Group #: _____

☐ **Send kit to client**
☐ **Send kit to broker**

BEST Life™
BEST Life and Health Insurance Company

P.O. Box 3023
Meridian, ID 83680-3023
(800) 433-0088
(949) 222-1004 fax
www.bestlife.com

Application for Essential Group Term Life Insurance

1. Name of Applicant: _____
(use exact legal name of entity to whom policy will be issued)

Main address of Applicant: _____
Street City State Zip

Exact Description of Business: _____

2. Legal Name and Addresses of Subsidiary or Affiliated Companies which are to be included:
_____
_____
_____

3. Group Insurance Benefits:
☐ Group Term Life
☐ Accidental Death & Dismemberment
☐ Supplemental Life
☐ Dependent Life
☐ Other (Describe): _____

4. Proposed Effective Date of Insurance: _____

5. Eligibility:
Classes of Eligible Persons: _____

Number of hours per week to be considered full-time: _____ Number of Eligible Persons: _____

Are any individuals currently disabled? ☐ Yes ☐ No If yes, give full name and Social Security Number. (Attach separate list, if needed, on Page 4.)
_____
_____
_____

Waiting Period: Current Employees: None New Employees: _____

6. It is understood and agreed as a condition precedent to the approval of this Application that:

A. an employee who is not working a minimum of _____ hours per week for the Policyholder, on the Policy Effective Date will not be covered under the Plan until he or she returns to full-time employment.

B. a dependent who is hospital confined or cannot engage in substantially all of the normal activities of a like person of the same age or sex who is in good health on the Policy Effective Date will not be covered under the plan until he or she is engaging in substantially all of the normal activities of a person of the same age or sex who is in good health.

7. Replacement: If the insurance applied for replaces, or is in addition to, any similar group insurance now or previously in force, give name of the carrier, the type of coverage and the date the insurance was or is to be discontinued

8. Premiums: Will employees contribute towards the cost of any insurance coverage? ☐ Yes ☐ No

Premiums will be paid ☐ Monthly ☐ Other, please specify _____

Advance Payment of **$** _____ is submitted with this application to be applied by the Company on premiums for insurance when and if issued.

9. Amount of Insurance: ☐ As quoted in our proposal of _____. If checked, please enclose copy of proposal. The following Schedule of Benefits need not be completed if the policy to be issued is as stated in the proposal.

Schedule of Benefits:

Class	Term Life	AD&D	Supplemental Life	Dependent Life

Age Reduction Schedule: _____

_____

_____

Terminates at Retirement

10. Employer Information: Tax I.D. Number: _____ Telephone Number: _____

Fiscal Year End Date: _____

Name and Title of Plan Administrator (Contractual Matters):

Address and Telephone Number of Plan Administrator:

Name, Title & Telephone Number of Correspondent (Accounting Matters):

Address for Billing – if different than on address on application.

11. Agent for Service of Legal Process (Name and /or Title):

Address of Agent/Agency: Email Address:

Tax ID/SS#: _____ Phone Number: _____ Fax Number: _____

Who should receive the Service Fees? ☐ Agent ☐ Agency

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.

Dated at _____ this _____ day of _____, 20_____.

Signature of Writing Agent Applicant

Name Title