EBA&M Corporation
Disabled Dependent Certification

TO BE COMPLETED BY THE EMPLOYEE

After completing the following section, please forward this form to your physician for his/her completion

1. Employee's Name (Last, First, Middle Initial)	1a. Member ID Number
2. Home Address (Number, Street, City, State and Zip Code)	
3. Group Name	3a. Group Number

4. Dependent's Name	4a. Dependent's Birth Date	4b. Dependent's Marital Status

I certify that the adult child identified above is chiefly dependent on me or my spouse or domestic partner for support and maintenance, and I authorize the release of medical information requested with respect to this certification.

_____ _____

Signature of Employee Date Signed

TO BE COMPLETED BY ATTENDING PHYSICIAN

A child age 26 and over who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition may be continued as a dependent on the parent's coverage. Your medical statement will help us to certify the eligibility of this dependent.

Please return the completed form to EBA&M Corporation via fax: (714) 437-1142 Or mail to: PO BOX 17179, Irvine, CA 92623

The above named child has the following physical or mental condition that makes him/her incapable of obtaining self-sustaining employment:

What length of time is this disability expected to continue?

Name of Physician	Physician's Signature	Date Signed
Address of Physician		