

**CITY OF CLEARWATER**  
**Affidavit of Disability for Over Age Dependent Child for Clearwater Employees**  
**100 S Myrtle Ave**  
**Clearwater, FL 33756**  
**727-562-4870**

Enrolled dependent children who normally lose their eligibility under this plan solely because of age, but who are disabled by reason of a physically or mentally disabling injury, illness, or condition may have their eligibility extended by written application within 31 days of the date the dependent child reaches the age eligibility would otherwise cease. To qualify, the disabled dependent child must be incapable of self sustaining employment and be chiefly dependent upon the employee for support and maintenance. This affidavit is required for the disabled dependent child to remain on the health plan.

**Employee Name** \_\_\_\_\_

**Dependent Child's Name** \_\_\_\_\_

**I, the undersigned physician certify that** \_\_\_\_\_ **is incapable of self-sustaining employment because of** \_\_\_\_\_

**Prognosis** \_\_\_\_\_

**Estimated date of ability for self-sustaining employment** \_\_\_\_\_

\_\_\_\_\_  
**Physician Name** \_\_\_\_\_ **Date** \_\_\_\_\_

\_\_\_\_\_  
**Address** \_\_\_\_\_

\_\_\_\_\_  
**Type of Practice** \_\_\_\_\_

**I, the undersigned parent or guardian, certify that**

\_\_\_\_\_, \_\_\_\_\_  
**Dependent Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**is an unmarried child (including any stepchild, legally adopted child, or foster child), is chiefly dependent upon me for support and maintenance, and is incapable of self-sustaining employment by reason of physical of mental handicap.**

\_\_\_\_\_  
**Parent or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_