

Short Term Disability Employer Application

Application Checklist

For group enrollment for 5 or more lives

INSTRUCTIONS: To apply for group short term disability insurance, please submit the following items:

- Complete the Employer Application and obtain all signatures
- Attach Copy of Quote
- A Copy of firm's most recent state Quarterly Wage Report showing the names of all employees
- Obtain a business check for one month's estimated premium payable to BEST Life and Health Insurance Company
- Mail all documents and 1st month's premium check to:

BEST Life and Health Insurance Company
P.O. Box 19721
Irvine, CA 92623-9721

For additional information or assistance, contact us at:

Toll-free: 800.237.8543
Local: 949.253.4080
Fax: 949.553.0883
E-mail: info@bestlife.com
www.bestlife.com

Short Term Disability Employer Application

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	E-Mail	
Nature of Firm's Business	SIC Code	Person at Firm to Contact for Service and Administration of the Dental Plan			
Years in Business	Number of Full-time Employees on Payroll	Number of Employees applying for Coverage	Description of any Classes Not Eligible		

Requested Effective Date:

Elimination Period (Day Accident Benefits Begin On/Day Sickness Benefits Begin On): 0/7 7/7 14/14 29/29

Benefit Duration: 13 Weeks 26 Week 52 Weeks (Available on voluntary and custom plans only)

Monthly Benefit: 60% 67% 70% \$_____ per week

Pre-existing Condition (Months Before Eff. Date/Months After Eff. Date): None 3/12 6/12 12/12 12/24

Include Maternity? Yes No

Waiting Period for New Employees: 1 Full Calendar Month 2 Full Calendar Months 3 Full Calendar Months 4 Full Calendar Months

Waiting Period is waived for present Full-time Employees: Yes No

Is this plan a takeover from another group's plan? Yes No If yes, please provide the prior carrier's certificate book or contract.

Employer Contribution (employer must pay at least 25% for employer-sponsored groups): _____%

Contributory (Voluntary) Non-Contributory (Employer-contributory)

Financial Disclosure Statement

The undersigned Employer understands that by adopting one or more BEST Life plans, it is establishing an employee welfare benefit plan for its employees. The Employer's plan is funded through the BEST Trust, which the Employer joins. The insurance company(s) issue group insurance policies to the Trustee of the BEST Trust. These policies provide the coverage selected by the Employer. The BEST Trust receives payments from the Employer and remits insurance premiums to the insurance carrier(s), and to affiliates of the BEST Trust providing services to Employers maintaining Welfare plans, and to the BEST Trust.

One of the entities providing services to your plan and to the BEST Trust is Beneficial Administration Company, an administrative service contractor only, and an affiliate of the BEST Trust. This company receives a portion of each premium dollar.

By signing this Trust Membership Application the Employer, if approved by the Trustee, becomes a Trustor of the Trust. The Employer thereby subscribes to and agrees to be bound by all the terms and conditions of the Trust Agreement and 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.

