Form TDI-46
(Rev. 1/2000)

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 To Dept.: ____________ To Claimant: __________		
Claim or File No.		Telephone No.	FAX No.

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: ____
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  ____

Authorized Signature	Title

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.

INSTRUCTIONS TO CLAIMANT

1. Give specific reasons for appealing for each item of denial checked on the face of this form.
2. Attach any medical evidence and/or employment records that will support your appeal.
3. Complete all copies of this form received from your employer or insurance company.
4. Mail two copies promptly to: **Department of Labor and Industrial Relations**
Disability Compensation Division
P.O. Box 3769
Honolulu, Hawaii 96812-3769
5. Retain one copy for your record.
6. File the Claimant's Appeal within 20 days after the date of the receipt of this notice.

Auxiliary aids and services are available upon request. Please call: (808) 586-9188; TTY (808) 586-8847; and for neighbor islands, TTY 1-888-569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

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.

CLAIMANT'S APPEAL

My claim for Disability Benefits has been denied and I hereby appeal such denial, for the following reason(s): (Answer only with respect to items of denial checked on face of this form.)

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Date Notice of Denial of Claim for Disability Benefits received by Claimant: ______________________

Claimant's Signature ______________________________ Date: ______________