



NATIONAL GUARDIAN LIFE INSURANCE COMPANY
 GROUP VISION INSURANCE APPLICATION
 11090 White Rock Road, Suite 175
 Rancho Cordova, CA 95670



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: ____ / ____ / ____

Premium:

Initial Premium Rates:

Employee Only \$ _____ Employee +Children \$ _____

Employee +Spouse \$ _____ Family \$ _____

Initial Rate Guarantee Period: _____ through _____

A check for the first month's premium and other applicable fees must be attached to begin processing

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

Vision Plan Selection:

Benefits are on a: Policy Calendar Rolling Benefit year basis

Eligibility:

Employees working _____ hours per week are eligible for coverage

Will be effective for coverage upon: 30 Days 60 Days 90 Days

1st of the month following _____ days Other _____

An eligible dependent child must be less than ____yrs. old; or less than ____ yrs. old if a full-time student

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 employees of this group. I will furnish with application, and upon any future request, any other information requested.

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 PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION TO OBTAIN INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Signed: _____ / ____ / ____
Name Title Date

National Guardian Life Representative _____ / ____ / ____

Date

NVI/NDN GRP APP 2019

Agent/Producer (if applicable)	Tax I.D. Number
Firm Name (if applicable)	National Guardian Life Insurance Company Appointment <input type="checkbox"/> On File <input type="checkbox"/> Application attached
Address	
Phone: Fax:	E-mail:
FOR ADMINISTRATIVE USE ONLY	
Group Set Up Information	Account Management Approval
Account Manager: _____	Signature _____ Date ____ / ____ / ____
Notes:	% Commission

NVI/NDN GRP APP 2019