



BEST Life and Health Insurance Company

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

Employee Request for BEST Life Vision

☐ New Enrollment ☐ Add Dependents ☐ Name Change

EMPLOYEE INFORMATION

Form with fields: Last Name, First Name, M.I., DOB, Age, Gender, SSN, Residence Street Address, City, State, Zip, Name of Company, Group #, Job Title, Date of F/T Hire, Marital Status, etc.

Are you insuring your dependents? ☐ Yes ☐ No

If 'Yes' complete the section below and explain any differences in last name, if applicable. If no, complete the waiver of coverage section below.

Eligible dependents include spouses and unmarried dependent children. Dependent children are covered through age 25. Coverage can be extended for dependent children residing: FL and NE through age 29; and OH through age 27.

DEPENDENT INFORMATION

Table with 7 columns: Qualifying Event, Dependent Name, Relation, Full-Time Student?, Sex, SSN, Date of Birth. Includes checkboxes for Loss of Coverage and New Dependent.

I certify that my date of birth, date of employment and other information on this form are correct and that I am working at the employer's place of business in full time employment at least 30 hours per week.

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.

Your Signature in black ink _____ Date _____

WAIVER OF COVERAGE

Complete if you or any of your eligible dependants are declining or refusing any type of offered coverage. Check all that apply:

I waive Vision coverage for: ☐ Myself and any dependants ☐ Spouse only ☐ Spouse and dependent child(ren)

Reason for waiving coverage (you must provide a reason for waiving coverage) ☐ Other coverage ☐ Cost

I understand that if I desire to apply for vision insurance for myself and dependents at a later date, outside of open enrollment and any qualifying events, under the Beneficial Employees Security Trust, I/we will be eligible for no more than a total of \$75 of vision benefits during the first 12 months of coverage.

Your Signature in black ink _____ Date _____

COBRA Electives

COBRA Electives: If you are currently continuing coverage under COBRA or a state continuation plan, what is the exact date of your qualifying event? Table with columns for BEST Use Only, WAIVER, COBRA EE, EE, DEP. Refusal, SPOUSE EE, COB, DEP 19+ FTS, Eff. DATE, ER#, COVERAGES, PREV EE/DEP, NEW CHG, WP, #EES, LATE L, NEWBORN N, APP = A DECL = D, INITIALS.