



BEST Life and Health Insurance Company

Group Employer Application Health Solutions High Deductible Health Plans – National

FIRM INFORMATION

Requested Effective Date: [] 1st or [] 15th of the month ____, 20__
[] Partnership [] Corporation [] Sole Proprietor
Employer Name
Employer Federal Tax Number
Street Address City State Zip
Billing Address P.O. Box City State Zip
Date Company Formed E-Mail Telephone Number Fax Number
Exact Nature of Business SIC Code of Industry Contact Person

EMPLOYER/EMPLOYEE INFORMATION

Number of Employees On Payroll Full-Time Eligible Enrolling
Total number of employees in waiting period (Employees in waiting period of less than 6 months must complete enrollment forms).
The Firm's Waiting Period for new eligible employees – All new employees are eligible the first of the month following: (Check appropriate box below.) Current employees not subject to the waiting period unless specified by Employer. For firms of 2-4 lives, there is a MANDATORY 90-day waiting period for new employees. Maximum of 3 months available for Ohio and Tennessee firms.
[] One [] Two [] Three [] Four Calendar months
Employer Contribution (Note: employer must pay at least 50% for employees) _____% for employees _____% for dependents
Does your firm currently have Workers' Compensation Coverage? [] Yes [] No If yes, please provide the carrier's name
Is this group requesting portability of benefits? [] Yes [] No (If yes, please complete the next two lines).
Name of current health plan Date From Date To Reason for transfer
Was prior coverage self-funded? [] Yes [] No (In order to receive full or partial credit, you must provide BEST Health Plans with copies of invoices for the last 12 months.)
Are all eligible employees paid wages and subject to W-2 withholding requirements? [] Yes [] No
If no, list employees by name and state how they are compensated. (In some states, 1099 employees are not eligible for coverage.)
Are there any employees applying for coverage receiving extended benefits under COBRA? [] Yes [] No (If yes, please list names below).
PPO network requested: Are there any employees living outside of the Firm's state of business? [] Yes [] No (If yes, please list names and the state they reside in below.)

IN-NETWORK / NON-NETWORK PLAN COVERAGES

Groups with 2-9 employees enrolling must select only one plan of benefits. Groups with 10 or more employees enrolling may select two plans, as long as minimum of 15% of all employees enroll in either plan. Please note that boxes for the below plans must also be noted on the Employee Enrollment Form. Please contact your BEST Health plans sales associate or your broker for details.
Table with 7 columns: PLAN 1, PLAN 2, PLAN 3, PLAN 4, PLAN 5, PLAN 6. Rows: Individual Deductible, Family Deductible, Coinsurance Options, Stop Loss.

Optional Additional Coverage:

- [] Maternity (optional 2-14, required with 15 lives) [] Health Savings Account [] Group Dental** [] Vision Care** [] Group Life and AD&D (minimum \$15K required)
[] Voluntary Life* (groups of 10+, \$10K minimum) [] Flat Amount of \$_____ [] Schedule (attach description) **Requires separate application

I hereby certify that the above information is true and correct, and may be relied upon by the company for determining the final Risk Adjustment Factors and Rates. I hereby certify that: (a) the broker of record has advised me of all other group medical plans offered by the plan's insurance company and (b) I understand my rights to request to preview the Summary Brochure, Evidence of Coverage Booklet and rating and Renew ability Practices of any medical plan offered by the plan's insurance company.

Employer Signature: Print Name/Title: Date:

HDHP0309

(continued on other side)

ASSOCIATION AND TRUST MEMBERSHIP APPLICATION

Application is hereby made for membership in 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 ELGIBILITY: 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, and coverage will be terminated effective on the 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 may be cancelled. Additionally, I understand that if my firm has 2-7 employees, we must maintain a participation requirement of 100% of all eligible employees, and if my firm has 8+ employees, we must maintain a participation requirement of 75% of all eligible employees, and that as the employer I must pay at least 50% of the employees' small group medical plan costs.

IMPORTANT PLAN INFORMATION: The undersigned Employer understands that by adopting one or more BEST Life plans, it is establishing an employee welfare benefit plan for its employees. The employer understands that the general definition of an employee is a person who usually works at least 30 hours per week at the firm's business location with federal, state and social security tax withheld from their salary. The Employer's plan is funded through the BEST Trust and sponsored by the BEST Employers Association ("BEA"), which the Employer joins. The insurance company(s) issue group insurance policies to the Trustee of the BEST Trust. These policies provide the coverage selected by the Employer.

The BEST Trust receives payments from the Employer and remits insurance contributions to the insurance carrier(s), and to affiliates of the BEST Trust providing services to Employers maintaining Welfare plans and to the BEST Trust. One of the insurance carriers is BEST Life and Health Insurance Company. One of the entities providing services to your plan and to the BEST Trust is Beneficial Administration Company, an affiliate of the BEST Trust. These two (2) companies receive a portion of each contribution dollar.

By signing this Trust Membership Application, the Employer, if approved by the Trustee (applies to groups with 51 or more employees), becomes a Subscribing Employer of the Trust and a member of BEA. A \$3.00 monthly due for BEA will be charged along with the insurance premium for the plan the Employer selects. This will also provide access to benefits offered by BEA and may vary by availability, vendor, or state of residence of the participating employer. 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. However, to the extent that such Policy and/or Certificate of Coverage is in conflict with the laws of another state demonstrating statutory governing jurisdiction over an out-of-state multiple employer trust Policy, then such Policy and/or Certificate of Coverage may be amended to comply with the minimum requirements of that state.

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.

The producer, insurance broker, or insurance agent is my representative in securing this coverage for my firm.

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.

X _____ / /
 Signature of Company Officer Print Name & Title Dated

BENEFIT REPRESENTATIVE REPORT

<p align="center"><i>(Please Print)</i></p> <p>Name _____</p> <p>It is not necessary to complete the following information if you are currently receiving service fees from BEST Health Plans unless changes in address, etc. need to be made. Just sign and date the form below.</p> <p>Your Agency Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Who Should Receive the Service Fees? <input type="checkbox"/> Benefit Representative <input type="checkbox"/> Company/Firm</p> <p>Social Security Number - - - Federal Tax ID _____</p> <p>Date of Birth / / License No. _____ State _____</p> <p>Phone No. _____ FAX No. _____</p> <p>E-mail Address _____</p> <p>Please list any special handling needed for this client:</p>	<p align="center"><i>(Please Complete)</i></p> <p align="center">Special Instructions to BEST Health Plans</p> <ol style="list-style-type: none"> May we contact the client if we need additional information? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this your first case with BEST Health Plans? <input type="checkbox"/> Yes <input type="checkbox"/> No This is: <input type="checkbox"/> an existing client <input type="checkbox"/> a new client with my company The 'New Client Kit' (certificate book, claim forms, etc.) should be sent to: <input type="checkbox"/> The benefit representative <input type="checkbox"/> The client The underwriter assigned to my case should contact me? <input type="checkbox"/> Yes <input type="checkbox"/> No <p>General Agent (GA):</p>
---	--

I hereby certify that I hold a valid Life, Accident and 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 that I know nothing unfavorable about this firm or any individual applying for insurance unless fully described in this application material. Furthermore, I certify that:

- This firm is a bona fide business establishment and participation requirements are being met.
- I have advised my client not to terminate any existing coverage until this coverage is approved.
- Coverage, eligibility provisions, waiting periods and limitations have been fully explained to, and understood by, the Employer identified in this document.
- I have no right to bind, modify or alter provisions of this program.

I understand and agree that the insurance applied for herein does not begin until this application is received and approved by BEST Life and Health Insurance Company, the insurance certificates are issued and the first premium is received and accepted.

Agent's Signature:	Print Name:	Date:
--------------------	-------------	-------