BEST Life and Health Insurance Company

BEST IndemnityPlus Dental Plans Group Employer Application

(For all states except Arizona, California and Utah)

Requested Effective Date: ☐ 1st or ☐ 15th of the month _____, 20____ ☐ Dental ☐ Life ☐ Vision

INDEMNITYPLUS PLAN TYPE	High (100/90/60) Plan	Mid (100/80/50) Plan	Basic (100/80/0) Plan	Value (100/50/0) Plan
Choose Calendar Year Maximum	☐ $2,500 ☐ $2,000 ☐ $1,500 ☐ $1,000	☐ $2,000 ☐ $1,500 ☐ $1,200 ☐ $1,000	☐ $1,500 ☐ $1,000 ☐ $500	☐ $1,500 ☐ $1,000 ☐ $500
Choose Deductible	☐ $0 ☐ $25 ☐ $50 ☐ $75 ☐ $100	☐ $0 ☐ $25 ☐ $50 ☐ $75 ☐ $100	☐ $0 ☐ $25 ☐ $50 ☐ $75 ☐ $100	☐ $0 ☐ $25 ☐ $50 ☐ $75 ☐ $100
Perio Option	☐ Class II ☐ Class III	☐ Class II ☐ Class III	☐ Class II ☐ Class III	☐ Class II ☐ Class III
Endo Option	☐ Class II ☐ Class III	☐ Class II ☐ Class III	☐ Class II ☐ Class III	☐ Class II ☐ Class III
Choose Orthodontia Option	☐ Adult & Child $1,000 Child Only: ☐ $1,000 ☐ $1,500	☐ Adult & Child $1,000 Child Only: ☐ $1,000 ☐ $1,500	Not offered	Not offered
*Voluntary Option**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
*Two-Year Initial Rate Guarantee Option***	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
*Dual Option (check plans selected)***	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Reimbursement Level	☐ 80th % ☐ 90th %	☐ 80th % ☐ 90th %	☐ 80th % ☐ 90th %	☐ 80th % ☐ 90th %

** Employer is contributing less than 50% for each employee.** Certain requirements apply. Please see Plan Brochure for details.*

VISION PLAN TYPE

Access Vision Plan Choice	Frequency Choice	Deductible Choice	Lenses/Contacts Choice	Voluntary Option*
☐ Plan Series 1 ($60 Exam / $35 Single Lens / $80 Frames/$125 Contacts Allowance) ☐ Plan Series 2 ($60 Exam / $45 Single Lens / $100 Frames/$125 Contacts Allowance) ☐ Plan Series 3 ($60 Exam / $55 Single Lens / $115 Frames/$125 Contacts Allowance)	☐ Plan A (12/12/12/12) ☐ Plan B (12/12/24/12) ☐ Plan C (12/12/24/24) ☐ Plan D (12/24/24/24)	☐ $0 ☐ $10 ☐ $25	☐ Lenses, Frames AND Contacts ☐ Lenses, Frames OR Contacts	☐ Yes ☐ No

Vision PPO (EyeMed) Plan Choice	Frequency Choice	Voluntary Option*
☐ Plan Series 1 ($10 Exam Co-pay/ $10 Lens Co-pay / $130 Contact Lens Allowance) ☐ Plan Series 2 ($10 Exam Co-pay/ $25 Lens Co-pay / $130 Contact Lens Allowance) ☐ Plan Series 3 ($10 Exam Co-pay/$25 Lens Co-pay / $115 Contact Lens Allowance) ☐ Materials Only Plan ($10 Lens Co-pay/ $130 Contact Lens Allowance)	☐ A 12/12/12/12 ☐ B 12/12/24/12 For Materials Only plans: ☐ A 12/12/12 (Lens/Frame/Contacts) ☐ B 12/24/12 (Lens/Frame/Contacts)	☐ Yes ☐ No

Please answer the following questions:

1. Employer Contribution for Employees (for employer-contributory plans, the Employer must pay at least 50% for each employee.): %, For Dependent Coverage: %.
   Number of Total Employees on Payroll: _____ Number of Full-Time Employees: _____ Description of Classes not Eligible:

2. ☐ Yes ☐ No Does the employer now have or has the employer had a comparable group dental plan in force during the past twelve (12) consecutive months?
   For employer-contributory: 12-month wait on Major and Ortho services is waived for employees who have had 12 consecutive months of comparable prior group coverage and who are in a group with 5-9 employees enrolling with proof of continuous and comparable prior group coverage; all employees in a group 10+ employees enrolling.
   For voluntary: 12-month wait on Major and Ortho services is waived for employees who have had 12 consecutive months of comparable prior group coverage and who are in a group with 5-9 employees enrolling with proof of continuous and comparable prior group coverage; all employees in a group with 10-24 employees enrolling and 50% participation with proof of comparable prior group coverage; if 50% participation is not met, waiver will only apply to employees who have proof of 12 consecutive months of prior group coverage (proof must be provided); all employees in a group with 25+ employees enrolling.
   A copy of your most recent dental bill listing the covered employees and their effective dates must accompany this application.

3. ☐ Yes ☐ No Are all full-time employees enrolling in the group dental plan?

4. ☐ Yes ☐ No Are any employees enrolling in the policy currently receiving extended benefits under COBRA? If yes, please list names:

5. ☐ Yes ☐ No Waiting Period is waived for Present Employees.

