



Phone: (800) 433-0088 • e-mail: cs@bestlife.com • www.bestlife.com

Requested Effective Date: 1st or 15th (of the month, 20	_								☐ Dental ☐ Life ☐ Vision
			FIRM INF	ORMATIO	N					
Employer Name							Employer Fede	eral Tax Numb	oer	
Street Address		City						State		ZIP
Billing Address P.O. Box		City						State		ZIP
Email				Telephone Nu	ımber			Fax Numbe	er	
Exact Nature of Business		SIC Code of Industry			Contact Person					
PPO Plan Type	PPO Plan Type High (100/90/60)		Mid (100/80/50) Plan			Basic (100/80/0) Plan		Plan	Value (100/50/0) Plan	
Choose Calendar Year Maximum In- and Out-of-Network maximums	\$2,500 \$2,000 \$2,000 \$1,000			\$2,000 \$1,500 \$1,000		\$1,500 \$1,000 \$500		500	\$1,500 \$1,000 \$500	
Choose Deductible	\$0 \$25 \$50 \$75 \$100					\$0 \$25 \$50 \$75 \$100		75	\$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			☐ Class II	s II 🔲 Class III		☐ Class II ☐ Class III	
Choose Orthodontia Option Adult & Child \$1,000 Child Only: \$\Bigsim \text{\$1,000} \Bigsim \text{\$1}\$			☐ Adult & Child \$1,000 Not offer Child Only: ☐ \$1,000 ☐ \$1,500			Not offered	t offered		Not offered	
Voluntary Option* ☐ Yes ☐ No		☐ Yes ☐ No ☐		☐ Yes ☐ No			☐ Yes ☐ No			
Dual Option (check plans selected)**	Oual Option (check plans selected)** □ Yes □ No		☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes			☐ Yes ☐ No		☐ Yes ☐ No	
Two-Year Initial Rate Guarantee Option** ☐ Yes ☐ No			☐ Yes ☐ No ☐ Yes ☐ No			No	☐ Yes ☐ No		No	
* Employer is contributing less than 509	% for each employee. **Ce	rtain requiremen			ıre for a	letails.				
Access Vi	sion Dlan Chaige			LAN TYPE	Dod	uatible Chain	Lon	oca/Cantaata	Chains	Valuntary Ontion*
Access Vision Plan Choice 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 Plan B Plan C	(12/12/12/12) (12/12/24/12) (12/12/24/24) (12/12/24/24)	\$ \$ \$ \$	\$10 Lenses, Frames		es, Frames Al	ND Contacts	Voluntary Option* ☐ Yes ☐ No
	yeMed) Plan Choice				Frequency Choice				Voluntary Option*	
☐ Plan Series 1 (\$10 Exam Co-pay/ \$10 Lens Co-pay / \$130 Contact Lens Allowanc ☐ Plan Series 2 (\$10 Exam Co-pay/ \$25 Lens Co-pay / \$130 Contact Lens Allowance			□ ∧ 12/12				s/Frame/Contacts)			
			☐ B 12/12			□ A	12/12/12 (Lens/F	rame/Contac	ts)	es 🔲 No
☐ Plan Series 3 (\$10 Exam Co-pay/\$25 L	ens Co-pay / \$115 Contact	Lens Allowance)				□ A		rame/Contac	ts)	es 🔲 No
☐ Plan Series 3 (\$10 Exam Co-pay/\$25 L☐ Materials Only Plan (\$10 Lens Co-pay/	ens Co-pay / \$115 Contact \$130 Contact Lens Allowan	Lens Allowance)				□ A	12/12/12 (Lens/F	rame/Contac	ts)	со 🗀 но
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ASSOCIATION AND TRUST MEMBERSHIP APPLICATION

Application is hereby made for membership in BEST Employers Association, which sponsors Beneficial Employees Security Trust of Utah, by:

Legal Name of Employer

Street Address (do not list P.O. Box)

City

State

Zip

County

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 companies issue 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.

Signature of Company Officer Print Name & Title Dated

Signature of Company Cinesi	Till Name a Tile								
Benefit Representative Report									
(Please Print) Name	(Please Complete) Special Instructions to BEST Life								
It is not necessary to complete the following information if you are currently receiving service fe from BEST Life unless changes in address, etc. need to be made. Please sign and date the for below. Your Agency Name									
Address	3. This is: ☐ an existing client ☐ a new client with my company								
City State Zip Who Should Receive the Service Fees? ☐ Benefit Representative ☐ Company/Firm	The 'New Client Kit' (certificate book, claim forms, etc.) should be sent to: ———————————————————————————————————								
Social Security Number Federal Tax ID	 ☐ The Benefit Representative ☐ The Client 5. The underwriter assigned to my case should contact me? ☐ Yes ☐ No 								
Date of Birth / / License No. State	General Agent (GA):								
Phone No. FAX No.	_								
Email Address									
Please list any special handling needed for this client:									

Thereby 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.

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Agent's Signature:		Print Name:	Date: