**NATIONAL GUARDIAN LIFE INSURANCE COMPANY**

GROUP VISION APPLICATION

Administered by: **Superior Vision Services, Inc.**

11101 White Rock Road

Rancho Cordova, CA 95670

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Group Effective Date:  | **,**  |  | Group No.  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Legal Group Name |  | Tax ID Number |  |
| Physical Address |  | ERISA Number |  |
| City \ State \ Zip |  | SIC \ lndustry |  |
| Billing Address |  | # of Employees |  |
| City \ State \ Zip |  | # of Eligible |  |
| Eligibility Contact |  | Phone |  | Fax |  |
| Billing Contact |  | Phone |  | Fax |  |

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.)**

|  |
| --- |
| **Eligibility:** Employees working  hours per week will be effective for coverage upon: [ ]  30 Days [ ]  60 Days [ ] 90 Days |
| [ ]  1st of the month following  days  | [ ]  Other |  |

An eligible Dependent must be less than **19** years old or less than **N/A**  years 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 |  | Email |  |
| [ ]  Agent |  | Phone |  | Email |  |

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:  |  | Date: |  |
|   |
| Print Name:  |  | Title: |  |
|  |
| National Guardian Representative:  |  | Date: |  |

|  |  |
| --- | --- |
| Agent  | Tax I.D. # |
|  |  |
| Agency | Phone |
|  |  |
| Address | Fax |
|  |  |
| City/State/Zip | Email |
|  |  |

**National Guardian Life Insurance Company appointment on file**: **[ ]  Yes**  **[ ]  No** **[ ]  Pending** **[ ]  N/A**