

**CLAIM FOR DISABILITY BENEFITS**
**INSTRUCTIONS FOR FILING A CLAIM FOR DISABILITY BENEFITS**

- Step 1 Obtain a claim form (TDI-45) from your employer
- Step 2 Answer all questions in **Part A, Claimant's Statement**. Please type or print. Make sure to sign your name, or if you are unable to, have a responsible person sign for you. To avoid unnecessary delays, 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.
- Step 3 Have your employer complete and sign **Part B, Employer's Statement**.
- Step 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 (23) or Part B (13).

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.

**PART A - CLAIMANT'S STATEMENT**

1. Legal Name (First, Middle, Last)	2. Social Security Number	3. Birthdate	
4. Mailing Address (Street, City, State, Zip Code)	5. Contact Number Home: _____ Cell: _____	6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
8. Emergency Contact	9. Relationship	10. Phone Number <input type="checkbox"/> Home <input type="checkbox"/> Cell _____	

**DISABILITY INFORMATION**

11. My disability was caused by: <input type="checkbox"/> Sickness <input type="checkbox"/> Pregnancy <input type="checkbox"/> Accident If accident, give date, location and circumstances:	
12. The first day I was unable to perform the duties of my job:  _____ (month/day/year)	13. <input type="checkbox"/> I have not recovered from my disability <input type="checkbox"/> I have recovered from my disability. Date recovered _____
Was this disability caused by your job? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	14. <input type="checkbox"/> I have not returned to work. <input type="checkbox"/> I have returned to work. Date returned _____

**EMPLOYMENT INFORMATION**

15. Present Employer	16. Present Employer's Mailing Address (Street, City, State, Zip Code)							
17. Occupation	18. I am a union member <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of union _____							
19. Employers I worked for during the past 52 weeks in Hawaii Employer name and address	Period of Employment						Weekly	
	From Month	Day	Year	To Month	Day	Year	Hours	Wages
a.								
b.								
c.								
d.								
20. Does your employer have a printed TDI notice posted and maintained conspicuously in your employment area? Did your employer inform you of your entitlement to TDI benefits? Did your employer provide you this claim form when you first requested it for this disability?							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**OTHER BENEFITS**

21. 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"/> Workers' Compensation Benefits <input type="checkbox"/> Employer's Sick Leave Plan <input type="checkbox"/> Unemployment Insurance Benefits <input type="checkbox"/> Damage for Personal Injury <input type="checkbox"/> Other (Health and Welfare Fund; Union Plan, etc.)
22. During the 52 weeks (year) prior to the start of my disability, I have received TDI benefits for another period of disability: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, from whom _____ from _____ to _____
23. 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	Email Address	Date
Representative's signature, if claimant is unable to sign	Representative's Name (Print)	Relationship

**PART B - EMPLOYER'S STATEMENT**

\_\_\_\_\_ % PREMIUM PAID BY EMPLOYER

**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 Dept. of Labor No.																				
4. TDI Group & Account 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 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)				8. Worked: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time Date hired: _____ (Month) (Day) (Year)  Date last worked prior to disability: _____ (Month) (Day) (Year)  If returned to work, give date: _____																				
9. Check days normally worked: <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> 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:																				
Week No.	Week Ending			No. Days Worked	Gross Amount	Calendar Quarter Ending	No. of Weeks Worked	No. of Hours Worked Per Wk.	Total Wages Earned															
	Month	Day	Year																					
1																								
2																								
3																								
4																								
5																								
6																								
7																								
8																								
Total	XXXX	XXXX	XXXX																					
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: \$ _____				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  Was an Employer's Report of Industrial Injury WC-1 filed? <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, advise name and address of Worker's Compensation carrier: _____ _____ _____																				
12. Has or will this employee receive all or any portion of the period of disability covered by this claim:  <table style="width:100%; border:none;"> <tr> <td style="width:30%;">Wage</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Salary</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Sick leave pay</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Vacation pay</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Separation pay</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> </table> If yes, show period: From: _____ through _____ Amount \$ _____ (month/day/year) (month/day/year)										Wage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Salary	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sick leave pay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vacation pay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Separation pay	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wage	<input type="checkbox"/> Yes	<input type="checkbox"/> No																						
Salary	<input type="checkbox"/> Yes	<input type="checkbox"/> No																						
Sick leave pay	<input type="checkbox"/> Yes	<input type="checkbox"/> No																						
Vacation pay	<input type="checkbox"/> Yes	<input type="checkbox"/> No																						
Separation pay	<input type="checkbox"/> Yes	<input type="checkbox"/> No																						
13. Mail the doctor's statement to:																								

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

Print name of employer or employer's representative		Signature of employer or employer's representative		Date	
Title		Email Address		Tel No.	
				Fax No.	



# PACIFIC GUARDIAN LIFE

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## 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 (23) or Part B (13)

1. Claimant's Name (First, Middle, Last)	2. Age	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
4. Physical requirements of claimant's occupation as related by claimant		
5. Diagnosis		
6. If pregnancy, advise expected date of birth _____ <input type="checkbox"/> Normal Delivery <input type="checkbox"/> C-Section If disability is pregnancy with complications, advise complications: _____		
7. Was claimant's disability caused by claimant's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Was a Physician's Report WC-1 filed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, filed with _____		
8. Was claimant hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No From: _____ through _____ (month/day/year) (month/day/year) Surgery Indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Scheduled date of surgery _____ (month/day/year)		
9. 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")		
10. Are you referring the claimant to another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give name _____ <b>or</b> 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/Specialty	Office Address	Email Address
Doctor's Signature	Date	Telephone No.	Fax No.