EPIC
EMPLOYERS' PROTECTIVE INSURANCE COMPANY, INC.

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: ☐ Female ☐ Male	5. Marital Status: ☐ Married ☐ Single
6. Address:		City:	State: / Zip Code:
7. Mobile Phone: ( ) -	☐ Check to opt out of receiving text messages about your claim	8. Other Phone: ( ) -	9. Email Address: ☐ Check to opt out of receiving emails about claim

Disability Information

10. My disability was caused by: ☐ Illness ☐ Accident ☐ 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? ☐ Yes ☐ No ☐ Unknown
13. I have recovered from my disability. If yes, date recovered: ☐ Yes (*Specify Date*) ☐ No / /	14. I have returned to work. If yes, date returned to work: ☐ Yes (*Specify Date*) ☐ 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? ☐ Full Time ☐ Part Time	20. Hourly or Salaried? ☐ Hourly ☐ Salaried	21. Earnings Per week: $	
22. Occupation/Job Title:	23. Union member? If yes, name of union: ☐ Yes ☐ No		

24. Did you work for any other Hawaii employers during the past 52 weeks? ☐ Yes ☐ 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? ☐ Yes ☐ No
26. Did your employer inform you of your entitlement to TDI benefits? ☐ Yes ☐ No
27. Did your employer provide you this claim form when you first requested it for this disability? ☐ Yes ☐ No

Other Benefits

28. In addition to TDI benefits, I am receiving or claiming benefits from the following (check all that apply):
☐ Federal Disability Insurance Benefits ☐ Workers Compensation Benefits ☐ Employer's Sick Leave Plan
☐ Unemployment Insurance Benefits ☐ Damages for Personal Injury ☐ 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: ☐ Yes ☐ 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.	_____ / / Claimant's Signature Date
	_____ / / Representative's Signature, if Claimant Unable to Sign Date

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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

_____ / / Phone: ( ) -
Signature of Employer or Employer's Representative Title Date 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: ☐ Female ☐ 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? ☐ Yes ☐ No
If Yes, was Physician's Report WC-2 filed? ☐ Yes ☐ No
If Yes, Carrier Name and Phone Number: _____ ( ) -

8. Was claimant hospitalized? ☐ Yes ☐ No If yes, dates of hospitalization: From: / / To: / /
Is surgery indicated? ☐ Yes ☐ 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? ☐ Yes ☐ No If yes, to whom? _____

11. Was the claimant referred to you? ☐ Yes ☐ 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: / /