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

Do Not Fax
←Mail to this Address

APPLICATION FOR BENEFITS

APPLICANT PERSONAL AND WORK INFORMATION

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

First Name:_____ M.:____ Last Name:_____
Address:_____
_____
City/Town: _____ State: _____ Zip: _____

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

Gender: Male ☐ Female ☐
Home Phone Number: __ __ __ - __ __ __ - __ __ __Cell #:__ __ __ - __ __ __ - __ __ __ _

E-mail address:_____
I prefer to receive information in: English ☐ Spanish ☐ Portuguese ☐

What program are you applying for (check one only)?

☐ **Illness/surgery/ injury**
☐ **Care for a seriously ill Family Member**
☐ **Bond with Child**

Please provide the following dates if pertinent to you today:

Date you returned to work to normal hours**:** ___ /____ /_____
Date you recovered from illness or injury: ___ /____ /_____
Date you returned to work to reduced hours: ___ /____ /_____

If you are filing for Caregiver or Bonding benefits, how many weeks are you requesting?_____
(Maximum of 4 weeks only)

COMPLETE THIS SECTION IF FILING FOR YOUR OWN ILLNESS / SURGERY / INJURY

What is your illness or injury? _____
The first workday you were unable to work due to this illness, surgery or injury: ___ /____ /_____
Date of your medical examination for this illness/injury, closest to the unable to work date listed above: ___ /____ /_____
(As required by law, you must be physically examined by a doctor the week prior , 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:_____Address:_____

Doctor or Medical Practitioner:_____
Address:_____
City/Town: _____ State: _____ Zip: _____
Phone Number: __ __ __ - __ __ __ - __ __ __ __
(Forms will be mailed to you to submit to your Doctor)

Doctor or Medical Practitioner:_____
Address:_____
City/Town: _____ State: _____ Zip: _____
Phone Number: __ __ __ - __ __ __ - __ __ __ __
(Forms will be mailed to you to submit to your Doctor)

REQUIRED FOR ALL PROGRAMS

Enter your last day of work or date you last performed services: __ __ /__ __ /__ __

Have you applied for or received Temporary Disability Insurance Benefits in the last 12 months? Yes☐ No☐
Have you applied for or received Temporary Caregiver Insurance 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 were you paid?_____

COMPLETE THIS SECTION IF FILING FOR TEMPORARY CAREGIVER INSURANCE PROGRAM (TCI)

If you are caring for a family member **or** bonding with child, what date do you want your claim to begin: Month: ____ Day:_____ Year:_____
(NOTE: The date of this application must be no later than 30 days after the start date of your claim. Social Security #'s required only if child is over 12 months of age).

Information of individual for whom you are caring for **or** bonding with?
Legal First Name: _____Last Name:_____Middle _____
Address: _____
Telephone Number: _____-_____-_____ Date of Birth: Month_____Day_____Year_____ Gender: ☐ Male ☐ Female

The Care Recipient is your: ☐Spouse & Common Law Marriage ☐Domestic Partner- Same Sex Relationship ☐Parent ☐Parent-in-law ☐Grandparent ☐Child ☐Adopted Child ☐Foster Child

The Bonding Recipient is your: ☐Newborn Child ☐Adopted Child ☐Foster Child ☐Other: Please explain_____
Child's Social Security Number:_____-_____-_____ (Required only if over 12 months of age)
Date of Adoption: Month: _____ Day:_____ Year:_____ Date Foster Child was Placed with you: Month: _____ Day:_____ Year:_____

Copy of the following documents are required as proof of relationship for bonding claims (do not send originals- they will not be returned).
What proof and copy of document are you providing with this application (check one below):
(Document may be sent at a later date when received. The document must show your name and the child's name.)

☐ Child's Birth Certificate ☐ Proof of Adoption ☐ Proof of Foster Care Placement ☐Proof of Legal Guardianship
(Benefit payments will not be provided without proof of relationship; however, you must file within 30 days of your first leave date.)

FOR OFFICE USE ONLY

DEP	PHYS	PHYS	DD	SE	TCI	WC	UI	BYB	BYE

APPLICANT EMPLOYER INFORMATION- Please include all employers in the last 2 years, attach a separate sheet with your S.S. # 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? _____
Job Title:_____
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? _____
Job Title:_____
Was your work performed in RI? Yes ☐ No ☐
Are you a corporate officer, partner or owner? Yes ☐ No ☐

Check each day of the week you normally work: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

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 __ __ /__ __ /__ __

YOUR DEPENDENTS ALLOWANCE- REQUIRED TO CALCULATE THE CLAIM'S BENEFIT RATE

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, list name, address & social security number of the person who they reside with:
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- REQUIRED FOR ALL PROGRAMS:

Do you currently have an illness or injury connected to your job or as a result of your job, a Worker's Compensation issue? Yes ☐ No ☐
Have you filed a Workers' Compensation claim for this disability or any other disability? Yes☐ No☐ Date of injury or start of 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 PERFERRED BENEFIT PAYMENT METHOD- REQUIRED FOR ALL PROGRAMS.

Select your preferred **payment method** for benefit payments. ☐ **Direct Deposit** into my account (Complete a Direct Deposit Form) **Or**
☐ **Electronic Payment Card**-EPC (Works like a debit card, fees may apply if not used properly)

► SIGNATURE REQUIRED◄

Rhode Island Temporary Disability Insurance (TDI) I understand to claim **TDI benefits** 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 TDI any medical information, including hospital records, which may be requested. I understand that I am responsible to report to TDI the date that I return to work part time or full time to prevent any overpayments of benefits. I understand that I'm responsible for costs/fees incurred by my QHP for providing medical records to TDI.
Temporary Caregiver Insurance Program (TCI) I understand that all information I have provided regarding the **TCI Program** is true and correct. I agree to provide the medical certification required as proof of care needed for my seriously ill family member. I also understand that I am responsible **to pay taxes** on all benefit payments received from the TCI Program. I understand that I am responsible to report to TDI the date that I return to work to part time or full time to prevent any overpayments of benefits.

☐ By signing this acknowledgement, I am indicating that I have been informed of the TDI & TCI Program requirements above and understand them.

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