GUARDIAN®

Dependent Eligibility Certification Form

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

Student Certification

1. Is the dependent a full-time student at an accredited public or private institution of higher education? ☐ YES ☐ NO
2. Name of school in which dependent is enrolled: _____
3. Address of school: _____
4. Telephone # of school: _____
5. Expected date of graduation (if this year): ___/___/___
   mm / dd / yy
6. 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 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

GG015024-PA (6/16)

The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004.
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