BEST Life
BEST Life and Health Insurance Company

BEST Life EyeMed Vision PPO Plans Group Employer Application

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

VISION PPO PLAN TYPE	Plan Options
Choose Plan	☐ 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)
Choose Frequency Option	☐ A: 12/12/12/12 (Exam/Lens/Frame/Contacts) ☐ B: 12/12/24/12 (Exam/Lens/Frame/Contacts) For Materials Only plans: ☐ A: 12/12/12 (Lens/Frame/Contacts) ☐ B: 12/24/12 (Lens/Frame/Contacts)
*Voluntary Option**	☐ Yes ☐ No
*Bundled with another BEST Life Product**	☐ Yes ☐ No

** Certain requirements apply. If this vision plan is being bundled with another BEST Life product, complete a separate employer application for the other products.*

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. Just 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.	

E-mail Address

(Please Complete)

Special Instructions to BEST Life

1. May we contact the client if we need additional information? ☐ Yes ☐ No
2. This is my first case with BEST Health Plans? ☐ 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. Have the Underwriter assigned to my case call me? ☐ Yes ☐ No
6. Please list any 'special handling' needed for this client:

I hereby certify that I hold a valid Life, Accident & 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 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 participating requirements are being met.
2. I have advised my client not to terminate any existing coverage until receiving notice that the coverage being applied for is approved.
3. Coverage, eligibility provision, 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 agree that insurance does not begin until this application is approved by BEST Life and Health Insurance Co., my insurance certificate is issued, and the first premium is paid.

X

Agent Signature | Agent: Print Name | Date

**For first case please include a current copy of your State Life and Health license(s). If your state charges an appointment fee, it will be deducted from your service fee check.*

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

I certify that I have read the General Information section, understand it, and have enrolled all eligible employees and their dependents in accordance with information on the General Information page. I have discussed coverages, eligibility, and the expenses not covered with the Producer and understand them fully.

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.

Employer Contribution for Employees (for employer-contributory plans, the Employer must pay at least 50% for each employee): _____ %, For Dependent Coverage: _____ %.

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 of the conditions and limitations of the plan.

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

☐ Yes ☐ No Are all full-time employees enrolled in the plan?

☐ Yes ☐ No Are any employees applying for coverage receiving extended benefits under COBRA? If yes, please list names:

_____

☐ Yes ☐ No Waiting Period is waived for Present Employees?

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

Description of Classes not Eligible | Number of Total Employees on Payroll | Number of Full-time Employees

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 less than 5 employees, 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 that by adopting one or more BEST 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 B.E.S.T Trust receives payments from participating employer(s) and remits these payments to the insurance companies. One of the insurance carriers is BEST Life and Health Insurance Company. The insurance companies may contract with a third party administrator to provide administrative services on their behalf. One of these third party administrators is Beneficial Administration Company, Inc. (BAC). Beneficial Administration Company and BEST Life and Health Insurance Company receive a portion of the employer payments as compensation for services each performs. The managing trust or of the B.E.S.T. Trust is a party in interest in Beneficial Administration Company, Inc. and BEST Life and Health Insurance Company.

By signing this Trust Membership Application, the Employer, if approved by the Trustee becomes a subscribing employer 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 Master Group Policy is issued to the Trustee of the Beneficial Employees Security Trust of Utah, and each participating Employer unit adopts the Trust to participate in the plan. The Master Group Policy is governed by the laws of the state of Utah. In the event of dispute or litigation, I agree to be bound by the terms and conditions of the arbitration clause in the *Plan Certificate Booklet.*

Beneficial Administration Company and/or BEST Life reserve the right to decline any new business application which, in their opinion, does not meet sound underwriting standards or which affects the financial stability of the Trust. I agree that insurance does not begin until this application is approved by BEST Life and Health Insurance Co., my insurance certificate is issued, and the first premium is paid.

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 and Title | Dated