BEST Life™
BEST Life and Health Insurance Company

**Group #: _____**

# Group Term Life Application

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

## APPLICANTS INFORMATION

| Name of Group Applicant | Industry | SIC Code |
|---|---|---|
| | | |

| Name and Title of Employer Contact | Email Address | Phone Number |
|---|---|---|
| | | |

| Street Address | City | State | Zip | Fax Number |
|---|---|---|---|---|
| | | | | |

| Employer's I.D. Number | Details of any subsidiaries or affiliates to be insured. |
|---|---|
| | |

| Type of Business | Amount of Premium Submitted |
|---|---|
| ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Sole Proprietor ☐ Other: | |

| Percent of Premium Paid by Employer | Waiting Period | Requested Effective Date of Insurance |
|---|---|---|
| For employees: % For dependents: % | Current employees: New employees: | |

| Definition of eligible employees (include hrs. per wk. For full time status) | Total Number Eligible |
|---|---|
| | |

| Does this insurance replace existing insurance with any company? | If yes, give details of coverage to be terminated. |
|---|---|
| ☐ Yes ☐ No Termination Date: | Company: Policy Number: |

*NOTE: There is an "actively at work" requirement for coverage to be in force. Employees not able to work or dependents not able to perform the normal activities for their age will not be insured until this requirement is satisfied.*

## LIFE COVERAGE

(Check Coverage Desired)

☐ Group Life Insurance
☐ Accidental Death & Dismemberment
☐ Supplemental Life
☐ Dependent Life Insurance
☐ Other _____
☐ Other _____

| Class Description | Scheduled Amount | Reduction Schedule |
|---|---|---|
| Class | | Age % |
| Class | | % |
| Class | | % |
| Class | | % |
| Class | | % |

Special Requests:

Changes in coverage amounts are effective on the: ☐ Policy anniversary date ☐ First of the month following the change

### FRAUD WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

*The group insurance for which you are applying will not be effective until BEST Life and Health Insurance Company determines that your group meets certain underwriting standards. You will be notified of your acceptance.*

| Applicant Name and Title | Signature (applicant) | Date |
|---|---|---|
| | | |

| Agent Name and License Number | Agent Signature |
|---|---|
| | |

| Agency Name and Address | Agent Phone Number | Agent Fax Number |
|---|---|---|
| | | |

| Agent Email Address | The "New Client Kit" (Certificate of Insurance, Claim Forms, etc.) should be sent to: |
|---|---|
| | ☐ The benefit representative ☐ The client ☐ TPA: |