6. Waiting Period for New Employees: First of the Month following continuous full time employment of:
   ☐ 1st of the month following date of hire ☐ 1 Full Calendar Month (standard) ☐ 2 Full Calendar Months ☐ 3 Full Calendar Months ☐ 4 Full Calendar Months

EMPLOYER ACKNOWLEDGEMENT & ASSOCIATION AND TRUST MEMBERSHIP APPLICATION

Employer Name | Employer Federal Tax Number ( ) - ( ) -

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

Billing Address / P.O. Box | City | State | Zip | Email

Nature of Firm's Business | SIC Code | Person at Firm to Contact for Service and Administration of the Dental Plan

Employer Name

I understand and agree that the insurance hereby applied for is not effective until this application and the full initial premium is delivered to, received by and approved by BEST Life and Health Insurance Company.

I certify that this is a bona fide business with a legitimate business purpose and which has a true employer-employee relationship with the individuals designated as employees. I understand that any false statements made in this application constitute the legal basis for termination or cancellation of coverage retroactive to the effective date and denial of all claims incurred.

Termination of Coverage—Employee coverage and dependent coverage will terminate on the earliest of the following dates: (1) the date the employee ceases to be an eligible employee or the date the dependent is no longer eligible as a dependent under the plan; (2) the date the plan is terminated; (3) the date the employer terminates the coverage by failing to pay the required premium; (4) the date the group policy is terminated; (5) the date the group no longer meets minimum participation requirements. The benefits are subject to all the conditions and limitations of the plan.

Eligible dependent coverage terminates on the earliest of the following: (1) when the dependent no longer meets the definition of a dependent; (2) on the first day of the month in which premiums were not paid; or (3) when the member terminates coverage.

FIRM ELIGIBILITY:

A firm or employer must be an active business operation to request coverage. The business must continue on an active basis to retain eligibility for coverage. Coverage will be terminated on the effective date the business ceases active operation. I understand that if my firm drops in size to 1 employee, and if additional employees are not enrolled and active for coverage within 2 months, all of my selected insurance coverage will be cancelled.

IMPORTANT PLAN INFORMATION

The undersigned Employer understands and agrees that by adopting one or more BEST plans, it is establishing an employee welfare benefit plan for its employees. The employer further understands and agrees that the general definition of an employee is a person who usually works at least 30 hours per week at the firm's business location with federal, state and social security tax withheld from their salary. The Employer's plan is funded through the Beneficial Employees Security Trust of Utah ("B.E.S.T.") and sponsored by the BEST Employers Association ("BEA") to which the Employer joins. The insurance company issues group insurance policies to the Trustee of B.E.S.T. These policies provide the coverage(s) the Employer selects for their employees.

B.E.S.T. receives the subscribing employer's payment and remits the insurance premium(s) to the insurance carrier(s) or to affiliates, Beneficial Administration and BEST Health Plans, provide services to Employers and to B.E.S.T. One of the insurance carriers is BEST Life and Health Insurance Company ("BEST Life").

The Employer agrees and understands that by signing this Trust Membership Application, it becomes a Subscribing Employer of the Trust. A subscribing employer of the Trust agrees to be bound by all the terms and conditions of the Trust Agreement. A subscribing employer of the Trust further agrees that the Trustee shall not be liable to any participating Employers, to any person insured, or to anyone else in connection with the operation of the Group Insurance Trust Fund.

The Employer agrees and understands that by signing this Trust Membership Application, it becomes a member of BEA and a $2.00 monthly due will be charged along with the insurance premium for the plan the Employer selects. This will also provide access to benefits offered by BEA and may vary by availability, vendor, or state of residence of the participating employer.

The Master Group Policy is issued to the Trustee of B.E.S.T. To participate in the plan, each subscribing employer adopts the Trust. The Master Group Policy is governed by the laws of the state of Utah. However, to the extent that such Policy and/or Certificate of Insurance is in conflict with the laws of another demonstrating statutory governing jurisdiction over an out-of-state multiple employer trust Policy, then such Policy and/or Certificate of Insurance may be amended to comply with the minimum requirements of that State.

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.

X / /

Signature of Company Officer | Print Name & Title | Dated

Benefit Representative Report

(Please Print)

Name

It is not necessary to complete the following information if you are currently receiving service fees from BEST Life unless changes in address, etc. need to be made. Please sign and date the form below.

Your Agency Name

Address

City | State | Zip

Who Should Receive the Service Fees? ☐ Benefit Representative ☐ Company/Firm

Social Security Number - - | Federal Tax ID

Date of Birth / / | License No. | State

Phone No. | FAX No.

Email Address

(Please Complete)
Special Instructions to BEST Life

1. May we contact the client if we need additional information?
   ☐ Yes ☐ No
2. Is this your first case with BEST Life? ☐ Yes ☐ No
3. This is: ☐ an existing client ☐ a new client with my company
4. The 'New Client Kit' (certificate book, claim forms, etc.) should be sent to:
   ☐ The Benefit Representative ☐ The Client
5. The underwriter assigned to my case should contact me? ☐ Yes ☐ No

General Agent (GA):

Please list any special handling needed for this client:

I hereby certify that I hold a valid Life, Accident and Health license issued by the state in which this document was executed and that all of the information contained herein is correct, to the best of my knowledge, and that I know nothing unfavorable about this firm or any individual applying for insurance unless fully described in this application material. Furthermore, I certify that:

1. This firm is a bona fide business establishment and participation requirements are being met.
2. I have advised my client not to terminate any existing coverage until this coverage is approved.
3. Coverage, eligibility provisions, waiting periods and limitations have been fully explained to, and understood by, the Employer identified in this document.
4. I have no right to bind, modify or alter provisions of this program.

I understand and agree that the insurance applied for herein does not begin until this application is received and approved by BEST Life and Health Insurance Company, the insurance certificates are issued and the first premium is received and accepted.

Agent's Signature:	Print Name:	Date: