GUARDIAN®

Dependent Eligibility Certification Form

General Information

Member Name:	Group Plan #:
Dependent Name:	Dependent Date of Birth:
Member Address:	
Member SS #: _____	

Dependent / Student Certification (Up to age 26)

1. Does dependent child rely on you for support and reside in your home? ☐ 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): ____ /____ /____
   MO DAY YR
6. Student ID #: _____

Dependent / Extended Coverage Certification (Ages 26-30)

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.

_____ _____

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 14319, Lexington, KY 40512