

OFFICE USE ONLY		A _____
		D _____
		E _____
/ /	Employee Number	Coverage Code
Adjustment		



LONG TERM DISABILITY

Request for LONG TERM DISABILITY Plan Participant Enrollment

<i>Name of Company Where Employed</i>						<p>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 each certificate of insurance issued to me. However, if I am absent from full-time employment on such date(s) as the result of an accident or sickness I agree that coverage is not effective. I understand that my employer's application will 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. I understand that BEST Life reserves the right to decline anyone or all persons listed on this request for group insurance.</p>
<i>Employee Name</i>		Last	First	M.I.		
<i>Employee Home Address</i>			City	State	Zip	
Home Phone	Social Security Number		Date of Birth	Age	Sex	
() -	- -		/ /			
Height	Weight	Marital Status	Date of F/T Employment	Job Title	Monthly Earnings	
			/ /			
Do you have or are you applying for other disability income coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No						<p>Employee Signature _____ Date _____</p>
If yes to the above question, indicate carrier and monthly benefit: _____						

CONFIDENTIAL MEDICAL INFORMATION

The following information is submitted as evidence of my insurability, if required.

- Have you in the past 10 years (other than for routine examination, check-ups, immunizations) consulted or been treated by a physician/practitioner, or been confined or treated in a hospital or similar institution, or been advised to have an operation which has not been performed or to enter a treatment program you are not currently receiving? Yes No
- Have you had or been told of, or consulted with a physician/practitioner for, or been treated for any of the following: High blood pressure, heart trouble or murmur, disorder of the blood or vessels; Alcohol or drug abuse; Tuberculosis; Kidney/bladder prostate or reproductive organs; Cancer, tumor, cyst or growth; Brain disorder; Spine, back disorder, chronic pain or fatigue, fibromyalgia, arthritis, rheumatism, gout, or any other bone, joint or muscle disorder; Diabetes, blood or sugar in the urine, thyroid or other glandular disorder; Mental or nervous disorder or epilepsy; Ulcer, colitis or other digestive system disorder; hernia or liver disorder (including hepatitis)? Yes No
- Are you now pregnant? Yes No
If yes, when is your anticipated date of delivery? _____
- Have you:

(a) received advice or treatment from a physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) been diagnosed by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Have you been absent from work more than five consecutive working days because of illness or injury during the past five years? Yes No
- Are you under regular medical care or taking medication of any disease or disorder? Yes No

We pay all benefits according to the law of the State in which the policy was written.

COMPLETE AND SIGN THE REVERSE SIDE / FOLLOWING PAGE

If you answered yes to any of the health questions on the previous page, please provide full details below. Include date of onset, diagnosis, all details of condition, and details of routine exams, names and addresses of Physicians and Hospitals.

Attach an additional sheet if necessary.

Nature of Illness or Injury and Date and Duration of Medical Attention	Recovery Complete (Yes/No)	Names and Addresses Physicians/Hospitals

I'm applying to BEST Life and Health Insurance Company for group long-term disability insurance coverage. The answers on this enrollment form, a copy of which will be a part of my insurance certificate if issued, are given to obtain this coverage. I hereby certify that I have read the statements contained on this application or that they have been read to me and that all statements made by me on this application are true and complete to the best of my knowledge and belief. I understand that misstatements or omissions in the application may be used to contest the validity of insurance, reduce coverage or deny a claim. I authorize my employer to deduct from my earnings any required contribution toward the premium. I further authorize any physician, hospital, clinic, insurer or other organization or person having any records or knowledge concerning me to give this information to BEST Life and Health Insurance Company. A photocopy of this authorization will be as valid as the original.

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.

Date: _____ Signature of Applicant **X** _____