

RHODE ISLAND DEPARTMENT OF LABOR AND TRAINING TEMPORARY DISABILITY INSURANCE (TDI)

PO BOX 20100, Cranston, Rhode Island 02920 - 0241
Phone: (401)-462-8420 | TTY via RI Relay 711

Email: dt.tdi@dt.ri.gov | Web: dt.ri.gov/tdi

APPLICATION FOR BENEFITS - TEMPORARY DISABILITY INSURANCE

API	PLICANT	PERSO	NAL A	ND WO	RK IN	NFOF	RMATI	ON				
Name (First, Middle Initial, Last, Suffix)												
Mailing Address (Street or PO Box) Include a	partment no	umber, if a	applica	ble								
City/Town	State/Provi	nce Zip	o/Posta	I Code	Email	Addr	ess					
Social Security Number	Date of Birt	h (Month	/Day/Ye	ear)	Hom	ne Ph	one Nu	ımber		Cell		
Gender Race (Optional):	Black, Indian,	White, Hawaiia	Asia n/Pacit		ulti-rac	1		ity (Optio	,	Hispanic/ atinx,	Latinx N/A	
I prefer to receive information in: English	Spanish		Whic	h progra	m are	you a	applying	g for?				
Portuguese (phone calls only)				Illness		Surc	gerv	Inju	rv			
Portuguese (phone calls only) Illness Surgery Injury Please provide the following information if pertinent to you today												
Date you returned to working normal hours (mm/dd/yyyy): ————————————————————————————————								rs				
Date you recovered from liness or injury (mm/aa/yyyy):												
COMPLETE THIS SE						N ILL	NES	S/SURG	ERY/	INJURY		
What is the nature of your illness or injury? $ _$												
The first workday you were unable to work du	ie to illness	, surgery,	or inju	ry (mm/d	d/yyyy	/):						
Date of your medical examination for this illness/injury, closest to the date you were unable to work listed above (mm/dd/yyyy):												
(By law, you must be physically examined by a doctor the week prior, the week of, or the week following the date you were unable to work).												
Were you hospitalized for this disability? YES NO Dates admitted to the hospital: From To (mm/dd/yyyy) (mm/dd/yyyy)									dd/yyyy)			
Hospital Mailing Address (Street or PO Box) I	nclude unit	number,	if appli	cable	City/To	own			State/	Province	Zip/Posta	al Code
Doctor or Medical Practitioner:				Doctor o	r Medi	cal P	ractitio	ner:				
Address:				Address:								
City/Town:												
Phone Number:				-								
Enter your last day of work or date you last pe												
		•	•	,			Yes	No				
Have you applied 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? APPLICANT EMPLOYER INFORMATION - Please include all employers in the last 2 years, attach a separate sheet with your Social Security Number and name at the top, if needed												
Employer:				Employ	or:							
Address:												
City/Town:												
				•								
Phone Number:												
Employment Dates:												
How many hours per week do you normally w					-	-		-		•		
Job Title:												
Was your work performed in RI?		res		Was yo						0	Yes	No
Are you a corporate officer, partner or owner?		res	No	•		•		r, partne	r or ow		Yes	No
Check each day of the week you normally wo		Sun	Mon	Tu		We		Thurs		Fri	Sat	
Have you earned wages or performed service List beginning and ending dates of any period								Yes nent Date	es:	No	_To	



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YOUR DEPENDENTS ALLOWANCE - RE	QUIRED	TO CALCULA	ATE THE CLA	IM'S BEN	IEFIT RATE				
How many dependent children do you support? (Include childre	en under 1	8 and those 18 a	and older who are	e incapacita	ated.)				
List only the names of children who are your natural, adopted, (Documentation is required for court-appointed wards and for court-appointed wards are your natural, adopted,				ds to whom	you provide support.				
Name (First, Middle Initial, Last, Suffix)	Relatio	nship to You	Birthdate (mm	/dd/yyyy)	/yyyy) Social Security Number				
		T							
Do you have legal custody of the above child(ren)? Yes	No	1	0.		dren as dependents				
Do all the children listed above live with you? Yes If no, list the name, address, and Social Security number of the	No	under the Rhode Island Temporary Disability Act? Yes No							
they live with below.	If yes, indicate the name, address, and Social Security Number of the person claiming such children.								
Name (First, Middle Initial, Last, Suffix)	Name (First, Middle Initial, Last, Suffix)								
Address		Address							
Social Security Number		Social Security Number							
If any legal dependent named above is 18 or older, please indi	cate the typ	pe of incapacity (mental or physic	cal).					
Name:		Incapacity Type	e:						
WORKES' COMPENSATION INFOR	MATION -			ork connec	eted				
Do you have a job-related illness or Workers' Compensation is				No					
Have you filed a Workers' Compensation claim for this disabilit		her disability?		No					
Date of injury or start of illness (mm/dd/yyyy):	,,	, .	163 1	NO					
Name of company where injury occurred:		Add	lress:						
Have you received any Workers' Compensation payments for t	his or any		Yes	No	·				
If yes, dates: From:									
If yes, please provide the contact information for your Workers'	,	 If vou have a la	wver representi	na vou in th	is matter, please provide				
Compensation Company.		his/her name and address							
Name:		Lawyer Name:							
Address:		Address:							
City/Town: Zip:		City/Town:		State:	Zip:				
If no, please explain why not:									
SELECT YOUR PREF	ERRED B	BENEFIT PAYMI	ENT METHOD						
Direct Deposit into my accou (Complete the Direct Deposit For			nic Payment Ca y apply if not use		Vorks like a debit card,				
SIG	NATURE I	REQUIRED							
I understand that to claim TDI benefits I am/was physically unable to work, inclu provided on this application is true and complete. Also, I hereby authorize my Q information, including hospital records, which may be requested. I understand the overpayment of benefits. I understand that I'm responsible for costs/fees incurred.	ualified Health nat I am respo	ncare Provider, hospit ensible to report to TD	tal, or other health ca	re provider to r	make available to TDI any medical				
	ea by my QHP	ioi providing medica							
By signing this acknowledgement, I am indicating that I have				ove and unders	stand them.				
		med of the TDI Progr		ove and unders	stand them.				