TDI-1 no bar (7-12)

Dept. of Labor and Training
Temporary Disability Insurance
P.O. Box 20100 Cranston, RI 02920-0941 Phone: 401-462-8420

Do Not Fax
←Mail to this Address

APPLICATION FOR BENEFITS

PERSONAL AND WORK INFORMATION

I prefer to receive information in:

English ☐ Spanish ☐ Portuguese ☐

Your e-mail address:_____

Date of Birth (Month/Day/Year): ____ /_____ /_____

Gender: Male ☐ Female ☐

Phone Number: __ __ __ - __ __ __ - __ __ __ __

Social Security Number: __ __ __ - __ __ - __ __ __ __

First Name:_____ M.:____ Last Name:_____

Address:_____

_____

City/Town: _____ State: _____ Zip: _____

If you have recovered and/or returned to work since this illness or injury began, please fill in dates below.

Date recovered from illness or injury: ___ /_____ /_____

Date returned to work to reduced hours: ___ /_____ /_____

Date returned to work to normal hours: ___ /_____ /_____

Job title (prior to injury or illness): _____

The last day you actually worked before this illness or injury: ___ /_____ /_____

The first workday you were unable to work due to this illness or injury: ___ /____ /_____ (Note: Dates **must** correspond to normal work days)

During the week in which your **last day of work** occurred, did you work less than your **normal** schedule of hours? Yes ☐ No ☐

If yes, indicate below the gross earnings (before taxes) for the week in which **your last day of work occurred.** (Our weeks run from Sun. thru Sat.)
Include overtime, vacation and sick leave pay; exclude holiday pay if you did not work the holiday.

Please indicate below, the hours worked each day during the week in which your last day of work occurred.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hours	Rate of Pay	Gross Earnings (Before taxes)
Hours Worked									$	$

Check each **day** you **normally** work: Sun☐ Mon☐ Tues☐ Wed☐ Thurs☐ Fri☐ Sat ☐

Your normal work schedule is: Part-time ☐ Full-time ☐ Total hours per week:_____

What are your gross wages (before taxes) during **one** normal/full work week (Sun. thru Sat.): $ _____

Please select all that applies: Salary☐ Bi-weekly☐ Hourly ☐ Per Diem☐ On-Call ☐ Commission ☐

MEDICAL INFORMATION

What is your illness or injury? _____Is this illness or injury connected to your job? Yes☐ No☐

If yes, please complete the section on the back page marked" Workers' Compensation Information".

Date of your medical examination for this illness/injury, closest to the unable to work date listed above: ___ /____ /_____

(This date must occur the week prior to, the week of, or the week following your unable to work date.)

Were you hospitalized for this disability? Yes☐ No☐ Dates admitted to hospital: From:_____To: _____

Name of Hospital:_____Adress:_____

Doctor or Medical Practitioner:_____

Address:_____

City/Town: _____ State: _____ Zip: _____

Phone Number: __ __ __ - __ __ __ - __ __ __ __

Did you provide the Medical Certification Form (TDI-3 form, found on website) to this Medical Practitioner? ☐ Yes ☐No If no, please explain:_____

Doctor or Medical Practitioner:_____

Address:_____

City/Town: _____ State: _____ Zip: _____

Phone Number: __ __ __ - __ __ __ - __ __ __ __

Did you provide the Medical Certification Form (TDI-3 form, found on Website) to this Medical Practitioner? ☐ Yes ☐No If no, please explain:_____

BENEFITS HISTORY

Have you applied for or received TDI Benefits in the last 12 months? Yes☐ No☐

Have you applied for or received Unemployment Insurance Benefits in the last 12 months: Yes☐ No ☐ If yes, the last week ending date you were paid from Unemployment Insurance: __ __ /__ __ /__ __ From which state?_____

FOR OFFICE USE ONLY

DEP	PHYS	PHYS	DD	SE	WC	UI	BYB	BYE

PLEASE COMPLETE BOTH SIDES OF FORM

EMPLOYER INFORMATION- Please include all employers in the last 2 years. To add more employers, attach a separate sheet with your social security number and name at the top.

