



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: \_\_\_\_\_  
 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  Dependent Life  
 Accidental Death & Dismemberment  Other (Describe): \_\_\_\_\_  
 Supplemental Life

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 \_\_\_\_\_