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