Form TDI –45(a)
(Ver. 1/2000)
(Rev. 7/2021)

INSTRUCTIONS FOR FILING A CLAIM FOR DISABILITY BENEFITS

1. Obtain a claim form (TDI-45) from your employer.

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.

3. Have your doctor complete and sign **Part C, Doctor's Statement**.

4. Have your employer complete and sign **Part B, Employer'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).

5. If you have any questions or problems with obtaining the claim form, TDI-45, call the Disability Compensation Division at **(808) 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 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.

Form TDI-45

(Ver. 1/2000)
(Rev. 7/2021)

Symetra Life Insurance Company
c/o John Mullen and Company
P.O. Box 2096 Honolulu, HI 96805
Ph. (808) 531-9733 Fax. (808) 531-0053 Email: claims@johnmullen.com

CLAIM FOR HAWAII DISABILITY BENEFITS

PART A - CLAIMANT'S STATEMENT

1. My name is: (First, middle, last) Type or print	2. Social Security No.	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
   _____ Pregnancy

9. The first day I was unable to perform the duties of my job: _____ (month) (day) (year)	10. Was this disability caused by your job? _____ 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: _____

EMPLOYER 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: Employer name and address	Period of Employment						Weekly	
	From Mo.	Day	Yr.	To Mo.	Day	Yr.	Hours	Wages
a.								
b.								
c.								

	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 _____ Unemployment Insurance Benefits
    _____ Workers' Compensation Benefits _____ Damages for Personal Injury
    _____ Employer's Sick Leave Plan _____ 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 periods of disability:
    _____ Yes _____ No
    If yes, from when _____ From _____ To _____
22. Mail the doctor's statement to the insurance carrier unless otherwise indicated here:

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

Percentage of premium paid by employer _____ employee _____

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

7. In reporting wage information below, use gross wages, which include wages and all other remuneration, such as commissions, bonuses, tips and the 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.)

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

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: $_____

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 ___ Thur ___ Fri ___ Sat

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

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

Calendar Qtr Ending	No. of Wks Worked	No. of Hrs Worked/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 Workers' Compensation carrier: _____
_____
_____
_____

13. Mail the doctor's statement to:

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c/o John Mullen and Company
P.O. Box 2096
Honolulu, HI 96805
Ph. (808) 531-9733
Fax. (808) 531-0053
Email: claims@johnmullen.com

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

	Yes	No
.....Wages?		
.....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.* / *Fax No.*

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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. ICD Code or 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 If yes, from _____ to _____ 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.