

SERFF Tracking Number: NGLI-128477660 State: Arkansas  
Filing Company: National Guardian Life Insurance Company State Tracking Number:  
Company Tracking Number: AMEND-MET(06/2012)  
TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision  
Product Name: Multiple Employer Trust Amendment  
Project Name/Number: /AMEND-MET(06/2012)

## Filing at a Glance

Company: National Guardian Life Insurance Company

Product Name: Multiple Employer Trust SERFF Tr Num: NGLI-128477660 State: Arkansas

Amendment

TOI: H20G Group Health - Vision SERFF Status: Closed-Approved- State Tr Num:  
Closed

Sub-TOI: H20G.000 Health - Vision Co Tr Num: AMEND-MET(06/2012) State Status: Approved-Closed

Filing Type: Form Reviewer(s): Rosalind Minor

Authors: Peggy Kratz, DeeAnna Disposition Date: 06/21/2012

Chaput

Date Submitted: 06/18/2012 Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number: AMEND-MET(06/2012)

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Trust

Overall Rate Impact:

Filing Status Changed: 06/21/2012

State Status Changed: 06/21/2012

Deemer Date:

Created By: DeeAnna Chaput

Submitted By: DeeAnna Chaput

Corresponding Filing Tracking Number:

Filing Description:

National Guardian Life Insurance Company

NAIC# 66583; FEIN# 39-0493780

Multiple Employer Trust Amendment: AMEND-MET(06/2012)

Dear Commissioner/Director

The attached Multiple Employer Trust Amendment form (AMEND-MET(06/2012)) is submitted for your review and

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approval. This form is new and does not replace any previously approved form.

The Multiple Employer Trust Amendment form will be attached to limited benefit health insurance policy forms (dental, vision, critical illness, etc.). The purpose of this form is to amend the approved forms for use with an employer group trust.

We request approval of the amendment for previously approved policy forms, in addition to forms that may be approved in the future. Currently, we anticipate using this amendment form with the group vision policy (NVIGRP 5/07) and certificate (NVIGRPCTV2 5/07), approved on 8/16/2007, under SERFF Tracking No. NGLI-125252193.

We request approval of this form for use with groups located in your state, as well as for certificates issued to residents of your state on an out-of-state basis- when the group policy is issued in another state.

The Multiple Employer Trust Amendment form is intended for use with various employer group trusts. It will be initially offered through The Lower Agency (TLA) Multiple Employer Trust, domiciled in Missouri; and approved in Arkansas on 3/8/2010, under SERFF tracking no. NGLI-126488200. This amendment form will be attached to the previously approved certificate (noted above) issued for delivery to Arkansas enrollees on an out-of-state basis.

The previously approved form NDVRX GRPAPP-MET 08-08 will be used as the group application for participation in the trust; and form NDVRX Enroll-MET 08-08 will be used for enrolling insureds: both forms were approved on 3/8/2010 with the TLA trust filing noted above.

Your approval of this form would be greatly appreciated. Please contact me at the number or email address provided if you have any questions or concerns.

Sincerely,

DeeAnna Chaput  
Product Compliance Analyst  
National Guardian Life Insurance Company  
(608)443-5317  
dmchaput@nglic.com  
State Narrative:

## **Company and Contact**

### **Filing Contact Information**

DeeAnna Chaput, Product Compliance Analyst dmchaput@nglic.com  
- Group Markets

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2 E. Gilman Street 608-443-5317 [Phone]  
 Madison, WI 53701 608-443-5365 [FAX]

**Filing Company Information**

National Guardian Life Insurance Company CoCode: 66583 State of Domicile: Wisconsin  
 P.O. Box 1191 Group Code: 1211 Company Type: LAH  
 Madison, WI 53701-1191 Group Name: State ID Number:  
 (800) 626-7931 ext. 5325[Phone] FEIN Number: 39-0493780

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: One Amendment form filing at \$50.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
National Guardian Life Insurance Company	\$50.00	06/18/2012	60217534

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/21/2012	06/21/2012

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## Disposition

Disposition Date: 06/21/2012

Implementation Date:

Status: Approved-Closed

Comment:

This submission is being approved with the understanding that all METs must be registered with our License Division prior to marketing the product through the MET. Please refer to ACA 23-92-101.

Thank you for your cooperation.

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Explanation of Variable Data	Approved-Closed	Yes
Form	Multiple Employer Trust Amendment	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: AMEND-MET(06/2012)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/21/2012	AMEND-MET(06/2012)	Policy/Contract	Multiple Employer Trust Amendment	Initial		50.700	AMEND-MET(062012).pdf
		Certificate: Amendment, Insert Page, Endorsement or Rider					

**NATIONAL GUARDIAN LIFE INSURANCE COMPANY**  
**Two East Gilman Street, PO Box 1191, Madison, Wisconsin 53701**

**POLICY/ CERTIFICATE AMENDMENT**

**The Group Policy To Which This Amendment Is Attached Is Issued To A Multiple Employer Trust.  
The Group Policy Provides [Vision Benefits] to Employees of  
Employers Who Agree to Participate in the Trust**

**The Policy and Certificate is amended as follows:**

**A. The following definitions are added:**

**Employer** – The entity for whose Employees benefits are being provided that has been approved by Us to participate under the Policy issued to the Policyholder.

