



**NATIONAL GUARDIAN LIFE INSURANCE COMPANY  
GROUP DENTAL & VISION EMPLOYER APPLICATION**

Administered by Cypress Dental Administrators  
7510 Shoreline Drive, Suite A-1, Stockton, CA 95219  
Toll Free: (800)350-3989 Fax: (209)478-5614



**Group Effective Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Please submit copy of plan and rates chosen with enrollment forms**

Legal Company Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

Contact for Administration & Eligibility \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Contact for Billing \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

# Employees \_\_\_\_\_ # Eligible \_\_\_\_\_ SIC Cod: \_\_\_\_\_

Primary Contact Email Address \_\_\_\_\_ Website \_\_\_\_\_

Agent Contact Name \_\_\_\_\_ Agent Contact Email Address \_\_\_\_\_

**A check for the first month's premium and other applicable fees must be attached to begin processing.  
Make check payable to Cypress Dental Administrators**

We elect to offer the following coverage to our employees:

Dental Insurance - Voluntary or Employer Funded (circle one)

Vision Insurance - Voluntary or Employer Funded (circle one)

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 26 yrs. old regardless of the dependent's student status, marital status or employment status.

Participation: Depending on group size and coverage elected, specific participation requirements will 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 Cypress Dental Administrators now and in the future to verify the number and names of full-time employees of this firm. 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 may be a \$0-20 monthly administrative billing charge, based on group size.

Please send (check one):

Plan documents on CD w/printed ID cards sent to Employer Attn: \_\_\_\_\_ Email Address: \_\_\_\_\_

Printed plan documents w/printed ID cards sent to Employer Attn: \_\_\_\_\_ Email Address: \_\_\_\_\_

Printed plan documents w/printed ID cards sent to Employee's home address

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 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.

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 (in Texas and Kansas may be guilty) guilty of a crime and may be subject to fines and confinement in prison.

Signed: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name

Title

Date

Cypress Dental Administrators \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date

**Please Send Completed:**

- Group Application
- Roster or Employee Enrollment Forms
- Copy of plan and rates chosen
- Initial premium payment

**To:** Cypress Dental Administrators  
7510 Shoreline Drive, Suite A-1  
Stockton, CA 95219

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Fax (209)478-5614

[www.cypressadmin.com](http://www.cypressadmin.com)