BEST Life™
BEST Life and Health Insurance Company

Employer Agreement

Company Address:
Industry SIC Code:

To apply for a quoted plan, attach a completed, signed original copy of this form to the quote number and plan detail being applied for.

EMPLOYER / EMPLOYEE INFORMATION

Quote Number:	Effective Date:	Number of Employees On Payroll:	Number of Full-Time Employees:

1. Are any employees applying for coverage also receiving extended benefits under COBRA? ☐ Yes ☐ No *(If yes, please list names below).*

_____

2. Employer Contribution for Employees (for employer-contributory plans, the Employer must pay at least 50% for each employee.)
   For Employee: _____%
   For Dependent Coverage: _____%
   Number of Total Employees on Payroll: _____
   Number of Full-Time Employees: _____
   Description of Classes not Eligible: _____

3. Are all full-time employees enrolling in the group plan?	Dental: ☐ Yes ☐ No	Vision: ☐ Yes ☐ No
4. The Waiting Period for current employees – Current employees may be subject to the waiting period unless specified by the Employer. Is the waiting period waived for current employees?	Dental: ☐ Yes ☐ No	Vision: ☐ Yes ☐ No

5. The Waiting Period for new eligible employees (Check appropriate box below. For more than one waiting period, provide explanation below.)
   New employees are eligible on the first of the month after _____ days of continuous full time employment:
   ☐ Date of hire ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days

_____

_____

6. Does the employer now have or has had a comparable group dental plan in force during the past twelve (12) consecutive months? ☐ Yes ☐ No

   For employer-contributory: 12-month wait on Major and Ortho services is waived for employees who have had 12 consecutive months of comparable prior group coverage and who are in a group with 5-9 employees enrolling with proof of continuous and comparable prior group coverage; all employees in a group with 10+ employees enrolling.

   For voluntary: 12-month wait on Major and Ortho services is waived for employees who have had 12 consecutive months of comparable prior group coverage and who are in a group with 5-9 employees enrolling with proof of continuous and comparable prior group coverage; all employees in a California group with 10+ employees enrolling.

   A copy of your most recent dental bill listing the covered employees and their effective dates must accompany this application.

EMPLOYER ACKNOWLEDGEMENT & ASSOCIATION AND TRUST MEMBERSHIP APPLICATION

Employer Name | Employer Federal Tax Number

Street Address | City | State | Zip

Billing Address / P.O. Box | City | State | Zip

Telephone | Fax | Email

Nature of Firm's Business | SIC Code | Person at Firm to Contact for Plan Service and Administration

My broker has permission to view the information associated with this benefit plan on the BEST Life online broker portal. ☐ Yes ☐ No

X

Signature of Company Officer | Print Name & Title | Date

FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 for more than 90 consecutive days, 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 initially subscribes to. 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.

X _____

Signature of Company Officer | Print Name & Title | Date

BENEFIT REPRESENTATIVE INFORMATION

(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. Please sign and date the form below.

Agency Name:

Address:

City: | State: | Zip:

Who Should Receive the Service Fees?
☐ Benefit Representative ☐ Company/Firm

SSN: | Fed Tax ID:

License #: | Exp. Date: | State:

Date of Birth:

Phone: | FAX:

Email Address:

Special Instructions *(Please Complete)*

1. May we contact the client if we need additional information?
   ☐ Yes ☐ No

2. Is this your first case with BEST Life? ☐ 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. Please have the underwriter assigned to my case contact me.
   ☐ Yes ☐ No

General Agent (GA):

Please list any special handling needed for this client:

I hereby 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.

X

Agent's Signature | Print Name | Date