

STATE DISABILITY INSURANCE

Return of Benefits / Overpayment Refund Form

Use this form when returning disability insurance benefit payments that were issued in error, overpaid, or if you returned to work earlier than anticipated. Please return this completed form along with the check or money order.

1. CLAIMANT INFORMATION

FULL NAME

SOCIAL SECURITY NUMBER (LAST 4 DIGITS)

STREET ADDRESS

CLAIM ID / ACCOUNT NUMBER

CITY

STATE

ZIP CODE

PHONE NUMBER

2. REASON FOR RETURN OF BENEFITS

- ☐ Returned to work earlier than expected. Date returned to work: _____
- ☐ Received duplicate payment for the same period.
- ☐ Benefits paid for a period during which wages/sick leave were fully paid by the employer.
- ☐ Received Workers' Compensation benefits for the same period.
- ☐ Other (Please explain below):

3. PAYMENT DETAILS

AMOUNT BEING RETURNED (\$)

CHECK / MONEY ORDER NUMBER

ORIGINAL PAYMENT/ISSUE DATE

4. CERTIFICATION AND SIGNATURE

I declare under penalty of perjury that the information provided on this form is true and correct to the best of my knowledge.

CLAIMANT SIGNATURE

DATE

Please mail this completed form along with your check or money order payable to the State Disability Insurance Department.