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 ___ yrs. Old or less than ___ 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. [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 injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Signed: ____ _______/______/_______

Name Title Date

National Guardian Representative ____ _____/______/_______

Date