Complete & Return to:
Benefit Services of Hawaii, Inc.
P.O. Box 840
Honolulu, HI 96808-0840
Telephone (808) 538-8901

CLAIM FOR DISABILITY BENEFITS

Benefits Underwritten by:
USAble Life

PART A - Claimant's Statement
Type or print

Form TDI-45

1. My name is: (First, middle, last)	2. Social Security No.	3. Birth Date
4. Address (Street, City or Town, State, Zip Code)		
5. Telephone No. ( )	6. ❑ Male ❑ Female	7. ❑ Single ❑ Married

DISABILITY INFORMATION

8. My disability was caused by: ❑ sickness ❑ accident Describe (if accident, give date, place and circumstances):	
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 ❑ have recovered from my disability. Date recovered _____	12. I ❑ have not ❑ have returned to work. Date returned to work _____

EMPLOYMENT INFORMATION

13. My present employer is: (or last employer if unemployed) Name and address - include street, city, state and zip code	14. Prior to my disability, I worked for this employer: From _____ (month) (day) (year) To _____ (month) (day) (year)
	15. I worked: _____ hours per week **and** I earned: _____ per week
16. Occupation:	17. I am a union member ❑ Yes ❑ No If Yes, name of union:

18. Other Hawaii employers I worked for during the past 52 weeks. Employer name and address	Period of Employment From Mo.	From Day	From Yr.	To Mo.	To Day	To Yr.	Weekly Hours	Weekly Wages
a.								
b.								
c.								
d.								

19. Does your employer have a TDI printed notice posted and maintained conspicuously in your employment area? ❑ Yes ❑ No

Did your employer give you a certificate of insurance informing you of your entitlement to TDI benefits? ❑ Yes ❑ No

Did your employer provide you this claim form when you first requested it for this disability? ❑ Yes ❑ No

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
- ❑ Unemployment Insurance Benefits
- ❑ Workers' Compensation Benefits
- ❑ Damages for Personal Injury
- ❑ Employer's Sick Leave Plan
- ❑ Other (Health & Welfare Fund; Union Plan, etc.)

21. During the 52 weeks (year) before my disability began, I have received TDI benefits for other period of disability.
❑ Yes ❑ No
If yes, from whom _____ From _____ To _____

22. Mail the doctor's statement to the address shown above 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 unable to sign	Print Representative's Name	Relationship

PART B - EMPLOYER'S STATEMENT (Please type or print)

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 DOL number

4. TDI policy number	5. Firm or trade name	6. Business address (include street, city, state, and zip)

7. In reporting wage information below, use gross 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 his weekly or monthly salary earned in the last week or month prior to the date his 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.)

Week No.	Week Ending Month	Day	Year	No. Days Worked	Gross Amount
1					
2					
3					
4					
5					
6					
7					
8					
TOTAL	XXXX	XXX	XXX		

C. If claimant received any or all of his earnings on a commission or piecework basis, enter these earnings for the last 52 weeks prior to the date his disability began:

This covers the dates:

From: _____ through _____
mo./day/year mo./day/year

$ _____

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:

Calendar Quarter Ending	Number of Weeks Worked	No. of Hours Worked per Wk.	Total Wages Earned

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 below.
Name: _____
Address: _____

12. Has or will this employee receive ❑ wages, ❑ salary, ❑ sick leave, ❑ vacation or ❑ separation pay for all or any portion of the period of disability covered by this claim? ❑ Yes ❑ No If yes, show period:
From: _____ through _____
mo./day/year mo./day/year
and Amount $ _____

13. Mail the doctor's statement to:

I hereby certify that the above information is true and compete to the best of my knowledge.

Signature of employer or his representative	Print name	Title	Date

Employer tax ID no. (Needed for FICA Reporting)	Telephone No. ( )	Fax No. ( )

PART C - DOCTOR'S STATEMENT

IMPORTANT: Please compete and mail within 7 working days after examination to the address listed on the front 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	ICD-9 **(cannot process without)**

6. If pregnancy, advise EDC _____ . If disability is pregnancy with complications, please advise complications above.

7. Was claimant's disability caused by his 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:	Month	Day	Year
Date of your first treatment of this disability			
(See 4 above) First date claimant unable to perform the duties of employment			
Date of your most recent treatment of this disability			
Date claimant will be able to perform usual work (estimate) (undetermined or unknown unsatisfactory) (See 4 above)			

10. Are you referring claimant to another physician or was claimant referred to you. ❑ Yes ❑ No
If yes, give name:

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

Doctor's Name (Please print)		Office address (include street, city, state and zip)		
Doctor's signature	**Provider's Tax ID No.**	**Telephone No. ( )**	**Fax No. ( )**	**Date**

Benefits Underwritten By:

USAble Life

For Assistance Contact:
Benefit Services of Hawaii, Inc.
P.O. Box 840
Honolulu, HI 96804-0840
Telephone (808) 538-8901

INSTRUCTIONS FOR FILING A CLAIM FOR DISABILITY BENEFITS

Form TDI 45-a

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 davs 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 employer complete and sign **Part B, Employer's Statement.**

4. Have your doctor complete and sign **Part C, Doctor's Statement.** Have your doctor mail this form to the insurance carrier listed, unless otherwise directed by your employer in Part A (22) or Part B (13).

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, TW 1-888-569-6859. A request for reasonable accommodations should be made no later than ten working days prior to the needed accommodations.

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.