

**FIRM INFORMATION**

Requested Effective Date: <input type="checkbox"/> 1 <sup>st</sup> or <input type="checkbox"/> 15 <sup>th</sup> of the month _____, 20____		<input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> 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 ( <i>Employees in waiting period of less than 6 months must complete enrollment forms.</i> )				
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 are not subject to the waiting period unless specified by the Employer. For firms of 2-4 lives, there is a MANDATORY 90-day waiting period for new employees. <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three				
Employer Contribution ( <i>Note: employer must pay at least 50% for employees</i> ) _____ % for employees _____ % for dependents				
Does your firm currently have Workers' Compensation Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the carrier's name				
Is this group requesting portability of benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No ( <i>If yes, please complete the next two lines.</i> )				
Name of current health plan	Date From	Date To	Reason for transfer	
Was prior coverage self-funded? <input type="checkbox"/> Yes <input type="checkbox"/> No ( <i>In order to receive full or partial credit, you must provide BEST Health Plans with copies of invoices for the last 12 months.</i> )				
Are all eligible employees paid wages and subject to W-2 withholding requirements? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No ( <i>If yes, please list names below.</i> )				
PPO network requested: Are there any employees living outside of the Firm's state of business? <input type="checkbox"/> Yes <input type="checkbox"/> No ( <i>If yes, please list names and the state they reside in below.</i> )				

**IN-NETWORK / NON-NETWORK PLAN COVERAGES**

	<input type="checkbox"/> PLAN 1	<input type="checkbox"/> PLAN 2	<input type="checkbox"/> PLAN 3	<input type="checkbox"/> PLAN 4	<input type="checkbox"/> PLAN 5	<input type="checkbox"/> PLAN 6
Individual Deductible	\$1,500/\$3,000	\$2,000/\$4,000	\$2,500/\$5,000	\$3,000/\$6,000	\$4,000/\$8,000	\$5,000/\$10,000
Family Deductible: <input type="checkbox"/> Embedded, or <input type="checkbox"/> Aggregate	\$3,000/\$6,000	\$4,000/\$8,000	\$5,000/\$10,000	\$6,000/\$12,000	\$8,000/\$16,000	\$10,000/\$20,000
Coinsurance Options (*not available with plan Stop Loss \$5,000/\$10,000)	<input type="checkbox"/> 100%/80%		<input type="checkbox"/> 90%/70%*		<input type="checkbox"/> 80%/60%*	

**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:
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## 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 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, 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, all of my selected insurance coverage may be cancelled. Additionally, I understand that if my firm has 2 employees, we must maintain a participation requirement of 100% of all eligible employees, and if my firm has 3 or more 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 employee's small group medical plan costs.

**IMPORTANT PLAN INFORMATION:** The undersigned Employer understands that by adopting one or more BEST 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.

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.**

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Signature of Company Officer
Print Name & Title
Dated

### BENEFIT REPRESENTATIVE REPORT

(Please Print)	(Please Complete)
Name _____	<b>Special Instructions to BEST Health Plans</b>
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.	1. May we contact the client if we need additional information? <input type="checkbox"/> Yes <input type="checkbox"/> No
Your Agency Name _____	2. Is this your first case with BEST Health Plans? <input type="checkbox"/> Yes <input type="checkbox"/> No
Address _____	3. This is: <input type="checkbox"/> an existing client <input type="checkbox"/> a new client with my company
City _____ State _____ Zip _____	4. The 'New Client Kit' (certificate book, claim forms, etc.) should be sent to: <input type="checkbox"/> The benefit representative <input type="checkbox"/> The client
Who Should Receive the Service Fees? <input type="checkbox"/> Benefit Representative <input type="checkbox"/> Company/Firm	5. The underwriter assigned to my case should contact me <input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number - - - - - Federal Tax ID _____	General Agent (GA):
Date of Birth / / License No. _____ State _____	
Phone No. _____ FAX No. _____	
E-mail Address _____	

Please list any special handling needed for this client:

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:

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 this coverage is approved.
3. Coverage, 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.

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:
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