DISABLED DEPENDENT CERTIFICATION

Employee Name: _____

Dependent Name: _____

Relationship: _____ **Date of Birth:** _____

I declare under penalty of perjury that the above noted dependent:

☐ **Is my qualified dependent who is incapable of self-sustaining employment as the result of mental or physical handicap, and who remains chiefly dependent upon me for financial support.** (Attach attending physician certification.)

I understand that the above certification will be used as a basis for determining dependent eligibility under the Plan, and that it is my obligation to advise the Plan of any change in dependency status.

I agree to notify Emergent Holdings Human Resources immediately if this dependent becomes capable of self-sustaining employment or if this dependent ceases to be chiefly dependent upon me for financial support.

SIGNED: _____

(Employee)

DATE: _____

PHYSICIAN CERTIFICATION OF DISABILITY

Dependent Name: _____

Employee Name: _____

☐ **I certify that the above dependent is incapable of self-sustaining employment due to the following physical and/or mental handicap:**

The above dependent has been totally disabled since:

_____
(Date)

He/she is expected to remain totally disabled until:

_____
(Date)

Physician Signature: _____
(Name and degree)

Date Signed: _____

Physician Name: _____
(Please Print Full Name)

Physician Address: _____
(Street Address)

_____
(City, State, and Zip)

Telephone Number: _____