BEST Life and Health Insurance Company

Short Term Disability Employer Application

Application Checklist

For group enrollment for 5 or more lives

INSTRUCTIONS: To apply for group short term disability insurance, please submit the following items:

- ☐ Complete the Employer Application and obtain all signatures
- ☐ Attach Copy of Quote
- ☐ A Copy of firm's most recent state Quarterly Wage Report showing the names of all employees
- ☐ Obtain a business check for one month's estimated premium payable to BEST Life and Health Insurance Company
- ☐ Mail all documents and 1st month's premium check to:

BEST Life and Health Insurance Company
P.O. Box 19721
Irvine, CA 92623-9721

For additional information or assistance, contact us at:

Toll-free: 800.237.8543
Local: 949.253.4080
Fax: 949.553.0883
E-mail: info@bestlife.com
www.bestlife.com

BEST Life and Health Insurance Company

Short Term Disability Employer Application

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 of the Dental Plan

Years in Business | Number of Full-time Employees on Payroll | Number of Employees applying for Coverage | Description of any Classes Not Eligible

Requested Effective Date:

Elimination Period (Day Accident Benefits Begin On/Day Sickness Benefits Begin On): ☐ 0/7 ☐ 7/7 ☐ 14/14 ☐ 29/29

Benefit Duration: ☐ 13 Weeks ☐ 26 Week ☐ 52 Weeks (Available on voluntary and custom plans only)

Monthly Benefit: ☐ 60% ☐ 67% ☐ 70% ☐ $_____ per week

Pre-existing Condition (Months Before Eff. Date/Months After Eff. Date): ☐ None ☐ 3/12 ☐ 6/12 ☐ 12/12 ☐ 12/24

Include Maternity? ☐ Yes ☐ No

Waiting Period for New Employees: ☐ 1 Full Calendar Month ☐ 2 Full Calendar Months ☐ 3 Full Calendar Months ☐ 4 Full Calendar Months

Waiting Period is waived for present Full-time Employees: ☐ Yes ☐ No

Is this plan a takeover from another group's plan? ☐ Yes ☐ No If yes, please provide the prior carrier's certificate book or contract.

Employer Contribution (employer must pay at least 25% for employer-sponsored groups): _____%

☐ Contributory (Voluntary) ☐ Non-Contributory (Employer-contributory)

Financial Disclosure Statement

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's plan is funded through the BEST Trust, 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 premiums 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 entities providing services to your plan and to the BEST Trust is Beneficial Administration Company, an administrative service contractor only, and an affiliate of the BEST Trust. This company receives a portion of each premium dollar.

By signing this Trust Membership Application the Employer, if approved by the Trustee, becomes a Trustor of the Trust. 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.

Enrollment Participation Statement

I certify that I have read the Enrollment Guidelines, understand them, and have enrolled only eligible employees in accordance with the Participation Requirements. I have discussed coverages, eligibility, and pre-existing condition limitations 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.

Approval of enrollment and employee eligibility requirements (including Health Information when applicable) must be met before the insurance can be effective. Any in force coverage will not be cancelled until I receive written notification of such approval from BEST Life.

FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I agree 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.

Company Officer-Signature	Title & Print Name	Date

Benefit Representative Report

(Please Print)

Name

It is not necessary to complete the following information if you are currently receiving service fees from BEST Life unless changes in address, etc. need to be made. Please 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 Life

1. May we contact the client if we need additional information? ☐ Yes ☐ No
2. Is this your first case with BEST Life? ☐ 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 Certificates of Insurance are issued and the first premium is received and accepted.

Agent's Signature:	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.