HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (EUTF)

DISABILITY CERTIFICATION FOR DEPENDENT CHILDREN

PHYSICIAN'S STATEMENT

I certify I examined _____, birth date _____ and found (him)(her) to be incapable of self-support because of a mental or physical incapacity which began on _____ (approximate date), before (he)(she) reached age 19.

In my opinion, the above person: ◯ Will be incapable of self-support for the duration of (his) (her) life, or

◯ May become self-supporting if (he) (she) responds to treatment

Approximate date of recovery _____

Physician Name: _____ Tel. No. _____

Address: _____

Signature: _____ Date: _____

PARENT'S STATEMENT

I certify that the above person meets all of the criteria below:

- Is my child
- Is incapable of self-support because of a mental or physical incapacity and the incapacity occurred prior to age 19
- Is not married

FOR RETIREES ONLY

Check one: ◯ Is eligible for Medicare Parts A & B (EUTF requires enrollment in Part B if eligible)

- My child's Medicare card is attached to this form.

◯ Is not eligible for Medicare Parts A & B.

- A completed General Affidavit attesting to the fact that he/she is not eligible for Medicare is attached.

I hereby request he/she be continued as a family member under my EUTF benefit plans. I agree to submit additional proof of disability as often as required by the EUTF or its insurance carriers. I will notify EUTF of all changes to the above criteria. I authorize the EUTF and its insurance carriers to use the above information only in compliance with federal and Hawaii laws governing the privacy of health information.

I hereby declare the above statements are true to the best of my knowledge and belief and I understand that I am subject to penalty for perjury.

Employee/Retiree Name (Parent): _____

Address: _____

Phone No._____ SSN: XXX-XX-_____ (last 4 digits)

_____ _____

Parent's Signature Date

Form D-1 (Rev. 4.7.16)

Clear Form Print Form