

Dependent Eligibility Certification Form

General Information	
Subscriber Name:	Policy #:
Dependent Name:	Dependent Date of Birth:
Dependent Address:	
Dependent Member ID #:	
Student Certification	
 Is the dependent a full-time student at an accredited public or private in Name of school in which dependent is enrolled:	
Adult Dependent Certification	
Is your dependent child:	
 YES NO unmarried? YES NO is a full-time student at an accredited public or private institution of higher education? YES NO is dependent claimed on your Federal Tax Forms? 	
Disability Certification	1
 Is dependent now incapable of self –support because of a disability? Age of dependent when disability occurred: Nature of disability (Please provide as much detail as possible): 	☐ YES ☐ NO
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 ANY INFORMATION REQUEST IN REGARD TO THE CERTIFICATION.	OF MY KNOWLEDGE AND AUTHORIZE RELEASE
Subscriber Signature Date 9	Signed
Any person who includes any false or misleading information on an application for ins subject to criminal and civil penalties.	surance commits a fraudulent insurance act and is
Please complete this form and return it to the following:	
The Guardian Life Insurance Company of America, P.O. Box 981569, El Paso, TX	K 79998-1569
GG015024-OH-DTC	A9/14/18
DENTAL DISABILITY LIFE VISION CRITICAL ILLNESS	CANCER ACCIDENT STOP LOSS