BEST Life™
BEST Life and Health Insurance Company

Group #: _____

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

Group Term Life Application

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

A person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud. All statements made by the Insured in the absence of fraud, are representations and not warranties.

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: