NATIONAL GUARDIAN LIFE INSURANCE COMPANY

Administered by: AlwaysCare

GROUP INSURANCE APPLICATION

Application is hereby made to National Guardian Life on the basis of the information contained in this application, the group risk specifications, the enrollment data, and available experience data. The application in its entirety, and any required additional information, is subject to Home Office approval before insurance can become effective.

Once approved, the application will be attached to and made part of the Group Policy(ies). Insurance will become effective on the requested effective date shown below, unless written notice of a different effective date is sent.

If this application is not approved, no insurance is in effect at any time, and any deposit premium AlwaysCare has received will be returned.

This application is made with the following deposit premium. The premium amount is estimated, as the amount due for the first month, and will be applied toward the first premium on the proposed Group Policy(ies): $ _____

If any insurance requires member contributions, any underwriting requirements for enrollment must be met before insurance can become effective.

Legal Name of Group_____

Physical Address _____

City\State\Zip _____

Billing Address (If different) _____

City\State\Zip _____

Federal Tax ID _____

Members: _____ # Eligible: ____ # of Members with Dependents: ___

Group Effective Date: _____ /_____ / _____

Contact for Administration & Eligibility:

_____

Phone: (_____) _____

Fax: (_____) _____

E-mail Address: _____

Contact for Billing _____

Phone: (_____) _____

Fax: (_____) _____

E-mail Address: _____

Plan Selection: ☐ **Policy Year** ☐ **Calendar Year**

☐ **Dental Insurance** ☐ **Hearing Rider** (where applicable):

☐ **Vision Insurance** Attached to: ☐ Dental ☐ Vision

☐ **Basic Life (Policyholder Funded)**

☐ **AD&D** ☐ **Dependent Life**

☐ **Supplemental / Voluntary Life**

☐ **AD&D** ☐ **Dependent Life**

☐ **Short Term Disability**

☐ **Long Term Disability**

☐ **Critical Illness**

☐ **Accident**

Policyholder contributions:

Dental	$_____ per month or ____ % of premium
Vision	$_____ per month or ____ % of premium
Basic Life and AD&D	$_____ per month or ____ % of premium
Supplemental / Voluntary Life and AD&D	$_____ per month or ____ % of premium
Short Term Disability	$_____ per month or ____ % of premium
Long Term Disability	$_____ per month or ____ % of premium
Critical Illness	$_____ per month or ____ % of premium
Accident	$_____ per month or ____ % of premium

Eligibility: Permanent, full-time employees working 30 hours (Standard) or _____ (other) per week are eligible for coverage.
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. Coverage becomes effective the first of the month following eligibility.

W-2 Services Option (for Short Term Disability and Long Term Disability coverage only):
☐ Option 1: Withhold state and federal income taxes, and the employee's portion of FICA. Prepare and file W-2 Forms.
☐ Option 2: Withhold federal income taxes, and the employee's portion of FICA. Applicant waives W-2 Forms services.

A detailed description of the W-2 services elected by applicant pursuant to this application will be sent to the applicant via mail. Such services will be performed in accordance with the above election and established standard procedures.

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 members 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.

Monthly Administration Fee: I understand there is a **$5.00** monthly administrative billing charge for groups with less than 10 employees enrolled.

IMPORTANT NOTES:
Unless agreed to otherwise, membership cards, welcome letters and coverage summaries are printed and provided in a single package following group approval. The certificate of coverage, group policy, administration manuals and other information will be provided on a customized, group-specific CD-ROM to enable the Policyholder to distribute as needed via email or printouts to all enrolled Members. Members may also print ID Cards and certificates by visiting our website at www.AlwaysCareBenefits.com.

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 that 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.

The applicant understands that the requested group insurance will:

a. be issued only if the requested insurance is acceptable to National Guardian Life (the Company) and is legally permissible;
b. be issued under a group Policy or Policies in the language customarily used by the Company;
c. be subject to the Company's usual underwriting requirements (including Evidence of Insurability, if applicable);
d. be subject to all exclusions and limitations of the policy; and take effect on the date determined by the Company.

The Applicant understands that no agent or broker has the authority to guarantee the acceptability of the requested insurance. The effective date of insurance for which a member is required to submit satisfactory Evidence of Insurability will be determined in accord with the Policy's terms, and will be subject to the Active Work requirement. The applicant agrees not to:

a. collect or pay premiums (other than the Binder Premium) for such insurance, before receiving the Company's notice of approval; or
b. distribute material describing Policy coverage to persons to be insured, without the Company's prior written consent.

WARNING: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicant Signature: _____ _____/_____/_____
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 ☐Yes ☐ No **(Please attach Appointment Paperwork if not appointed)**
Address City/State/Zip	Phone Fax Email Address

TO BE COMPLETED BY ALWAYSCARE BENEFITS

Group Set Up Information	Account Management Approval
Group Code: _____	Account Manager:_____
SIC Code: _____	Signature_____ Date ____/____/_____

Notes: