Guardian®

Dependent Extended Eligibility Certification Form

General Information	
Subscriber Name:	Policy #
Dependent Name:	Dependent Date of Birth:
Dependent Address:	
Dependent Member ID #: _____	

Dependent /Extended Coverage Certification

1. Is the dependent unmarried? ☐ Yes ☐ No
2. Is the dependent a resident of Florida or student (full or part-time)? ☐ Yes ☐ No

   If Yes, please explain: _____
3. Is the dependent provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan?

   ☐ Yes ☐ No If Yes, indicate plan: _____
4. Is the dependent entitled to Medicare? ☐ Yes ☐ No

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.

_____ _____

Subscriber 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 to the following:

The Guardian Life Insurance Company of America, P.O. Box 981569, El Paso, TX 79998-1569

GG-015024ACO/FL-DTC

A9/14/18