



PART A – CLAIMANT INFORMATION

EPIC TDI Policy Number:

1. First Name:		Middle Name:		Last Name:		Suffix:	
2. Social Security Number (9 digits):		3. Date of Birth: / /		4. Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		5. Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single	
6. Address:				City:		State:	Zip Code:
7. Mobile Phone: () -		<input type="checkbox"/> Check to opt out of receiving text messages about your claim		8. Other Phone: () -		9. Email Address: <input type="checkbox"/> Check to opt out of receiving emails about claim	

Disability Information

10. My disability was caused by: <input type="checkbox"/> Illness <input type="checkbox"/> Accident <input type="checkbox"/> Pregnancy		If accident, please provide details:					
11. The first day I was unable to perform the duties of my job: / /				12. Was this disability caused by your job? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
13. I have recovered from my disability. If yes, date recovered: <input type="checkbox"/> Yes (Specify Date) <input type="checkbox"/> No / /				14. I have returned to work. If yes, date returned to work: <input type="checkbox"/> Yes (Specify Date) <input type="checkbox"/> No / /			

Employment Information

15. My present employer (or last employer, if unemployed):							
16. Employer Address:				City:		State:	Zip Code:
17. Employment dates? (MM/DD/YYYY): From: / / To: / /				18. Hours worked per week?			
19. Full Time or Part Time? <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time			20. Hourly or Salaried? <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried			21. Earnings Per week: \$	
22. Occupation/Job Title:				23. Union member? If yes, name of union: <input type="checkbox"/> Yes <input type="checkbox"/> No			
24. Did you work for any other Hawaii employers during the past 52 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide information for each below:							
Employer Name and Phone Number:		Period of Employment (MM/DD/YYYY):			Weekly Hours:	Weekly Wages:	
A. _____		A. / / To: / /			A.	A. \$	
B. _____		B. / / To: / /			B.	B. \$	
25. Does your employer have a printed TDI notice posted and maintained conspicuously in your employment area? <input type="checkbox"/> Yes <input type="checkbox"/> No							
26. Did your employer inform you of your entitlement to TDI benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No							
27. Did your employer provide you this claim form when you first requested it for this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No							

Other Benefits

28. In addition to TDI benefits, I am receiving or claiming benefits from the following (check all that apply):							
<input type="checkbox"/> Federal Disability Insurance Benefits		<input type="checkbox"/> Workers Compensation Benefits		<input type="checkbox"/> Employer's Sick Leave Plan		<input type="checkbox"/> Unemployment Insurance Benefits	
<input type="checkbox"/> Damages for Personal Injury		<input type="checkbox"/> Other (Health & Welfare Fund, Union Plan, etc.)					
29. During the 52 weeks (one year) prior to this disability, I received TDI benefits for other periods of disability: <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, from which employer? _____ From: / / To: / /							
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.				_____ / /		Date	
				Claimant's Signature		_____ / /	
				Representative's Signature, if Claimant Unable to Sign		_____ / /	
						Date	



PART B – EMPLOYER’S STATEMENT

EPIC TDI Policy Number:

IMPORTANT: To expedite payment of your employee’s TDI benefits, please complete and submit this form to EPIC within 10 days as required by law. **E-mail:** claiminfo@employersprotectiveinsurance.com or **Fax:** (808) 748-0269

1. Claimant’s Name (First, Middle, Last):	2. Claimant’s Occupation / Job Title:		
3. Employer’s Name:	4. Employer Department of Labor #: - -		
5. Employer’s Address:	City:	State:	Zip Code:

6. 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: Salary per Week: \$ _____ Salary per 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 Number	Week Ending Month/Day/Year	Hourly Rate	Number of Hours Worked	Gross Amount
1	/ /	\$		\$
2	/ /	\$		\$
3	/ /	\$		\$
4	/ /	\$		\$
5	/ /	\$		\$
6	/ /	\$		\$
7	/ /	\$		\$
8	/ /	\$		\$
-	-	Totals:		\$

C. If claimant received any or all earnings on a commission or piecework basis, enter these earning for the last 52 weeks prior to the date claimant’s disability began.
This covers the period from: / / Through: / / Earnings: \$ _____

7. Employee worked: Full Time Part Time Date of Hire: / /
Date Employee last worked prior to disability: / / If returned to work, give date: / /

8. Check days normally worked: Sun Mon Tue Wed Thu Fri Sat
If on rotation, give number of days worked per week:

9. 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 Hours Worked per Week	Total Wages Earned
/ /			\$
/ /			\$
/ /			\$
/ /			\$

10. Do you think this disability was caused by the claimant’s job? Yes No Unknown
If yes, was an Employer’s Report of Industrial Injury WC-1 filed? Yes No
If yes, Carrier Name: Phone: () -
Adjuster’s Name: E-mail:

11. Has or will this employee receive any of the following benefits for the period of disability covered by this claim?
 Wage? Salary? Sick leave pay? Vacation pay? Separation pay?

12. Percentage of TDI premium paid by: Employer % Employee %

13. Send Physician’s Statement (Part C) to EPIC by **E-mail:** claiminfo@employersprotectiveinsurance.com or **Fax:** (808) 748-0269

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 Phone: () -
E-mail:



PART C – PHYSICIAN’S STATEMENT

EPIC TDI Policy Number:

IMPORTANT: To expedite payment of your patient’s TDI benefits, Please complete and submit this form to EPIC within 7 days as required by law. **E-mail:** claiminfo@employersprotectiveinsurance.com or **Fax:** (808) 748-0269

1. Patient’s Name:	First Name:	Middle Name:	Last Name:	Suffix:
2. Date of birth: / /	3. Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male			
4. Physical requirements of claimant’s occupation as related by claimant:				
5. Diagnosis:				
6. If pregnancy, expected delivery date: / / Advise of any complications:				
7. Was claimant’s disability caused by claimant’s employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, was Physician’s Report WC-2 filed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Carrier Name and Phone Number: _____ () -				
8. Was claimant hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, dates of hospitalization: From: / / To: / / Is surgery indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type of surgery?				
9. Complete the following (see #5 above) – DO NOT use “undetermined” or “unknown”				
Date of your first treatment of this disability:		/ /		
First date claimant unable to perform the duties of employment:		/ /		
Date of your most recent treatment of this disability:		/ /		
Date claimant will be able to perform usual work (estimate):		/ /		
10. Are you referring claimant to another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, to whom? _____				
11. Was the claimant referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, by whom? _____				

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

Physician’s Name:	First:	Middle:	Last:	Suffix:
Clinic / Practice Name:			Specialty:	
Office Address:		City:	State:	Zip Code:
Telephone Number: () -		Fax Number: () -		Email:
Physician’s Signature:				Date: / /