MetLife

METLIFE INSURANCE COMPANY
CLAIM FOR DISABILITY BENEFITS

Metropolitan Life Insurance Company
c/o FiRMS Claims Services
PO Box 2866
Honolulu HI 96803
Phone: 1-808-527-7007
Fax: 1-808-533-0778
Email: tdi@ficoh.com
Hours of Operation: Mon-Fri 8am to 5pm

Benefits Underwritten By:

Metropolitan Life Insurance Company

INSTRUCTIONS:

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, 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.
2. Have your employer complete and sign **Part B, Employer's Statement.**
3. Have your doctor complete and sign **Part C, Doctor's Statement**. Have your doctor mail this form to the insurance carrier listed, unless otherwise directed by your employer in Part A (22) or Part B (13).
4. If you have any questions or problems with obtaining the claim form, TDI-45, call the Disability Compensation Division at **1-808-586-9188**.

Auxiliary aids and services are available upon request. Please call 1-808-586-9188; TTY 1-808-586-8847; 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.

PART A - CLAIMANT'S STATEMENT

1. My name is (First, middle, last) Type or print		2. Social Security Number	3. Birth Date
			mm/dd/yy
4a. Address (Street, City or Town, State, Zip Code)	4b. Email address	5. Telephone No.	6. ❑ Male ❑ Female / 7. ❑ Single ❑ Married

DISABILITY INFORMATION

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

9. The first day I was unable to perform the duties of my job: mm/dd/yy
(month) (day) (year)

10. Was this disability caused by your job?
❑ Yes ❑ No ❑ Unknown

11. ❑ I **have not recovered** from my disability.
❑ I **have recovered** from my disability. Date recovered: mm/dd/yy

12. ❑ I **have not returned** to work.
❑ I **have returned** to work
Date returned: mm/dd/yy

EMPLOYMENT INFORMATION

13. My present employer is: (or last employer if unemployed)
(Name and address – include street, city, state, zip code)

14. Prior to my disability, I worked for this employer:
From: mm/dd/yy To: mm/dd/yy

15. I worked: _____ hours per week **and**
I earned: $ _____ per week

16. Occupation

17. I am a union member
❑ Yes Name of Union: _____
❑ No

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

Employer name and address	Period of Employment From Mo. Day Yr.	Period of Employment To Mo. Day Yr.	Weekly Hours	Weekly Wages
a.				
b.				
c.				
d.				

19. Does your employer have a printed TDI notice posted and maintained 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 with this claim form when you first requested it for this disability? YES ❑ NO ❑

OTHER BENEFITS

20. In addition to TDI benefits, I am 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)

21. 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 mm/dd/yy to mm/dd/yy

22. 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
	mm/dd/yy

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 important that you complete the following information for prompt submittal to your insurance carrier.*

1. Claimant's name	2. Claimant's occupation	3. Employer DOL number

4. TDI Policy Number	5. Firm or trade name	6. Business address (include street, city, state, and zip)

7. In reporting wage information below, use gross 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 $ _____ 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 No.	Week Ending Month	Day	Year	No. Days Worked	Gross Amount
1					
2					
3					
4					
5					
6					
7					
8					
TOTAL	XXXX	XXXX	XXXX		

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 dates:

From mm/dd/yy (month/day/year) through mm/dd/yy (month/day/year)

Earnings: $ _____

13. Mail the doctor's statement to:

Metropolitan Life Insurance Company
c/o FiRMS Claims Services
PO Box 2866
Honolulu HI 96803

8. Worked: ❑ Full-time ❑ Part-time

Date hired: mm/dd/yy (month) (day) (year)

Date last worked prior to disability: mm/dd/yy (month) (day) (year)

If returned to work, give date: mm/dd/yy (month) (day) (year)

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	No. of Weeks Worked	No. of Hours 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 Worker's Compensation carrier:

_____

12. Has or will the employee receive	YES	NO
Wages		
Salary		
Sick leave pay		
Vacation		
Separation pay		

for all or any portion of the period of disability covered by this claim?

If yes, show period:
From: mm/dd/yy (mo/day/yr)
Through: mm/dd/yy (mo/day/yr)

Amount: $ _____

Signature of employer or employer's representative	Print Name	Title	Tel No.

Employer Tax ID no. (Needed for FICA reporting)	Fax No.	Date
		mm/dd/yy

PART C – DOCTOR'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).*

1. Claimant's name	2. Age	3. Sex

4. Physical requirements of claimant's occupation as related by claimant:

5. Diagnosis:	6. ICD-10 or current (must complete)

7. If pregnancy, advise EDC mm/dd/yy .
If disability is pregnancy with complications, please advise complications above.

8. 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 _____

9. Was claimant hospitalized? ❑ Yes ❑ No If yes, from mm/dd/yy to mm/dd/yy
Surgery indicated? ❑ Yes ❑ No Type _____

10. Complete the following:	Month	Day	Year
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)			

11. Are you referring claimant to another physician? ❑ Yes ❑ No If yes, give name: _____
OR
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)	Office address (include street, city, state, and zip)	Provider's Tax ID No.

Doctor's signature	Date	Telephone No.	Fax. No.
	mm/dd/yy		