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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) 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

THE HARTFORD
Email: GBDHawaiiClaims@thehartford.com
Fax Number: (833) 357-5153
Phone Number: (888) 301-5615

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. For the quickest service, email or fax your completed claim form to:
Email: GBDHawaiiClaims@thehartford.com
Fax: (833) 357-5153

If those are not available to you, you can mail your completed claim form to this address:
The Hartford
1003 Bishop St., Suite 2700
Honolulu, HI 96813

V. If you have any questions regarding your claim please contact The Hartford at **(888) 301-5615**

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.

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THE HARTFORD

Email: GBDHawaiiClaims@thehartford.com
Fax Number: (833) 357-5153 Phone Number: (888) 301-5615

PART A – CLAIMANT'S STATEMENT **Claim for Disability Benefits**

1. My name is: (First, middle, last) Type or print | 2. TDI Policy Number: | 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) | 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: Period of Employment

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

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		
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			Number Days Worked	Gross Amount
	Month	Day	Year		
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. Email, Fax, or Mail Physician Statement to: **The Hartford 1003 Bishop St., Suite 2700 Honolulu, HI 96813**
Email: GBDHawaiiClaims@thehartford.com
Fax Number: (833) 357-5153 Phone Number: (888)-301-5615

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

THE HARTFORD
1003 Bishop St., Suite 2700 Honolulu, HI 96813
Email: GBDHawaiiClaims@thehartford.com
Fax Number: (833) 357-5153 Phone Number: (888) 301-5615

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	
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

Form **W-4S**

Department of the Treasury
Internal Revenue Service

Request for Federal Income Tax Withholding From Sick Pay

Give this form to the third-party payer of your sick pay.
Go to *www.irs.gov/FormW4S* for the latest information.

OMB No. 1545-0074

2023

Your first name and middle initial	Last name	**Your social security number**

Home address (number and street or rural route)

City or town, state, and ZIP code

Claim or identification number (if any)	
I request federal income tax withholding from my sick pay payments. I want the following amount to be withheld from each payment. (See **Worksheet** below.)	$

Employee's signature: Date:

Separate here and give the top part of this form to the payer. Keep the lower part for your records.

Worksheet (Keep for your records. Do not send to the IRS.)

1	Enter amount of adjusted gross income that you expect in 2023	**1**	
2	If you plan to itemize deductions on Schedule A (Form 1040), enter the estimated total of your deductions. See Pub. 505 for details. If you don't plan to itemize deductions, enter the standard deduction. (See the instructions on page 2 for the standard deduction amount, including additional standard deductions for age and blindness.) **Note:** There is no deduction for personal exemptions for 2023	**2**	
3	Subtract line 2 from line 1	**3**	
4	Tax. Figure your tax on line 3 by using the **2023** Tax Rate Schedule X, Y-1, Y-2, or Z on page 2. **Do not** use any tax tables, worksheets, or schedules in the 2022 Instructions for Form 1040	**4**	
5	Credits (child tax and higher education credits, credit for child and dependent care expenses, etc.) . .	**5**	
6	Subtract line 5 from line 4	**6**	
7	Estimated federal income tax withheld or to be withheld from other sources (including amounts withheld due to a prior Form W-4S) during 2023 or paid or to be paid with 2023 estimated tax payments . . .	**7**	
8	Subtract line 7 from line 6	**8**	
9	Enter the number of sick pay payments you expect to receive this year to which this Form W-4S will apply	**9**	
10	Divide line 8 by line 9. Round to the nearest dollar. This is the amount that should be withheld from each sick pay payment. Be sure it meets the requirements for the amount that should be withheld, as explained under *Amount to be withheld* below. If it does, enter this amount on Form W-4S above . .	**10**	

General Instructions

Purpose of form. Give this form to the third-party payer of your sick pay, such as an insurance company, if you want federal income tax withheld from the payments. You aren't required to have federal income tax withheld from sick pay paid by a third party. However, if you choose to request such withholding, Internal Revenue Code sections 3402(o) and 6109 and their regulations require you to provide the information requested on this form. Don't use this form if your employer (or its agent) makes the payments because employers are already required to withhold federal income tax from sick pay.

Note: If you receive sick pay under a collective bargaining agreement, see your union representative or employer.

Definition. Sick pay is a payment that you receive:

- Under a plan to which your employer is a party, and
- In place of wages for any period when you're temporarily absent from work because of your sickness or injury.

Amount to be withheld. Enter on this form the amount that you want withheld from each payment. The amount that you enter:

- Must be in whole dollars (for example, $35, not $34.50).
- Must be at least $4 per day, $20 per week, or $88 per month based on your payroll period.
- Must not reduce the net amount of each sick pay payment that you receive to less than $10.

For payments larger or smaller than a regular full payment of sick pay, the amount withheld will be in the same proportion as your regular withholding from sick pay. For example, if your regular full payment of $100 a week normally has $25 (25%) withheld, then $20 (25%) will be withheld from a partial payment of $80.

Caution: You may be subject to a penalty if your tax payments during the year aren't at least 90% of the tax shown on your tax return. For exceptions and details, see Pub. 505, Tax Withholding and Estimated Tax. You may pay tax during the year through withholding or estimated tax payments or both. To avoid a penalty, make sure that you have enough tax withheld or make estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. You may estimate your federal income tax liability by using the worksheet above.

Sign this form. Form W-4S **is not** valid unless you sign it.

