# NATIONAL GUARDIAN GROUP DENTAL / VISION
## GROUP APPLICATION

Administered by Dentist Direct, LLC
75 South 500 West, Bountiful, UT 84010
Group No. _____________

Legal Company Name_______________________________________________________ Phone (_______)__________________

Address __________________________________________________________________Fax (_______)___________________

City/State_____________________________________________________________ Zip Code ___________________________

SIC Code ________________________Contact for Administration & Eligibility _____________________________________________

Phone (______)______________________ Contact for Billing _______________________________________________________

Phone (______)______________________ # Employees: _______ # Eligible _______ # of Employees with Dependents _________

Group Effective Date: _______ / ________ / ________
A check for the first month's premium and other applicable fees must be attached to begin processing. Eligibility data will be submitted using:
Enrollment forms Email or electronic media

We elect to offer the following coverages to our employees:
Dental Insurance Vision Insurance

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.
(same as employer health plan)
Participation: Depending on group size and coverage elected, specific participation requirements will 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 firm. I will furnish with application, and upon any future request, a current census and State Quarterly Unemployment Tax Report, and any other information requested.

Monthly Administration Fee: I understand there is a [$15] monthly administrative billing charge.

Value-Added Marketing: We authorize National Guardian Life Insurance Company to send value-added marketing notices to those employees enrolled in this program. Such marketing materials will offer additional, insurance products and will be mailed to each members home.
Yes No
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 Company 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 (IN TEXAS AND KANSAS MAY BE GUILTY) GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Signed: ________________________________________________________________________ _______/______/_______
Name Title Date

National Guardian Representative _____________________________________________________ _____/______/_______
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 |
| **TO BE COMPLETED BY ADMINISTRATOR** | |
| Group Set Up Information<br><br>Account Manager:_____________________ | Account Management Approval<br><br>Signature______________________________<br><br>Date ______/_______/_______ |
| Notes: | % Commission<br><br>Dental:<br><br>Vision:<br><br>Life: |

Please mail completed Group Applications and accompanying Enrollment Forms and Initial Payment to:

National Guardian Life Insurance Company
c/o Dentist Direct, LLC