737 Bishop Street, Suite 1200
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Phone: (808) 941-4622
Toll-Free: (888) 941-4622

DISABLED DEPENDENT CERTIFICATION

SECTION 1: TO BE COMPLETED BY THE SUBSCRIBER

Subscriber's name (last, first, middle initial):

Group policy number:

Subscriber's ID number:

Subscriber's address (number, street, city, state, zip code):

Full name of dependent child:

Child's birth date:

Child's marital status: single married widowed divorced

Child's relationship to you:

Child's sex: Male Female

Child's age when disability began:

Is the child permanently residing in your household? yes no If "no," please explain:

Is the child dependent upon you for support? yes no
If "yes," what percentage of support do you contribute?

Is child listed as a dependent on your last federal income tax return? yes no

Was the child ever employed? yes no
Is the child employed now? yes no
If either answer is "yes," list employer's name, address, and dates of employment:

Monthly wages/earnings:

Is the child now on Medicare, or eligible in the next 6 months? yes no
If "yes," Medicare number:

Is the child now covered under any other hospital/medical/surgical/coverage? yes no
If "yes," provide name of insurance company and group or policy number:

I hereby certify that the above information is correct to the best of my knowledge and authorize release of any information requested with respect to this certification.

Member's signature: Date:

SECTION 2: TO BE COMPLETED BY THE ATTENDING PHYSICIAN
(Any fee for completion of this form is the responsibility of the Member)

Is the child now incapable of self-support because of a disability? yes no

Has such disability existed continuously before child attained age 19? yes no

Prognosis estimate (estimate months or years):

Nature of disability/diagnosis:

Severity of disability:

Please list specific functional disabilities causing dependent status:

Will child ever be able to provide self-support? yes no possibly (please explain):

Name and address of physician (please print clearly): Phone: Date of last appointment:

I hereby certify that the above information is correct to the best of my knowledge.

Physician's signature: Date: