DLT Department of Labor and Training
RHODE ISLAND

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: dlt.tdi@dlt.ri.gov | **Web:** dlt.ri.gov/tdi

APPLICATION FOR BENEFITS - TEMPORARY DISABILITY INSURANCE

APPLICANT PERSONAL AND WORK INFORMATION

Name (First, Middle Initial, Last, Suffix)

Mailing Address (Street or PO Box) Include apartment number, if applicable

City/Town	State/Province	Zip/Postal Code	Email Address

Social Security Number	Date of Birth (Month/Day/Year)	Home Phone Number	Cell

Gender ☐ M ☐ F ☐ X

Race (Optional): ☐ Black, ☐ White, ☐ Asian ☐ Indian, ☐ Hawaiian/Pacific, ☐ Multi-racial

Ethnicity (Optional): ☐ Hispanic/Latinx ☐ Not Hispanic/Latinx, ☐ N/A

I prefer to receive information in: ☐ English ☐ Spanish ☐ Portuguese (*phone calls only*)

Which program are you applying for? ☐ Illness ☐ Surgery ☐ Injury

Please provide the following information if pertinent to you today

Date you returned to working normal hours (mm/dd/yyyy): _____

Date you returned to working reduced hours (mm/dd/yyyy): _____

Date you recovered from illness or injury (mm/dd/yyyy):

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

What is the nature of your illness or injury? _____

The first workday you were unable to work due to illness, surgery, or injury (mm/dd/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 _____ (mm/dd/yyyy) To _____ (mm/dd/yyyy)

Name of hospital:

Hospital Mailing Address (Street or PO Box) Include unit number, if applicable	City/Town	State/Province	Zip/Postal Code

Doctor or Medical Practitioner: _____ Doctor or Medical Practitioner: _____

Address: _____ Address: _____

City/Town: _____ City/Town: _____

Phone Number: _____ Phone Number: _____

Enter your last day of work or date you last performed services (mm/dd/yyyy): _____

Have you applied or received Temporary Disability Insurance in the last 12 months? ☐ 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: _____ Employer: _____

Address: _____ Address: _____

City/Town: _____ City/Town: _____

Phone Number: _____ Phone Number: _____

Employment Dates: _____ Employment Dates: _____

How many hours per week do you normally work? _____ How many hours per week do you normally work? _____

Job Title: _____ Job Title: _____

Was your work performed in RI? ☐ Yes ☐ No Was your work performed in RI? ☐ Yes ☐ No

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

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

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

List beginning and ending dates of any period of self-employment during the past 2 years. Employment Dates: _____ To _____

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

How many dependent children do you support? (Include children under 18 and those 18 and older who are incapacitated.)

List only the names of children who are your natural, adopted, or stepchildren, or are court-appointed wards to whom you provide support. (Documentation is required for court-appointed wards and for children over 18 who are incapacitated).

Name (First, Middle Initial, Last, Suffix)	Relationship to You	Birthdate (mm/dd/yyyy)	Social Security Number

Do you have legal custody of the above child(ren)? ☐ Yes ☐ No

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

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

If no, list the name, address, and Social Security number of the person they live with below.

Name (First, Middle Initial, Last, Suffix)

Address

Social Security Number

If yes, indicate the name, address, and Social Security Number of the person claiming such children.

Name (First, Middle Initial, Last, Suffix)

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:

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

Do you have a job-related illness or Workers' 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 (mm/dd/yyyy): _____

Name of company where injury occurred: _____ 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 Company.

Name: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

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

Lawyer Name: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

If no, please explain why not:

SELECT YOUR PREFERRED BENEFIT PAYMENT METHOD

☐ **Direct Deposit** into my account (Complete the Direct Deposit Form) or ☐ **Electronic Payment Card** - EPC (Works like a debit card, fees may apply if not used properly

SIGNATURE REQUIRED

I understand that 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 overpayment of benefits. I understand that I'm responsible for costs/fees incurred by my QHP for providing medical records to TDI.

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

Your Signature | Social Security Number | Date