BEST Life

BEST Life and Health Insurance Company

Application for Group Term Life

☐ I wish to apply for coverage under the Group Term Insurance Plan.
☐ I am covered under the Group Term Insurance Plan and want to increase my coverage.

EMPLOYEE-SPOUSE DATA

1. EMPLOYER: _____

2. EMPLOYEE NAME: _____ 3. SOCIAL SECURITY: ___ - ___ - _____

4. HOME ADDRESS: _____ City _____ State _____ Zip _____

5. BIRTH DATE: _____ 6. BASIC SALARY: _____ ☐ Weekly ☐ Monthly ☐ Annually

7. AMOUNT APPLIED FOR: _____ (Limited to 5 times annual earnings)

8. BENEFICIARY*: _____ RELATIONSHIP: _____

*If no beneficiary is selected, your benefits will be paid according to the laws of your state.

9. I WISH TO APPLY FOR LIFE INSURANCE FOR MY SPOUSE. ☐

SPOUSE NAME _____ BIRTH DATE _____ BIRTH PLACE _____

AMOUNT APPLIED FOR: _____ ($10,000 to $50,000—limited to 50% of #7 above.)

10. SPOUSE BENEFICIARY RELATIONSHIP

11. I wish to cover my child(ren) for Life Insurance. ☐ $5,000 ☐ $10,000

NAME _____ BIRTH DATE __/__/__ NAME _____ BIRTH DATE __/__/__

NAME _____ BIRTH DATE __/__/__ NAME _____ BIRTH DATE __/__/__

THIS SECTION TO BE COMPLETED BY EMPLOYER'S INSURANCE/PERSONNEL DEPARTMENT

Waiting Period? ☐ Yes ☐ No If "Yes": ☐ 1st of month following date of hire. ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days

Date of full-time employment: _____ Group Insurance Eligibility Date: _____

_____ _____

Signed Title

ALL APPLICANTS PLEASE READ AND SIGN BELOW

I understand that the insurance for which I applied shall not become effective until this application is accepted and approved by BEST Life and Health Insurance and that the first premium must be paid prior to the death of any proposed insured. I represent that all statements and answers recorded on this application are true, complete and made to obtain the insurance for which I applied.

I hereby authorize the deduction by my employer from my earnings of amounts necessary to cover the cost of the insurance issued as indicated above. I declare that all of the statements contained in this application are, to the best of my belief and knowledge, true and correct and that no material information has been withheld or omitted concerning the past and present state of my health and that any willful misstatements shall make any insurance based upon this application void at the option of BEST Life and Health Insurance.

Applicant's Signature ***X*** _____ Date _____

All Applicants must sign here and date.

Spouse's Signature ***X*** _____ Date _____

All Applicants must sign here and date.

AUTHORIZATION TO OBTAIN INFORMATION WHEN *APPLYING FOR MORE THAN BASIC GUARANTEED ISSUE AMOUNT*

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical related facility, insurance company, the Medical Information Bureau, consumer reporting agency or employer to release to BEST Life and Health Insurance, its reinsurer(s) or its legal representative any information they may have as to diagnosis, treatment and prognosis of any physical or mental condition including drug and/or alcohol abuse and/or other information of me, my minor children or my spouse.

I UNDERSTAND that any information obtained will be used to determine eligibility for insurance and will not be released by BEST Life and Health Insurance to any person or organization EXCEPT its reinsurer(s), the Medical Information Bureau, and any other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required, or as I may further authorize. I also understand that I may revoke this authorization as it applies to drug and/or alcohol abuse information at anytime, except to the extent it will not affect any action taken or information released prior to the revocation.

I KNOW that I may request to receive a copy of this Authorization and the Disclosure Notice to Applicants for Insurance.

I AGREE that a photographic copy of this authorization shall be as valid as the original and shall be valid for two years from the date shown below.

I AGREE that insurance does not begin until this application is approved by BEST Life and Health Insurance Company, 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.

BOTH EMPLOYEE AND SPOUSE MUST SIGN APPLICATION WHEN BOTH ARE APPLYING FOR COVERAGE

Applicant's Signature ***X*** _____ Date _____

All Applicants must sign here and date.

Spouse's Signature ***X*** _____ Date _____

All Applicants must sign here and date.

PLEASE BE CERTAIN APPLICATION IS COMPLETED IN FULL AND SIGNED IN BLACK INK