

Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

Disabled Dependent Certification (Dependent child age 26 or older)

Must print in Black or Blue ink ONLY

Employee ID	Rcd No.	Employee Last Name, First Name	
E-mail Address		Telephone	Department
Name of Medical Plan		Name of Dental Plan	

COMPLETE ONE FORM FOR EACH DEPENDENT CHILD AGE 26 OR OLDER

Dependent Name	Date of Birth	Relationship to Employee
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Provider Certification:

By providing my information and signature below, I certify that the dependent listed above is incapable of self-sustaining employment due to physical or mental disability. I also certify that all dependent information provided is true and correct to the best of my knowledge.

Please provide the following:

Type of disability: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary		If temporary, provide end date:
Name of Provider:		
Provider Address:		
License No.:		Telephone:
Provider Signature		Date:

Employee Certification:

By providing my signature below, I certify that the dependent listed above is incapable of self-sustaining employment due to a physical or mental disability. I have obtained verification of this disability from the licensed healthcare provider listed above, and certify that all information provided is true and correct. I also understand that failure to timely provide all requested information will result in my dependent being ineligible for coverage on my County medical and dental plans pursuant to the terms of the County medical and dental contracts.

Employee (Print & Sign)	Date:
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Payroll Specialist (Print & Sign)	Telephone:	Date:
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DISTRIBUTION: Original - EBSD-HR (0440)

Office Use Only

Reviewed by (Employee ID)	Date

REV. HR 06/11/2014

Disabled Dependent Certification

RETURN FORM TO:

San Bernardino County
Employee Benefits and Services Division (EBSB)
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440