STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
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BRIAN SANDOVAL
Governor

DAMON HAYCOCK
Executive Officer

PATRICK CATES
Board Chairman

Certification of Disabled Dependent Child

TO BE COMPLETED BY PEBP PARTICIPANT (PRIMARY INSURED)

Participant's Name:			Participant's Social Security No.:
Disabled Dependent's Full Name:			
Address:	City:	State:	Zip Code:
Birth Date:	Social Security No.:	Phone No.:	

In accordance with NAC 287.312:

I certify that my dependent child is eligible for continued PEBP healthcare coverage and is an unmarried dependent child age 26 years or older with a physical or mental disability and meets the following criteria:

My dependent child has a physical or mental disability that occurred prior to age 26 years or during the time the dependent is covered under my PEBP coverage; and

My dependent child age 26 years or older is incapable of self-sustaining employment and primarily dependent on me for support and maintenance due to a documented physical or mental disability; and

The above named dependent is claimed as a tax dependent on my preceding year's federal tax filing **(please attach a copy of your previous year's tax return)**; and
My dependent child has had continual health insurance coverage since the age of 26 years **(if not covered under PEBP, please attach proof of coverage)**.

Participant's Signature:	Date:

In accordance with NRS 686A.291 Criminal penalty for insurance fraud. A person who commits insurance fraud is guilty of a category D felony and shall be punished as provided in NRS 193.130.
In accordance with NRS 689A.290, An agent, broker, solicitor, examining physician, applicant or other person shall not knowingly or willfully make any false or fraudulent statement or representation in or with reference to any application of insurance. A person who violates this section is guilty of a category D felony and shall be punished as provided in NRS 193.130. In addition to any other penalty, the court shall order the person to pay restitution.

Participant's Name:	Participant's Social Security No.:
Physician's Name:	

PHYSICIAN'S STATEMENT

The following must be completed by the child's physician.

Physician's Name:		Phone No.:	
Address:	City:	State:	Zip Code:

PATIENT INFORMATION (Disabled Child)

Is patient capable of employment and independent support?	Yes	No

Has disability existed continuously since before the age of 26? If no, when did disability first exist? Date:_____	Yes	No

Diagnosis:
Prognosis:

Physician's Signature:	Date:

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