



## DISABLED DEPENDENT CERTIFICATION

(Dependent child age 26 or older)

San Bernardino County  
 Employee Benefits and Services Division (EBSD)  
 157 West Fifth Street, First Floor  
 San Bernardino, CA 92415-0440  
 (909) 387-5787 Fax (909) 387-5566

<b>Employee ID</b>	<b>Rcd No.</b>	<b>Employee Last Name, First Name</b>	
<b>Department</b>		<b>Name of Medical Plan</b>	<b>Name of Dental Plan</b>

### COMPLETE ONE FORM FOR EACH DEPENDENT CHILD AGE 26 OR OLDER

<b>Dependent Name</b>	<b>Date of Birth</b>	<b>Relationship to Employee</b>
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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 attached verification of this disability from a licensed healthcare provider, 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.

<b>Retiree Signature</b>	<b>Telephone</b>	<b>Date</b>
	(     )	

*DISTRIBUTION: Original – EBSD-HR (0440)*

**RETURN FORM TO:**

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