HAWAII LABORERS' HEALTH AND WELFARE TRUST FUND

FREQUENTLY ASKED QUESTIONS – DISABILITY CREDITS

1. WHAT IS THE DIFFERENCE BETWEEN T.D.I., WORKER'S COMPENSATION, AND DISABILITY CREDITS?

a. **T.D.I.** (Temporary Disability Insurance) may help to replace some of your lost income if you are disabled due to a non-work-related illness or injury. If eligible, you may request for a form from the Administrator's Office. ALL forms must be submitted to the Administrator's Office.

b. **Worker's Compensation** may help to replace some of your lost income and pay for medical bills if you become disabled due to a work-related illness or injury. If eligible, you may request this form from your employer.

c. **Disability Credits** *(applicable to hourly Construction & Non-Construction employees only)* is a benefit to help you keep your eligibility for Health & Welfare Benefits (e.g. Medical/Dental) for a period of time while you are unable to work. When submitted timely, 'Credits' are applied in lieu of work hours to help keep you eligible for benefits. If eligible, you may request for a form from the Administrator's Office.

2. HOW DO I KNOW IF I'M ELIGIBLE FOR DISABILITY CREDITS?

If you become disabled and you are eligible for Health & Welfare Benefits at the time the disability occurred AND are working for a contributing employer, then you are eligible for disability credits.

However, to RECEIVE your disability credits, you must file your paperwork with the Administrator's office in a timely manner.

3. HOW DO I APPLY TO RECEIVE DISABILITY CREDITS?

There are very specific deadlines that you must meet to get your disability credits. Please be mindful of these deadlines to ensure you get the benefits you are entitled to!

a. You must submit your Disability Certificate **NO LATER THAN 45 DAYS after the date you first became disabled.**

b. You will need your doctor to complete the **Disability Certificate EVERY MONTH**.

c. The Disability Certificate must be **SIGNED/DATED IN THE SAME MONTH** that you are applying for credits.

d. You must submit each Disability Certificate **no later than the 30th of each month for which you are applying for credits** to qualify monthly.

Example:

March:	April:	May:
✓ Become disabled March 15 ✓ You and your doctor completed initial Disability Certificate in March** ✓ Submitted initial Disability Certificate to TF office preferably in March, but NO LATER THAN APR. 29TH! **= ELIGIBLE FOR DISABILITY CREDITS IN MARCH**	✓ Still disabled ✓ You and your doctor completed Disability Certificate again in April ✓ Submitted April Disability Certificate to TF office before APR 30th **= ELIGIBLE FOR DISABILITY CREDITS IN APRIL**	✓ Still disabled ✓ You and your doctor completed Disability Certificate again in May ✓ Didn't submit May Disability Certificate until June 2nd. **= NOT ELIGIBLE FOR DISABILITY CREDITS IN MAY (missed deadline)**

** Note: if you were disabled in March but didn't see your doctor and get the Disability Certificate until April, as long as the Certificate is signed and submitted BEFORE Apr. 29th, that Certificate will serve as your application for credits for BOTH March and April.

******** SAMPLES OF COMPLETED DISABILITY CERTIFICATES ARE ATTACHED ********

4. WHAT HAPPENS IF I MISS THE DEADLINES TO TURN IN MY DISABILITY CERTIFICATES?

If you miss the deadlines, you will not be eligible to earn your disability credits for that month, which may cause you to lose eligibility for benefits. If you have hours in your Hour Bank, those hours will be used to maintain your eligibility. However, note that your Bank Hours are also there to help you maintain eligibility during other times when you do not work enough hours to maintain eligibility (e.g. work not available).

5. HOW MANY DISABILITY CREDITS CAN I RECEIVE EACH MONTH?

If eligible, you will be given 7 hours of credit for each workday that you are unable to work with a maximum of 35 hours of credit per week, up to a maximum of 100 hours in a month.

