Employment Development Department
State of California

ATTACHMENT D

Taxpayer Assistance Center, Attention: Specialized Coverage Desk, P.O. Box 2068, Rancho Cordova, CA 95741-2068, 916-654-6288

Application for Elective Coverage of State Disability Insurance* ONLY

For Department Use Only
Account No. _____
Statistical Code _____
Effective Date _____
Approved By _____
Date _____
Employer Notified _____ (Date)
Send _____
Number of Employees _____

IMPORTANT

This form is not an application for an account number under the compulsory provisions of the California Unemployment Insurance Code (CUIC). Do not complete this form unless you wish to apply for State Disability Insurance coverage **ONLY** for your employees under Section 702.6, 710.4, 710.5, 710.6, or 710.9 of the CUIC. Coverage under these sections of the CUIC does not make provision for Unemployment Insurance benefits.

Complete this form only for:

1. **Employing units with eligible employees who are California residents whose services are covered by the unemployment compensation laws of another state that does not have a disability insurance program under Section 702.6 of the CUIC. OR**
2. **Employees of any of the following:**
   - **A public school employer under Section 710.4 of the CUIC.**
   - **A public agency employer under Section 710.5 of the CUIC.**
   - **An Indian tribe under Section 710.6 of the CUIC.**
   - **A community college district under Section 710.9 of the CUIC.**

NOTE: If your application is approved, the elective coverage agreement will be subject to all of the requirements and conditions outlined in the *Information Concerning Elective Coverage for State Disability Insurance **ONLY** Under Section 702.6, 710.4, 710.5, 710.6, or 710.9 of the California Unemployment Insurance Code* (DE 1378P) form. Please retain your copy of the DE 1378P for reference.

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Please Type or Print

1. Name of Employer CITY OF STOCKTON (209) 937-8459 (Phone)
2. Business Address 425 N. EL DORADO ST., STOCKTON SAN JOAQUIN COUNTY CA 95202
   (Number and Street) (City) (County) (State) (ZIP Code)
3. Mailing Address SAME AS ABOVE
   (Number and Street) (City) (County) (State) (ZIP Code)
4. Type of Employer – (Check one)
   - ☐ Employing Unit With Eligible Employees – Section 702.6
   - ☐ Public School – Section 710.4
   - ☐ Indian Tribe – Section 710.6
   - ☑ Public Agency – Section 710.5
   - ☐ Community College District – Section 710.9
5. Law under which agency/employer was established. (Does not apply to Indian Tribes.)
   (a) California General Laws
   Title of Act _____ Number _____ Year Enacted _____
   OR
   (b) California Codes
   Title of Code CA. CONSTITUTION Number ARTICLE 11 Part _____ Chapter _____
   Sections 3 to 15
6. Members of governing body of the employer.

Name	Title	Residence Address
KURT WILSON	CITY MANAGER	(209) 937-8212
ANTHONY SILVA	MAYOR	(209) 937-8499
CHRISTINA FUGAZI	VICE MAYOR	(209) 937-8244

*Includes Paid Family Leave (PFL).

7. This application covers employees of the following appropriate units:

	Show Name of Bargaining Unit or Describe Type of Services
☑ Bargaining Unit	OPERATIONS AND MAINTENACE UNIT
☐ Management	
☐ Confidential	
☐ Unrepresented	
☐ Academic	
☐ Other	

8. Complete this schedule covering all elected officers and appointees who perform services for the agency named in Item 1. Exclude individuals listed in Item 6.

(a) Elected offices: (These individuals are ineligible for coverage.)
Title of Position

(b) Person holding appointive positions: (These individuals are eligible for coverage unless appointed to fill a vacant elected office.)

Title of Position	No. of Positions in this Category	By Whom Appointed	No. of Such Individuals Desiring Coverage

(c) Total number of employees to be covered (excluding elected officers and those appointed by the Governor).

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9. Deductions should not be made from your employees' wages for the purpose of paying employee contributions required under the CUIC until your election is approved.

10. On what date do you wish elective coverage to commence? Keep in mind that the commencement date of an elective coverage agreement shall not be prior to the first day of the calendar quarter in which the application is filed, nor later than the first day of the following calendar quarter.

☐ First day of current quarter ☑ First day of next quarter

11. Attach a copy of either:
- The negotiated agreement between the employer and the recognized employee organization or written petition signed by a majority of the eligible employees to be covered by the election under Section 702.6 of the CUIC.
  OR
- The resolution in which the governing body described in Item 6 approved the filing of an application for elective coverage under Section 710.4, 710.5, 710.6, or 710.9 of the CUIC.

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The employing unit with eligible employees or governmental or tribal entity described in Item 1 hereby files its application under Section 702.6, 710.4, 710.5, 710.6, or 710.9 of the CUIC to become an employer subject to the CUIC. It is understood that upon approval of the election by the Director, the Employing Unit/Public School/Public Agency/Indian Tribe/Community College District will be an employer subject to the CUIC for State Disability Insurance purposes **ONLY** to the same extent as other employers as of the date specified in the approval, and will remain a subject employer for at least two complete calendar years and thereafter, until this election is terminated as provided by the CUIC.

I declare that this application has been examined by me, and to the best of my knowledge, it is true and correct and made in good faith under the provisions of the CUIC.

This declaration must be signed by one or more individuals shown under Item 6.

(Signed) _____ Date _____
(Signed) _____ Date _____
(Signed) _____ Date _____