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

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:	☐ Permanent	☐ 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:

This document/form incorporates use of e-signature(s) in accordance with the San Bernardino County Policy #03-12 and Standard Practice 1.

Payroll Specialist (Print & Sign)	Telephone:	Date:

DISTRIBUTION: Original - EBSD-HR (0440)

Office Use Only

Reviewed by (Employee ID)	Date