



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	
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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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.

Employee Signature	Telephone ()	Date
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Payroll Specialist Name (Print and Sign)	Telephone ()	Date
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