



737 Bishop Street, Suite 1200
Honolulu, Hawaii 96813

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: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> widowed <input type="checkbox"/> divorced
Child's relationship to you:	Child's sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Child's age when disability began:
Is the child permanently residing in your household? <input type="checkbox"/> yes <input type="checkbox"/> no If "no," please explain:		
Is the child dependent upon you for support? <input type="checkbox"/> yes <input type="checkbox"/> no If "yes," what percentage of support do you contribute?	Is child listed as a dependent on your last federal income tax return? <input type="checkbox"/> yes <input type="checkbox"/> no	
Was the child ever employed? <input type="checkbox"/> yes <input type="checkbox"/> no Is the child employed now? <input type="checkbox"/> yes <input type="checkbox"/> 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? <input type="checkbox"/> yes <input type="checkbox"/> no If "yes," Medicare number:
Is the child now covered under any other hospital/medical/surgical/coverage? <input type="checkbox"/> yes <input type="checkbox"/> 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? <input type="checkbox"/> yes <input type="checkbox"/> no	Has such disability existed continuously before child attained age 19? <input type="checkbox"/> yes <input type="checkbox"/> 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? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> 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: _____