

APPLICANTS INFORMATION

Name of Group Applicant		Industry		SIC Code	
Name and Title of Employer Contact		Email Address		Phone Number	
Street Address		City	State	Zip	Fax Number
Employer's I.D. Number	Details of any subsidiaries or affiliates to be insured.				
Type of Business				Amount of Premium Submitted	
<input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other:					
Percent of Premium Paid by Employer		Waiting Period		Requested Effective Date of Insurance	
For employees: %	For dependents: %	Current employees:	New employees:		
Definition of eligible employees (include hrs. per wk. For full time status)				Total Number Eligible	
Does this insurance replace existing insurance with any company?			If yes, give details of coverage to be terminated.		
<input type="checkbox"/> Yes <input type="checkbox"/> No Termination Date:			Company: Policy Number:		

NOTE: There is an "actively at work" requirement for coverage to be in force. Employees not able to work or dependents not able to perform the normal activities for their age will not be insured until this requirement is satisfied.

LIFE COVERAGE

(Check Coverage Desired)

<input type="checkbox"/> Group Life Insurance <input type="checkbox"/> Accidental Death & Dismemberment <input type="checkbox"/> Supplemental Life		<input type="checkbox"/> Dependent Life Insurance <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	
Class Description	Scheduled Amount	Reduction Schedule	
Class		Age	%
Class			%
Class			%
Class			%
Class			%

Special Requests:

Changes in coverage amounts are effective on the: Policy anniversary date First of the month following the change

FRAUD WARNING

A person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud. All statements made by the Insured in the absence of fraud, are representations and not warranties.

The group insurance for which you are applying will not be effective until BEST Life and Health Insurance Company determines that your group meets certain underwriting standards. You will be notified of your acceptance.

Applicant Name and Title		Signature (applicant)		Date
Agent Name and License Number		Agent Signature		
Agency Name and Address		Agent Phone Number		Agent Fax Number
Agent Email Address	The "New Client Kit" (Certificate of Insurance, Claim Forms, etc.) should be sent to:			
<input type="checkbox"/> The benefit representative <input type="checkbox"/> The client <input type="checkbox"/> TPA:				