

Employee Request for BEST Life PPO OptionDental and BEST Life Vision

BEST Life and Health Insurance Company

Phone: (800) 433-0088 • a.mail: cs@hestlife.com

Phone: (800) 433	-0088 • e-mail: cs@bestl	ife.com • www.bestlife.c	<u>om</u>						☐ New E	nrollment	☐ Add	Dependents [☐ Name Change	
			EM	IPLOYE	E IN	FORM	10ITA	V						
Last Name First Nam			ime			D	ОВ	Age	Gende		N			
Residence S	treet Address					City				State	Zip			
Name of Company Gro			oup #, if known Job Title				[Date of F/T Hire			Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced			
If changing your name, provide new name:				Do you have any of lf yes, how many?						igible dependent children? Yes No				
Will this repla	ace other dental insu	rance? Yes							ow many.	☐ Group ☐ Individual				
	rior Coverage		Effective Date of Prior (Cover	overage Anticipate			Other ed Termination Date of Prior Coverage			
If 'Yes', comple Eligible dependare full-time st	kre you insuring your dependents?													
	Qualifying Event		DE	PENDA	NT IN	IFORM	IATIO	N						
		Depend	dent Nam	ne			lation	Full-Time Student?		nder	SSN	Date of Birth		
	erage					Spo	ouse	Yes/No Yes/No		/F				
_	erage New Depende								Yes/No	_	/F /F			
	erage New Depende								Yes/No	_	/F		-	
Loss of Cove							Yes/No		/F					
the insurer. I understand that coverage is not in force until the effective date shown on the Certificate of Insurance issued to me; however, if I am absent from full-time employment on such dates as the result of an accident or sickness, I agree that coverage is not effective. I determine the coverage in force and that coverage is not in force if an application for that coverage has not been made by my employer. Additionally, if I am accepted, this request for group insurance will become part of the agreement between BEST Life and Health Insurance Company and myself. I, and any enrolled family members, agree to be bound by the arbitration clause in the BEST Life and Health Insurance Certificate Booklet, if any, instead of trial by a court of jury. 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.														
Your Signa	ture in black ink									Date				
			V	VAIVER	OF C	COVER	AGE							
Complete if you or any of your eligible dependents are declining or refusing any type of offered coverage. Check all that apply: I waive Dental coverage for: Myself and any dependents Spouse only Child(ren) only Spouse and dependent child(ren)														
I waive Vision coverage for: ☐ Myself and any dependents ☐ Spouse only ☐ Child(ren) only ☐ Spouse and dependent child(ren) Reason for waiving coverage (you must provide a reason for waiving coverage) ☐ Other coverage ☐ Cost														
understand that if I desire to apply for dental insurance for myself and dependents at a later date, outside of open enrolling and any qualifying events, under the Beneficial Employees Security Trust, I/we will be eligible or Class I, Preventive Procedures during the first 12 months of continuous coverage, eligible for Class I, Preventive Procedures and for 50% of the benefits for Class II Basic Procedures not to exceed a maximum of \$500 during the second 12 months of continuous coverage. I understand that if I desire to apply for vision insurance for myself and dependents at a later date 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	Date				
						lective								
COBRA Elec	tives: If you are curren	tly continuing coverag		RA or a st	ate cor	ntinuation	n plan, v	what is th	e exact date	of your qu	alifying e	event?		
BEST WAIVER COBRA EE			EE	dent	R	EP. Ref = No Co = Other	verage	SPOUSE EE		E EE	COB Yes No		DEP 19+ FTS Y H Y	
Eff. DATE	ER#	COVERAGES	PREV EE/DEP	NEW CHG		WP	#El	ES	LATE L	NEWE		APP = A DECL= D	INITIALS	

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