BEST Life
BEST Life and Health Insurance Company

Group Employer Application Health Solutions II – Texas

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 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.
Calendar Months: ☐ One ☐ Two ☐ Three

Employer Contribution *(Note: employer must pay at least 50% for employee)* __________ % 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 COVERAGES

Individual Deductible	☐ \$500/\$1,000 ☐ \$750/\$1,500 ☐ \$1,000/\$2,000 ☐ \$1,500/\$3,000 ☐ \$2,000/\$4,000 ☐ \$2,500/\$5,000 ☐ \$5,000/\$10,000
Co-Pay	☐ \$0 ☐ \$10 ☐ \$20 ☐ \$30 ☐ \$40
Coinsurance	☐ 100/70 ☐ 90/70 ☐ 80/60 ☐ 80/50 ☐ 70/50
Stop Loss	☐ \$5,000/\$10,000 ☐ \$10,000/\$20,000 ☐ \$20,000/\$30,000
Rx Options	☐ \$10 Generic/\$25 Brand Formulary/\$40 Non-Formulary ☐ \$10 Generic/\$30 Brand Formulary/\$50 Non-Formulary ☐ \$15 Generic/\$90 Brand Formulary/\$150 Non-Formulary
No Deductible	☐ Discount Only ☐ 50% Coinsurance
Rx Deductible	☐ \$0 ☐ \$50 ☐ \$100 ☐ \$200

Other Options: ☐ Supplemental Accident ☐ Maternity (optional 2-14, required with 15 lives) ☐ Group Dental* ☐ Vision Care* ☐ Group Life and AD&D (minimum \$15K)
☐ 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:

(continued on other side)

© 2010 BEST Life and Health Insurance Company

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, 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 and agrees that by adopting one or more BEST plans, it is establishing an employee welfare benefit plan for its employees. The employer further understands and agrees 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 Beneficial Employees Security Trust of Utah ("B.E.S.T.") and sponsored by the BEST Employers Association ("BEA") to which the Employer initially subscribes to. The insurance companies issue group insurance policies to the Trustee of B.E.S.T. These policies provide the coverage(s) the Employer selects for their employees.

B.E.S.T. receives the subscribing employer's payment and remits the insurance premium(s) to the insurance carrier(s) or to affiliates, Beneficial Administration and BEST Health Plans, provide services to Employers and to B.E.S.T. One of the insurance carriers is BEST Life and Health Insurance Company ("BEST Life").

The Employer agrees and understands that by signing this Trust Membership Application, it becomes a Subscribing Employer of the Trust. A subscribing employer of the Trust agrees to be bound by all the terms and conditions of the Trust Agreement. A subscribing employer of the Trust 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 Employer agrees and understands that by signing this Trust Membership Application, it becomes a member of BEA and a $2.00 monthly due 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 Master Group Policy is issued to the Trustee of B.E.S.T. To participate in the plan, each subscribing employer adopts the Trust. 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 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.

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

(Please Print)

Name

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.

Your Agency Name

Address

City State Zip

Who Should Receive the Service Fees? Benefit Representative Company/Firm

Social Security Number - - Federal Tax ID

Date of Birth / / License No. State

Phone No. FAX No.

E-mail Address

(Please Complete)

Special Instructions to BEST Health Plans

1. May we contact the client if we need additional information? ☐ Yes ☐ No
2. Is this your first case with BEST Health Plans? ☐ Yes ☐ No
3. This is: ☐ an existing client ☐ a new client with my company
4. The 'New Client Kit' (certificate book, claim forms, etc.) should be sent to: ☐ The benefit representative ☐ The client
5. The underwriter assigned to my case should contact me? ☐ Yes ☐ No

General Agent (GA):

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:

MEDTXER1110

© 2010 BEST Life and Health Insurance Company