claim benefits and certify that for the period covered by this claim I was unemployed and disabled. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law and that such violation is punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to the best of my knowledge and belief true, correct, and complete. By my signature on this claim statement, I authorize the California Department of Industrial Relations and my employer to furnish and disclose to State Disability Insurance all facts concerning my disability, wages or earnings, and benefit payments that are within their knowledge. By my signature on this claim statement, I authorize release and use of information as stated in the "Information Collection and Access" portion of this form (see Informational Instructions, page D). I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.

CLAIMANT'S SIGNATURE (DO NOT PRINT) OR SIGNATURE MADE BY MARK (X) DATE SIGNED

A40. IF YOUR SIGNATURE IS MADE BY MARK (X), CHECK THE BOX AND IT MUST BE ATTESTED BY TWO WITNESSES WITH THEIR ADDRESSES. []

1st WITNESS SIGNATURE (PRINT AND SIGN) DATE SIGNED

NUMBER/STREET/APARTMENT OR SPACE#, PO BOX OR PRIVATE MAIL BOX ADDRESSES NOT ACCEPTABLE. CITY STATE ZIP CODE

2nd WITNESS SIGNATURE (PRINT AND SIGN) DATE SIGNED

NUMBER/STREET/APARTMENT OR SPACE#, PO BOX OR PRIVATE MAIL BOX ADDRESSES NOT ACCEPTABLE. CITY STATE ZIP CODE

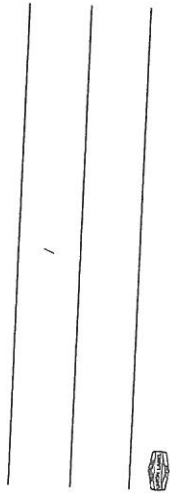
A41. [] CHECK THIS BOX IF YOU ARE THE PERSONAL REPRESENTATIVE SIGNING ON BEHALF OF CLAIMANT AND COMPLETE THE FOLLOWING:

(FIRST) (MI) (LAST) I, [] REPRESENT THE CLAIMANT IN

THIS MATTER AS AUTHORIZED BY [] DECLARATION OF INDIVIDUAL CLAIMING DISABILITY INSURANCE BENEFITS DUE AN INCAPACITATED OR DECEASED CLAIMANT, DE 2522 (SEE INSTRUCTION & INFORMATION A, UNDER HOW TO APPLY #4) [] POWER OF ATTORNEY (ATTACH COPY)

PERSONAL REPRESENTATIVE'S SIGNATURE (DO NOT PRINT) DATE SIGNED

Place stamp here.
Post Office will
not deliver mail
without postage.



STATE OF CALIFORNIA
EMPLOYMENT DEVELOPMENT DEPARTMENT
PO BOX 989777
WEST SACRAMENTO CA 95798-9777

