



BEST Life and Health Insurance Company

Phone: (800) 433-0088 • e-mail: cs@bestlife.com • www.bestlife.com

Employee Request for Enrollment Groups of 2 to 50 Health Solutions High Deductible Health Plans - Arizona

New Enrollment Add Dependents Name Change

EMPLOYEE INFORMATION

Form with fields for Last Name, First Name, M.I., DOB, Age, Gender, Height, Weight, SSN, Residence Street Address, City, State, Zip, Name of Company, Group # if known, Job Title, Weekly Hours, Date of F/T Hire, Marital Status, etc.

Are you insuring your dependents? Yes No. If 'Yes' complete the section below and explain any differences in last name, if applicable. If no, complete the waiver of coverage section below.

Eligible dependants include spouses and unmarried dependent children. Dependent children are covered through age 20, extended through age 25 if they are full-time students.

DEPENDENT INFORMATION

Table with columns: Qualifying Event (Select One), Dependent Name, Full-Time Student?, Date of Birth, Sex, SSN, Height (in.), Weight (lbs.).

OPTIONAL COVERAGES

If your employer is offering optional group coverage which do you request: Dental Vision Health Savings Account Name of Trustee/Bank:

WAIVER OF COVERAGE

Complete if you or any of your eligible dependents are declining or refusing any type of offered coverage. Select all that apply.

I am enrolling for Life insurance coverage ONLY. I waive Medical coverage I waive Dental coverage I waive Vision coverage Waiver of coverage is for: Myself and any dependents Spouse only Child(ren) only Spouse and dependent child(ren) Reason for waiving coverage (you must provide a reason for waiving coverage) Other coverage Cost

Please see the attached Important Information And Notice Requirements Pursuant to The Health Insurance Portability And Accountability Act of 1996 (HIPAA). I acknowledge that by declining enrollment for myself or my dependants (including my spouse and any newborn children), I or my dependants may, under certain conditions, be considered late enrollees and subject to an 18 month pre-existing conditions exclusion (may vary by state) if I/we enroll at a later date.

Your Signature in black ink Date

COBRA

COBRA Electives: If you are currently continuing coverage under COBRA or a state continuation plan, what is the exact date of your qualifying event?

Table with columns: BEST Use Only, ER. EFF. DT, PRE-EX, COBRA EE, 1=Employee, DEP REF, SPOUSE EE, DEP 19+ FTS, Eff. Date, ER#, COVERAGES, PREV EE DEP, WP, #EES, LATE, NEWBORN, APP A DECL D, INITIALS

HEALTHCARE EVALUATION FOR ALL EMPLOYEES AND DEPENDANTS APPLYING FOR COVERAGE
FRAUDULENT INFORMATION WARNINGS

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.

SIGNATURE REQUIRED BELOW

I, the undersigned, certify that my date of birth, date of employment and other information on this form are correct and that I am working at the employer's place of business in full-time employment at least 30 hours per week (number of hours may vary by state) and that federal, state and social security taxes are withheld from my earnings. I authorize my employer to make deductions from my earnings necessary to provide my contribution for this coverage and understand that my employer is performing this service for my benefit and not as an agent of the insurer. I understand that coverage is not in force until the effective date shown on each certificate of coverage issued to me. I understand that my employer's application will determine the coverages in force and that coverage is not in force if application for that coverage has not been made by my employer.

I understand and agree that all disputes, disagreements or controversies arising from or relating in any way to the Group Insurance Policy, including, but not limited to, whether this Arbitration Provision is valid and enforceable and whether an issue is subject to arbitration, where otherwise unable to be resolved, shall be resolved by mandatory binding arbitration.

Medical Authorization (I/We) hereby authorize any physician, medical practitioner, hospital, or clinic that has records or knowledge of me or my health or my dependents or their health, to give to the Beneficial Employees Security Trusts any such information. I know that I may request to receive a copy of the Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original and that this Authorization shall be valid for two years from the date shown below. 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.

Has any person assisted you in the completion of this form? Yes No

If 'Yes', please print that person's name: _____

Employee Signature in black ink

Date

Employee and Family Medical Questionnaire

Section 1: Employer/Employee Information

Employer Name: _____

Names of Family Members Applying for Coverage	Relationship	Date of Birth	Gender Male/Female	Height	Weight
	Employee				
	Spouse				
	Dependent				
	Dependent				
	Dependent				

Section 2: Family Health History

Within the past five (5) years has a physician or other licensed healthcare practitioner ("practitioner") diagnosed or treated you or anyone in your family applying for coverage, or is anyone currently getting treatment? Use an "X" to mark "YES" or "NO" in the boxes heading each category of conditions below and mark with an "X" any of the following conditions that apply.

