Form TDI-45
(Rev.1/2000)

Human Resource Services
BYU-Hawaii
55-220 Kulanui St. #1969
Laie, HI 96762

CLAIM FOR DISABILITY BENEFITS

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: _____ (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: _____

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: Employer name and address	Period of Employment						Weekly	
	From Mo.	Day	Yr.	To Mo.	Day	Yr.	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	_____ 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 whom _____ 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

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. 990-000-0356
4. TDI Policy Number	5. Firm or trade name BYU- Hawaii	6. Business address 55-220 Kulanui St. Laie, HI 96762

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.	Week 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 ___ Thu ___ 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 Quarter Ending	No. of Weeks 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:

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.

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 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.