

For Assistance Contact:  
Benefit Services of Hawaii  
P.O. Box 840  
Honolulu, HI 96808-0840  
Telephone (808) 538-8900  
Fax (808) 538-8930

Benefits Underwritten By:



## 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 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 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.

Complete & Return to:  
Benefit Services of Hawaii  
P. O. Box 840  
Honolulu, HI 96808-0840  
Telephone (808) 538-8900  
Fax (808) 538-8930

**CLAIM FOR DISABILITY BENEFITS**

Benefit Underwritten by:



Form TDI-45

**PART A – CLAIMANT’S STATEMENT**  
*(Please type or print)*

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. <input type="checkbox"/> Male <input type="checkbox"/> Female	7. <input type="checkbox"/> Single <input type="checkbox"/> Married

**DISABILITY INFORMATION**

8. My disability was caused by: <input type="checkbox"/> sickness <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
11. I <input type="checkbox"/> have not <input type="checkbox"/> have recovered from my disability. Date recovered _____	12. I <input type="checkbox"/> have not <input type="checkbox"/> 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 _____ To _____ (month) (day) (year) (month) (day) (year)					
	15. I worked: _____ hours per week and I earned: _____ per week					
16. Occupation:	17. I am a union member <input type="checkbox"/> Yes <input type="checkbox"/> 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			Weekly		
	From: (mo./day/year)		To: (mo./day/year)		Hours	Wages
	a.					
	b.					
	c.					
d.						

19. Does your employer have a printed TDI notice posted and maintained conspicuously in your employment area?  Yes  No  
Did your employer inform 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.)	
<input type="checkbox"/> Federal Disability Insurance Benefits	<input type="checkbox"/> Unemployment Insurance Benefits
<input type="checkbox"/> Workers' Compensation Benefits	<input type="checkbox"/> Damages for Personal Injury
<input type="checkbox"/> Employer's Sick Leave Plan	<input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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	Social Security No.	2. Claimant's occupation	3. Employer Department of Labor No.
--------------------	---------------------	--------------------------	-------------------------------------

4. TDI Policy Number	5. Employer	6. Business address
----------------------	-------------	---------------------

<p>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.</p> <p>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:</p> <p align="center">Week \$ _____ Month \$ _____</p> <p>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.)</p>	<p>8. Worked: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time</p> <p>Date hired: _____</p> <p align="center">(month) (day) (year)</p> <p>Date last worked prior to disability: _____</p> <p align="center">(month) (day) (year)</p> <p>If returned to work, give date: _____</p> <p align="center">(month) (day) (year)</p>
<p>9. Check days normally worked  <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat          If on rotation, give number of days worked per week: _____</p>	

Week No.	Week Ending			No. Days Worked	Gross Amount	Calendar Quarter Ending	No. of Weeks Worked	No. of Hrs Worked per Wk.	Total Wages Earned
	Month	Day	Year						
1									
2									
3									
4									
5									
6									
7									
8									
Total	xxxx	xxxx	xxxx						

<p>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:</p> <p>This covers the period:</p> <p>From: _____ through _____          (month/day/year) (month/day/year)</p> <p>Earnings: \$ _____</p>	<p>11. Do you think this disability was caused by the claimant's job?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Was an Employer's Report of Industrial Injury WC-1 filed?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, advise name and address of Workers' Compensation carrier:</p> <p>Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>_____</p>
---	---

<p>13. Mail the doctor's statement to:</p>	<p>12. Has or will this employee receive all or any portion of the period of disability covered by this claim . . . . . Wages? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>. . . . . Salary? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>. . . . . Sick leave pay? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>. . . . . Vacation pay? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>. . . . . Separation pay? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, show period:</p> <p>From: _____ (mo/day/yr)</p> <p>Through _____ (mo/day/yr)</p> <p>Amount: \$ _____</p>
--	---

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

Signature of employer or employer's representative	Print Name	Title	Date
Employer tax ID no. (Needed for FICA Reporting)	Telephone No.	Fax No.	

**PART C – DOCTOR’S STATEMENT**  
*(Please type or print)*

**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	Last 4 digits of Social Security No.	2. Age	3. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
4. Physical requirements of claimant's occupation as related by claimant:				
5. Diagnosis: (must be completed)				
6. ICD-9 (cannot process without)				
7. If pregnancy, advise expected date of birth _____. If disability is pregnancy with complications, advise complications above.				
8. Was claimant's disability caused by claimant's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was Physician's Report WC-2 filed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, filed with _____				
9. Was claimant hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, from _____ to _____ Surgery indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____				
10. Complete the following:			Month	Day
Date of your first treatment of this disability				
First date claimant unable to perform the duties of employment (see #4 above)				
Date of your most recent treatment of this disability				
Date claimant will be able to perform usual work (estimate) (DO NOT use "undetermined" or "unknown") (See #4 above)				
11. Are you referring claimant to another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give name: _____ OR Was claimant referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> 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)		Degree		
Office Address				
Doctor's signature	Date	Telephone No. (     )	Fax No. (     )	



P.O. Box 1650 · Little Rock, Arkansas 72203-1650

## FRAUD NOTICE

For your protection, the laws of some states may require us to furnish you with the following notice:

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or a statement of claim with materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act. Please see below for special notice required by state law.

**AZ:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of loss is subject to criminal and civil penalties.

**AR, LA, MD, RI, and WV:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**CA:** For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**CO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with respect to a settlement or award from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies to the extent required by applicable law.

**DE:** Any person knowingly and with the intent to injure, defraud or deactivate any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**DC: WARNING:** it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and /or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**FL:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**HI:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**ID:** Any person knowingly and with the intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

**IN:** A person knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

**KY:** Any person who knowingly and with the intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**ME:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**MN:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**NH:** A person who with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**NJ:** Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties.

**NM:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**OH:** A person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

**OK: WARNING:** any person who knowingly and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**OR:** A person who knowingly and with the intent to defraud an insurance company, files a claim containing false, incomplete or misleading information material to such claim, may be guilty of insurance fraud.

**PA:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**TN, VA and WA:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**TX:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature