Guardian

Dependent Eligibility Certification Form

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

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): ___/___/___ mm / dd / yy
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 REQUEST 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

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