BEST ✩ Life
BEST Life & Health Insurance Company

BEST IndemnityPlus Dental Plans Group Employer Application

Requested Effective Date: ☐ 1st or ☐ 15th of the month _____, 200______ ☐ Dental ☐ Life ☐ Stand Alone Vision

INDEMNITYPLUS PLAN TYPE	High Plan	Mid Plan	Basic Plan
Choose Calendar Year Maximum	☐ $2,500	☐ $2,000	☐ $1,000
	☐ $2,000	☐ $1,500	☐ $750
	☐ $1,500	☐ $1,200	☐ $500
	☐ $1,000	☐ $1,000	
Choose Deductible	☐ $0 ☐ $25 ☐ $50 ☐ $75 ☐ $100	☐ $0 ☐ $25 ☐ $50 ☐ $75 ☐ $100	☐ $0 ☐ $25 ☐ $50 ☐ $75 ☐ $100
Perio Option	☐ Class II ☐ Class III	☐ Class II ☐ Class III	☐ Class II ☐ Class III
Endo Option	☐ Class II ☐ Class III	☐ Class II ☐ Class III	☐ Class II ☐ Class III
Choose Orthodontia Option	☐ Adult & Child ☐ Child Only $1,000 ☐ Child Only $1,500	☐ Adult & Child ☐ Child Only $1,000 ☐ Child Only $1,500	☐ Child Only $1,000 ☐ Child Only $1,500
*Voluntary Option**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
*Two-Year Initial Rate Guarantee Option**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
*Dual Option (check plans selected)**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Reimbursement Level	☐ 80th % ☐ 90th %	☐ 80th % ☐ 90th %	☐ 80th % ☐ 90th %

Certain requirements apply. Please see Plan Brochure for details.

VISION PLAN TYPE			
Plan Choice	Voluntary Option*	Deductible Choice	Lenses/Contacts Choice
☐ Plan A (12/12/12/12) ☐ Plan B (12/12/24/12) ☐ Plan C (12/12/24/24) ☐ Plan D (12/24/24/24)	☐ Yes ☐ No	☐ $0 ☐ $10 ☐ $25	☐ Lenses, Frames **AND** Contacts ☐ Lenses, Frames **OR** Contacts

Please answer the following questions:

1. ☐ Yes ☐ No **Does the employer now have or has the employer had a comparable group dental plan in force during the past twelve (12) consecutive months?**
For employer-sponsored: 12-month wait on Class III and Class IV services is waived for employees who have had 12 consecutive months of comparable coverage under a prior plan and who are in a group with 5-9 employees enrolling with proof of continuous coverage and comparable prior group coverage; all employees in a group 10+ employees enrolling.
For voluntary: 12-month wait on Class III and Class IV services is waived for employees who have had 12 consecutive months of comparable coverage under a prior plan and who are in a group with 5-9 employees enrolling with proof of continuous coverage and comparable prior group coverage; all employees in a group with 10-24 employees enrolling and 50% participation with proof of comparable prior group coverage; if 50% participation is not met, waiver will only apply to employees who have proof of 12 consecutive months of coverage under a prior plan (proof of comparable and continuous prior group coverage must be provided); all employees in a California group with 10+ employees enrolling; all employees in a group with 25+ employees enrolling.
A copy of your most recent dental bill listing the covered employees and their effective dates must accompany this application.

2. ☐ Yes ☐ No **Are all full-time employees enrolling in the group dental plan?**

3. ☐ Yes ☐ No **Are any employees enrolling in the policy currently receiving extended benefits under COBRA?** If yes, please list names:
____
____

4. ☐ Yes ☐ No **Waiting Period is waived for Present Employees.**

5. **Waiting Period for New Employees:** First of the Month following continuous full time employment of:
☐ 1st of the month following date of hire ☐ 1 Full Calendar Month (standard) ☐ 2 Full Calendar Months ☐ 3 Full Calendar Months ☐ 4 Full Calendar Months

Employer Contribution for Employees (for employer-sponsored plans, the Employer must pay at least 50% for each employee.): %, For Dependent Coverage: %.

Description of Classes not Eligible: Number of Total Employees on Payroll: ______________________

______________________________________ Number of Full-Time Employees: ______________________

I understand and agree that the insurance hereby applied for is not effective until this application and the full initial premium is delivered to, received by and approved by BEST Life and Health Insurance Company.

Employer Signature:	Print Name:	Date:

EMPLOYER ACKNOWLEDGEMENT & ASSOCIATION AND TRUST MEMBERSHIP APPLICATION

Employer Name | Employer Federal Tax Number

Street Address | City | State | Zip | Telephone Number ( ) - | Fax Number ( ) -

Billing Address P.O. Box | City | State | Zip | E-Mail

Nature of Firm's Business | SIC Code | Person at Firm to Contact for Service and Administration of the Dental Plan

(continued on other side)

Employer Name

I certify that this is a bona fide business with a legitimate business purpose and which has a true employer-employee relationship with the individuals designated as employees. I understand that any false statements made in this application constitute the legal basis for termination or cancellation of coverage retroactive to the effective date and denial of all claims incurred.

Termination of Coverage—Employee coverage and dependent coverage will terminate on the earliest of the following dates: (1) the date the employee ceases to be an eligible employee or the date the dependent is no longer eligible as a dependent under the plan; (2) the date the plan is terminated; (3) the date the employer terminates the coverage by failing to pay the required premium; (4) the date the group policy is terminated; (5) the date the group no longer meets minimum participation requirements. The benefits are subject to all the conditions and limitations of the plan.

Eligible dependent coverage terminates on the earliest of the following: when the dependent no longer meets the definition of a dependent; on the first day of the month in which premiums were not paid, or when the member terminates coverage.

FIRM ELIGIBILITY:

A firm or employer must be an active business operation to request coverage. The business must continue on an active basis to retain eligibility for coverage. Coverage will be terminated on the effective date the business ceases active operation. I understand that if my firm drops in size to 1 employee for more than 90 consecutive days, all of my selected insurance coverage will be cancelled.

IMPORTANT PLAN INFORMATION

The undersigned Employer understands and agrees that by adopting one or more BEST plans, it is establishing an employee welfare benefit plan for its employees. The employer further understands and agrees that the general definition of an employee is a person who usually works at least 30 hours per week at the firm's business location with federal, state and social security tax withheld from their salary. The Employer's plan is funded through the Beneficial Employees Security Trust of Utah ("B.E.S.T.") to which the Employer subscribes. The insurance companies issue group insurance policies to the Trustee of B.E.S.T. These policies provide the coverage(s) the Employer selects.

B.E.S.T. receives the subscribing employer's payment and remits the insurance premium to the insurance carrier(s) or to affiliates filing a common federal income tax form that provide services to Employers and to B.E.S.T. One of the insurance carriers is BEST Life and Health Insurance Company ("BEST Life").

The Employer agrees and understands that by signing this Trust Membership Application, it becomes a Subscribing Employer of the Trust. A subscribing employer of the Trust agrees to be bound by all the terms and conditions of the Trust Agreement. A subscribing employer of the Trust further agrees that the Trustee shall not be liable to any participating Employers, to any person insured, or to anyone else in connection with the operation of the Group Insurance Trust Fund.

The Master Group Policy is issued to the Trustee of B.E.S.T. To participate in the plan, each subscribing employer adopts the Trust. The Master Group Policy is governed by the laws of the state of Utah. However, to the extent that such Policy and/or Certificate of Coverage is in conflict with the laws of another demonstrating statutory governing jurisdiction over an out-of-state multiple employer trust Policy, then such Policy and/or Certificate of Coverage will be amended to comply with the minimum requirements of that state.

X   /   /

Signature of Company Officer	Print Name & Title	Dated

Benefit Representative Report

(Please Print)

Name ______________________

It is not necessary to complete the following information if you are currently receiving service fees from BEST Health Plans unless changes in address, etc. need to be made. Just sign and date the form below.

Your Agency Name

Address

City | State | Zip

Who Should Receive the Service Fees? ☐ Benefit Representative ☐ Company/Firm

Social Security Number - - | Federal Tax ID

Date of Birth / / | License No. | State

Phone No. | FAX No.

E-mail Address

(Please Complete)

Special Instructions to BEST Health Plans

1. May we contact the client if we need additional information?
   ☐ Yes ☐ No
2. Is this your first case with BEST Health Plans? ☐ Yes ☐ No
3. This is: ☐ an existing client ☐ a new client with my company
4. The 'New Client Kit' (certificate book, claim forms, etc.) should be sent to:
   ☐ The benefit representative ☐ The client
5. The underwriter assigned to my case should contact me? ☐ Yes ☐ No

General Agent (GA):

Please list any special handling needed for this client:

I hereby certify that I hold a valid Life, Accident and Health license issued by the state in which this document was executed and that all of the information contained herein is correct, to the best of my knowledge, and that I know nothing unfavorable about this firm or any individual applying for insurance unless fully described in this application material. Furthermore, I certify that:

1. This firm is a bona fide business establishment and participation requirements are being met.
2. I have advised my client not to terminate any existing coverage until this coverage is approved.
3. Coverage, eligibility provisions, waiting periods and limitations have been fully explained to, and understood by, the Employer identified in this document.
4. I have no right to bind, modify or alter provisions of this program.

I understand and agree that the insurance applied for herein does not begin until this application is received and approved by BEST Life and Health Insurance Company, the insurance certificates are issued and the first premium is received and accepted.

