



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): <u> </u> / <u> </u> / <u> </u> MO YR	
5. Student ID#: _____	
Disability Certification	
1. Is dependent now incapable of self-support because of a disability? <input type="checkbox"/> YES <input type="checkbox"/> 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, New York, NY
10004-4025