Issued by
The Union Labor Life Insurance Company
Washington, DC 20001

Mail Completed Form To
National Elevator Health Benefit Plan
PO Box 476
Newtown Square, PA 19073-0476

Fax (610) 325-9029

Policy # C 4347

STATE OF HAWAII
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:	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	
Employer name and address	From Month	From Day	From Year	To Month	To Day	To Year	Hours	Wages

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

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 periods of disability.
❒ Yes ❒ No
If yes, from whom _____ From _____ To _____

22. Mail the doctor's statement to other 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.

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 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/Week	Total Wages Earned

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)

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 ....Wages?

	Yes	No
.....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 _____. I 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: _____
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.