

Group Term Life Enrollment Roster

INSTRUCTIONS: List employees in alphabetical order. If insuring dependents, please complete the section below. If enrolling Dependent Children over the age of 20, please indicate if they are a full-time student.

Employer Name: _____

Employee SS# (XXX-XX-XXXX)	Last Name, First Name MI	Date Of Birth (MM/DD/YY)	Sex (M/F)	Requested amount in excess of guarantee issue, if applicable	Dependent Amount	Dependent Name	Relationship (S, C)	Sex (M/F)	Full Time Student? Y or N	Date Of Birth (MM/DD/YY)
- -		/ /			1. _____	1. _____	_____	—	—	/ /
	Street Address	City	State	ZIP	2. _____	2. _____	_____	—	—	/ /
					3. _____	3. _____	_____	—	—	/ /
					4. _____	4. _____	_____	—	—	/ /
					5. _____	5. _____	_____	—	—	/ /
- -		/ /			1. _____	1. _____	_____	—	—	/ /
	Street Address	City	State	ZIP	2. _____	2. _____	_____	—	—	/ /
					3. _____	3. _____	_____	—	—	/ /
					4. _____	4. _____	_____	—	—	/ /
					5. _____	5. _____	_____	—	—	/ /
- -		/ /			1. _____	1. _____	_____	—	—	/ /
	Street Address	City	State	ZIP	2. _____	2. _____	_____	—	—	/ /
					3. _____	3. _____	_____	—	—	/ /
					4. _____	4. _____	_____	—	—	/ /
					5. _____	5. _____	_____	—	—	/ /
- -		/ /			1. _____	1. _____	_____	—	—	/ /
	Street Address	City	State	ZIP	2. _____	2. _____	_____	—	—	/ /
					3. _____	3. _____	_____	—	—	/ /
					4. _____	4. _____	_____	—	—	/ /
					5. _____	5. _____	_____	—	—	/ /
- -		/ /			1. _____	1. _____	_____	—	—	/ /
	Street Address	City	State	ZIP	2. _____	2. _____	_____	—	—	/ /
					3. _____	3. _____	_____	—	—	/ /
					4. _____	4. _____	_____	—	—	/ /
					5. _____	5. _____	_____	—	—	/ /
- -		/ /			1. _____	1. _____	_____	—	—	/ /
	Street Address	City	State	ZIP	2. _____	2. _____	_____	—	—	/ /
					3. _____	3. _____	_____	—	—	/ /
					4. _____	4. _____	_____	—	—	/ /
					5. _____	5. _____	_____	—	—	/ /
- -		/ /			1. _____	1. _____	_____	—	—	/ /
	Street Address	City	State	ZIP	2. _____	2. _____	_____	—	—	/ /
					3. _____	3. _____	_____	—	—	/ /
					4. _____	4. _____	_____	—	—	/ /
					5. _____	5. _____	_____	—	—	/ /
- -		/ /			1. _____	1. _____	_____	—	—	/ /
	Street Address	City	State	ZIP	2. _____	2. _____	_____	—	—	/ /
					3. _____	3. _____	_____	—	—	/ /
					4. _____	4. _____	_____	—	—	/ /
					5. _____	5. _____	_____	—	—	/ /

Employee SS# (XXX-XX-XXXX)	Last Name, First Name MI	Date Of Birth (MM/DD/YY)	Sex (M/F)	Requested amount in excess of guarantee issue, if applicable	Dependent Amount	Dependent Name	Relationship (S, D)	Sex (M/F)	Full Time Student? Y or N	Date Of Birth (MM/DD/YY)
- -		/ /			1. _____	1. _____	_____	__	__	/ /
Street Address		City	State	ZIP	2. _____	2. _____	_____	__	__	/ /
					3. _____	3. _____	_____	__	__	/ /
					4. _____	4. _____	_____	__	__	/ /
					5. _____	5. _____	_____	__	__	/ /
- -		/ /			1. _____	1. _____	_____	__	__	/ /
Street Address		City	State	ZIP	2. _____	2. _____	_____	__	__	/ /
					3. _____	3. _____	_____	__	__	/ /
					4. _____	4. _____	_____	__	__	/ /
					5. _____	5. _____	_____	__	__	/ /
- -		/ /			1. _____	1. _____	_____	__	__	/ /
Street Address		City	State	ZIP	2. _____	2. _____	_____	__	__	/ /
					3. _____	3. _____	_____	__	__	/ /
					4. _____	4. _____	_____	__	__	/ /
					5. _____	5. _____	_____	__	__	/ /
- -		/ /			1. _____	1. _____	_____	__	__	/ /
Street Address		City	State	ZIP	2. _____	2. _____	_____	__	__	/ /
					3. _____	3. _____	_____	__	__	/ /
					4. _____	4. _____	_____	__	__	/ /
					5. _____	5. _____	_____	__	__	/ /
- -		/ /			1. _____	1. _____	_____	__	__	/ /
Street Address		City	State	ZIP	2. _____	2. _____	_____	__	__	/ /
					3. _____	3. _____	_____	__	__	/ /
					4. _____	4. _____	_____	__	__	/ /
					5. _____	5. _____	_____	__	__	/ /

EMPLOYEES MUST ALSO COMPLETE A BENEFICIARY INFORMATION CARD.

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 Certificate of Insurance.

FURTHER:

I (We) verify that this life 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 of Insurance 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 Certificate of Insurance is issued, and the first premium is paid.

X

Employer Signature

Title

Date

SEND COMPLETED FORMS TO: BEST Life and Health Insurance Company · P.O. BOX 19721 · Irvine, CA 926239721

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