BEST Life™
BEST Life and Health Insurance Company

Group #: _____

Request for Short Term Disability Plan Participant Enrollment Form

Name of Company Where Employed	Date of F/T Employment	Job Title	Monthly Earnings

Employee Last Name	First Name	M.I.	Date of Birth

Employee Home Address	City	State	Zip	Home Phone

Social Security Number	Marital Status	Sex	Height	Weight	Do you have or are you applying for other disability income coverage? ☐ Yes ☐ No If yes, indicate carrier and monthly benefit below:

CONFIDENTIAL MEDICAL INFORMATION

The following information is submitted as evidence of my insurability, if required.

1. Have you in the past 10 years (other than for routine examination, check-ups, immunizations) consulted or been treated by a physician/practitioner, or been confined or treated in a hospital or similar institution, or been advised to have an operation which has not been performed or to enter a treatment program you are not currently receiving?
   ☐ Yes ☐ No

2. Have you had or been told of, or consulted with a physician/practitioner for, or been treated for any of the following: High blood pressure, heart trouble or murmur, disorder of the blood or vessels; Alcohol or drug abuse; Tuberculosis; Kidney/bladder prostate or reproductive organs; Cancer, tumor, cyst or growth; Brain disorder; Spine, back disorder, chronic pain or fatigue, fibromyalgia, arthritis, rheumatism, gout, or any other bone, joint or muscle disorder; Diabetes, blood or sugar in the urine, thyroid or other glandular disorder; Mental or nervous disorder or epilepsy; Ulcer, colitis or other digestive system disorder; hernia or liver disorder (including hepatitis)? ☐ Yes ☐ No

3. Have you:
   a. treatment from a physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No
   b. been diagnosed by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No

4. Are you under regular medical care or taking medication of any disease or disorder? ☐ Yes ☐ No

We pay all benefits according to the law of the State in which the policy was written.

If you answered "yes" to any of the above health questions, please provide full details below. Include date of onset, diagnosis, all details of condition, routine exams, and names and addresses of Physicians and Hospitals. Attach an additional sheet if necessary.

Nature of Illness or Injury and Date and Duration of Medical Attention	Recovery Complete (Yes/No)	Names and Addresses Physicians/Hospitals
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

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. I authorize my employer to make deductions from my earnings necessary to provide my contribution for this coverage and understand that my employer is performing this service for my benefit and not as an agent of the insurer. I understand that coverage is not in force until the effective date shown on each certificate of insurance issued to me. However, if I am absent from full-time employment on such date(s) as the result of an accident or sickness I agree that coverage is not effective. I understand that my employer's application will determine the coverages in force and that coverage is not in force if an application for that coverage has not been made by my employer. I understand that BEST Life reserves the right to decline anyone or all persons listed on this request for group insurance.

FRAUD WARNING: AS REQUIRED BY LAW, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH MAY BE CONSIDERED CRIME.

I'm applying to BEST Life and Health Insurance Company for group short-term disability insurance coverage. The answers on this application, a copy of which will be a part of my insurance certificate if issued, are given to obtain this coverage. I hereby certify that I have read the statements contained on this application or that they have been read to me and that all statements made by me on this application are true and complete to the best of my knowledge and belief. I understand that misstatements or omissions in the application may be used to contest the validity of insurance, reduce coverage or deny a claim. I authorize my employer to deduct from my earnings any required contribution toward the premium. I further authorize any physician, hospital, clinic, insurer, or other organization or person having any records or knowledge concerning me to give this information to BEST Life and Health Insurance Company. This authorization expires 24 months from the date of the Applicant's signature. A photocopy of this authorization will be as valid as the original.

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.

Date: _____ Signature of Applicant ***X*** _____