



BEST Life and Health Insurance Company

P.O Box 19721

Irvine, CA 92623-9721

(800) 433-0088

(949) 222-1004 fax

www.bestlife.com

- Send kit to client
- Send kit to broker

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: _____

Exact Description of Business: _____

Street _____ City _____ State _____ Zip _____

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.

