



BEST Life and Health Insurance Company

P.O Box 19721, Irvine, CA 92623-9721
(800) 433-0088 • (949) 222-1004 fax
www.bestlife.com

Instructions For Filing Initial Proofs For Waiver of Premium Benefits

1. Before submitting initial claim proofs for Waiver of Premium Benefits, the claimant must have been totally disabled and unable to engage in any type of occupation for wage or profit for at least nine consecutive months.
2. If the claimant meets the above condition, the following forms must be completed in their entirety and returned to us:
 - a. The Claimant's Statement completed by the employee or association member;
 - b. The Employer's Statement completed by the Employer, Union or Association whichever is applicable;
 - c. The Attending Physician's Statement completed by the claimant's physician(s) who can certify disability from the date last worked.
3. We require the claimant's original enrollment card and beneficiary changes, if any.
4. If your group life insurance schedule of benefits is based on salary, we require copies of the claimant's payroll records for the three month period immediately preceding the date the disability commenced.
5. Any other information that you feel is pertinent and should be included with the above should be forwarded to:

BEST Life and Health Insurance Company
ATTN: Policy Benefits/Life
PO Box 19721
Irvine, CA 92623-9721



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Claimant's Statement
Total Disability Benefits

This statement must be fully answered by the Insured or his duly appointed Guardian or Committee, if insane. If, due to physical condition, Insured is unable to answer these questions, a beneficiary or nearest relative may do so.

STATEMENT NO. 1
Full Name of Insured, Social Security #, Occupation (State Exact duties in full)
Date of Insured's Birth, Height, Weight, Describe fully Insured's present condition
To what extent is Insured unable to follow any occupation?, Give exact date of injury or beginning of illness causing present condition
When was Insured compelled to give up part of his or her duties?, How does Insured spend his or her time?
Has Insured done any kind of work since commencement of disability? If so, give particulars. When does Insured expect to return to work?
Names and addresses of every physician or practitioner who attended or prescribed for Insured during present illness.
For what disease or injury has Insured required the services of a physician or practitioner prior to present disability?
If presently confined to a hospital, sanitarium or other institution, give its name and address. Is Insured's estate represented by a Committee or Guardian? (If so, furnish copy of appointment.)
What other Life, Government, Health or Accident Insurance providing for disability benefits have you?

FRAUD WARNING: AS REQUIRED BY LAW, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH MAY BE CONSIDERED CRIME.

AUTHORIZATION

TO PHYSICIANS OR PRATITIONERS, HOSPITALS, CLINICS, PHARMACISTS, INSURANCE COMPANIES, MEDICAL INFORMATION BUREAU, EMPLOYERS AND OTHER PERSONS OR INSTITUTIONS: This authorizes you to give the BEST Life and Health Insurance Company, or its authorized representative who is employed to assist in the evaluation of my claim, any information, data or records you may have regarding me, my employment, my benefits or my condition (including records pertaining to psychiatric, drug or alcohol use history, and any disability I may have had). I understand that any information obtained pursuant to this authorization will be used to evaluate my claim and may be transferred to an agency or person employed by the BEST Life and Health Insurance Company to assist with this purpose. I understand I have the right to request a copy of this authorization and that a copy will be sent to me if requested. A photocopy of this authorization may be accepted by you.

Signature of Insured X

Date:

Witness

Address:

Telephone Number:



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Employer's Statement
Total Disability Benefits

This statement must be completed by the Employer, or his duly authorized agent, as a Superintendent, Paymaster, etc. It must not be completed by a Clerk, Bookkeeper or Foreman, unless specially authorized, nor by any Agent of BEST Life and Health Insurance Company.

STATEMENT NO. 3A
Form with fields for: Name of Insured, Group Policy No., Certificate No., Address of Employee, City, State, Zip, Phone Number, Nature of Business, Insured's Job Title, Hours Worked Per Week, Weekly Earnings, Duration of Employment, Insurance Class, Date Insured was compelled to give up part of his or her duties, Date Insured was compelled to give up all duties, Is Insured's illness or injury the sole cause of absence from duty?, Has Insured been absent from work before because of any illness or injury?, Date premium payments terminated on Insured's coverage, Amount of Insurance.

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Signature

X

Witness

Official Position

Date:

Date:

Spaces below to be filled out by Company

Disability Claim No. _____
BEST Life and Health Insurance Company
STATEMENT No. 1
Pol. No. _____ Date _____

STATEMENT No. 3A
Name _____
Address _____
Date Received _____

NOTICE

In furnishing this blank the Company does not thereby admit that there is any policy in force in the Company covering the person claiming to be disabled, and the Company expressly reserves all its rights and defenses.

There is no need to employ any person to help collect any sums rightly due under the insurance policies of BEST Life and Health Insurance Company, nor need any one incur any expense for this purpose except to pay the customary charges or fees required to complete the several forms or statements to be furnished.

STATEMENT No. 3A: Employer's Statement: To be made by Insured's Employer. If the Insured was employed by an association, company, corporation, etc., this statement should be made by an officer of such concern; preferably by the officer under whom the Insured was employed.

Please answer every question distinctly and fully and write below any additional information or details which you think are pertinent.

ADDITIONAL INFORMATION OR DETAILS



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Continuance of Total Disability

Policy Number:
Claim Number:

This statement must be fully answered by the Insured or his duly appointed Guardian or Committee, if insane. If, due to physical condition, Insured is unable to answer these questions, a beneficiary or nearest relative may do so.

CLAIMANT'S STATEMENT
Full Name of Insured Current Address
If presently confined to a hospital, sanitarium or other institution, give its name and address. Is Insured confined to his/her bed or home? State which and from what date.
If not confined, how does Insured spend his/her time?
Describe fully Insured's present condition and state how and to what extent he/she is unable to follow any occupation for remuneration or profit.
Is condition showing improvement (give full particulars)
Names and addresses of every physician or practitioner in attendance or consulted.
Who was Insured Last Employer? (Give name and address) Is Insured's position being held open for him/her?
Has Insured done any kind of work since commencement of present disability? If so, give full particulars and dates. When does Insured expect to be able to work?
Is Insured receiving any disability income, allowance or pension from any other source? If so give name of each company or source of payment with amounts of weekly or monthly payments.
If Insured is mentally disabled, when was he/she adjudged incompetent and who was appointed by the court as committee or guardian for his/her estate?

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I hereby certify that the above answers are true and complete to the best of my knowledge.

Signature of Insured X

Date:

Witness

Address:

Telephone Number:

CTDIS0109