NATIONAL GUARDIAN LIFE INSURANCE COMPANY

GROUP DENTAL & VISION INSURANCE APPLICATION
P.O. Box 1424 Milwaukee, WI 53201

Group No. _____ SIC No._____

Legal Name of Group_____ Phone (_____)_____

Physical Address _____ Fax (_____)_____

City\State\Zip_____ **E-Mail Address**_____

Billing Address (If different)_____ Phone (_____)_____

City\State\Zip_____ Fax (_____)_____

Contact for Administration & Eligibility _____ **Contact for Billing** _____

Employees: _____ # Eligible _____ # of Employees with Dependents _____ Group Effective Date: _____ /_____ / _____

Dental Premium:
Initial Premium Rates:
Employee Only $_____ Employee +Children $_____
Employee +Spouse $_____ Family $_____

Vision Premium:
Initial Premium Rates:
Employee Only $_____ Employee +Children $_____
Employee +Spouse $_____ Family $_____

Initial Rate Guarantee Period: _____ through _____

Policyholder Contribution: (for voluntary coverage please enter $0)
$_____ per month _____ % of premium Payroll Frequency:_____

A check for the first month's premium and other applicable fees must be attached to begin processing.
Eligibility data will be submitted using:
☐ National Guardian Life enrollment forms
☐ E-mail or electronic media (Employer must keep signed enrollment forms on file for future reference.)

We elect to offer the following insurance coverages to our Employees:

Dental Plan Selection:
Benefits are on a ◯ Policy ◯ Calendar year basis.

☐ Plan Name: _____
Deductible:_____
Annual Maximum: $_____
Orthodontia: ◯ Yes ◯ No; Maximum $_____

Vision Plan Selection:
Benefits are on a: ◯ Policy ◯ Calendar ◯ Rolling Benefit year basis

☐ Plan Name: _____
Frequency*: 12/ 12/ 12/ 12/ 12 _____
Additional Plan features: Co-Pays; Benefit Allowances

*Frequency (Months) - Exam/Lenses/Frames/Contacts/*Other* :

Eligibility:
Employees working _____ hours per week are eligible for coverage.
An eligible employee must have been actively at work on a full-time basis for _____ months in order to be eligible for coverage.
An eligible dependent child must be less than ___yrs. old; or less than _____ yrs. old if a full-time student; unless primarily dependent upon You for support and maintenance, and incapable of self-sustaining employment by reason of developmental disability or physical handicap, subject to the terms of the Policy.

Participation: Depending on group size and coverage elected, specific participation requirements may apply. Participation must be met before the insurance can be effective and must be maintained continuously while insurance is in force to prevent cancellation of coverage.

I understand and agree that audits will be made by National Guardian Life Insurance Company now and in the future to verify the number and names of full-time employees of this group. I will furnish with application, and upon any future request, a current census and State Quarterly Unemployment Tax Report, and any other information requested.

See reverse side

Please send Membership Materials and Enrollment Materials to (CHECK ONE):

☐ Group Attn: _____Phone: (_____)_____

☐ Broker or Agent/Producer

Under ERISA (Employee Retirement Income Security Act of 1974), it is required that there be a named fiduciary for each employee benefit plan. It is understood that the undersigned Employer is the named fiduciary for each employee benefit plan. I understand and agree if, on the effective date, an employee is not in permanent full-time active work or unable to perform usual and customary duties, coverage will not be effective until the employee returns to an active eligible status. I hereby certify that the information provided herein is true and complete to the best of my knowledge and that I have read and understand this form.

The information contained herein describes the essential provisions of the elected coverage(s) discussed between the above client and an authorized National Guardian Life Insurance Co. representative. By signing this form, both parties agree that these are the essential provisions the client is purchasing. The details of this form may be changed by either party with mutual agreement.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Signed: _____ _____/_____/_____
Name Title Date

National Guardian Life Representative Signed: _____ _____/_____/_____
Date

NVI/NDN GRP APP 2019-FL

Agent/Producer Name (if applicable) Please Print	Tax I.D. Number/License Identification Number
Firm Name (if applicable)	National Guardian Life Insurance Company Appointment ❑ On File ❑ Application attached
Address	
Phone: Fax:	E-mail:
FOR ADMINISTRATIVE USE ONLY	
Group Set Up Information Account Manager:_____	Account Management Approval Signature_____ Date ____/____/_____
Notes:	% Commission

See reverse side