Guardian®

Dependent Eligibility Certification Form

General Information

Member Name:	Group Plan #:
Dependent Name:	Dependent Date of Birth:
Member Address:	
Member SS #:	

Student Certification

1. Name of school in which dependent is enrolled:
2. Address of school:
3. Telephone # of school:
4. Expected date of graduation (if this year): / /
   MO DAY YR
5. Student ID #:

Disability Certification

1. Is dependent now incapable of self-support because of a disability? ☐ YES ☐ NO
2. Age of dependent when disability occurred: _____
3. Nature of disability (Please provide as much detail as possible):

   _____

   _____
4. Prognosis (estimate months or years): _____
5. Name and address of Primary Care Physician: _____

   _____

   _____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED IN REGARD TO THE CERTIFICATION.

_____ _____
Member Signature Date Signed

Any person who includes any false or misleading information on an application for insurance commits a fraudulent insurance act and is subject to criminal and civil penalties.

Please complete this form and return it in the envelope provided to the following:

☐ The Guardian Life Insurance Company of America, Northeast Regional Office, P.O. Box 14319, Lexington, KY 40512