

Dependent Eligibility Certification Form

General Information	
Member Name:	Group Plan #:
Dependent Name:	Dependent Date of Birth:
Member Address:	
Member SS #:	
Student Certification	
Name of school in which dependent is enrolled:	
2. Address of school:	
3. Telephone # of school:	
4. Expected date of graduation (if this year):////	
5. Student ID #:	
Disability Certification	
1. Is dependent now incapable of self-support because of a disability?	ES □ 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	