



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
ebbsd@hr.sbcounty.gov

Must print in Black or Blue ink ONLY

Employee ID	Rcd No.	Last Name, First Name	
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 retiree medical and dental plans pursuant to the terms of the County retiree medical and dental contracts.

Retiree Signature	Telephone ()	Date
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DISTRIBUTION: Original – EBSD-HR (0440)

RETURN FORM TO:

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