



CLAIM FOR TEMPORARY DISABILITY INSURANCE

DOE OHR 900-001

Last Revised: 01/01/2011
Former DOE Form#s: TDI-1

DEPARTMENT OF EDUCATION
Office of Human Resources
Temporary Disability Insurance Unit
680 Iwilei Rd, Suite 490, Honolulu, HI 96817

INSTRUCTIONS: To avoid unnecessary delay, present your claim form to your department under Step 3, below, no later than ninety (90) days after you are unable to perform the duties of your job. If you file beyond ninety (90) days, attach a statement explaining why you were unable to file earlier. After you file a claim, a departmental representative will notify you if you are eligible for benefits.

Follow the three (3) steps below:

Step 1: Answer all questions in PART A, Claimant Statement. Make sure you sign your name, or if you are unable to, have a responsible person sign for you.

Step 2: Have your licensed physician complete and sign PART B, Licensed Physician Statement, then return it to you.

Step 3: Submit form to your school/supervisor for the completion of PART C, Department Statement, #1 through #8 ONLY, AND the signature of the department head/principal/vice principal for claim acknowledgement.

PART A - CLAIMANT STATEMENT

I. EMPLOYEE INFORMATION	
1. Name: _____ Last First M.I.	2. SSN: _____
3. Address: _____ City: _____ State: _____ Zip: _____	4. Tel#: _____
II. DISABILITY INFORMATION	
5. My disability was caused by: <input type="checkbox"/> Sickness <input type="checkbox"/> Accident Describe (if accident, give date, place and circumstances): _____	
6. The first day I was unable to perform the duties of my job < _____ MM/DD/YYYY	
7. Was this disability caused by my job? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
8. Have I recovered from my disability? <input type="checkbox"/> Yes Date recovered: _____ <input type="checkbox"/> No MM/DD/YYYY	
9. Have I returned to work? <input type="checkbox"/> Yes Date returned to work: _____ <input type="checkbox"/> No MM/DD/YYYY	
III. EMPLOYMENT INFORMATION	
10. District: _____ School/Office: _____	11. Work Address: _____ City: _____ State: _____ Zip: _____
12. Prior to my disability, I worked for this employer From: _____ To: _____ MM/DD/YYYY MM/DD/YYYY	13. I worked: _____ hours per week
	14. I earned: \$ _____ per week
15. Occupation(s): _____	16. Bargaining Unit: <input type="checkbox"/> BU _____; or <input type="checkbox"/> Excluded

PART B - LICENSED PHYSICIAN STATEMENT**INSTRUCTIONS:** Please complete and return to employee within seven (7) working days after examination.

1. Claimant Name: _____ Last First M.I.	
2. Physical requirements of claimant's occupation as related by claimant: _____	
3. Diagnosis: _____	
4. If pregnancy advise expected due date _____ MM/DD/YYYY If disability is pregnancy with complications, advise in diagnosis (item #3) above.	
5. Was the claimant's disability caused by his/her employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was Licensed Physician's WC-2 filed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, filed with: _____	
6. Was claimant hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, from: _____ to: _____ "MM/DD/YYYY "MM/DD/YYYY Surgery indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____	
7. Complete the following:	
a. Date of your first treatment of this disability	_____ MM/DD/YYYY
b. First date claimant unable to perform duties of employment (see 2 above)	_____ MM/DD/YYYY
c. Date of your most recent treatment of this disability	_____ MM/DD/YYYY
d. Estimated date claimant will be able to perform usual work (see 2 above)	_____ MM/DD/YYYY
8. Check one: <input type="checkbox"/> I am referring claimant to another licensed physician <input type="checkbox"/> Claimant was referred to me Name of licensed physician referring claimant to/referred to me by: _____	
<i>I hereby certify that the above information is true and complete to the best of my knowledge.</i>	
Licensed Physician Signature: _____	Date: _____ MM/DD/YYYY
Print Licensed Physician Name: _____	Tel#: _____
Office Address: _____	City: _____ State: _____ Zip: _____

PART C - DEPARTMENT STATEMENT

INSTRUCTIONS: Department Head, Principal, or Vice Principal - Complete PART C, Items #1 through #8 only AND Sign. **DO NOT COMPLETE #9 AND #10.**

1. Claimant worked: Full-Time Part-Time

2. Date hired: _____ MM/DD/YYYY
3. Date last worked prior to disability: _____ MM/DD/YYYY

4. If returned to work, give date: _____ MM/DD/YYYY

5. Days normally worked: Sun Mon Tue Wed Thu Fri Sat
If on rotation, give number of days worked per week: _____ days/week

6. Do you think this disability was caused by claimant's job? Yes No Unknown

7. Was an Employer's Report of Industrial Injury WC-1 filed? Yes No

8. Has or will this employee received wages, salary, sick leave, or vacation pay for all or any part of the period of disability covered by this claim? No Yes From: _____ To: _____ Amt: \$ _____
MM/DD/YYYY "" MM/DD/YYYY

9. Enter the following for the past fifty-two (52) weeks prior to date disability began:

Calendar Quarter Ending	Number of Weeks Worked	No. of Hours Worked Per Week	Total Wages Earned

10. In reporting wage information below use gross wages which include wages and all other remuneration such as cash value of meals, lodging, etc. (Answer either A or B). If claimant was paid:

A. On a salary basis and received no other form of remuneration, enter monthly salary amount for month disability began: \$ _____
B. On an hourly or salary basis and received other forms of remuneration give rate per hour: \$ _____
Enter weekly earnings for the past eight (8) weeks prior to date disability began, including last date worked.

Week No.	Week Ending			No. Days Worked	Total Wages Earned
	Month	Day	Year		

Complete for A and B

Weekly benefit amount: \$ _____
No. of weeks eligible: _____

DEPARTMENT HEAD/PRINCIPAL/VICE PRINCIPAL CERTIFICATION

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

Department Head, Principal, or Vice Principal Signature: _____ Date: _____
MM/DD/YYYY

Department Head, Principal, or Vice Principal Name: _____ Title: _____

DOE, TDI UNIT ONLY

Approved Disapproved Date: _____
MM/DD/YYYY