Employer:_____

Address:_____

City/Town: _____ State: _____ Zip: _____

Phone Number: __ __ __ - __ __ __ - __ __ __ __

Employment Dates: __ __ /__ __ /__ __ to __ __ /__ __ /__ __

How many hours per week do you normally work? _____

Was your work performed in RI? Yes☐ No☐

Are you a corporate officer, partner or owner? Yes☐ No☐

Employer:_____

Address:_____

City/Town: _____ State: _____ Zip: _____

Phone Number: __ __ __ - __ __ __ - __ __ __ __

Employment Dates: __ __ /__ __ /__ __ to __ __ /__ __ /__ __

How many hours per week do you normally work? _____

Was your work performed in RI? Yes☐ No☐

Are you a corporate officer, partner or owner? Yes☐ No☐

Have you earned wages or performed services through self-employment in the past 2 years? Yes☐ No☐

List beginning and ending dates of any period of self-employment during the past two years. Employment Dates: __ __ /__ __ /__ __ to __ __ /__ __ /__ _

DEPENDENTS ALLOWANCE

For how many dependent children do **you provide support** to? _____ (Include children under 18 as well as children 18 and older who are incapacitated.)

List below only the names of children who are your natural, adopted or step children, or are court-appointed wards that you provide support:

(Documentation is required for court appointed wards and children over 18 years of age that are incapacitated.)

Child's First Name **Last Name**	**Relationship** (natural, adopted, step or court ward)	**Birth date** (mm/dd/yy)	**Social Security Number** (**Required** for children 12 months of age or older)

Do you have legal custody of all the children listed above? Yes☐ No☐

Do all children listed above live with you? Yes☐ No☐

If no, indicate name address and social security number of the person with whom they reside.

Name: _____

Address:_____

Social Security Number: __ __ __ /__ __ / __ __ __ __

If any legal dependent named above is 18 or older, please indicate the type of incapacity (mental or physical).

Name: _____Incapacity Type: _____

Is any other person claiming your child/children as dependents under the Rhode Island Temporary Disability Act? Yes☐ No☐

If yes, indicate the name, address and social security number of the person claiming such children.

Name: _____

Address:_____

Social Security Number: __ __ __ /__ __ / __ __ __ __

WORKERS' COMPENSATION INFORMATION- Complete if injury/illness is work connected:

Have you filed a Workers' Compensation claim for this disability? Yes☐ No☐ Date of injury/illness: ___ /____ /_____

Name and address of company where injury occurred:

Name:_____Address:_____

Have you received any Workers' Compensation payments for this or any other disability? Yes☐ No☐ If yes, dates from: _____to: _____

If **yes**, please provide the contact information for your Workers' Compensation Insurance Company.

Workers' Compensation Insurance Co.:_____

Address:_____

City/Town: _____ State: _____ Zip: _____

If **no**, please explain why not::

If you have a lawyer representing you in this matter, please provide his/her name and address.

Lawyer Name: _____

Address:_____

City/Town: _____ State: _____ Zip: _____

Select Your Preferred Benefit Payment Method:

Select your preferred **payment method** for benefit payments.

☐ Direct Deposit into my account (Complete the direct deposit form) **Or** ☐ Electronic Payment Card (Works like a debit card-EPC) (You may incur fees if card is not used properly)

► SIGNATURE REQUIRED ◄

Certification and Medical Information Release for Rhode Island Temporary Disability Insurance: I certify that I am/was physically unable to work, including self-employment, during the period for which I am claiming benefits, and that the information I have provided on this application is true and complete. Also, I hereby authorize my Qualified Healthcare Provider, hospital or other health care provider to make available to the Rhode Island Temporary Disability Insurance Division any medical information, including hospital records, which may be requested.

Your Signature: _____ Social Security Number: __ __ __ /__ __ / __ __ __ __ Date __ __ /__ __ /__