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: ☐ sickness, ☐ 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? ☐ Yes, ☐ No, ☐ Unknown
8. I ☐ have not ☐ have recovered from my disability. Date recovered: ______	9. I ☐ have not ☐ 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: ☐ BU ______ or ☐ 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	Yr.		
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:
    - ☐ Fed. Disability Ins. Benefits
    - ☐ Unemployment Ins. Benefits
    - ☐ Damages for Personal Injury
    - ☐ Workers' Comp. Benefits
    - ☐ State Sick Leave Plan
    - ☐ Accidental Inj. Lv. (Act 64)
    - ☐ Other (Health & Welfare Fund, Union Plan, etc.)

19. During the current calendar year, I have received TDI benefits for other periods of disability.
    ☐ Yes, ☐ 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

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

6. Was claimant hospitalized? ☐ Yes ☐ No If yes, from ____________ to ____________
   Surgery indicated? ☐ Yes ☐ 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 ☐ or was claimant referred to you ☐?
   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: ____________

PART C – DEPARTMENT'S STATEMENT

IMPORTANT: Part C must be completed in its entirety.

1. Claimant worked:
   ☐ Full-time; ☐ Part-time

2. Date hired:
   (Mo/Day/Yr) _____ / _____ / _____

3. Date last worked prior to disability:
   (Mo/Day/Yr) ______ / ______ / ______

4. If returned to work, give date:
   (Mo/Day/Yr) _______ / _______ / ________

5. Circle days normally worked: Su M T W Th F Sa
   If on rotation, give number of days worked per week: ____________ days/week.

6. Do you think disability was caused by claimant's job?
   ☐ Yes, ☐ No, ☐ Unknown

7. Was an Employer's Report of Industrial Injury WC-1 filed?
   ☐ Yes, ☐ No

8. Has or will this employee receive wages, salary, sick leave, or vacation pay for all or any part of the period of disability covered by this claim?
   ☐ No, ☐ Yes from __________________ (Month/Day/Year) through ___________________ (Month/Day/Year). Amount: ______________________

9. Enter the following for the past 52 weeks prior to date disability began:

Calendar Quarter Ending	Number of Weeks Worked	No. of Hours Worked per Wk.	Total Wages Earned

10. In reporting wage information below, use gross wages which include wages and all other remuneration such as cash value of meals, lodging, etc. (Answer either A or B.) If claimant was paid:

    A. On a salary basis and received no other form of remuneration, enter monthly salary amount for month disability began: $ ________________.

    B. On an hourly or salary basis and received other forms of remuneration give rate per hour: $ _______________.
    Enter weekly earnings for the past 8 weeks prior to date disability began, including last date worked.

Week No.	Week Ending			No. Days Worked	Gross Amount
	Month	Day	Year		
1					
2					
3					
4					
5					
6					
7					
8					
TOTAL	XXXX	XXXX	XXXX		

Complete for A and B
Weekly Benefit Amount $ ____________
No. of Weeks Eligible ____________

☐ Meets requirements; approved.

☐ Disapproved; Reason: ______________________________

____

____
Signature of Department Head/Designee

____
Title Date