Statement of income tax withheld. After the end of the year, you'll receive a Form W-2, Wage and Tax Statement, reporting the taxable sick pay paid and federal income tax withheld during the year. These amounts are reported to the IRS.

Changing your withholding. Form W-4S remains in effect until you change or revoke it. You may do this by giving a new Form W-4S or a written notice to the payer of your sick pay. To revoke your previous Form W-4S, complete a new Form W-4S and write "Revoked" in the money amount box, sign it, and give it to the payer.

(continued on back)

Specific Instructions for Worksheet

You may use the worksheet on page 1 to estimate the amount of federal income tax that you want withheld from each sick pay payment. Use your tax return for last year and the worksheet as a basis for estimating your tax, tax credits, and withholding for this year.

You may not want to use Form W-4S if you already have your total tax covered by estimated tax payments or other withholding.

If you expect to file a joint return, be sure to include the income, deductions, credits, and payments of both yourself and your spouse in figuring the amount you want withheld.

Caution: If any of the amounts on the worksheet change after you give Form W-4S to the payer, you should use a new Form W-4S to request a change in the amount withheld.

Line 2—Deductions

Itemized deductions. Itemized deductions include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your adjusted gross income. See Pub. 505 for details.

Standard deduction. For 2023, the standard deduction amounts are:

Filing Status	Standard Deduction
Married filing jointly or qualifying surviving spouse	$27,700*
Head of household	$20,800*
Single or Married filing separately	$13,850*

*If you're age 65 or older or blind, add to the standard deduction amount the additional amount that applies to you as shown in the next paragraph. If you can be claimed as a dependent on another person's return, see *Limited standard deduction for dependents*, later.

Additional standard deduction for the elderly or blind. An additional standard deduction of $1,500 is allowed for a married individual (filing jointly or separately) or a qualifying surviving spouse who is 65 or older or blind, $3,000 if 65 or older **and** blind. If both spouses are 65 or older or blind, an additional $3,000 is allowed on a joint return. If both spouses are 65 or older **and** blind, an additional $6,000 is allowed on a joint return. Additional standard deductions are also allowed on your separate return for your spouse who is 65 or older and/or blind if your spouse has no gross income and can't be claimed as a dependent by another taxpayer. An additional $1,850 is allowed for an unmarried individual (single or head of household) who is 65 or older or blind, $3,700 if 65 or older **and** blind. See the 2023 Estimated Tax Worksheet—Line 2 Standard Deduction Worksheet in Pub. 505.

Limited standard deduction for dependents. If you are a dependent of another person, your standard deduction is the greater of (a) $1,250 or (b) your earned income plus $400 (up to the regular standard deduction for your filing status). If you're 65 or older or blind, see Pub. 505 for additional amounts that you may claim.

Certain individuals not eligible for standard deduction. For the following individuals, the standard deduction is zero.

- A married individual filing a separate return if either spouse itemizes deductions.
- A nonresident alien individual. For exceptions, see Pub. 519, U.S. Tax Guide for Aliens.
- An individual filing a return for a period of less than 12 months because of a change in his or her annual accounting period.

Line 5—Credits

Include on this line any tax credits that you're entitled to claim, such as the child tax credit and credit for other dependents, higher education credits, credit for child and dependent care expenses, earned income credit, or credit for the elderly or the disabled. See the Tax Credits table in Pub. 505 for more information.

Line 7—Tax Withholding and Estimated Tax

Enter the federal income tax that you expect will be withheld this year on income other than sick pay and any payments made or to be made with 2023 estimated tax payments. Include any federal income tax already withheld or to be withheld from wages and pensions.

2023 Tax Rate Schedules

Schedule X—Single

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$11,000	**$0 + 10%**	**$0**
11,000	44,725	**1,100 + 12%**	**11,000**
44,725	95,375	**5,147 + 22%**	**44,725**
95,375	182,100	**16,290 + 24%**	**95,375**
182,100	231,250	**37,104 + 32%**	**182,100**
231,250	578,125	**52,832 + 35%**	**231,250**
578,125	and greater	**174,238.25 + 37%**	**578,125**

Schedule Z—Head of household

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$15,700	**$0 + 10%**	**$0**
15,700	59,850	**1,570 + 12%**	**15,700**
59,850	95,350	**6,868 + 22%**	**59,850**
95,350	182,100	**14,678 + 24%**	**95,350**
182,100	231,250	**35,498 + 32%**	**182,100**
231,250	578,100	**51,226 + 35%**	**231,250**
578,100	and greater	**172,623.50 + 37%**	**578,100**

Schedule Y-1—Married filing jointly or Qualifying surviving spouse

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$22,000	**$0 + 10%**	**$0**
22,000	89,450	**2,200 + 12%**	**22,000**
89,450	190,750	**10,294 + 22%**	**89,450**
190,750	364,200	**32,580 + 24%**	**190,750**
364,200	462,500	**74,208 + 32%**	**364,200**
462,500	693,750	**105,664 + 35%**	**462,500**
693,750	and greater	**186,601.50 + 37%**	**693,750**

Schedule Y-2—Married filing separately

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$11,000	**$0 + 10%**	**$0**
11,000	44,725	**1,100 + 12%**	**11,000**
44,725	95,375	**5,147 + 22%**	**44,725**
95,375	182,100	**16,290 + 24%**	**95,375**
182,100	231,250	**37,104 + 32%**	**182,100**
231,250	346,875	**52,832 + 35%**	**231,250**
346,875	and greater	**93,300.75 + 37%**	**346,875**

Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.