

Department's Mailing Address:

HRD(TDI)-1
Rev. 2/00

Department:	_____
Attn:	_____
Address:	_____

CLAIM FOR TEMPORARY DISABILITY BENEFITS

INSTRUCTIONS: To avoid unnecessary delay, present your claim form to your department under Step 3, below, 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, a departmental representative will notify you if you are eligible for benefits. Follow the 3 steps below:

- Step 1. 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.
- Step 2. Have your doctor complete and sign Part B, Doctor's Statement.
- Step 3. Have your doctor mail this form to your department (see top portion of this page for your department's mailing address).

PART A – CLAIMANT'S STATEMENT

1. My name is: (First, middle, last) Type or print	2. Social Security Number
3. Address (Street, City or Town, State, Zip Code)	4. Telephone Number

DISABILITY INFORMATION

5. My disability was caused by: <input type="checkbox"/> sickness, <input type="checkbox"/> accident. Describe (if accident, give date, place and circumstances): _____	
6. The first day I was unable to perform the duties of my job: _____ (month) (day) (year)	7. Was this disability caused by your job? <input type="checkbox"/> Yes, <input type="checkbox"/> No, <input type="checkbox"/> Unknown
8. I <input type="checkbox"/> have not <input type="checkbox"/> have recovered from my disability. Date recovered: _____	9. I <input type="checkbox"/> have not <input type="checkbox"/> have returned to work. Date returned to work: _____

EMPLOYMENT INFORMATION

10. Department: Division:	11. Work Address: _____ (Street) (City) (State) (Zip)						
12. Prior to my disability, I worked for this employer From _____ to _____ (Mo.) (Day) (Yr.) (Mo.) (Day) (Yr.)	13. I worked: _____ Hrs. per week	14. I earned: \$ _____ per week					
15. Occupation:	16. Bargaining Unit: <input type="checkbox"/> BU _____ or <input type="checkbox"/> Excluded						
17. Other Hawaii employers I worked for during the past 52 weeks. Employer Name and Address	Period of Employment			Weekly			
	From			To		Hours	Wages
	Mo.	Day	Yr.	Mo.	Day		
	a.						
	b.						
c.							
d.							

PART A – CLAIMANT’S STATEMENT (CONTINUED)

OTHER BENEFITS

18. In addition to TDI benefits, I am receiving or claiming benefits from the following:		
<input type="checkbox"/> Fed. Disability Ins. Benefits	<input type="checkbox"/> Unemployment Ins. Benefits	<input type="checkbox"/> Damages for Personal Injury
<input type="checkbox"/> Workers’ Comp. Benefits	<input type="checkbox"/> State Sick Leave Plan	<input type="checkbox"/> Accidental Inj. Lv. (Act 64)
<input type="checkbox"/> Other (Health & Welfare Fund, Union Plan, etc.)		
19. During the current calendar year, I have received TDI benefits for other periods of disability.		
<input type="checkbox"/> Yes, <input type="checkbox"/> No If yes, from whom _____ From _____ to _____		

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 – DOCTOR’S STATEMENT

IMPORTANT: Please complete and mail within 7 working days after examination to the employee’s department (see top portion of first page for department’s mailing address).

1. Claimant’s Name: _____	2. Physical requirements of claimant’s occupation as related by claimant: _____		
3. Diagnosis: _____			
4. If pregnancy advise EDC _____. If disability is pregnancy with complications, advise in item #3 above.			
5. Was claimant’s disability caused by his/her employment: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was Physician’s Report WC-2 filed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, filed with _____			
6. Was claimant hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, from _____ to _____ Surgery indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____			
7. Complete the following:	Mo.	Day	Yr.
a. Date of your first treatment of this disability			
b. First date claimant unable to perform the duties of employment (see 2 above)			
c. Date of your most recent treatment of this disability			
d. Estimated date claimant will be able to perform usual work (see 2 above)			
8. Are you referring claimant to another physician <input type="checkbox"/> or was claimant referred to you <input type="checkbox"/> ? Give name of physician: _____			
I hereby certify that the above information is true and complete to the best of my knowledge.			
Print Dr.’s name: _____ Office Add.: _____			
Doctor’s signature: _____ Tel. No. _____ Date: _____			

