



BEST Life and Health Insurance Company

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Employee Request for Enrollment Groups of 2 to 50
Health Solutions High Deductible Health Plans - National

New Enrollment [] Add Dependents [] Name Change

EMPLOYEE INFORMATION

Form with fields: Last Name, First Name, M.I., DOB, Age, Gender, Height, Weight, SSN, Residence Street Address, City, State, Zip, Name of Company, Group #, Job Title, Weekly Hours, Date of F/T Hire, Marital Status, etc.

Are you insuring your dependents? [] Yes [] No

If 'Yes' complete the section below and explain any differences in last name, if applicable. If no, complete the waiver of coverage section below.

Eligible dependents include spouses and unmarried dependent children. Dependent children are covered through age 25. Coverage can be extended for dependent children residing in: OH through age 27.

DEPENDENT INFORMATION

Table with 8 columns: Qualifying Event, Dependent Name, Full-Time Student?, Date of Birth, Sex, SSN, Height, Weight. Includes rows for Spouse and New Dependent.

OPTIONAL COVERAGES

If your employer is offering optional group coverage which do you request: [] Dental [] Vision [] Health Savings Account Name of Trustee/Bank:

WAIVER OF COVERAGE

Complete if you or any of your eligible dependents are declining or refusing any type of offered coverage. Select all that apply.

[] I am enrolling for Life insurance coverage ONLY.

[] I waive Medical coverage [] I waive Dental coverage [] I waive Vision coverage

Waiver of coverage is 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

Please see the attached Important Information And Notice Requirements Pursuant to The Health Insurance Portability And Accountability Act of 1996 (HIPAA). I acknowledge that by declining enrollment for myself or my dependants (including my spouse and any newborn children), I or my dependants may, under certain conditions, be considered late enrollees and subject to an 18 month pre-existing conditions exclusion (may vary by state) if I/we enroll at a later date.

Your Signature in black ink Date

COBRA

COBRA Electives: If you are currently continuing coverage under COBRA or a state continuation plan, what is the exact date of your qualifying event?

Summary table with columns: BEST Use Only, ER, EFF, DT, PRE-EX, COBRA EE, 1=Employee, DEP REF, SPOUSE EE, DEP 19+ FTS, Eff. Date, ER#, COVERAGES, PREV EE DEP, WP, #EES, LATE, NEWBORN, APP A DECL D, INITIALS

HDHPNAEE1010

(continued on other side)

HEALTHCARE EVALUATION FOR ALL EMPLOYEES AND DEPENDANTS APPLYING FOR COVERAGE

FIRMS OF 2-50 ELIGIBLE EMPLOYEES COMPLETE THIS SECTION

1. Has any applicant in the last five years had, been medically advised of having, been treated for, or been referred for treatment (including medications), advice or hospitalization for any of the following? CHECK APPROPRIATE BOX(ES); PROVIDE DETAILS FOR ALL 'YES' ANSWERS BELOW. For questions A through D, CIRCLE the condition(s) that apply.

<p>A. Any disorder/disease of the heart, lungs, liver, pancreas, colon, back, bones, muscles or joints or arthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Any disorder/disease of the digestive system, urinary tract, kidneys, reproductive system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. Stroke, paralysis, leukemia, cancer, tumors, neurological or seizure disorder, or birth defect? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>D. Any mental, nervous or behavioral disorder, chemical imbalance, alcoholism or drug abuse or addiction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>E. Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'YES', last blood sugar reading and date? Date: _____</p> <p>F. High blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'YES', last 3 blood pressure readings and date _____ Dates: _____</p>
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2. "Have you had or been told you had or been tested for any immune deficiency disorder, AIDS or ARC in the last 10 years? Yes No

3. In the past three years has any applicant had medical expenses or claims of \$5000 or more or been hospitalized? Yes No

4. Is the employee or dependant pregnant (whether applying for coverage or not)? Yes No If yes, name _____
Anticipated due date: Any history of complications, premature birth, or C-Section? Yes No

5. Have you or any dependants used tobacco products in the last five years? Yes No

PRESCRIPTION MEDICATION – Please list below all medications prescribed or taken by you or your dependents currently and in the past two years.

Name of Individual	Name of Medication	Reason for Medication (Diagnosis)	How Long	Results

Please provide detail for all YES answers to the health questions above. You may have your treating provider complete this section.
Print legibly and complete all columns. Attach additional paper if necessary and be sure to sign and date it.

Name of Person Treated	Name of Condition/ Diagnosis	Duration Dates From (Mo/Yr) to (Mo/Yr)	Explain Treatment, Hospitalization, Tests and Surgery	Medications	Date Last Treated	Final Results/Degree of Recovery

FRAUDULENT INFORMATION WARNINGS

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.

SIGNATURE REQUIRED BELOW

I, the undersigned, 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 (number of hours may vary by state) and that federal, state and social security taxes are withheld from my earnings. 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 coverage issued to me. I understand that my employer's application will determine the coverages in force and that coverage is not in force if application for that coverage has not been made by my employer.

I understand and agree that all disputes, disagreements or controversies arising from or relating in any way to the Group Insurance Policy, including, but not limited to, whether this Arbitration Provision is valid and enforceable and whether an issue is subject to arbitration, where otherwise unable to be resolved, shall be resolved by mandatory binding arbitration.

Medical Authorization (I/We) hereby authorize any physician, medical practitioner, hospital, or clinic that has records or knowledge of me or my health or my dependents or their health, to give to the Beneficial Employees Security Trusts any such information. I know that I may request to receive a copy of the Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original and that this Authorization shall be valid for two years from the date shown below. 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.

Has any person assisted you in the completion of this form? Yes No

If 'Yes', please print that person's name: _____

Employee Signature in black ink

Date