Underwritten by:

USAble Life

UPDATE FORM TEMPORARY DISABILITY INCOME

IMPORTANT READ CAREFULLY

1. You and your physician must complete and sign the appropriate sections of this form.
2. Return to us by: ________________________ to avoid interruption of your disability income benefits.

Return Form To:
Benefit Services of Hawaii
P.O. Box 840
Honolulu, HI 96808-0840
Telephone: (808) 538-8900
Email: TDICustomerService@usablelife.com
Fax: (808) 538-8930

CLAIMANT INFORMATION

Please PRINT and complete all information. Incomplete answers may cause delay.

Claimant's Name (First, middle, last)	Date of Birth	Claim Number

Claimant's Mailing Address (Street, City or Town, State, Zip Code)	Home or Other Telephone Number

Employer's Name

Authorization to Obtain Information

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of me or my health, past or present, to furnish such information to USAble Life (the “Company”), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original.

FRAUD WARNING: Except as noted in separate Fraud 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.

Date: ______________________ **Signature of Insured:** ____

ATTENDING PHYSICIAN'S STATEMENT

Please answer ALL questions.

Diagnosis & Concurrent Conditions:	ICD Code (must have to process claim):	If pregnancy, advise delivery date: ______________ Method: ☐ Vaginal ☐ C-Section

Disabled means total inability of an employee to perform the duties of the employee’s employment caused by sickness, pregnancy, termination of pregnancy, or accident other than a work injury.

1. Is the patient totally and temporarily disabled? ☐ Yes ☐ No

If yes, how long was or will patient be unable to work? From_____________ Through______________ Date patient can return to work ______________ (Please complete restrictions and limitations below).

2. Could the patient return to work on an earlier date with work restrictions? ☐ Yes ☐ No

Date on which patient could return to work with restrictions ________________________ (Please complete restrictions and limitations below).

Dates of Treatment:

Date of first visit__________ Date of last visit__________ Frequency of visits__________ Date of next appointment ________________

Nature of Treatment (Include surgery, medications, etc.):

Current Restrictions and Limitations, and Expected Duration:

Describe any circumstances causing disability to be prolonged:

Physician's Signature		Date
Physician's Name		Degree
Address		Telephone
City	State	ZIP

CL-TDI-UP (3-16)