Benefits Underwritten By:

USAble Life

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

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.

Complete & Return to:
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CLAIM FOR DISABILITY BENEFITS

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

Benefit Underwritten by:
USAble Life

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/day/year)			To: (mo./day/year)			Weekly Hours	Weekly 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.)

☐ 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	Social Security No.	2. Claimant's occupation	3. Employer Department of Labor No.

4. TDI Policy Number	5. Employer	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 the 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 Month	Day	Year	No. Days Worked	Gross Amount
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:
_____
(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	No. of Weeks Worked	No. of Hrs 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:

Name: _____
Address: _____
_____
_____

13. Mail the doctor's statement to:

12. Has or will this employee receive all or any portion of the period of disability covered
by this claim . . . . . .Wages? ☐ Yes ☐ No
. . . . . .Salary? ☐ Yes ☐ No
. . . . . .Sick leave pay? ☐ Yes ☐ No
. . . . . Vacation pay? ☐ Yes ☐ No
. . . . . Separation pay? ☐ Yes ☐ No

If yes, show period:
From: _____ (mo/day/yr)
Through _____ (mo/day/yr)
Amount: $_____

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 ☐ Male ☐ 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? ☐ Yes ☐ No

If yes, was Physician's Report WC-2 filed? ☐ Yes ☐ No

If yes, filed with _____

9. Was claimant hospitalized? ☐ Yes ☐ No If yes, from _____ to _____

Surgery indicated? ☐ Yes ☐ No Type _____

10. 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") (See #4 above)			

11. Are you referring 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

Office Address

Doctor's signature	Date	Telephone No.	Fax No.
		( )	( )

⚠ USABLE® LIFE | **FRAUD NOTICE**

FOR YOUR PROTECTION, THE LAWS OF SOME STATES MAY REQUIRE US TO FURNISH YOU WITH THE FOLLOWING NOTICE:
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. Please see below for special notices required by state law.

AL Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AK Residents Only: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA Residents Only: 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 Residents Only: 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 regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DE, ID, IN, OK Residents Only: Any person who knowingly, and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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

KS Residents Only: 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 may be guilty of a crime and subject to fines and confinement in prison as determined by a court of law.

KY Residents Only: Any person who knowingly and with 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 and TN Residents Only: 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 and denial of insurance benefits.

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

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

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

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

OH Residents Only: Any 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 a false or deceptive statement is guilty of insurance fraud.

OR Residents Only: 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 may be guilty of a crime and subject to fines and confinement in prison.

PA Residents Only: 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.

VT Resident Only: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

VA and WA Residents Only: 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.

▼ SIGN AND DATE BELOW

I have read and understand the Fraud Warning that applies to my state of residence.

LAST NAME, FIRST NAME, MI *(PRINTED)*	SIGNATURE	TODAY'S DATE