RESET FORM

PACIFIC GUARDIAN LIFE

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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 ☐ Male ☐ Female	7. Marital Status ☐ Single ☐ Married
8. Emergency Contact	9. Relationship	10. Phone Number ☐ Home ☐ Cell _____	

DISABILITY INFORMATION

11. My disability was caused by: ☐ Sickness ☐ Pregnancy ☐ 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)
Was this disability caused by your job? ☐ Yes ☐ No ☐ Unknown

13. ☐ I **have not recovered** from my disability
☐ I **have recovered** from my disability. Date recovered _____

14. ☐ I **have not returned** to work.
☐ 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 ☐ Yes ☐ 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 From Month	Day	Year	To Month	Day	Year	Weekly Hours	Wages
a.								
b.								
c.								
d.								

20. 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

21. 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
☐ Damage for Personal Injury
☐ Employer's Sick Leave Plan
☐ 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: ☐ Yes ☐ 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)

Week No.	Week Ending			No. Days Worked	Gross Amount
	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: $ _____

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: _____

9. Check days normally worked:

❑ Sun ❑ Mon ❑ Tues ❑ Wed ❑ Thurs ❑ 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	No. 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 Worker's Compensation carrier:

_____

_____

_____

_____

12. Has or will this employee receive all or any portion of the period of disability covered by this claim:

Wage	❑ Yes	❑ No
Salary	❑ Yes	❑ No
Sick leave pay	❑ Yes	❑ No
Vacation pay	❑ Yes	❑ No
Separation pay	❑ Yes	❑ No

If yes, show period: From: _____ through _____ Amount $ _____
(month/day/year) (month/day/year)

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.

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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 ❑ Male ❑ Female
4. Physical requirements of claimant's occupation as related by claimant		
5. Diagnosis		

6. If pregnancy, advise expected date of birth _____ ❑ Normal Delivery ❑ C-Section

If disability is pregnancy with complications, advise complications:

_____

7. Was claimant's disability caused by claimant's employment? ❑ Yes ❑ No ❑ Unknown

Was a Physician's Report WC-1 filed? ❑ Yes ❑ No If yes, filed with _____

8. Was claimant hospitalized? ❑ Yes ❑ No From: _____ (month/day/year) through _____ (month/day/year)

Surgery Indicated? ❑ Yes ❑ No Type _____ Scheduled date of surgery _____ (month/day/year)

9. Complete the following:	Month	Day	Year
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? ❑ Yes ❑ No If yes, give name _____

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)	Degree/Specialty	Office Address	Email Address

Doctor's Signature	Date	Telephone No.	Fax No.