

NATIONAL GUARDIAN LIFE INSURANCE COMPANY
GROUP VISION APPLICATION

Block Vision, Inc. 6737 West Washington Street, Suite 2202, Milwaukee, WI 53214 PH: 1-866-265-0517

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: ____/____/____

Payroll Frequency: _____

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:

Plan: Employer Paid (Company pays 50% or more of premium cost) Voluntary (Company pays less than 50% of premium cost)

Rate-tier Structure: 2-rate 3-rate 4-rate

Frequency (Exam/Lens/Frame/Contacts): Platinum (12/12/12/12) Gold (12/12/24/12) Silver (12/24/24/24)

Plan Type: Full-Service Eyewear-Only Exam-Only

Retail Frame Allowance: \$ _____

Copays: Exam Copay \$ _____ Eyewear Copay \$ _____

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 21 yrs. Old or less than 24 yrs. 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 full-time employees of this group. I will furnish with application, and upon any future request, a current census and State Quarterly Unemployment Tax Report, and any other information requested.

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 presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed: _____ /_____/_____
Name Title Date
National Guardian Representative _____ /_____/_____
Date