



NATIONAL GUARDIAN LIFE INSURANCE COMPANY
GROUP DENTAL / VISION APPLICATION
Argus Dental & Vision, Inc.

Group No. \_\_\_\_\_ SIC No. \_\_\_\_\_

Legal Name of Group \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Physical Address \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

City\State\Zip \_\_\_\_\_ EMAIL 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

Policyholder Contribution:

Dental: \$ \_\_\_\_\_ per month \_\_\_\_\_ % of premium Payroll Frequency: \_\_\_\_\_

Vision: \$ \_\_\_\_\_ per month \_\_\_\_\_ % of premium

A check for the first month's premium and other applicable fees must be attached to begin processing. Eligibility data will be submitted using:

- checkbox National Guardian enrollment forms
checkbox Email or electronic media (Employer must keep signed enrollment forms on file for future reference.)

Plan Selection: We elect to offer the following coverage's to our Employees:

- checkbox Dental Insurance: Policy Year, Calendar Year, Deductible, Annual Maximum, Co-Pay, Orthodontia
checkbox Vision Insurance: Series, Frequency

Eligibility:

Permanent, full-time employees working \_\_\_\_\_ hours per week are eligible for coverage (Standard: 30 hours).
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 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 [full-time employees] [members] 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.

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

- Group Attn: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 Broker or Agent

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.

**WARNING:** 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 Representative \_\_\_\_\_ FL Lic. No. \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

Agent (if applicable)	Tax I.D. Number
Firm Name (if applicable)	National Guardian Life Insurance Company appointment on file
Address	National Guardian Life Insurance Company application attached
City/State/Zip	Phone Fax Email Address
<b>TO BE COMPLETED BY NATIONAL GUARDIAN LIFE INSURANCE COMPANY</b>	
Group Set Up Information	Account Management Approval
Account Manager: _____	Signature _____ Date ____ / ____ / ____
Notes:	