Medical Waiver Request Form

A refund or waiver of certain fees or charges may be granted in documented cases of hospitalization. Please note that a refund or waiver is not guaranteed, and you must be the hospitalized party, traveling companion, or an immediate family* member in order to qualify for any such refund or waiver. Proof of relation may be requested.

Please fill out the entire form. Any blank areas may cause a delay in our response to you. The Hawaiian Airlines Consumer Affairs Office will respond to you within 30 business days. Please return this form only and no other additional documents.

Passenger Name(s):	
Original Departure Date:	
Original Return Date:	
Flight #(s):	
Email address:	
Mailing Address:	
Reservation Confirmation Code(s) (six letters):	

Name of Hospitalized Patient:	
Relation to Traveler:	
Date Admitted:	
Date Released:	

Name of Attending Physician:		
Physician Address:		
Physician Phone:		
Signature of Attending Physician:		Date:

***Immediate Family** is defined as spouse, child, parent, sister, brother, stepparent, stepchild, stepsister, stepbrother, grandparent, grandchild, step grandparent, step grandchild, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law and sister-in-law.

I certify that the information provided on this form is true. By signing below, I authorize my physician(s) and hospital(s) to release my medical information relating to the hospitalization described above. I also authorize Hawaiian Airlines to access such medical information.

Patient's Signature (if Patient is under 18 years old, please provide Guardian's Signature):		Date:

Mail or fax completed form to: Consumer Affairs | PO Box 30008 | Honolulu, HI 96820 | Fax #: 808-838-6777

NOTE: The completed form CANNOT be saved. It can ONLY be PRINTED using the button to the left. Attempting to SAVE the completed form will result in loss of all data fields.