Disabled Dependent Certification

Health Net of California, Inc. and Health Net Life Insurance Company (Health Net)

Subscriber information

After completing this section, please forward this form along with the enclosed envelope to your physician for his or her completion.

Subscriber name – Last:	First:	MI:	Subscriber ID #:
Address:			
City:		State:	ZIP:
Group name:			Group #:
Dependent name:			Dependent birth date:

Is he or she more than 50% dependent upon you for support? ☐ Yes ☐ No

I authorize the release of medical information requested with respect to this certification.

Signature of subscriber: ______________________________ Date: ____________________

To be completed by attending physician

A dependent child who is incapable of self-support due to a continuously disabling illness or injury may be continued as a family member on the parent's Health Net contract. Your medical statement will help us to determine the eligibility of this dependent.

Note: This is not a request for genetic information, as defined under The Genetic Nondiscrimination Act of 2008 (GINA). In response to this request, please do not provide Health Net with any of the above individual's genetic information. If the medical records we have requested contain genetic information, please be advised that GINA requires the redaction of such information prior to responding to this request. Thank you for your assistance in complying with this regulatory requirement.

Please return the completed form to Health Net in the enclosed envelope. Mail to: PO Box 9103, Van Nuys, CA 91409-9103

Please give us specifics as to the nature of the disability. (Attach supporting documentation.)

Please specifically explain how the disability causes the patient to be incapable of working or living independently.

To what extent does the disability limit normal activity? (Attach supporting documentation.)

What is your prognosis, including your estimates of length of time this disability may be expected to continue? (Attach supporting documentation.)

Physician signature:	Name of physician:	Date signed:	
Address:	City:	State:	ZIP:

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