HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION
220 S King Street, Suite 1200
Honolulu, Hawaii 96813

Disabled Dependent Certification

SECTION 1: TO BE COMPLETED BY 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. Subscriber'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 (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:		