Important Information to Assist with Completion of the Hawaii TDI-45 Claim Form - Part B

Valued Customer:

There is a section of the TDI-45 Claim Form (Employer Section Part B and page 6) where clarification may be helpful. We hope this document will aid in completion of the claim form.

Taxability of Benefits:

Please see the below excerpt from IRS Publication 15A to assist you in calculating the taxable percent of benefits. Taxability is expected to be less than 100 percent when the employee is contributing to the cost of the coverage.

Excerpt from IRS Publication 15A, Page 17 and 18: ***Group policy.*** If both the employer and the employee contributed to the sick pay plan under a group insurance policy, figure the taxable sick pay by multiplying total sick pay by the percentage of the policy's cost that was contributed by the employer for the 3 policy years before the calendar year in which the sick pay is paid. If the policy has been in effect fewer than 3 years, use the cost for the policy years in effect or, if in effect less than 1 year, a reasonable estimate of the cost for the first policy year.

Example. Alan is employed by Edgewood Corporation. Because of an illness, he was absent from work for 3 months during 2015. Key Insurance Company paid Alan $2,000 sick pay for each month of his absence under a policy paid for by contributions from both Edgewood and its employees. All of the employees' contributions were paid with after-tax dollars. For the 3 policy years before 2015, Edgewood paid 70% of the policy's cost and its employees paid 30%.

Because 70% of the sick pay paid under the policy is due to Edgewood's contributions, $1,400 ($2,000 × 70%) of each payment made to Alan is taxable sick pay. The remaining $600 of each payment that is due to employee contributions is not taxable sick pay and is not subject to employment taxes. Also, see *Example of Figuring and Reporting Sick Pay*, later in this section.

For more information please visit: https://www.irs.gov/pub/irs-pdf/p15a.pdf

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
P.O. Box 14302
Lexington, KY 40512-4302
Phone Number: (888) 236-4918 Fax Number: (855) 819-8915

INSTRUCTIONS FOR FILING A CLAIM FOR DISABILITY BENEFITS

This application package is divided into three sections:

I. 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.

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

III. Have your employer complete and sign **Part B, Employer's Statement**.

IV. Fax or mail the completed application to:

The Hartford
P.O. Box 14302
Lexington, KY 40512-4302
Fax Number: (855) 819-8915

V. If you have any questions regarding your claim please contact The Hartford at **(888) 236-4918.**

If you have any questions for the State of Hawaii 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 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.

Clear Form

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
P.O. Box 14302
Lexington, KY 40512-4302
Phone Number: (888) 236-4918 Fax Number: (855) 819-8915

Claim for Disability Benefits

THE HARTFORD

PART A – CLAIMANT'S STATEMENT

1. My name is: (First, middle, last) Type or print | 2. TDI Policy Number: 299815 | 3. Social Security Number:

4. Birth Date: | 5. Sex: ☐ Male ☐ Female | 6. Marital Status: ☐ Single ☐ Married | 7. Address: (Street, City or Town, State & Zip Code)

8. Email Address:

9. Personal Cell Telephone Number: ( ) Alternate Telephone Number: ( )

May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No

Signature Date

Disability Information

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

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

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

13. ☐ I have not recovered from my disability. ☐ I have recovered from my disability Date recovered:
☐ 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) Mohawk ESV

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:	From: (mm/dd/yyyy) To: (mm/dd/yyyy)	Weekly hours	Weekly Wages
a.			
b.			
c.			
d.			

Period of Employment

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	
299815	Mohawk ESV	
1. Claimant's name	2. Business Address	3. Telephone number ( )
4. Firm or trade name	5. Claimant's occupation	6. Employer Department of Labor Number

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 and Accident Insurance Company**
P.O. Box 14302 Lexington, KY 40512-4302
Phone Number: (888) 236-4918 Fax Number: (855) 819-8915

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

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
P.O.Box 14302 Lexington, KY 40512-4302
Phone Number: (888) 236-4918 Fax Number: (855) 819-8915
Email: APSupload@thehartford.com

THE HARTFORD

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
299815	Mohawk ESV

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

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
P.O. Box 14302
Lexington, KY 40512-4302
(888) 236-4918 Fax Number: (855) 819-8915

EMPLOYER AND EMPLOYEE: Please complete and submit with your TDI-45 claim form:

EMPLOYER:

What percentage of the TDI is paid by the Employer _____%.
If blank, we will assume the employer pays 100% of the plan costs.

Are you deducting FICA taxes from this employee? ☐ Yes ☐ No

If no, state grounds for exception:_____

_____

_____ _____
Employer's Signature Date

EMPLOYEE:

DISABILITY CLAIMANT'S REQUEST FOR FEDERAL INCOME TAX WITHHOLDING

☐ **DO NOT** withhold any income tax from my Disability Payments.
* STOP – Sign and Date form.

☐ **I REQUEST** voluntary income tax withholdings from my Disability Payments.
* Enter the whole dollar amount to be withheld from each.

WEEKLY BENEFIT (STATUTORY DISABILITY) AMOUNT

Type or Print Full Name | Social Security Number

Home Address (Number and Street, City, State and Zip Code)

A. Employer Name and Address
Mohawk ESV
160 S. Industrial Blvd.
Calhoun, GA. 30701

Policy Number
70 TDI

B. Federal law requires us to withhold federal income tax from your check if you request us to do so. We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number.

If you want us to withhold tax, please indicate the dollar amount to be withheld per benefit check. $_____
(Whole dollars only, minimum is $ 20.00 per week).

_____ _____
Signature of Disability Claimant Date

[1] The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.