6. HOW LONG CAN I RECEIVE DISABILITY CREDITS?

a. Occupational Disability – Disability credits for an occupational disability is limited to 6 months, unless extended by action of the Trustees. After the initial 6-month period, you may apply in writing for 1 additional 6-month extension, for a total of 12 months. No disability extension will be granted after the 12 months.

b. Non-Occupational Disability – Disability credits for a non-occupational disability is limited to 6 months. No disability extension will be granted beyond the initial 6 months.

c. **IMPORTANT NOTE**: – Your initial Disability Certificate is due no later than 45 days after the disability occurred. If you do not notify the Administrator's Office within this 45-day period, retroactive disability credits will NOT be applied. Instead, disability credits will be applied on a prospective basis from when notification is received. Furthermore, prospective disability credits will only be applied up to the (6) consecutive months allowed, beginning with the month disability commenced.

7. WHAT WILL HAPPEN IF I EXHAUST MY DISABILITY CREDITS AND THE DOCTOR HAS NOT RELEASED ME BACK TO WORK?

After the 12-month period has expired for occupational disabilities or the 6-month period has expired for non-occupational disabilities, you may continue your benefits by making payments as provided for under either of the COBRA Programs options.

For more information, please contact the Member Services Department at the Administrator's Office at (808) 441-8700 or (808) 520-8078 Toll-Free.

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1440 KAPIOLANI BLVD., SUITE 800 - HONOLULU, HAWAII 9[illegible]
PHONE (808) 441-8600 - NEIGHBOR ISLANDS DIAL D[illegible]

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SAMPLE INITIAL CERTIFICATE:
Submitted 4/8/24 ✓
Approved for MARCH credits

DISABILITY CERTIFICATI[illegible]

Member's Name:	John Aloha
Member's Social Security Number:	555-45-6789
Address: (Street, City, St & Zip Code)	789 Kealoha Dr., Pearl City, HI 96819
Phone Number:	808-232-2222

MEMBER'S STATEMENT
(Incomplete statements will be sent back and may delay benefits)

My present/last employer is: XYZ Construction	
Date my disability commenced: Mar. 15, 2024 ✓	
I was working for my 'present/last employer' on the date my disability commenced?	**YES** or **NO**
If ***NO***, please provide date employment terminated:	
I am currently collecting unemployment? (circle one)	**YES** or **NO**
If ***YES***, please provide date unemployment benefits began:	
My disability was caused by employment? (circle one)	**YES** or **NO**
If circled 'Yes', please provide the following:	
Name of Workmen's Compensation Carrier:	
Phone Number:	

I certify under penalty of perjury that all of the above statements are true and correct to the best of my knowledge. I further understand that a false statement may disqualify me for Disability Credits and that the Trustees shall have the right to recover any credits/payments made because of a false statement.

Member's Signature: X [signature] **Date:** 3/29/2024 ✓

PHYSICIAN'S STATEMENT

Injury/disability date:	3/15/2024		
Date unable to work:	3/15/2024		
Nature of injury: ***(Do not leave blank or unknown)***	Torn ligament		
Date of patient's last visit with you:	3/16/2024		
Is patient still disabled and unable to work? (circle one)	**YES**	**NO**	
RELEASED to return to covered employment: *(check one)*	☐ **FULL TIME Date:**	☐ **LIGHT DUTY Date:**	☐ **PENDING** (Note details)
Physician's Phone Number:	808-987-6543		
Physician's Name (please print)	Dr. Derrick Wise		
Physician's Signature: ***(Rubber stamp required)***	[signature]		Date: 3/27/24 ✓

IMPORTANT NOTE TO MEMBER:

In the event that you become disabled, you must notify the Administrator's Office in writing immediately or no later than 45 days after the initial disability commences to qualify for disability credits. **You must send in an updated disability certificate by the 30th of each month until you return back to covered employment**. If the Administrator's Office does not receive this form timely, you may disqualify yourself from continuous Health & Welfare Coverage.

Office Use Only	**Wk Mo**		**Wk Hrs**		**Hrs App**		**Eli. Mo**	

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SAMPLE SUBSEQUENT CERTIFICATE: Submitted 4/28/24 ✓ Approved for APRIL credits

DISABILITY CERTIFICATION

Member's Name:	John Aloha
Member's Social Security Number:	555-45-6789
Address: (Street, City, St & Zip Code)	789 Kealoha Dr., Pearl City, HI 96819
Phone Number:	808-232-2222

MEMBER'S STATEMENT

(Incomplete statements will be sent back and may delay benefits)

