HSTA VEBA TRUST
Disability Certification for Dependent Children

DC-1

Employee's Last Name, First, M.I.			Social Security Number:	
Mailing Address:			Phone Number – Work	Phone Number – Home
City:	State:	Zip Code:		

Dependent's Last Name, First, M.I.	**Birth Date**	**Social Security Number**	**Relationship**

Physician's Statement:

I certify I examined the above person and found ❑him/❑her to be incapable of self-support because of a mental or physical disability which began on _____, 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			Phone Number	
Mailing Address:				
City:	State:	Zip Code:		

Physician's Signature: _____ **Date:** _____

Employee's Statement:

I certify that the above person is my child, is disabled, is dependent on me for support, and is not married.

I hereby request he/she be continued as a family member under my HSTA-VEBA Trust benefit plans. I agree to submit additional proof of disability as often as required by the HSTA-VEBA Trust or its insurance carriers. I will notify HSTA-VEBA Trust of all changes affecting my child's disability or marital status.

I authorize the HSTA-VEBA Trust and its insurance carriers to use the above information only in compliance with federal and Hawaii laws governing the privacy of health information.

Employee Signature: _____ **Date:** _____

HSTA-VEBA Trust Use:

Trust Certification:	Effective/Change Date:	Cancellation Date:
Data Input:	Renewal Date:	Comments:

Please Return Completed Forms to:
HSTA VEBA Trust
1259 Aala Street, Suite 202
Honolulu, HI 96817
Phone: 808-440-6940 or 1-800-637-4926
Fax: 808-440-6941