WHAT YOU NEED TO KNOW NOW FOR APPLICABLE STATE BENEFITS

Hawaii Employees ONLY

If you work in Hawaii, you may be entitled to a Temporary Disability Insurance (TDI) benefit, insured by Reliance Standard Life Insurance (RSLI). You must apply separately for this benefit by completing the TDI-45 form included in your Intake Packet and return to TRISTAR at the address noted on the form. TRISTAR processes the claims for RSLI.

Instructions for filing a claim for Temporary Disability Insurance:

1) 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, submit your claim form to TRISTAR, 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.

2) Ask your employer to complete and sign **Part B**, **Employer's Statement**.

3) You need your Health Care Provider (HCP) to complete **Part C**, **Doctor's Statement**.

After TRISTAR receives your completed claim, they will notify you if you are eligible for benefits. If your claim is approved, you will receive a check directly from TRISTAR on behalf of RSLI.

If you have any additional questions regarding this coverage, please contact your Matrix Claims Examiner.

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.

INSTRUCTIONS FOR FILING A CLAIM FOR DISABILITY BENEFITS

TRISTAR Claims Management Services of Hawaii is the Third-Party Claims Administrator handling claims on behalf of Reliance Standard Life Insurance. To file a claim for Temporary Disability Insurance (TDI) benefits from an employer insured by Reliance Standard Life Insurance in the State of Hawaii:

1. Complete the attached TDI-45 Claim form.

2. **Part A – Claimant's Statement,** you will need to complete. Make sure you sign your name, or if you are unable to, have a responsible person sign for you. To avoid unnecessary delay, make sure all areas are filled-in, and you have signed and dated the form. Note: A completed claim form should be submitted to us 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 with us, you will be notified if you are eligible for benefits.

3. **Part B - Employer's Statement,** have an authorized employer representative complete (it is usually someone in your company's Human Resources Department and/or Payroll Department). To avoid unnecessary delay, make sure all areas are filled-in and authorized employer representative has signed and dated the form.

4. **Part C – Doctor's Statement,** have your doctor complete. To avoid unnecessary delay, make sure all areas are filled-in and doctor has signed and dated the form.

5. If you have any questions or problems with obtaining the TDI-45 Claim form, call the Disability Compensation Division at (808) 586-9188.

Auxiliary aids and services are available upon request. Please call: (808) 586-9188; TTY (808) 586-8847; and for neighbor island, TTY 1 (888) 568-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

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WHERE TO SUBMIT YOUR CLAIM FORM

After full completion of the TDI-45 Claim form, submit to:

Mail: TRISTAR Claims Management Services
Attn: TDI Claims
P O Box 135030
Honolulu, HI 96801

Or email: TDI.FI@tristargroup.net Or fax: (562) 495-6687.

For phone inquiries regarding your claim, call (808)470-0860 extension 5101.

Send Completed From to:
Reliance Standard Life Insurance
C/O TRISTAR Claims Management Services
P.O. Box 135030
Honolulu, HI 96801
Email: icsfax@tristargroup.net or Fax: (562) 495-6687

Benefits Underwritten By:

PART A – CLAIMANT'S STATEMENT (Type or Print)

CLAIMANT INFORMATION:

1. FIRST NAME:
2. MIDDLE INITIAL:
3. LAST NAME:
4. ADDRESS: (Street)
5. CITY and STATE:
6. ZIP CODE:
7. GENDER: ☐ MALE ☐ FEMALE
8. EMAIL ADDRESS
9. SOCIAL SECURITY NUMBER:
10. DATE OF BIRTH
11. HOME PHONE:
12. CELL PHONE:
13. MARITAL STATUS: ☐ SINGLE ☐ MARRIED

DISABILITY INFORMATION:

14. WAS YOUR DISABILITY CAUSED BY: ☐ SICKNESS ☐ ACCIDENT
15. FIRST DAY OF DISABILITY: (MM/DD/YYYY)
16. WAS THIS DISABILITY CAUSED BY YOUR JOB? ☐ NO ☐ YES ☐ UNKNOWN
17. PLEASE DESCRIBE YOUR DISABILITY: (IF THE DISABILITY WAS CAUSED BY AN ACCIDENT, PLEASE INDICATE THE DATE, PLACE AND CIRCUMSTANCES)
18. HAVE YOU RECOVERED FROM YOUR DISABILITY? ☐ NO ☐ YES – DATE RECOVERED:
19. HAVE YOU RETURNED TO WORK? ☐ NO ☐ YES – DATE RETURNED:

EMPLOYMENT INFORMATION:

20. PRESENT EMPLOYER: (OR LAST IF UNEMPLOYED)
21. EMPLOYER ADDRESS: (Include City, State, zip code)
22. DATES WORKED PRIOR TO DISABILITY: FROM: TO:
23. HOURS WORKED PER WEEK:
24. INCOME EARNED PER WEEK: $
25. OCCUPATION:
26. UNION MEMBER? ☐ NO ☐ YES – UNION NAME:

27. OTHER HAWAII EMPLOYERS YOU HAVE WORKED FOR DURING THE PAST 52 WEEKS: PLEASE PROVIDE THE EMPLOYER'S NAME & ADDRESS:	PERIOD OF EMPLOYMENT (MM/DD/YYYY)		WEEKLY	
	FROM	TO	HOURS	WAGES
1.				$
2.				$
3.				$
4.				$

28. DOES YOUR EMPLOYER HAVE A PRINTED TDI NOTICE POSTED AND MAINTAINED CONSPICUOUSLY IN YOUR EMPLOYMENT AREA? ☐ YES ☐ NO
29. DID YOUR EMPLOYER INFORM YOU OF YOUR ENTITLEMENT TO TDI BENEFITS? ☐ YES ☐ NO
30. DID YOUR EMPLOYER PROVIDE YOU THIS CLAIM FORM WHEN YOU FIRST REQUESTED IT FOR THIS DISABILITY? ☐ YES ☐ NO

OTHER BENEFITS:

31. IN ADDITION TO TDI BENEFITS, ARE YOU 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.)
32. HAVE YOU RECEIVED TDI DISABILITY BENEFITS FOR OTHER PERIODS OF DISABILITY 52 WEEKS (1 YR) PRIOR TO YOUR CURRENT DISABILITY?
☐ NO ☐ YES – FROM WHOM? (PLEASE LIST DISABILITY PERIOD)

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 THE CLAIMANT IS UNABLE TO SIGN:
PRINT REPRESENATIVE'S NAME:
RELATIONSHIP TO CLAIMANT:

PART B – EMPLOYER'S STATEMENT

Percentage of premium paid by Employer: _______%, by Employee: _______% (for the purpose of FICA and Medicare tax withholdings)

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 Employee or Claims Administrator.

1. CLAIMANT NAME:	2. CLAIMANT OCCUPATION:	3. EMPLOYER DEPARTMENT OF LABOR NUMBER:

4. TDI POLICY NUMBER:	5. BUSINESS NAME:	6. BUSINESS ADDRESS (Include City, State, and zip code):

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.

7A. 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: $

7B. 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.)

WK #	WEEK ENDING (MM/DD/YYYY)	# DAYS WORKED PER WEEK ENDING	GROSS AMOUNT PER WEEK ENDING
1			$
2			$
3			$
4			$
5			$
6			$
7			$
8			$
	TOTALS		$

7C. IF THE 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:_____________________

EARNINGS: $

8. JOB POSITION:
☐ FULL-TIME ☐ PART-TIME

9. HIRE DATE:

10. DATE LAST WORKED PRIOR TO DISABILITY:

11. RETURN TO WORK DATE:

12A. DAYS NORMALLY WORKED:
☐ SUN ☐ MON ☐ TUE ☐ WED ☐ THU ☐ FRI ☐ SAT

12B. IF ON ROTATION, INDICATE THE NUMBER OF DAYS NORMALLY WORKED PER WEEK:

13. ENTER THE FOLLOWING FOR THE LAST 52 WEEKS PRIOR TO THE DATE THE EMPLOYEE'S DISABILITY BEGAN:

CALENDAR QUARTER ENDING	# OF WEEKS WORKED PER QUARTER	# OF HOURS WORKED PER WEEK	TOTAL WAGES EARNED PER QUARTER
			$
			$
			$
			$
			$

14. DO YOU THINK THIS DISABILITY WAS CAUSED BY THE CLAIMANT'S JOB?
☐ NO ☐ YES ☐ UNKNOWN

15. WAS AN EMPLOYER'S REPORT OF INDUSTRIAL INJURY WC-1 FILED?
☐ NO ☐ YES – PLEASE INDICATE WC CARRIER NAME AND ADDRESS:

16. HAS OR WILL THIS EMPLOYEE RECEIVE ALL OR ANY PORTION OF THE PERIOD OF DISABILITY COVERED BY THIS CLAIM:

TYPE	YES OR NO	PERIOD (MM/DD/YY)	AMOUNT
WAGES	☐Y ☐N		$
SALARY	☐Y ☐N		$
SICK LEAVE PAY	☐Y ☐N		$
VACATION PAY	☐Y ☐N		$
SEPARATION PAY	☐Y ☐N		$

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

EMPLOYER OR EMPLOYER'S REPRESENTATIVE'S NAME (Print)	TAX ID:	PHONE NUMBER:
EMAIL ADDRESS:		FAX NUMBER:
EMPLOYER OR EMPLOYER'S REPRESENTATIVE'S SIGNATURE:	TITLE:	DATE:

Send Completed From to:
Reliance Standard Life Insurance
C/O TRISTAR Claims Management Services
P.O. Box 135030
Honolulu, HI 96801
Email: icsfax@tristargroup.net or Fax: (562) 495-6687

Benefits Underwritten By:

reliancestandard
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

PART C – DOCTOR'S STATEMENT

IMPORTANT: To enable your patient to receive TDI benefits within 10 days as required by law, it is imperative that you complete the following information for prompt submittal to Employee or Claims Administrator.

1. CLAIMANT NAME:	2. AGE:	3. GENDER: ☐ M ☐ F	4. PHYSICAL REQUIREMENTS OF CLAIMANT'S OCCUPATION AS RELATED BY CLAIMANT:

5. DIAGNOSIS: (IF PREGNANCY, PLEASE INDICATE EXPECTED DATE OF BIRTH. IF DISABILITY IS PREGNANCY WITH COMPLICATIONS, PLEASE INDICATE COMPLICATIONS.)

6. DISABILITY CAUSED BY THE CLAIMANT'S JOB? ☐ NO ☐ YES	7. EMPLOYER'S REPORT OF INDUSTRIAL INJURY WC-2 FILED? ☐ NO ☐ YES – FILED WITH:
8. WAS THE CLAIMANT HOSPITALIZED: ☐ NO ☐ YES – DATES HOSPITALIZED:	9. SURGERY INDICATED: ☐ NO ☐ YES – TYPE:

10. DATE OF YOUR FIRST TREATMENT OF THIS DISABILITY:

11. DATE THE CLAIMANT WAS FIRST UNABLE TO PERFORM THE DUTIES OF EMPLOYMENT:

12. DATE OF YOUR MOST RECENT TREATMENT OF THIS DISABILITY:

13. DATE THE CLAIMANT WILL BE ABLE TO PERFORM USUAL WORK (ESTIMATE, DO NOT USE "UNDETERMINED" OR "UNKNOWN"):

14. ARE YOU REFERRING THE CLAIMANT TO ANOTHER PHYSICIAN: ☐ NO ☐ YES – PLEASE PROVIDE THE NAME:	15. WAS THE CLAIMANT REFERRED TO YOU: ☐ NO ☐ YES – BY WHOM:

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

DOCTOR'S NAME (Print):	PHONE NUMBER:	FAX NUMBER:
OFFICE ADDRESS (Include City, State, zip code):		
DOCTOR'S SIGNATURE:	PROVIDER'S TAX ID #:	DATE: