BEST Life
BEST Life and Health Insurance Company

Group Enrollment Roster

INSTRUCTIONS: List employees in alphabetical order. If insuring dependents, please complete the section below. **For FL, NE and OH residents only:** If enrolling Dependent Children 26 and older, please indicate if they are a full-time student. Part-time students allowed in FL. **IMPORTANT:** A signed electronic enrollment agreement is required. Please see the "Sign Here" tab for more details.

Employer Name:

Employee #	Enrolling on Dental / Vision? (D, V or DV)	Employee / Dependent SSN# (XXX-XX-XXXX)	Name Last, First, MI	Street Address	City	State	ZIP	Date of Birth (MM/DD/YY)	Sex (M/F)	Marital Status (S, M, D, W)	Date of Full Time Employeement (MM/DD/YY)	Job Title	# of Eligible Children (if none, state Zero)	Dependent Name	Relationship (S/C)	Sex (M/F)	Full Time Student? (Y/N)	Date of Birth (MM/DD/YY)
SAMPLE																		
1	**DV**	123-45-6789	Smith, Todd E.	123 Cherry Lane	Costa Mesa	CA	92614	01/02/70	M	M	10/15/02	Asst. Manager	2					
	DV	234-56-7891												Sally Smith	S	F	N	04/15/72

Electronic Group Enrollment Roster Agreement

INSTRUCTIONS: A signed copy of this form must be included with your electronic enrollment roster. Fax, email or mail a completed form to:

New Enrollments Department

BEST Life and Health Insurance Company

2505 McCabe Way

Irvine, CA 92614

Fax: (949) 724-1603.

E-mail: cs@bestlife.com

EMPLOYER VERIFICATION:

I (We) certify and verify that all employees applying for coverage listed above are actively at work and are working at least 30 hours per week, and that all employees and dependents (if electing dependent coverage) meet all eligibility and participation requirements listed in the brochure and certificate booklet.

FURTHER:

I (We) verify that this dental plan has been offered to all eligible employees. Completed waiver cards are attached for all employees and dependents electing not to participate in the plan. I (We) represent that all information on this application is correct to the best of my (our) knowledge. I (We) understand that our firm is not eligible for coverage until written confirmation is received from the insurance company. I (We) further agree to be bound by the arbitration clause in the BEST Life certificate booklet instead of a trial by a court or 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.

X ______________________________ ______________________ ______________

Employer Signature | Title | Date