For all "YES" answers and conditions that you mark with an "X", provide details in the table on the next page.

A. Heart/Circulatory <input type="checkbox"/> YES <input type="checkbox"/> NO	D. Cancer/Tumors <input type="checkbox"/> YES <input type="checkbox"/> NO	H. Bones/Muscles/Joints <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> A1. Anemia <input type="checkbox"/> A2. Angina <input type="checkbox"/> A3. Angioplasty/Stent <input type="checkbox"/> A4. Aneurysm <input type="checkbox"/> A5. Blood Clots <input type="checkbox"/> A6. Blood Disorder <input type="checkbox"/> A7. Bypass <input type="checkbox"/> A8. Cardiac Arrhythmia <input type="checkbox"/> A9. Chest Pain <input type="checkbox"/> A10. Congestive Heart Failure <input type="checkbox"/> A11. Coronary Heart Disease <input type="checkbox"/> A12. Heart Murmur <input type="checkbox"/> A13. Hemophilia <input type="checkbox"/> A14. High/Low Blood Pressure <input type="checkbox"/> A15. High Cholesterol <input type="checkbox"/> A16. Pacemaker <input type="checkbox"/> A17. Palpitations <input type="checkbox"/> A18. Sick Cell Anemia <input type="checkbox"/> A19. Stroke/TIA <input type="checkbox"/> A20. Varicose Veins <input type="checkbox"/> A21. Ventricular Tachycardia <input type="checkbox"/> A22. Other (_____)	<input type="checkbox"/> D1. Brain <input type="checkbox"/> D2. Breast <input type="checkbox"/> D3. Colon <input type="checkbox"/> D4. Cyst <input type="checkbox"/> D5. Hodgkin's Disease <input type="checkbox"/> D6. Leukemia <input type="checkbox"/> D7. Liver <input type="checkbox"/> D8. Lung <input type="checkbox"/> D9. Lymphoma <input type="checkbox"/> D10. Melanoma <input type="checkbox"/> D11. Ovarian <input type="checkbox"/> D12. Pituitary <input type="checkbox"/> D13. Prostate <input type="checkbox"/> D14. Stomach <input type="checkbox"/> D15. Testicular <input type="checkbox"/> D16. Thyroid <input type="checkbox"/> D17. Other (_____) <input type="checkbox"/> D18. Stage of Cancer if known _____	<input type="checkbox"/> H1. Bulging/Herniated Disk <input type="checkbox"/> H2. Carpal Tunnel Syndrome <input type="checkbox"/> H3. Fibromyalgia/CFS <input type="checkbox"/> H4. Fractures (Open or Closed) <input type="checkbox"/> H5. Gout <input type="checkbox"/> H6. Joint Replacement (Type: _____) <input type="checkbox"/> H7. Knee <input type="checkbox"/> H8. Muscular Dystrophy <input type="checkbox"/> H9. Neck/Back <input type="checkbox"/> H10. Shoulder <input type="checkbox"/> H11. Spina Bifida <input type="checkbox"/> H12. Sprain/Strain <input type="checkbox"/> H13. Other (_____)
B. Eyes/Ears/Nose/Throat <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> B1. Acoustic Neuroma <input type="checkbox"/> B2. Cataracts <input type="checkbox"/> B3. Chronic Sinusitis <input type="checkbox"/> B4. Cleft Lip/Palate <input type="checkbox"/> B5. Detached Retina <input type="checkbox"/> B6. Deviated Septum <input type="checkbox"/> B7. Ear Infections <input type="checkbox"/> B8. Glaucoma <input type="checkbox"/> B9. Retinopathy <input type="checkbox"/> B10. Other (_____)	E. Neurological <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> E1. Alzheimer's Disease <input type="checkbox"/> E2. Cerebral Palsy <input type="checkbox"/> E3. Epilepsy <input type="checkbox"/> E4. Head Injury <input type="checkbox"/> E5. Migraines <input type="checkbox"/> E6. Multiple Sclerosis <input type="checkbox"/> E7. Neuritis <input type="checkbox"/> E8. Paralysis/Hemiplegia <input type="checkbox"/> E9. Parkinson's Disease <input type="checkbox"/> E10. Seizures/Convulsions <input type="checkbox"/> E11. Other (_____)	I. Psychological <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> I1. ADD/ADHD <input type="checkbox"/> I2. Alcoholism <input type="checkbox"/> I3. Anxiety <input type="checkbox"/> I4. Autism <input type="checkbox"/> I5. Bipolar <input type="checkbox"/> I6. Depression <input type="checkbox"/> I7. Drug Abuse <input type="checkbox"/> I8. Eating Disorder <input type="checkbox"/> I9. Schizophrenia <input type="checkbox"/> I10. Suicide Attempt <input type="checkbox"/> I11. Other (_____)
C. Immune <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> C1. ALS <input type="checkbox"/> C2. AIDS <input type="checkbox"/> C3. HIV+ <input type="checkbox"/> C4. Immuno Deficiency <input type="checkbox"/> C5. Lupus <input type="checkbox"/> C6. Psoriasis <input type="checkbox"/> C7. Scleroderma <input type="checkbox"/> C8. Other (_____)	F. Transplants <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> F1. Pending <input type="checkbox"/> F2. On Waiting List <input type="checkbox"/> F3. Completed Transplant <input type="checkbox"/> F4. Bone Marrow <input type="checkbox"/> F5. Stem Cell <input type="checkbox"/> F6. Organ (Type: _____)	J. Diabetes/Endocrine <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> J1. Diabetes controlled by: <input type="checkbox"/> a. Diet <input type="checkbox"/> b. Oral Medication <input type="checkbox"/> c. Insulin <input type="checkbox"/> d. Other (_____) <input type="checkbox"/> J2. Adrenal Glands <input type="checkbox"/> J3. Growth Hormones <input type="checkbox"/> J4. Hyperthyroidism/Hypothyroidism <input type="checkbox"/> J5. Other (_____)
	G. Arthritis <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> G1. Arthritis <input type="checkbox"/> G2. Osteoarthritis <input type="checkbox"/> G3. Rheumatoid Arthritis <input type="checkbox"/> G4. Other (_____)	K. Reproductive <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> K1. Breast Disorder <input type="checkbox"/> K2. Endometriosis <input type="checkbox"/> K3. Fibroids <input type="checkbox"/> K4. Menstrual Disorder <input type="checkbox"/> K5. Ovarian Cysts <input type="checkbox"/> K6. Other (_____)

