



## Dependent Eligibility Certification Form

General Information	
Member Name:	Group Plan #:
Dependent Name:	Dependent Date of Birth:
Member Address:	
Member ID:	
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? <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, Northeast Regional Office, P.O. Box 14319, Lexington, KY 40512