**Policyholder** – The Trust that contracts with Us on behalf of the participating Employers.

**B. The Premiums provision is amended to provide that:**

Each Employer is responsible for the premium of its Employees. The first premium is due on the Effective Date of each Employer's coverage under the Policy. Premiums after the first are due on the Premium Due Date agreed to by the Employer and Us. Our right to change premium rates on any due date after the Initial Term applies to the Initial Term for each Employer.

**C. Any provisions regarding Termination of the Policy or Certificates are amended as follows:**

In addition to the Policy Termination rights of the Policyholder and Us, the following termination provisions apply to each Employer:

1. Each Employer may terminate coverage under the Policy by giving written notice to Us. Termination of the Employer's coverage will be effective on the later of: (1) the date We receive the notice; or (2) the requested Effective Date.
2. We may terminate an Employer's coverage, after the Employer's coverage has been in effect for one year, as follows:
  - a. With 60 days advance written notice to the Employer, we may terminate coverage for any reason.
  - b. With 30 days advance written notice to the Employer, we may terminate coverage if the Employer fails to maintain the following participation requirements:
    - When Insureds are not required to contribute to the cost of their own insurance, there must be 100% participation.
    - For groups of [2-9] Employees, [100%] participation is required for both Employees and their dependents.
    - For groups of [10 or more] Employees where benefits are funded by the Employees, [25%] participation is required for both Employees and their Dependents. A minimum of [10] must enroll.
    - Participation must not drop [25%] or more from the participation on the original effective date.
3. Termination may take effect on an earlier date when both We and an Employer agree.

If coverage under the Policy terminates for any reason, the Employer is liable to Us for all unpaid premium for the period during which the Policy was in force, with respect to those Insureds.

**D. The Entire Contract provision is deleted in its entirety and replaced by the following:**

The Entire Contract consists of:

1. the Policy;
2. the application of the Policyholder;
3. The application of each Employer;
4. the provisions shown in the Certificate;
5. the Insured enrollment forms; and
6. riders and endorsements, if any, adding or changing the provisions of the Policy or Certificate.

A copy of the Policyholder's application and each Employer's application is attached to this Policy on the date it is signed. All statements made in the applications, in the absence of fraud, are representations and not warranties. No statement made by an Insured under this Policy will be used to void insurance or deny a claim unless a copy of the statement is or has been given to that Insured or to His Beneficiary, if any.

**This Endorsement takes effect and expires on the same date as the policy to which it is attached.**

**There are no other changes to the policy/certificate.**

In witness whereof, the Company has caused this Amendment to be signed by its President and Secretary.

  
Secretary

  
President

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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	06/21/2012
<b>Comments:</b>		
<b>Attachments:</b>		
AMEND-MET(06 2012) CERTIFICATION OF READABILITY.pdf		
Certificate of Compliance - AMEND-MET(06 2012).pdf		

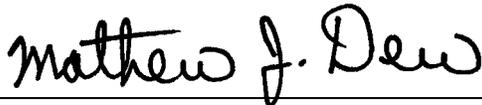
	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	06/21/2012
<b>Comments:</b>		
Group Application NDVRX GRPAPP-MET 08-08 will be used with this form; approved on 3/8/2010, under SERFF Tracking number NGLI-126488200.		
<b>Attachment:</b>		
NDVRX GRPAPP-MET 08-08.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Explanation of Variable Data	Approved-Closed	06/21/2012
<b>Comments:</b>		
<b>Attachment:</b>		
Variable Data_AMEND-MET (06 2012).pdf		

## CERTIFICATION OF READABILITY

I, Mathew J. Dew, an officer of National Guardian Life Insurance Company, certify that the Flesch score for the submitted form is listed below:

Form	Flesch Score
AMEND-MET(06/2012)	50.7



Signature

June 18, 2012

Date

**Mathew J. Dew**

Vice-President and General Counsel  
National Guardian Life Insurance Company



## CERTIFICATE OF COMPLIANCE

Name Of Insurer: National Guardian Life Insurance Company

Form No:

AMEND-MET(06/2012)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that this form and related writings comply with all laws, rules, bulletins and published guidelines applicable to the particular type of form.

