Dependent Eligibility Certification Form

General Information	
Member Name:	Individual Plan #:
Dependent Name:	Dependent Date of Birth:
Member Address:	
Member ID #: ______________________________	

Student & Dependent Certification

1. Is the child unmarried, a resident of Connecticut and not covered under another group health plan through the dependent's employer? ☐ YES ☐ NO
2. Is the child a full-time student at an accredited school? ☐ YES ☐ NO
3. If "YES", name and address of school in which dependent is enrolled: ________________________

   ____
4. Expected date of graduation (if this year): ____ /____ /____
   MO DAY YR

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 REQUEST 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, P.O. Box 254888 Sacramento, CA 95865

DENTAL | DISABILITY | LIFE | VISION | CRITICAL ILLNESS | CANCER | ACCIDENT | STOP LOSS

GuardianAnytime.com

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