My present/last employer is: XYZ Construction	
Date my disability commenced: Mar. 15, 2024	
I was working for my 'present/last employer' on the date my disability commenced?	**YES** or **NO**
If ***NO***, please provide date employment terminated:	
I am currently collecting unemployment? (circle one)	**YES** or **NO**
If ***YES***, please provide date unemployment benefits began:	
My disability was caused by employment? (circle one)	**YES** or **NO**
If circled 'Yes', please provide the following:	
Name of Workmen's Compensation Carrier:	
Phone Number:	

I certify under penalty of perjury that all of the above statements are true and correct to the best of my knowledge. I further understand that a false statement may disqualify me for Disability Credits and that the Trustees shall have the right to recover any credits/payments made because of a false statement.

Member's Signature: X John Aloha **Date:** 4/24/2024 ✓

PHYSICIAN'S STATEMENT

Injury/disability date:	3/15/2024		
Date unable to work:	3/15/2024		
Nature of injury: ***(Do not leave blank or unknown)***	Torn ligament		
Date of patient's last visit with you:	3/16/2024		
Is patient still disabled and unable to work? (circle one)	**YES**	**NO**	
RELEASED to return to covered employment: *(check one)*	☐ **FULL TIME** **Date:**	☐ **LIGHT DUTY** **Date:**	☐ **PENDING** (Note details)
Physician's Phone Number:	808-987-6543		
Physician's Name (please print)	Dr. Derrick Wise		
Physician's Signature: ***(Rubber stamp required)***	Derrick Wise	Date: 4/21/24 ✓	

IMPORTANT NOTE TO MEMBER:

In the event that you become disabled, you must notify the Administrator's Office in writing immediately or no later than 45 days after the initial disability commences to qualify for disability credits. **You must send in an updated disability certificate by the 30th of each month until you return back to covered employment**. If the Administrator's Office does not receive this form timely, you may disqualify yourself from continuous Health & Welfare Coverage.

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SAMPLE SUBSEQUENT CERTIFICATE: Submitted 6/2/24 ✗ Not approved for MAY credits

DISABILITY CERTIF[illegible]

Member's Name:	John Aloha
Member's Social Security Number:	555-45-6789
Address: (Street, City, St & Zip Code)	789 Kealoha Dr., Pearl City, HI 9681[illegible]
Phone Number:	808-232-2222

MEMBER'S STATEMENT
(Incomplete statements will be sent back and may delay benefits)

My present/last employer is: XYZ Construction	
Date my disability commenced: Mar. 15, 2024	
I was working for my 'present/last employer' on the date my disability commenced?	**(YES) or NO**
If ***NO***, please provide date employment terminated:	
I am currently collecting unemployment? (circle one)	**YES or (NO)**
If ***YES***, please provide date unemployment benefits began:	
My disability was caused by employment? (circle one)	**YES or (NO)**
If circled 'Yes', please provide the following:	
Name of Workmen's Compensation Carrier:	
Phone Number:	

I certify under penalty of perjury that all of the above statements are true and correct to the best of my knowledge. I further understand that a false statement may disqualify me for Disability Credits and that the Trustees shall have the right to recover any credits/payments made because of a false statement.

Member's Signature: X John Aloha **Date:** 5/22/2024 ✓

PHYSICIAN'S STATEMENT

Injury/disability date:	3/15/2024		
Date unable to work:	3/15/2024		
Nature of injury: ***(Do not leave blank or unknown)***	Torn ligament		
Date of patient's last visit with you:	5/1/24		
Is patient still disabled and unable to work? (circle one)	**(YES)**	**NO**	
RELEASED to return to covered employment: *(check one)*	☐ **FULL TIME Date:**	☐ **LIGHT DUTY Date:**	☐ **PENDING** (Note details)
Physician's Phone Number:	808-987-6543		
Physician's Name (please print)	Dr. Derrick Wise		
Physician's Signature: ***(Rubber stamp required)***	Derrick Wise	Date: 5/19/24 ✓	

IMPORTANT NOTE TO MEMBER:

In the event that you become disabled, you must notify the Administrator's Office in writing immediately or no later than 45 days after the initial disability commences to qualify for disability credits. **You must send in an updated disability certificate by the 30th of each month until you return back to covered employment**. If the Administrator's Office does not receive this form timely, you may disqualify yourself from continuous Health & Welfare Coverage.

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