HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
1003 Bishop Street
Suite 1720
Honolulu, Hawaii 96813

INSTRUCTIONS FOR FILING A CLAIM FOR DISABILITY BENEFITS

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

II. 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.

III. Have your physician complete and sign **Part C, Physician's Statement.**

IV. Have your employer complete and sign **Part B, Employer's Statement.** Have your employer mail this form to the insurance carrier listed unless otherwise directed by your employer in Part A (22) as your agent for service.

V. 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 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.

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
1003 Bishop Street
Suite 1720
Honolulu, Hawaii 96813
Claim for Disability Benefits

Clear Form

THE HARTFORD

PART A – CLAIMANT'S STATEMENT

1. My name is: (First, middle, last) Type or print		2. Social Security Number
3. Sex ☐ Male ☐ Female	4. Marital Status ☐ Single ☐ Married	5. Address (Street, City or Town, State & Zip Code)
6. TDI Policy Number **70TDI 036510**	7. Telephone Number ( )	8. Birth Date

Disability Information

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

10. The first day I was unable to perform the duties of my job: _____

11. Was this disability caused by your job? ☐ Yes ☐ No ☐ Unknown

12. ☐ I have not recovered from my disability. ☐ I have recovered from my disability. Date recovered: _____

13. ☐ I have not returned to work. ☐ I have returned to work. Date returned: _____

Employment Information

14. Name of my present employer: (or last employer, if unemployed)

15. Employer Telephone Number ( )

Address of my present employer (street, city, state & zip code)

16. Occupation:

17. Prior to my disability, I worked for this employer: From: _____ To: _____

18. I worked: _____ hours per week.

19. I earned: $ _____ per week

20. I am a union member ☐ Yes ☐ No Name of union: _____

21. Other Hawaii employers I worked for during the past 52 weeks:

Employer name and address	Period of Employment From: (mm/dd/yy) To:	Weekly hours	Weekly Wages
a.			
b.			
c.			
d.			

22. Does your employer have a printed TDI notice posted 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 you first requested it for this disability? ☐ Yes ☐ No

Other Benefits

23. 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 & Welfare Fund; Union Plan, etc.)

24. 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 _____

25. 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.

TDI Policy Number	Employer	
70TDI 036510	**Disney Worldwide Services, Inc.**	
1. Claimant's name	2. Business Address	3. Telephone number ( )
4. Firm or trade name **N/A**	5. Claimant's occupation	6. Employer Department of Labor Number **DCS**

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 $_____ Monthly $_____

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 Number	Week Ending Month	Day	Year	Number Days Worked	Gross Amount
1					
2					
3					
4					
5					
6					
7					
8					
Total	XXXXX	XXXXX	XXXXX		

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: _____ (month/day/year) Through _____ (month/day/year) Earnings: $_____

8. Employee Worked: ☐ Full-time ☐ Part-time Date Employee last worked prior to disability: _____
If employee returned to work, give date _____ Date hired: _____

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	Number of Weeks Worked	Number 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

12. Has or will employee receive all or any portion of the period of disability covered by this claim: Wages? ☐ Yes ☐ No
Salary? ☐ Yes ☐ No Sick leave pay? ☐ Yes ☐ No Vacation pay? ☐ Yes ☐ No Separation pay? ☐ Yes ☐ No
If yes, show period: From: _____ (mm/dd/yyyy) Through _____ (mm/dd/yyyy) Amount $_____

13. Mail Physician Statement to:
Hartford Life Insurance Company 1003 Bishop Street, Suite 1720 Honolulu, Hawaii 96813

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	( ) Telephone Number

PART C – PHYSICIAN'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).

TDI Policy Number	Employer
70TDI 036510	**Disney Worldwide Services, Inc.**

1. Claimant's name | 2. Sex ☐ Male ☐ Female | 3. Age

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:
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)	Phone Number ( )
Office Address (Street, City, State & Zip Code)	Fax Number ( )
Specialty	Degree
Signature of Physician	Date