

NATIONAL GUARDIAN LIFE INSURANCE COMPANY
GROUP VISION APPLICATION
 ExcelVision, 520 Eighth Avenue, Suite 900, New York, NY 10018

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)

Vision: \$_____ per month _____ % of premium, employee, \$_____ per month, dependent(s) _____ % of premium, dependent(s)

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 **checked** coverage to our Employees:

100% Employer Paid:	<input type="checkbox"/> Plan A, Employer Paid	<input type="checkbox"/> Plan B, Employer Paid	<input type="checkbox"/> Plan C, Employer Paid
Exam/Lenses/Frames	12/12/12	12/12/24	12/12/24
Copay Exam/Materials	\$10/\$10	\$10/\$25	\$15/\$30
Employee	\$7.74	\$6.00	\$5.18
Employee + Spouse	\$13.16	\$9.97	\$8.82
Employee + Child(ren)	\$13.55	\$10.27	\$9.08
Employee + Family	\$19.35	\$14.67	\$12.97
Voluntary: Min 2 Enrolled:	<input type="checkbox"/> Plan A, Voluntary	<input type="checkbox"/> Plan B, Voluntary	<input type="checkbox"/> Plan C, Voluntary
Exam/Lenses/Frames	12/12/12	12/12/24	12/12/24
Copay Exam/Materials	\$10/\$10	\$10/\$25	\$15/\$30
Employee	\$10.13	\$6.69	\$6.06
Employee + Spouse	\$19.74	\$12.98	\$11.81
Employee + Child(ren)	\$20.75	\$13.71	\$12.42
Employee + Family	\$28.85	\$19.06	\$17.26

Minimum Participation Requirement:

Employer Paid: 75 - 100% employer contribution for both employees & dependents. At least 75% participation of eligible employee

Voluntary: 0 - 49% employer contribution for employees. No employer contribution requirements for dependents. Two eligible, only one to enroll.

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 employees of this group. I will furnish with application, and upon any future request, any other information requested.

Monthly Administration Fee: I understand there is a **\$10.00** monthly administrative billing charge.

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

Group Attn: _____ Phone: (_____) _____

Broker or Agent

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.

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 GUILTY (IN TEXAS AND KANSAS MAY BE GUILTY) OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Signed: _____ / ____ / ____
Name Title Date

National Guardian Representative _____ / ____ / ____
NVI/NDN GRP APP 04/06 Date