Agent's Signature:	Print Name:	Date:

Phone: (800) 433-0088 • e-mail: cs@bestlife.com • www.bestlife.com

Employee Request for BEST Life Dental Only

☐ New Enrollment ☐ Add Dependents ☐ Name Change

EMPLOYEE INFORMATION

Last Name	First Name	M.I.	DOB	Age	Gender ☐ M ☐ F	SSN

Residence Street Address	City	State	Zip

Name of Company	Group #, if known	Job Title	Date of F/T Hire	Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced

If changing your name, provide new name:	Do you have any eligible dependent children? ☐ Yes ☐ No If yes, how many?

Will this replace other dental insurance? ☐ Yes ☐ No Name of Carrier	☐ Group ☐ Individual ☐ Other

Policy # of Prior Coverage	Effective Date of Prior Coverage	Anticipated Termination Date of Prior Coverage

Are you insuring your dependents? ☐ Yes ☐ No
If 'Yes' complete the section below and explain any differences in last name, if applicable. If no, complete the waiver of coverage section below.

Eligible dependents include spouses and unmarried dependent children. Dependent children are covered through age 20, extended through age 25 if they are full-time students. Dependent children residing in: FL are covered through age 29; UT are covered through age 25; TX, WA* and MT* are covered through age 24; IN*, MO, MS, TN and WV are covered through age 23. *Does not offer extended coverage through age 25.

DEPENDENT INFORMATION

Qualifying Event (Select One)	Dependent Name	Relation	Full-Time Student?	Gender	SSN	Date of Birth
☐ Loss of Coverage ☐ Marriage Date:		**Spouse**	**Yes/No**	**M/F**		
☐ Loss of Coverage ☐ New Dependent			**Yes/No**	**M/F**		
☐ Loss of Coverage ☐ New Dependent			**Yes/No**	**M/F**		
☐ Loss of Coverage ☐ New Dependent			**Yes/No**	**M/F**		
☐ Loss of Coverage ☐ New Dependent			**Yes/No**	**M/F**		

I certify that my date of birth, date of employment and other information on this form are correct and that I am working at the employer's place of business in full time employment at least 30 hours per week. I authorize my employer to make deductions from my earnings necessary to provide my contribution for this coverage and understand that my employer is performing this service for my benefit and not as an agent of the insurer. I understand that coverage is not in force until the effective date shown on the Certificate of Insurance issued to me; however, if I am absent from full-time employment on such dates as the result of an accident or sickness, I agree that coverage is not effective. I determine the coverage in force and that coverage is not in force if an application for that coverage has not been made by my employer. Additionally, if I am accepted, this request for group insurance will become part of the agreement between BEST Life and Health Insurance Company and myself. I, and any enrolled family members, agree to be bound by the arbitration clause in the BEST Life and Health Insurance *Certificate Booklet, if any,* instead of trial by a court of jury. I agree that insurance does not begin until this application is approved by BEST Life and Health Insurance Co., my insurance certificate is issued, and the first premium is paid.

Fraud Notice - The following general Fraud Notice is intended to comply with the laws of your state. If any part of such language is found in conflict, such language shall be construed as amended to the extent necessary in order to meet the minimum requirements of your state. Any person who, knowingly and with intent to defraud or deceive any insurance company, files an application containing any materially false, incomplete or misleading information may be guilty of committing a fraudulent insurance act which is a crime and may be subject to criminal prosecution.

Your Signature in black ink	**Date**

WAIVER OF COVERAGE

Complete if you or any of your eligible dependents are declining or refusing any type of offered coverage.

I waive Dental coverage for: ☐ Myself and any dependents ☐ Spouse only ☐ Child(ren) only ☐ Spouse and dependent child(ren)

Reason for waiving coverage ***(you must provide a reason for waiving coverage)*** ☐ **Other coverage** ☐ **Cost**

I understand that if I desire to apply for dental insurance for myself and dependents at a later date, outside of open enrollment and any qualifying events, under the Beneficial Employees Security Trust, I/we will be eligible for Class I, Preventive Procedures during the first 12 months of continuous coverage and during the second 12 months of continuous coverage, eligible for Class I, Preventive Procedures and for 50% of the benefits for Class II Basic Procedures not to exceed a maximum of $500 during the second 12 months of continuous coverage.

Your Signature in black ink	**Date**

COBRA Electives

COBRA Electives: If you are currently continuing coverage under COBRA or a state continuation plan, what is the exact date of your qualifying event?

BEST Use Only	WAIVER	COBRA EE ☐ Yes ☐ No	EE ____ 1 = Employee 2 = Dependent 3 = EE & Dependent	DEP. Refusal ____ R = No Coverage O = Other Coverage	SPOUSE EE ☐ Yes ☐ No	COB ☐ Yes ☐ No	DEP 19+ FTS Y H Y

Eff. DATE	ER#	COVERAGES	PREV EE/DEP	NEW CHG	WP	#EES	LATE L	NEWBORN N	APP = A DECL= D	INITIALS

DC0509

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