

DENIAL OF CLAIM FOR DISABILITY BENEFITS

(This form is prescribed for use by employers and insurance carriers for the denial of a claim for disability benefits. This notice is to be mailed to the claimant in triplicate to give the claimant the opportunity of filing an appeal with the Department of Labor and Industrial Relations.)

Claimant's Name and Address		Employer's Name and Address	
Social Security Number		Department of Labor Account Number	
First Date of Disability Claimed		Insurance Carrier's Name and Address	
Date Claim Filed	Date Notice Sent	Telephone No.	
Claim or File No.	To Dept.: _____ To Claimant: _____		

You are hereby notified that your claim for Disability Benefits is denied under the provisions of the Hawaii Temporary Disability Insurance Law for reason(s) checked below. (Check each item on which claim is being denied.)

- 1. You do not meet the eligibility requirements. You must work at least 20 hours each week for 14 weeks during the 52 weeks immediately preceding the first day of disability; and have earnings of at least \$400. Employment must have been with covered Hawaii employers.
- 2. You were not in current employment; i.e., you did not perform regular service in covered Hawaii employment immediately or not longer than two weeks prior to the onset of the sickness or accident causing disability, or prior to becoming totally disabled because of pregnancy.
- 3. You were not disabled beyond the 7 consecutive-day waiting period. (Statutory benefits commence on the 8th day of disability.)
- 4. You have received 26 weeks of benefits, the maximum payable during a benefit year.
- 5. Your claim was filed on _____. A claim must be filed within **90 days after** commencement of disability or as soon thereafter as is reasonably possible. Benefits need not be paid for any period more than 14 days prior to the date the required proof is furnished, unless good cause can be shown for the late filing. No benefits shall be paid unless proof of disability is furnished within 26 weeks after commencement of disability.
- No benefits are payable.
- Payments will commence 14 days prior to date claim was filed.
- 6. You have indicated that you are claiming benefits under the Workers' Compensation Law of this State or any other state.
- 7. Medical records indicate you were able to perform regular work on _____
Payment of benefits is denied after _____
- 8. The medical certification does not establish that you were unable to perform your regular work due to a disability.
- 9. You were not under the care of a physician, dentist, chiropractor, osteopath, naturopath, or equivalent during the period _____ to _____
- No benefits are payable.
- Payments will commence _____
- 10. You are entitled to benefits under your union contract.
- 11. We are not the insurance carrier for the employer listed above.
- Your claim has been forwarded to _____
- Your claim is returned. For correct insurance carrier, call TDI office, 586-9188.
- 12. Other reasons for denial: _____

Authorized Signature	Title
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TO CLAIMANT: If you do not agree with this denial of your claim, you must file an appeal within 20 days from the date of receipt of this notice by you. Use reverse side of this form to file your appeal.

