Administered by:
AlwaysCare

GROUP INSURANCE APPLICATION

Underwritten by: National Guardian Life Insurance Company and/or Starmount Life Insurance Company

Application is hereby made to the Company (Starmount Life Insurance Company and/or National Guardian Life Insurance Company) 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**+ ☐ **Vision Insurance**+

☐ **Hearing Rider**+ (where applicable)
Attached to: ☐ Dental ☐ Vision

☐ **Safety Glass Rider**+ (where applicable)
Attached to: ☐ 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***

* Underwritten by National Guardian Life Insurance Co.
+Underwritten by Starmount Life Insurance Co.

Policyholder contributions:

Dental	$_____	per month or ____ % of premium
Vision	$_____	per month or ____ % of premium
Basic Life –Employee	$_____	per month or ____ % of premium
Basic Life-Dependent	$_____	per month or ____ % of premium
Supplemental/Voluntary Life –Employee	$_____	per month or ____ % of premium
Supplemental/Voluntary Life –Dependent	$_____	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. Coverage becomes effective the first of the month following eligibility.

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 the Company now and in the future to verify the number and names of full-time employees/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.

Please see Page 2 for signature

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 via email or printouts to all enrolled Members. Members may also print ID Cards and certificates by visiting our website at www.AlwaysCareBenefits.com.

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

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 the Company 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 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 an employee is required to submit satisfactory Evidence of Insurability will be determined in accord with the Policy's terms. The Actively at Work requirement will apply. 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 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.

Applicant Signature: _____ _____/_____/_____
Name Title Date

Starmount Life or National Guardian Representative: _____ _____/_____/_____
Date

Agent (if applicable)	Tax I.D. Number
Firm Name (if applicable)	Starmount Life Insurance Company and/or National Guardian Life Insurance Company appointment is 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:	