



STATE OF HAWAII  
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS  
DISABILITY COMPENSATION DIVISION

Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

INSTRUCTION SHEET FOR FORM TDI-15  
TDI SELF-INSURER'S PLAN CERTIFICATION AND AGREEMENT

### Instructions

Please refer to Form TDI-14 (<http://labor.hawaii.gov/dcd/> and click on Forms) to understand how the Equivalency Tables are used to evaluate the disability benefits that are provided under your self-insured plan.

To have your plan reviewed for approval, complete Form TDI-15 in duplicate in accordance with the following instructions. **If you have a different schedule of benefits for separate classes of employees, complete one Form TDI-15 for each plan.**

#### I. PLAN CERTIFICATION

A. **Benefit Provisions of Plan.** Your TDI plan must contain all items under section A.

1. Item A.1.b. If you have employees who are **excluded** from your plan (such as union members), indicate the classes and the number of employees in each class who are excluded. Provide insurance company's name, policy or other ID number of the plan covering these excluded employees. If your collective bargaining agreement contains sick leave provisions, submit a copy of the agreement.
2. Item A.4. You must indicate under a, b and c the benefit provisions of your plan.
  - If you intend to provide statutory benefits, indicate the following on the certification:
    - (a) Weekly benefits at **58%** of weekly wages.
    - (b) Benefits to commence on the **8<sup>th</sup>** day of disability (waiting period is not more than 7 consecutive calendar days).
    - (c) Benefits to continue for **26** weeks during the benefit year.
  - If you intend to provide other-than-statutory benefits, the benefits must be at least as favorable as the statutory benefits (see section 3 below for acceptable examples).

3. Examples of benefit provisions which produce equivalency:

% of Wages Replaced	Day Benefits Begin	No. Weeks Continued	Aggregate Actuarial Value
58%	8 <sup>th</sup>	26	104 (Statutory)
67%	8 <sup>th</sup>	16	104
70%	1 <sup>st</sup>	7	105
100%	1 <sup>st</sup>	3	105

4. Under the TDI law, an employer is authorized, but not required, to withhold contributions from the eligible and covered employees. Complete section A.5 to indicate whether employee contributions will be deducted.

B. **Security for Payment of Benefits.** Check appropriate item B.1. or B.2. to indicate the means by which you plan to secure the payment of benefits.

#### II. AGREEMENT

A. Read all items of the agreement. Continuation of self-insured status is contingent upon adherence to the stipulations.

B. Your submission should include all the documents listed below:

1. Two completed TDI-15 forms.
2. A copy of your self-insured plan.
3. A copy of your latest annual report or audited financial statements (including the independent auditor's opinion and the accompanying notes).
4. If applicable, a copy of your collective bargaining agreement.

**The Disability Compensation Division will return one copy of the approved Certification and Agreement, or notify you as to what modifications need to be made to your plan before approval can be granted.**

Equal Opportunity Employer/Program  
Auxiliary aids and services are available upon request to individuals with disabilities.  
TDD/TTY Dial 711 then ask for (808) 586-9188

# INSTRUCTIONS FOR TDI SELF-INSURER'S PLAN CERTIFICATION AND AGREEMENT (Form TDI-15)

Page 2 of 2

The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form and required attachments accordingly.

**Please remember to sign and date the form before submitting it.**

## **Delivery Information**

### **Delivery by U.S. Mail**

Department of Labor and Industrial Relations  
Disability Compensation Division  
P.O. Box 3769  
Honolulu, Hawaii 96812-3769

### **Delivery In-Person**

Department of Labor and Industrial Relations  
Disability Compensation Division  
Princess Keelikolani Building  
830 Punchbowl Street, Room 209  
Honolulu, Hawaii 96813

STATE OF HAWAII  
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS (DLIR)  
DISABILITY COMPENSATION DIVISION  
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813  
**FORM TDI-15**  
**TDI SELF-INSURER'S PLAN CERTIFICATION AND AGREEMENT**

Employer Name		DOL No.
Contact person's name	Contact person's email address	
Mailing Address		
Telephone No. (     )	Fax No. (     )	

