BEST Life and Health Insurance Company

Group Term Life Enrollment Roster

INSTRUCTIONS: List employees in alphabetical order. If insuring dependents, please complete the section below. If enrolling Dependent Children between the ages of 20 and 25, please indicate if they are a full-time student.

Employer Name: ____

Employee SS# (XXX-XX-XXXX)	Last Name, First Name MI	Date Of Birth (MM/DD/YY)	Sex (M/F)	Requested amount in excess of guarantee issue, if applicable	Dependent Amount	Dependent Name	Relationship (S, D)	Sex (M/F)	Full Time Student? Y or N	Date Of Birth (MM/DD/YY)
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Street Address		City	State	ZIP	2.	2.				/ /
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					5.	5.				/ /
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Street Address		City	State	ZIP	2.	2.				/ /
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Street Address		City	State	ZIP	2.	2.				/ /
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Street Address		City	State	ZIP	2.	2.				/ /
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Street Address		City	State	ZIP	2.	2.				/ /
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Street Address		City	State	ZIP	2.	2.				/ /
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Street Address		City	State	ZIP	2.	2.				/ /
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Employee SS# (XXX-XX-XXXX)	Last Name, First Name MI	Date Of Birth (MM/DD/YY)	Sex (M/F)	Requested amount in excess of guarantee issue, if applicable	Dependent Amount	Dependent Name	Relationship (S, D)	Sex (M/F)	Full Time Student? Y or N	Date Of Birth (MM/DD/YY)
- -		/ /			1.	1.				/ /
Street Address		City	State	ZIP	2.	2.				/ /
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Street Address		City	State	ZIP	2.	2.				/ /
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Street Address		City	State	ZIP	2.	2.				/ /
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Street Address		City	State	ZIP	2.	2.				/ /
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Street Address		City	State	ZIP	2.	2.				/ /
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EMPLOYEES MUST ALSO COMPLETE A BENEFICIARY INFORMATION CARD.

EMPLOYER VERIFICATION:

I (We) certify and verify that all employees applying for coverage listed above are actively at work and are working at least 30 hours per week, and that all employees and dependents (if electing dependent coverage) meet all eligibility and participation requirements listed in the brochure and certificate booklet.

FURTHER:

I (We) verify that this dental plan has been offered to all eligible employees. Completed waiver cards are attached for all employees and dependents electing not to participate in the plan. I (We) represent that all information on this application is correct to the best of my (our) knowledge. I (We) understand that our firm is not eligible for coverage until written confirmation is received from the insurance company. I (We) further agree to be bound by the arbitration clause in the BEST Life certificate booklet instead of a trial by a court or jury. 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.

X ______________________ ______________________ ______________________

Employer Signature | Title | Date

SEND COMPLETED FORMS TO: BEST Life and Health Insurance Company · P.O. BOX 19721 · Irvine, CA 926239721

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