View Claim for Paid Family Leave (PFL) Benefits Parts A & B -- Statement of Claimant & Bonding Certification (DE 2501F)

Receipt Number: R100000040243321

Section 1 - Personal Information

Social Security Number:	XXX-XX-4276	EDD Customer Account Number:	5331231217
Legal Name:	Robert D Johnston	Other Names (If any, under which you have worked):	Robbie Johnston
Date of Birth:	06-10-1982	Gender:	Male
Mailing Address:	1341 Drake Dr Apt D Davis, CA 95616-0859 United States		
Phone Number:	530-205-8270		
Preferred Language:	English		

Section 2 - Employer Information

Employer Name:	St. Hope Public Schools	Occupation:	Teacher
State Government Employee?	No	If “Yes”, indicate Bargaining Unit Number:	
May we disclose benefit payment information to your employer(s)?	Yes	Do you have more than one employer?	No
Reason for Reducing Work Hours or Stopping Work:	Bonding with a child	If “Other,” please specify:	
Employer Mailing Address:	2315 34th St Sacramento, CA 95817-1211 United States	Employer Phone Number:	916-649-7725

Section 3 - Bonding Certification

Relationship to Child:	Biological Child	If you select Foster Care, Adoption or Guardianship, please provide the date of placement:	

Section 4 - Child’s Legal Name and Information

Child’s Social Security Number (if available):	XXX-XX-5963	Child’s Legal Name:	Indiana D Johnston

Child’s Gender:	Male	Child's Date of Birth:	12-29-2015
Is the child’s residence address different from your residence address?		No	

Section 5 - Proof of Relationship

Please indicate the type of “Proof of Relationship” you plan to provide from the list of approved “Proof of Relationship” documents:	Official Child's Birth Certificate

Section 6 - Child’s Residence Address

Do not include “PO Box”, “PMB,” “General Delivery” or “Rural Route Number.”

Child’s Residence Address:	1341 Drake Dr Apt D Davis, CA 95616-0859 United States

Section 7 - Additional Questions

Date You Last Worked:	05-03-2016

If the date you want your Paid Family Leave Claim to begin is prior to the Child’s Birth Date (or the date of foster care or adoption placement), you will be disqualified for the time period prior to Child’s Birth Date (or the date of foster care or adoption placement).

Date You Want Your Paid Family Leave Claim to Begin:	05-04-2016	Will you work at any time during your family leave?	No
Your claim effective date begins your non-payable waiting period. Would you like to be paid six continual weeks of benefits after your non-payable waiting period has been served?	No	If “No,” Date You Want to be Paid Through:	06-12-2016
Date You Returned to Work:		Date You Plan to Return to Work:	06-13-2016
If your employer(s) continued or will continue to pay you during your family leave, indicate type of pay:	Sick, Other Type Of Pay	If “Other,” please specify:	Paid Time Off

At any time during your Paid Family Leave, were you in the custody of law enforcement authorities because you were convicted of violating a law or ordinance?	No	Have you claimed or do you plan to claim Workers' Compensation benefits for any portion of the period covered by this claim?	No

Section 8 - Declaration

By my signature on this bonding certification, I authorize the medical provider, adoption agency, adoption party(ies), or foster care placement agency to disclose to the Employment Development Department all facts concerning the birth, adoption, or foster care placement of the above-named child. 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 punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements or documents, is to the best of my knowledge and belief true, correct, and complete. 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.

By my signature on this claim statement, I (1) claim Paid Family Leave benefits and certify that throughout the period covered by this claim I was providing care for or bonding with the care recipient named above; (2) authorize my employer(s) to disclose to EDD all facts concerning my employment that are within their knowledge; and (3) authorize release and use of information as stated in the Information Collection and Access section of the Important Paid Family Leave Program Information page. 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 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. 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.

Submitted by:	220-52029	Submitted on:	05-07-2016 02:08 AM