*Mathew J. Dew*

June 18, 2012

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Signature

Date

**Mathew J. Dew**

VP and General Counsel

Individual responsible for this filing:

Name: DeeAnna Chaput

Title: Product Compliance Analyst

Phone #: (608) 443-5317

Email: [dmchaput@nglic.com](mailto:dmchaput@nglic.com)

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**National Guardian Life Insurance Company (NGL) • Two East Gilman Street • PO Box 1191 •  
Madison WI 53701-1191**

**608.257.5611 • 800.548.2962 • Fax: 608.257.4308 • [www.nglic.com](http://www.nglic.com)**

**NATIONAL GUARDIAN LIFE INSURANCE COMPANY**

GROUP APPLICATION FOR [DENTAL]/ [VISION]/ [OUTPATIENT PRESCRIPTION DRUG] INSURANCE  
[TPA NAME AND ADDRESS]

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

**[Plan Selection:** We elect to offer the following coverages to our Employees:

Dental Insurance]  Vision Insurance]  Outpatient Prescription Drug Insurance]  
[Dental Plan Options: ] [Vision Plan Options: ] [RX Plan Options: ]]

**Coverage Elected and Premiums:**

**[Dental:**  \$ \_\_\_\_\_ per [month], per Certificate for Employee only  
 \$ \_\_\_\_\_ per [month], per Certificate for Employee and spouse [/Domestic Partner] only  
 \$ \_\_\_\_\_ per [month], per Certificate for Employee and one child only  
 \$ \_\_\_\_\_ per [month], per Certificate for Employee and children only  
 \$ \_\_\_\_\_ per [month], per Certificate for Employee, spouse [/Domestic Partner] and children ]

**[Vision:**  \$ \_\_\_\_\_ per [month], per Certificate for Employee only  
 \$ \_\_\_\_\_ per [month], per Certificate for Employee and spouse [/Domestic Partner] only  
 \$ \_\_\_\_\_ per [month], per Certificate for Employee and one child only  
 \$ \_\_\_\_\_ per [month], per Certificate for Employee and children only  
 \$ \_\_\_\_\_ per [month], per Certificate for Employee, spouse [/Domestic Partner] and children ]

**[RX Drug:**  \$ \_\_\_\_\_ per [month], per Certificate for Employee only  
 \$ \_\_\_\_\_ per [month], per Certificate for Employee and spouse [/Domestic Partner] only  
 \$ \_\_\_\_\_ per [month], per Certificate for Employee and one child only  
 \$ \_\_\_\_\_ per [month], per Certificate for Employee and children only  
 \$ \_\_\_\_\_ per [month], per Certificate for Employee, spouse [/Domestic Partner] and children

Premium is non-contributory –100% of eligible Employees must be covered]  
 Premium is contributory. Percentage Paid by Policyholder \_\_\_\_\_ %]

**[Total Premium Submitted with Application: \$ \_\_\_\_\_ ]**

Eligibility data will be submitted using:  Enrollment forms  Email or electronic media (Employer must keep signed enrollment forms on file for future reference.)

**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.]] (same as employer health plan)

**[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 may 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 the application, and upon any future request, [a current census and] any information requested for the purpose of issuing and administering benefits.

[Monthly Administration Fee: I understand there is a **[\$15.00]** monthly administrative billing charge.]

Please send Membership Materials and Enrollment Materials to (CHECK ONE):

NDVRX GRPAPP-MET 08-08

Group, Attn: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 Broker or Agent

The Employer agrees to participate in the [National Guardian Life Insurance Company's Employer/Employee Group Insurance Plan Trust]. The Employer acknowledges that as an "employer," the Employer is establishing this [dental] [vision] [prescription drug] plan. Neither National Guardian Life nor the policyholder/trustee is acting as a "sponsor" as defined in ERISA. Employer agrees that any compliance with ERISA that is applicable to the Employer is the responsibility of the Employer.

[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 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. I acknowledge that I have read the applicable Fraud Warning statement printed on this form.

Signed by Employer:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Name Title Date

Agent's Signature \_\_\_\_\_ Agent's Name (Printed) \_\_\_\_\_

NGL Agent # \_\_\_\_\_ Agent State License # \_\_\_\_\_

Date

**Fraud Warning:**

[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 [(in Georgia, Kansas, Nebraska, Texas and Oregon may be guilty)] of insurance fraud.]

**[In Arkansas and Louisiana:** 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."

**In Arizona:** Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

**In California:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**In Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

**In District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**In Florida:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**In Kansas:** 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 committing a fraudulent insurance act.

**In Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**In Massachusetts:** 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.

**In Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**In New Hampshire:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud.

**In New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**In New Mexico:** 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 civil fines and criminal penalties.

**In Ohio:** Any person who, with intent to defraud or knowing that he 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.

**In Oklahoma:** 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.

**In Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**In 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.

**In Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**In Washington:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.]

**MULTIPLE EMPLOYER TRUST AMENDMENT  
DEFINITION OF VARIABLE TEXT**

**AMENDMENT FORM – AMEND-MET(06/2012):**

**Page 1:**

1. The benefit type [Vision Benefits] may be changed to coincide with the benefit policy/certificate amended.
2. Part C. – The information is bracketed to allow changes based on a specific employer's rules with regard to employee participation requirements.