INSTRUCTIONS FOR FILING A CLAIM FOR DISABILITY BENEFITS

1. Obtain a claim form (TDI-45) from your employer.

2. Answer all questions in Part A, Claimant’s Statement. Make sure you sign your name, or if you are unable to, have a responsible person sign for you. To avoid unnecessary delay, present your claim form to your employer, no later than 90 days after you are unable to perform the duties of your job. If you file beyond 90 days, attach a statement explaining why you were unable to file earlier. After you file your claim, your employer or employer’s insurance carrier will notify you if you are eligible for benefits.

3. Have your doctor complete and sign Part C, Doctor’s Statement.

4. Have your employer complete and sign Part B, Employer’s Statement. Have your employer mail this form to the insurance carrier listed unless otherwise directed by your employer in Part A (22) as your agent for service.

5. If you have any questions or problems with obtaining the claim form, TDI-45, call the Disability Compensation Division at 586-9188.

Auxiliary aids and services are available upon request. Please call: (808) 586-9188; TTY (808) 586-8847; and for neighbor islands, TTY 1-888-569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation be subjected to discrimination, excluded from participation in, or denied the benefits of the department’s services, programs, activities, or employment.
## CLAIM FOR DISABILITY BENEFITS

### PART A – CLAIMANT’S STATEMENT

<table>
<thead>
<tr>
<th>1. My name is: (First, middle, last)</th>
<th>Type or print</th>
<th>2. Social Security Number</th>
<th>3. Birth Date</th>
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<tbody>
<tr>
<td>4. Address (Street, City or Town, State, Zip Code)</td>
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<td>5. Telephone No.</td>
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<td>____ Married</td>
</tr>
</tbody>
</table>

### DISABILITY INFORMATION

8. My disability was caused by: Describe (if accident, give date, place and circumstances)  
   - ____ Sickness  
   - ____ Accident  
   - ____ Pregnancy

9. The first day I was unable to perform the duties of my job:
   - (month) (day) (year)

10. Was this disability caused by your job?  
   - ____ Yes  
   - ____ No  
   - ____ Unknown

11. ____ I have not recovered from my disability.  
    ____ I have recovered from my disability.  
    Date recovered: _________________________

12. ____ I have not returned to work.  
    ____ I have returned to work.  
    Date returned: _________________________

### EMPLOYMENT INFORMATION

13. My present employer is: (or last employer, if unemployed)  
    (Name and address – include street, city, state, zip code)

14. Prior to my disability, I worked for this employer:  
    From: __________________________  
    To: ___________________________

15. I worked: _____________________ hours per week  
    and  
    I earned: $________________ per week

16. Occupation:

17. I am a union member  
   - ____ Yes  
   - ____ No  
   Name of union: _____________________________________

18. Other Hawaii employers I worked for during the past 52 weeks:  
   Employer name and address

### OTHER BENEFITS

20. In addition to TDI benefits, I am receiving or claiming benefits from the following: (Check those that apply.)  
   - ____ Federal Disability Insurance Benefits  
   - ____ Workers’ Compensation Benefits  
   - ____ Employer’s Sick Leave Plan  
   - ____ Unemployment Insurance Benefits  
   - ____ Damages for Personal Injury  
   - ____ Other (Health and Welfare Fund; Union Plan, etc.)

21. During the 52 weeks (year) before my disability began, I have received TDI benefits for other periods of disability  
   - ____ Yes  
   - ____ No  
   If yes, from whom ___________________________ From ___________ to ___________

22. Mail the doctor’s statement to the insurance carrier unless otherwise indicated here:

I hereby claim Temporary Disability Benefits and certify that the foregoing statements including any accompanying statements are true and complete to the best of my knowledge.

Claimant’s signature  
Date

Representative’s signature, if claimant is unable to sign  
Print representative’s name  
Relationship
**PART B – EMPLOYER’S STATEMENT**

**IMPORTANT:** To enable your disabled employee to receive TDI benefits within 10 days as required by law, it is imperative that you complete the following information for prompt submittal to your insurance carrier.

1. **Claimant’s name:**
2. **Claimant’s occupation:**
3. **Employer Department of Labor No.:**
4. **TDI Policy Number:**
5. **Firm or trade name:**
6. **Business address:**

7. In reporting wage information below, use gross wages, which include wages and all other remuneration such as commissions, bonuses, tips and the cash value of meals, lodging, etc. Answer either A, B, or C.

