NATIONAL GUARDIAN LIFE INSURANCE COMPANY
GROUP DENTAL / VISION APPLICATION
Beam Insurance Administrators LLC | PO Box 300 | Burlington, KY 41005

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: (for voluntary coverage please enter $0)
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: ☐ National Guardian enrollment forms
☐ Email or electronic media (Employer must keep signed enrollment forms on file for future reference.)

Plan Selection: We elect to offer the following coverages to our Employees:
☐ Dental Insurance:
☐ Policy Year ☐ Calendar Year
Deductible:_____ Annual Maximum: ____
Co-Pay: Class 1___ Class 2 ___ Class 3 ___
Orthodontia: ☐ Yes ☐ No Maximum_____

☐ Vision Insurance:
☐ VSP Choice ☐ Other_____
Frequency: ☐ 12/12/12/12 ☐ 12/12/24/12 ☐ Other_____

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 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, any other information requested.

See reverse side

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 defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

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 Fax Email Address
TO BE COMPLETED BY NATIONAL GUARDIAN LIFE INSURANCE COMPANY	
Group Set Up Information Account Manager:_____	Account Management Approval Signature_____ Date _____/_____/_____
Notes:	% Commission Dental: Vision: Life:

See reverse side