



BEST Life and Health Insurance Company

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

Form with fields: Last Name, First Name, M.I., DOB, Age, Gender (M/F), SSN, Residence Street Address, City, State, Zip, Name of Company, Group #, 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), Will this replace other dental insurance? (Yes/No), Name of Carrier, 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

Table with 7 columns: Qualifying Event (Select One), Dependent Name, Relation, Full-Time Student?, Sex, SSN, Date of Birth. Includes checkboxes for Loss of Coverage and New Dependent.

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.

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?

Table with 10 columns: 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

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