GUARDIAN®

Dependent Eligibility Certification Form

General Information

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

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): ____ /____ /____
   MO DAY YR
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 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, Midwest Regional Office, P.O. Box 8012, Appleton, WI 54912-8012
☐ The Guardian Life Insurance Company of America, Northeast Regional Office, P.O. Box 26050, Lehigh Valley, PA 18002-6050
☐ The Guardian Life Insurance Company of America, Western Regional Office, P.O. Box 2454, Spokane, WA 99210-2454

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