ENROLLMENT FORM FOR GROUP LIFE INSURANCE

National Guardian Life Insurance Company (NGL) - Phone 800.762.9883 - Fax 866.228.9927
Two East Gilman Street - PO Box 1191 - Madison WI 53701-1191

Mail Policy To: ☐ Agent ☐ Owner (Default)

PROPOSED INSURED ☐ MALE ☐ FEMALE

First Name | *MI* | *Last Name* | *Phone Number* | *Social Security Number* | *Age* | *Date of Birth*

OWNER - Complete only if other than Insured

First Name | *MI* | *Last Name* | *Social Security Number* | *Relationship to Insured*

OWNER MAILING ADDRESS

Street Address | *City* | *State* | *Zip* | *Email Address*

Face Amount $ _____ **Premium $** _____

PAYMENT PLAN ☐ Single Pay Life

Multi Pay Life: ☐ 3 Year ☐ 5 Year ☐ 7 Year ☐ 10 Year

PLAN - Complete for Single Pay

☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H

Initial Premium + Multi Pay Premium = Total Premium Amount (with app)

$ _____ $ _____ $ _____

PAYMENT MODE ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Direct ☐ EFT* ☐ MC/VISA* *Complete the premium withdrawal authorization

STATEMENT OF HEALTH (To be completed by Proposed Insured): Are you currently on oxygen, hospitalized, receiving hospice care, or residing in a nursing home, long term or residential care facility, or group home; **or** during the past two years have you been advised by a medical professional to have any surgical procedure that has not been performed; **or** have you been treated or are you being treated (including medication) by a medical professional for any of the following diseases or disorders: ☐ **YES** ☐ **NO**

Congestive Heart Failure	Immune System Disorder	Chronic Obstructive Pulmonary (lung) Disease	Amputation (caused by disease)
Heart Disease	Cirrhosis of the Liver	Emphysema	Alzheimer's/Dementia
Stroke	Drug or Alcohol Dependency	Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	
Cancer (other than skin)	Kidney failure (including dialysis)	Diabetic Coma/Insulin Shock	

If the health question is not answered or answered "Yes" and you are applying for a Multi Pay Plan, a Policy with limited death benefits during the early years will be issued. The full death benefit is paid for accidental death.

BENEFICIARY INFORMATION

Name of Primary Beneficiary, Estate of Insured, or NGL Trust

APPLICANT SIGNATURES

To the best of my knowledge and belief, the above information is true and complete. I understand that no insurance will be effective until this form is approved and the Policy is issued while the Insured is living. I acknowledge that the Policy applied for provides funds at the time of death which may be used for the purchase of funeral services and merchandise, but does not provide specific funeral services and merchandise. It is not an agreement with a funeral establishment. I understand that any information provided regarding the cost of funeral services was provided as general consumer information only. No representations were made that specific merchandise and/or service have been purchased or will be provided at the time of death. If I am the Owner for insurance on the life of the Proposed Insured, I certify that I have an insurable interest in his or her life. **I acknowledge that I have read the fraud warning statement on the last page of this form.**

Signed At | *State*

Signature of Proposed Insured | *Date* | *Signature of Owner (Required if other than Insured)* | *Date*

AGENT'S STATEMENT I certify that any information recorded by me on this form is true and accurate to the best of my knowledge.

Agent Signature | *Agent Name Printed* | *NGL Agent #* | ☐ Check here for Agent Split and see last page.

AGENT SPLIT DESIGNATION: Please list any agents not included in the **AGENT'S STATEMENT** section.

Agent listed in **AGENT'S STATEMENT** % _____

Additional Agent Signature	*Additional Agent Name Printed*	*Additional NGL Agent #*	*%*

ACKNOWLEDGMENT OF PAYMENT: This acknowledges payment from _____ in the amount of $ _____ in connection with the Policy applied for from NGL. If all of the conditions of the application are met and the application is accepted, a Policy will be issued. If the application is not accepted, the Insurer's only responsibility will be to refund the amount for which this Acknowledgment of Payment was given.

ELECTRONIC CHECK DISCLOSURE: When you provide a check as payment, you authorize us to either use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you will not receive your check back from your financial institution. In the event that the payment is not honored, NGL has the right to re-present the transaction. For inquiries please call 1-800-762-9883.

FRAUD WARNING STATEMENTS

For Residents of AK, DE, ID, IL, IN, MO, ND, NV, SC and WY: Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information is guilty of insurance fraud.

For Residents of District of Columbia: 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.

For Residents of GA, KS and NE: Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information may be guilty of insurance fraud.

For Residents of Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.