   A. If claimant was paid on a salary basis, enter claimant’s weekly or monthly salary earned in the last week or month prior to the date claimant’s disability began: Week $__________ Month $__________

   B. If paid on an hourly basis, give rate per hour $__________. Enter the weekly earnings for the past 8 weeks prior to the date disability began, including the last date worked. (Include reported tips.)

   C. If claimant received any or all earnings on a commission or piecework basis, enter these earnings for the last 52 weeks prior to the date claimant’s disability began:
   
   This covers the period: From: __________________ through __________________ (month/day/year) (month/day/year)
   
   Earnings: $________

8. **Worked: _____ Full-time _____ Part-time**

   **Date hired:** __________________ (month) (day) (year)

   **Date last worked prior to disability:**
   
   (month) (day) (year)

   **If returned to work, give date:**
   
   (month) (day) (year)

9. **Check days normally worked:**
   
   Sun ___ Mon ___ Tue ___ Wed ___ Thu ___ Fri ___ Sat ___

   **If on rotation, give number of days worked per week:**

10. **Enter the following for the last 52 weeks prior to the date the employee’s disability began:**

   **No. Days Worked**

   **Gross Amount**

   **Calendar Week Ending**

   **No. of Weeks Worked**

   **No. of Hrs Worked/Wk**

   **Total Wages Earned**

   **Week No.**

   **Month**

   **Day**

   **Year**

11. **Do you think this disability was caused by the claimant’s job? _____ Yes _____ No _____ Unknown**

   **Was an Employer’s Report of Industrial Injury WC-1 filed? _____ Yes _____ No**

   **If yes, advise name and address of Workers’ Compensation carrier:**

   ______________________________________________________________________________

12. **Has or will this employee receive all or any portion of the period of disability covered by this claim __________ Wages? __________ Salary? __________ Sick leave pay? __________ Vacation pay? __________ Separation pay?**

   **If yes, show period:**
   
   From: __________________ through __________________ (mo/day/yr)

   **Amount:** $________

   **Separation pay? _____ Yes _____ No**

   **Vacation pay? _____ Yes _____ No**

   **Sick leave pay? _____ Yes _____ No**

   **Wages? _____ Yes _____ No**

   **Salary? _____ Yes _____ No**

**PART C – DOCTOR’S STATEMENT**

**IMPORTANT:** Please complete and mail within 7 working days after examination to the insurance carrier listed above unless otherwise directed in Part A (22) or Part B (13).

1. **Claimant’s name:**
2. **Age:**
3. **Sex:**
4. **Physical requirements of claimant’s occupation as related by claimant:**

5. **Diagnosis:**

6. **If pregnancy, advise expected date of birth __________. If disability is pregnancy with complications, advise complications above.**

7. **Was claimant’s disability caused by claimant’s employment? _____ Yes _____ No**

   **If yes, was Physician’s Report WC-2 filed? _____ Yes _____ No**

   **If yes, filed with __________.**

8. **Was claimant hospitalized? _____ Yes _____ No**

   **If yes, from __________ to __________.**

   **Surgery indicated? _____ Yes _____ No Type ________________**

9. **Complete the following:**

   **Date of your first treatment of this disability:**

   **Month**

   **Day**

   **Year**

   **Date of your most recent treatment of this disability:**

   **Month**

   **Day**

   **Year**

   **Date claimant will be able to perform usual work (estimate) (DO NOT use “undetermined” or “unknown”) (See #4 above)**

   **First date claimant unable to perform the duties of employment (see #4 above)**

   **Date claimant able to perform usual work (estimate) (DO NOT use “undetermined” or “unknown”) (See #4 above)**

10. **Are you referring claimant to another physician? _____ Yes _____ No**

    **If yes, give name:**

11. **I hereby certify that the above information is true and complete to the best of my knowledge:**

12. **I hereby certify that the above information is true and complete to the best of my knowledge:**

**Signature of employer or employer’s representative:**

**Title:**

**Date:**

**Tel No.:**

**Fax No.:**

**Signature of employer or employer’s representative:**

**Title:**

**Date:**

**Tel No.:**

**Fax No.:**

**Doctor’s name (Please print):**

**Office Address:**

**Date:**

**Telephone No.:**

**Fax No.:**

**Doctor’s signature:**

**Date:**

**Fax No.:**