HMSA

Blue Cross Blue Shield of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

Disability Certification

To: Hawaii Medical Service Association

This is to certify that I have examined _____ born on _____ and find said person to be incapable of self-sustaining support by reason of physical or mental disability which has existed before attainment of age 26.

1. Diagnosis or ICD-9 Code (explain in detail) _____

_____

_____

2. Disability has been continuous from: _____
(Approximate Date)

Is this disability permanent? [ ] Yes [ ] No

3. In your opinion, will the individual recover sufficiently to be capable of self-sustaining support?
[ ] Yes [ ] No

4. If "yes" to 3, by when? _____

5. Remarks: _____

6. Attach medical notes, vocational rehabilitation evaluation, or any other pertinent information documenting the dependent's disability.

Print Name: _____ Signature: _____
Attending Physician Attending Physician

_____ _____
Date Physician's Address

TO BE COMPLETED BY HMSA MEMBER

I certify that the above named child who is listed as a dependent under my HMSA Agreement is incapable of self-sustaining support by reason of:

- physical or mental disability; and
- is chiefly dependent upon me for support and maintenance; and
- has been enrolled under this coverage or another HMSA coverage with continuous health care coverage since the child's 26th birthday.

In requesting that coverage be extended for said child as a dependent under my Family Plan, I understand and agree that such coverage for said child is extended only so long as the child remains incapable of self-sustaining support and continues to meet the above criteria.

HMSA reserves the right to recertify the said dependent's disability at our request, but not more frequently than annually after the child reaches 26 years of age.

Date: _____ Name of Subscriber: _____

HMSA Number: _____ Signature of Subscriber: _____

FOR HMSA USE ONLY

Reviewed for Eligibility by Membership Service: _____ Date: _____

Sent to Medical Management: _____ Date: _____