**I. PLAN CERTIFICATION FOR TEMPORARY DISABILITY INSURANCE (TDI)**

Approval is requested of this employer's self-insured TDI plan effective _____.		
A. This plan includes the following provisions:		
1. a. All employees are covered at all times. Number covered in Hawaii _____		
b. <b>Excluded</b> class of employees (if applicable):	Class	No. in Class
Plan covering excluded class _____		
2. Coverage extends for two weeks beyond termination of employment unless the terminated employee is covered under the new employer's TDI plan.		
3. Coverage includes disabilities resulting from sickness, pregnancy, termination of pregnancy, organ donation, or accident other than a work injury.		
4. Employees will be paid according to the following benefit schedule:		
a. Weekly benefits will be paid at _____% of weekly wages (at least 58%).		
b. Benefits will commence on the _____ calendar day of disability (no later than the 8 <sup>th</sup> calendar day).		
c. Benefits will continue for _____ weeks during the benefit year.		
d. The benefit year begins on _____ and ends _____.		
5. Employee contributions <input type="checkbox"/> will be <input type="checkbox"/> will not be deducted from employee's wages. If deductions are made, they will not exceed the lesser of 50% of the administrative cost nor 0.5% of taxable wages.		
B. Security for payment of benefits is assured as follows:		
1. <input type="checkbox"/> The employer's latest audited financial statements (or current annual report) to show satisfactory proof of financial solvency and ability to pay employees TDI benefits are attached for the DLIR's review and approval.		
2. <input type="checkbox"/> There are valid reasons for not submitting the employer's audited financial statements. We will obtain:		
a. <input type="checkbox"/> A surety bond in the amount required.		
b. <input type="checkbox"/> Authorized securities in the amount required.		

Equal Opportunity Employer/Program  
Auxiliary aids and services are available upon request to individuals with disabilities.  
TDD/TTY Dial 711 then ask for (808) 586-9188

**FORM TDI-15 TDI SELF-INSURER'S PLAN CERTIFICATION AND AGREEMENT**

Page 2 of 2

**II. AGREEMENT**

**This employer agrees to abide by the following stipulations:**

- A. The self-insured plan will remain in effect until:
  - 1. A notice to terminate is filed with and approved by the DLIR pursuant to §12-11-72 of the Hawaii Administrative Rules (HAR).
  - 2. Revoked by the DLIR for noncompliance with the TDI statutes, HAR or the self-insured plan pursuant to §12-11-75, HAR.
- B. All changes to the self-insured plan must be filed with and approved by the DLIR before being adopted.
- C. The employer will authorize the DLIR Director in the event of neglect or refusal of the self-insurer to pay any obligation, including benefits, fines, expenses and assessments, to sell without notice all or any part of the deposited securities or require the surety to pay forthwith to the Director the penal sum of the bond.
- D. The employer will permit the DLIR Director or the authorized representative access to the premises for the purposes of audits and investigations in the enforcement of the TDI law.
- E. The employer will submit its most recent audited financial statements (or annual report) **annually** for a review to determine its financial ability to continue TDI self-insurance.
- F. The employer will pay all obligations, including benefits, fines, expenses, and assessments imposed pursuant to Chapter 392, Hawaii Revised Statutes (HRS).
- G. The employer will comply with all provisions of the TDI statutes and the related Administrative Rules.
- H. The employer's claim service office in Hawaii or independent claims adjusting service in Hawaii with draft authority for the processing of payments as required by §392-42.5(a), HRS and §12-11-68, HAR is:

Name of claims adjusting service/office \_\_\_\_\_

Point of contact at claims adjusting service/office \_\_\_\_\_

Mailing address \_\_\_\_\_

Telephone number \_\_\_\_\_

Facsimile number \_\_\_\_\_

Email address \_\_\_\_\_

\*\*\*\*\*

**I understand that failure to abide by any provision of the agreement may result in revocation of the plan or in appropriate fines or penalties or any other action imposed by the DLIR provided by Chapter 392, HRS, or its related Administrative Rules, as amended.**

Employer's signature	Date
Employer's printed name/title	

FOR OFFICE USE ONLY	
DLIR Authorized Representative Signature/Title/date	Cancellation signature/date