



700 Bishop Street, Suite 300
 Honolulu, HI 96813.4100
 T 808.532.4007
 800.458.4600
 F 877.222.3198
 uhahealth.com

Dependent Disability Certification Form

Return to: UHA Health Insurance
 Attention: Employer Services
 700 Bishop Street, Suite 300
 Honolulu, HI 96813

This is to certify that I have examined _____, born on ____/____/____ and find said person to be incapable of self-sustaining employment by reason of physical or mental disability which existed before attainment of age 26. I understand that UHA will require medical records or other documentation to support this certification and I agree to promptly provide any records requested to UHA.

1. Nature of disability _____

2. Disability has been continuous from _____
Approximate Date
3. Is the disability permanent? Yes No
 If Yes, please explain:

4. In your opinion, will the individual recover sufficiently to be capable of self-sustaining employment? Yes No
5. If "yes" to #4 above, by what date _____
6. Remarks _____

Signature of Attending Physician _____
 Print Name _____
 Date _____
 Address _____

TO BE COMPLETED BY UHA SUBSCRIBER

I certify that the above-named dependent under my UHA coverage is incapable of self-sustaining employment by reason of physical or mental disability, relies primarily upon me for support and maintenance as a result of his or her disability, has had no break in insurance coverage and is not married. I understand and agree that such coverage for the dependent is extended only so long as the dependent remains incapable of self-sustaining employment, relies primarily upon me for support and maintenance, and is not married. I understand and agree that this document, other documentation requested by UHA, and supporting medical records and clinical notes are subject to review and must be acceptable to UHA's Chief Medical Officer and/or Medical Director. I understand other documentation may include proof of legal guardianship, medical power of attorney, federal disability certification or identification card, tax filings or continuous coverage.

Signature of Subscriber _____
 Print Name _____
 Date _____

(See other side for Disabled Dependent Enrollment Guidelines)

Disabled Dependent Enrollment Guidelines

A child who is age 26 or over may be enrolled as a dependent if he or she is disabled by providing UHA:

1. Written documentation acceptable to UHA demonstrating that:
 - a. The child is incapable of self-sustaining support because of a physical or mental disability.
 - b. The child's disability existed before the child turned 26 years of age.
 - c. The child relies primarily on parent or legal guardian, who is a UHA member, for support and maintenance as a result of their disability.
 - d. The child is enrolled with us under this coverage or another qualified health insurance coverage, and has had no break in health insurance coverage since before the child's 26th birthday.
2. The documentation must be provided to UHA within 31 days of the child's 26th birthday and subsequently at our request but not more frequently than annually.

To apply for disabled dependent coverage, the subscriber must:

- Have the dependent's physician complete UHA's **Dependent Disability Certification Form**. One form for one dependent.
- Assist UHA, if necessary, in obtaining the medical records or other medical documentation from the dependent's physician.
- Submit the completed Dependent Disability Certification Form to UHA at least 31 days prior to the dependent's 26th birthday.
- Upon request, provide proof of legal guardianship, medical power of attorney, federal disability certification or identification card such as Social Security disability certification letter or identification card from Centers for Medicare and Medicaid Services, tax filings or continuous coverage.

Once the completed form and documentation is received, UHA will use the information submitted to determine if the child qualifies as a disabled dependent under the subscriber's UHA coverage. All information is subject to review by UHA's Chief Medical Officer and/or Medical Director.