PACIFIC GUARDIAN LIFE INSURANCE CO., LTD.
1440 KAPIOLANI BOULEVARD
HONOLULU, HAWAII 96814
PHONE 942-1282

PLEASE PRINT ON LEGAL SIZE PAPER

RESET

CLAIM FOR DISABILITY BENEFITS

INSTRUCTIONS FOR FILING A CLAIM FOR DISABILITY BENEFITS

Step 1. Obtain a claim form (TDI-45) from your employer.
Step 2. 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. To avoid unnecessary delay, present your claim form to your employer 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, your employer or employer's insurance carrier will notify you if you are eligible for benefits.
Step 3. Have your employer complete and sign **Part B, Employer's Statement**.
Step 4. Have your doctor complete and sign **Part C, Doctor's Statement**. Have your doctor mail this form to the insurance carrier listed, unless otherwise directed by your employer in Part A (22) or Part B (13).
Step 5. If you have any questions or problems with obtaining the claim form, TDI-45, call the Disability Compensation Division at **586-9188**.

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 then 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.

PART A- CLAIMANT'S STATEMENT

1. My name is: (First, Middle, Last) Type or print	2. Social Security Number		3. Birth Date
4. Address (Street, City or Town, State, Zip Code)	5. Telephone No.	6. ☐ Male ☐ Female	7. ☐ Single ☐ Married

DISABILITY INFORMATION

8. My disability was caused by: Describe (if accident, give date, place and circumstances)
☐ Sickness
☐ Accident

9. The first day I was unable to perform the duties of my job:	10. Was this disability caused by your job?
_____ (month) (day) (year)	☐ Yes ☐ No ☐ Unknown
11. ☐ I **have not recovered** from my disability. ☐ I **have recovered** from my disability. Date recovered: _____	12. ☐ I **have not returned** to work. ☐ I **have returned** to work. Date returned: _____

EMPLOYMENT INFORMATION

13. My present employer is: (or last employer, if unemployed) (Name and address-include street, city, state, zip code)	14. Prior to my disability, I worked for this employer: From:_____ To:_____
	15. I worked: _____ hours per week **and** I earned: $_____ per week
16. Occupation:	17. I am a union member ☐ Yes **Name of union**:_____ ☐ No

18. Other Hawaii employers I worked for during the past 52 weeks:	Period of Employment						Weekly	
	From			To				
Employer name and address	Month	Day	Year	Month	Day	Year	Hours	Wages
a.								
b.								
c.								
d.								

	Yes	No
19. Does your employer have a printed TDI notice posted and maintained conspicuously in your employment area?	☐	☐
Did your employer inform you of your entitlement to TDI benefits?	☐	☐
Did your employer provide you this claim form when you first requested it for this disability?	☐	☐

OTHER BENEFITS

20. In addition to TDI benefits, I am receiving or claiming benefits from the following: (Check those that apply.)
_____ Federal Disability Insurance Benefits
_____ Workers' Compensation Benefits
_____ Employer's Sick Leave Plan
_____ Unemployment Insurance Benefits
_____ Damages for Personal Injury
_____ Other (Health and Welfare Fund; Union Plan, etc.)

21. During the 52 weeks (year) before my disability began, I have received TDI benefits for other period of disability:
_____ Yes _____ No
If yes, from whom _____ From_____ to_____

22. Mail the doctor's statement to the insurance carrier unless otherwise indicated here:
MAIL STATEMENT TO PAMCAH-UA LOCAL 675 HEALTH & WELFARE FUND.

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 is unable to sign	Print representative's name	Relationship

Form TDI-45 (Rev. 1/2002)

_____ % PREMIUM PAID BY EMPLOYER

PART B-EMPLOYER'S STATEMENT

IMPORTANT: *To enable your disabled employee to receive TDI benefits within 10 days as required by law, it is imperative that you complete the following information for prompt submittal to your insurance carrier.*

1. Claimant's Name	2. Claimant's Occupation	3. Employer Department of Labor No.

4. TDI Policy Number	5. Firm or Trade Name	6. Business Address
GL 194 000		

7. In reporting wage information below, use gross wages, which include wages and all other remuneration such as commissions, bonuses, tips and cash value of meals, lodging, etc. Answer either A, B, or C.

A. If claimant was paid on a salary basis, enter claimant's weekly or monthly salary earned in the last week or month prior to the date claimant's disability began:
Week $_____ Month $_____

B. If paid on an hourly basis, give rate per hour $_____. Enter the weekly earnings for the past 8 weeks prior to the date disability began, including the last date worked. (Include reported tips.)

8. Worked: _____ Full-time _____ Part-time

Date hired: _____
(month) (day) (year)

Date last worked prior to disability:
_____
(month) (day) (year)

If returned to work, give date:
_____
(month) (day) (year)

9. Check days normally worked
☐ Sun ☑ Mon ☑ Tue ☑ Wed ☑ Thu ☑ Fri ☐ Sat

If on rotation, give number of days worked per week:_____

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

10. Enter the following for the last 52 weeks prior to the date the employee's disability began:

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

11. Do you think this disability was caused by the claimant's job?
_____ Yes _____ No _____ Unknown

Was an Employer's Report of Industrial Injury WC-1 filed?
_____ Yes _____ No
If yes, advise name and address of Worker's Compensation carrier:

C. If claimant received any or all earnings on a commission or piecework basis, enter these earnings for the last 52 weeks prior to the date claimant's disability began:

This covers the period:
From:_____ through_____
(month/day/year) (month/day/year)
Earnings: $_____

13. Mail the doctor's statement to:

PAMCAH-UA LOCAL 675 HEALTH & WELFARE FUND
1109 BETHEL STREET, SUITE 403
HONOLULU, HI 96813

12. Has or will this employee receive all or any portion of the period of disability covered by this claim

	Yes	No
……Wage?		✔
……Salary?		✔
……Sick leave pay?		✔
……Vacation pay?		✔
……Separation pay?		✔

If yes, show period:
From: _____(mo/day/yr)
Through: _____ (mo/day/yr)

Amount
$_____

I hereby certify that the above information is true and complete to the best of my knowledge.

Signature of employer or employer's representative	Title	Date	Tel No. (808) 536-4408
	ADMINISTRATOR		Fax No. (808) 524-0658

PART C- DOCTOR'S STATEMENT

IMPORTANT: Please complete and mail within 7 working days after examination to the insurance carrier listed above unless otherwise directed in Part A (22) or Part B (13).

1. Claimant's Name	2. Age	3. Sex

4. Physical requirements of claimant's occupation as related by claimant:

5. Diagnosis:

6. If pregnancy, advise expected date of birth_____. If disability is pregnancy with complications, advise complications above.

7. Was claimant's disability caused by claimant's employment? _____ Yes _____ No
If yes, was Physician's Report WC-2 filed? _____Yes _____No If yes, filed with _____

8. Was claimant hospitalized? _____ Yes _____ No
Surgery indicated? _____ Yes _____No Type _____

9. Complete the following:	Month	Day	Year
Date of your first treatment of this disability			
First date claimant unable to perform the duties of employment (see #4 above)			
Date of your most recent treatment of this disability			
Date claimant will be able to perform usual work (estimate) (DO NOT use "undetermined" or "unknown") (See #4 above)			

10. Are you referring claimant to another physician? _____Yes _____No If yes, give name: _____
OR
Was claimant referred to you? _____Yes _____No If yes, give name: _____

I hereby certify that the above information is true and complete to the best of my knowledge.

Doctor's name (Please print)	Office Address		
Doctor's signature	Date	Telephone No.	Fax No.