Dental Insurance Application

Individual Dental Insurance and Vision Discounts!

1. Complete all areas in the application form below. **Please be sure to read all information fully and sign where indicated on the back.**
2. Indicate the type of coverage you want (Individual, Individual & Spouse, etc.) and how you want to pay (automatic checking account deduction or credit card charge).
3. Return this entire sheet in the envelope provided. **Send no money.** Once approved, your policy and ID card will be mailed or emailed to you.

National Guardian Life Insurance Company

Home Office: National Guardian Life Insurance Company • Two East Gilman St. • PO Box 1191 • Madison, WI 53701
Administrative Office: Dentist Direct, LLC • 75 South 500 West • Bountiful, UT 84010 • 1-866-696-6527

To Be Completed by Applicant:
Applicant's Name________________________________ ________________________________
Last First

Applicant's Address: ____

City: ______________________________ State:_____________ Zip:________________

Date of Birth: _____/_____/_____ Male Female Applicant's Social Security Number: _____-____-______

Name of Spouse (If to be insured): ____________________ ________________________________
Last First

Spouse Date of Birth: _____/_____/_____ Male Female Home Telephone Number: (___)__________________

Email Address: ________________ @ ________________________ Is it OK to email your policy? Yes No

Check Coverage Desired:

Individual Individual & Spouse One-Parent Family Two-Parent Family

Indicated Method of Payment:
Deduct premium payments from my checking account automatically. (My voided check is enclosed.)
Charge future payments to: Visa MasterCard
Credit Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Expiration (MM/YY): ____/____

I want to pay:
Every Month Every 3 Months Every 6 Months Every 12 Months

To Be Completed for Each Dependent Child (if to be insured):

Child's Name (Last, First, Middle Initial)	Date of Birth (MM/DD/YYYY)	Gender	Check if:
		Male Female	Handicapped Child Full-Time Student
		Male Female	Handicapped Child Full-Time Student
		Male Female	Handicapped Child Full-Time Student
		Male Female	Handicapped Child Full-Time Student
		Male Female	Handicapped Child Full-Time Student

Do you have any other dental insurance in force with another company? Yes No
Is this insurance intended to replace any other insurance now in force? Yes No

NDNIND2005 APP

Applicant's Statements and Agreements:

1. I understand the effective date of the policy will be the date recorded in the Policy Schedule of Benefits by Us.
2. I understand the policy I am applying for contains different Waiting Periods for certain benefits listed in the Policy Schedule of Benefits. This means that no benefits are payable during the listed Waiting Period. The Waiting period begins on the effective date of coverage.
3. I understand that dependent children, if any, will be covered until the end of the month following their 19th birthday (24th if full-time students).
4. I acknowledge receipt of, if applicable: Outline of Coverage
5. I understand that: (a) National Guardian Life Insurance Company is not bound by any statement made by me, the applicant, or any associate/agent of National Guardian Life Insurance Company unless written herein; (b) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (c) the policy together with this application, endorsements, benefits agreements and riders, if any, is the entire contract of insurance; (d) No change to the policy will be valid until approved by our president and secretary, and noted in or attached to the policy.

Notice of Information Practices:

To issue an insurance policy, we may need to obtain additional information about You and any other persons proposed for insurance. Some information will come from You and some may come from other sources. That information and any other subsequent information collected by Us may in some circumstances be disclosed to third parties without Your specific consent. You have the right to access and correct the information collected about You except information that relates to a claim or a civil or criminal proceeding. If You wish to have a more detailed explanation of our information practices, please submit a written request to Us. This notice applies only in Arizona, California, Georgia, Illinois, Maine, Minnesota, Montana, Nevada, North Carolina, Oregon, and Virginia.

Authorization to Obtain Information:

I authorize the following to give information (defined below) to National Guardian Life Insurance Company or any person or group acting on their part: any medical professional, any medical care institution, insurer, reinsurer, government agency, consumer reporting agency or employer. "Information" means facts of a medical nature in regard to my physical or mental condition, employment, or other insurance coverage, or any other nonmedical facts. I understand that this information will be used by National Guardian Life Insurance Company to determine eligibility for insurance and may be used to evaluate a claim for benefits during the time that it is valid. I agree that this authorization is valid for 30 months from the date signed. I know that I have a right to receive a copy of this authorization upon request. I agree that a copy of this authorization is as valid as the original.

I also understand that if I am receiving Medicaid benefits, the purchase of this coverage may not be necessary.

If I am applying to replace existing coverage with this policy, I acknowledge that the policies my have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current policy and its benefits for the benefits provided in the National Guardian Life Insurance Company Policy. I have read, or had read to me, the completed application, and I realize policy issuance is based upon statements and answers provided herein, and they are complete and true to the best of my knowledge and belief.

The undersigned hereby authorizes Dentist Direct, LLC to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account indicated herein and the depository indicated herein, hereinafter called "DEPOSITORY," to credit and/or debit the same to such account. This authorization is to remain in full force and effect until Dentist Direct, LLC has received written notification from me of its termination in such time and in such manner as to afford Dentist Direct, LLC and DEPOSITORY a reasonable opportunity to act on it.	**For Questions Contact:** *Dentist Direct Dental Plans* *75 South 500 West* *Bountiful, UT 84010* *1-866-696-6527* *1-866-MY-MOLAR*

Signed and Dated ______________________________ on _____/_____/_____
Date

Applicant's Signature: ______________________________

Agent's Signature: ______________________ Agent No: ______________ Date:_____/_____/___