Employer Application—It's easy to apply!

BEST LIFE AND HEALTH INSURANCE COMPANY

***Smart Choice Dental Plans℠* Insurance for 5–300**

Requested Effective Date: ____/____/____

(1st or 15th of month only)

Dental Plan selected:

❒ Plan A ❒ Plan C ❒ Optional Vision Plan

❒ Plan B ❒ Plan D ❒ Optional Group Life Plan (please obtain a portable life brochure to enroll this coverage)

ESTIMATED MONTHLY COST

A [ ] Industry Factor (If Applicable)   B [ ] Case Size Factor Discounts/Charges

Initial enrollment fee of $5.00 applies to initial new employees to a maximum of $50.00. If a BEST Health Plans or TRP medical plan is being applied for simultaneously with this dental/vision application, only one enrollment fee and only one administrative fee will apply.

Dental Rate		Vision Rate				Number of		
$ ______	+	$4.25	=	$ ______	X	______ Employee Only	=	$ ______
$ ______	+	$7.75	=	$ ______	X	______ Employee Plus One	=	$ ______
$ ______	+	$11.75	=	$ ______	X	______ Employee and Family	=	$ ______

Subtotal Dental & Vision **$** ______

Industry Factor (From Box A if applicable) = $ ______

Additional Discounts (From Box B) = $ ______

Monthly Administrative Fee = $ + 20.00

Total First Month's Remittance Payable to **BEST LIFE** - estimate = $ ______

(Final Rates may be different than the quote.)

EMPLOYER ACKNOWLEDGEMENT

Employer Name ______ Employer Fed. Tax Number ______

Address ______ City ______ State ______ Zip ______ Telephone Number ______

Nature of Firm's Business ______ Person at firm to contact for service and administration of the dental plan ______

I certify that I have read the "General Information" section, understand it, and have enrolled all eligible employees and their dependents in accordance with information in the General Information section. I have discussed coverages, eligibility, and the expenses not covered with the Producer and understand them fully.

I certify that this is a bona fide business with a legitimate business purpose 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. I understand that final rates are subject to final firm enrollment information, eligibility and any applicable industry additional charges.

Employer Contributions—To encourage continuing employee participation, it is recommended that the employer pay 100% of the employee cost.

Employer contribution for employees: ______ %, for dependent coverage ______ %. Will this plan be offered to employees only? ❒ Yes ❒ No

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.

❒ Yes ❒ No Does the employer now have a comparable dental plan which has been in force for the past consecutive 12 months? If yes, and 5 employees are currently enrolling, the 12 month waiting period for *Major Dentistry* may be waived, but only for those employees and dependents covered under the prior plan. To qualify for this benefit, **a copy of the prior dental *Certificate Booklet* and current bill** listing the covered employees and dependents must accompany this application.

❒ Yes ❒ No Are all full-time employees enrolled in the plan?

❒ Yes ❒ No Are any employees applying for coverage receiving extended benefits under COBRA? If yes, please list names:

______

❒ Yes ❒ No Waiting Period is waived for Present Employees

Waiting Period for new employees: first of the month following continuous full-time employment of:

❒ 1 Full Calendar Month (standard) ❒ 2 Full Calendar Months ❒ 3 Full Calendar Months ❒ 4 Full Calendar Months

Description of Classes not Eligible ______ Number of Total Employees on Payroll ______

By: ✗ ______

Signature of Company Officer ______ Name & Title ______ Dated ______

BEST Broker Code [ ]

Association and Trust Membership Application

Application is hereby made for membership in the BEST Employers Association which sponsors Beneficial Employees Security Trust of Utah, by:

(Legal Name of Employer) ____________________

Street Address (Do Not List P.O. Box) City State Zip County

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 one life for more than 90 consecutive days, all of my selected insurance coverage will be canceled.

IMPORTANT PLAN INFORMATION

The undersigned employer understands that by adopting one or more B.E.S.T. plans, it is establishing an employee welfare benefit plan for its employees. The Employer's plan is funded through the B.E.S.T. Trust, which the employer joins. The insurance company(ies) issue group insurance policies to the Trustee of the B.E.S.T. Trust. These policies provide the coverage selected by the employer.

The B.E.S.T. Trust receives payments from participating employer(s) and remits these payments to the insurance companies. One of the insurance companies is BEST LIFE and Health Insurance Company. The insurance companies may contract with a third party administrator to provide administrative services on their behalf. The managing trustor of the B.E.S.T. Trust is a party in interest in BEST LIFE and Health Insurance Company.

By signing this Trust Membership Application, the employer, if approved by the Trustee, becomes a subscribing employer to the Trust. The employer thereby subscribes to, and agrees to be bound by, all the terms and conditions of the Trust Agreement and 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 Master Group Policy is issued to the Trustee of the Beneficial Employees Security Trust of Utah and each participating employer unit adopts the Trust to participate in the plan. The Master Group Policy is governed by the laws of the state of Utah. In the event of dispute or litigation, I agree to be bound by the terms and conditions of the arbitration clause in the *Plan Certificate Booklet*.

BEST LIFE and Health Insurance Company reserves the right to decline any new business application which, in their sole opinion, does not meet sound underwriting standards or which affects the financial stability of the Trust.

By: ✗ ____________________

Signature of Company Officer Name & Title Dated

Benefit Representative Report

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. Just sign and date the form below.)

Your Company Name ____________________

Address ____________________

City State Zip

Who should receive the Service Fees?

❒ Benefit Representative ❒ Company

SS# ____________ Fed. Tax ID ____________

Ins. License No.* ____________ State ______

Date of Birth ____________________

Phone No. ( ) ____________ Fax No. ( ) ____________

Special Instructions to BEST LIFE

1. May we contact this client directly if we need additional information? ❒ Yes ❒ No
2. This is my 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*, claims forms, etc.) should be sent to: ❒ Benefit Representative ❒ Client
5. Have the underwriter assigned to my case call me. ❒ Yes ❒ No
6. Please list any "special handling" requirements for this client.

I hereby certify that I hold a valid Life, Accident & 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 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 receiving notice that the coverage requested herein is approved.
3. Coverages, 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.

✗ ____________________

Signature of Benefit Representative Name & Title Dated

*** For first case, please include a current copy of your State Life and Health license(s). If your state charges an appointment fee, it will be deducted from your service fee check.**