



BEST Life and Health Insurance Company

BEST Life EyeMed Vision PPO Plans Group Employer Application

Requested Effective Date: 1st or 15th of the month _____, 20____

| VISION PPO PLAN TYPE | Plan Options |
|---|--|
| Choose Plan | <input type="checkbox"/> Plan Series 1 (\$10 Exam Co-pay/ \$10 Lens Co-pay / \$130 Contact Lens Allowance) <input type="checkbox"/> Plan Series 2 (\$10 Exam Co-pay/ \$25 Lens Co-pay / \$130 Contact Lens Allowance) <input type="checkbox"/> Plan Series 3 (\$10 Exam Co-pay/\$25 Lens Co-pay / \$115 Contact Lens Allowance) <input type="checkbox"/> Materials Only Plan (\$10 Lens Co-pay/ \$130 Contact Lens Allowance) |
| Choose Frequency Option | <input type="checkbox"/> A: 12/12/12/12 (Exam/Lens/Frame/Contacts) <input type="checkbox"/> B: 12/12/24/12 (Exam/Lens/Frame/Contacts) For Materials Only plans: <input type="checkbox"/> A: 12/12/12 (Lens/Frame/Contacts) <input type="checkbox"/> B: 12/24/12 (Lens/Frame/Contacts) |
| Voluntary Option* | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bundled with another BEST Life Product* | <input type="checkbox"/> Yes <input type="checkbox"/> No |

* Certain requirements apply. If this vision plan is being bundled with another BEST Life product, complete a separate employer application for the other products.

Benefit Representative Report

| (Please Print) | (Please Complete) |
|--|---|
| Name _____ | Special Instructions to BEST Health Plans 1. May we contact the client if we need additional information? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. This is my first case with BEST Health Plans? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. This is: <input type="checkbox"/> an existing client <input type="checkbox"/> a new client with my company 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 5. Have the Underwriter assigned to my case call me? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Please list any 'special handling' needed for this client: |
| 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? <input type="checkbox"/> Benefit Representative <input type="checkbox"/> Company/Firm | |
| Social Security Number _____ Federal Tax ID _____ | |
| Date of Birth ____/____/____ License No. * _____ State _____ | |
| Phone No. (____) _____ - _____ FAX No. (____) _____ - _____ | |
| E-mail Address _____ | |

I hereby certify that I hold a valid Life, Accident & 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 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 participating requirements are being met.
- I have advised my client not to terminate any existing coverage until receiving notice that the coverage being applied for is approved.
- Coverage, eligibility provision, 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 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
Agent Signature _____ Agent: Print Name _____ Date _____

*For first case please include a current copy of your State Life and Health license(s). If your state charges an appointment fee, it will be deducted from your service fee check.

EMPLOYER ACKNOWLEDGEMENT & ASSOCIATION AND TRUST MEMBERSHIP APPLICATION

| | | | | | | |
|---------------------------|------|----------|--|-----------------------------|------------|--|
| Employer Name | | | | Employer Federal Tax Number | | |
| | | | | () - () - | | |
| Street Address | City | State | Zip | Telephone Number | Fax Number | |
| Billing Address P.O. Box | | City | State | Zip | E-Mail | |
| Nature of Firm's Business | | SIC Code | Person at Firm to Contact for Service and Administration | | | |

I certify that I have read the General Information section, understand it, and have enrolled all eligible employees and their dependents in accordance with information on the General Information page. I have discussed coverages, eligibility, and the expenses not covered with the Producer and understand them fully.

I certify that this is a bona fide business with a legitimate business purpose and which has a true employer-employee relationship with the individuals designated as employees. I understand that any false statements made in this application constitute the legal basis for termination or cancellation of coverage retroactive to the effective date and denial of all claims incurred.

Employer Contribution for Employees (for employer-contributory plans, the Employer must pay at least 50% for each employee): ____ %, For Dependent Coverage: ____ %.

Termination of Coverage—Employee coverage and dependent coverage will terminate on the earliest of the following dates: (1) the date the employee ceases to be an eligible employee or the date the dependent is no longer eligible as a dependent under the plan; (2) the date the plan is terminated; (3) the date the employer terminates the coverage by failing to pay the required premium; (4) the date the group policy is terminated; (5) the date the group no longer meets minimum participation requirements. The benefits are subject to all of the conditions and limitations of the plan.

Eligible dependent coverage terminates on the earliest of the following: when the dependent no longer meets the definition of a dependent; on the first day of the month in which premiums were not paid, or when the member terminates coverage.

Yes No Are all full-time employees enrolled in the plan?

Yes No Are any employees applying for coverage receiving extended benefits under COBRA? If yes, please list names:

Yes No Waiting Period is waived for Present Employees?

Waiting Period for New Employees: First of the Month following continuous full time employment of:

1st of the month following date of hire 1 Full Calendar Month (standard) 2 Full Calendar Months 3 Full Calendar Months 4 Full Calendar Months

| Description of Classes not Eligible | Number of Total Employees on Payroll | Number of Full-time Employees |
|-------------------------------------|--------------------------------------|-------------------------------|
| | | |

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. Coverage will be terminated on the effective date the business ceases active operation. I understand that if my firm drops in size to less than 5 employees, and if additional employees are not enrolled and active for coverage within 2 months, all of my selected insurance coverage will be cancelled.

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.

| | |
|------------------------------|----------------------|
| <u>X</u> | / / |
| Signature of Company Officer | Print Name and Title |
| | Dated |