L. Lung/Respiratory	<input type="checkbox"/> YES <input type="checkbox"/> NO	M. Intestinal	<input type="checkbox"/> YES <input type="checkbox"/> NO	N. Liver/Kidney/Urinary	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> L1. Allergies		<input type="checkbox"/> M1. Acid Reflux/GERD		<input type="checkbox"/> N1. Bladder Disorder	
<input type="checkbox"/> L2. Asthma		<input type="checkbox"/> M2. Colitis/IBS		<input type="checkbox"/> N2. Cirrhosis	
<input type="checkbox"/> L3. COPD (On Oxygen? _____)		<input type="checkbox"/> M3. Colon Disorder		<input type="checkbox"/> N3. Gaucher's Disease	
<input type="checkbox"/> L4. Cystic Fibrosis		<input type="checkbox"/> M4. Crohn's Disease		<input type="checkbox"/> N4. Hepatitis (Type: _____)	
<input type="checkbox"/> L5. Emphysema		<input type="checkbox"/> M5. Diverticulitis/Diverticulum		<input type="checkbox"/> N5. Jaundice	
<input type="checkbox"/> L6. Lung Disorder		<input type="checkbox"/> M6. Gallbladder		<input type="checkbox"/> N6. Kidney Disorder	
<input type="checkbox"/> L7. Pneumonia		<input type="checkbox"/> M7. Gastric Bypass		<input type="checkbox"/> N7. Kidney Stones	
<input type="checkbox"/> L8. Sarcoidosis		<input type="checkbox"/> M8. Hiatal Hernia/Reflux		<input type="checkbox"/> N8. Liver Disorder	
<input type="checkbox"/> L9. Sleep Apnea		<input type="checkbox"/> M9. Pancreatitis		<input type="checkbox"/> N9. Polycystic Kidney	
<input type="checkbox"/> L10. Tuberculosis		<input type="checkbox"/> M10. Ulcer		<input type="checkbox"/> N10. Prostate	
<input type="checkbox"/> L11. Valley Fever		<input type="checkbox"/> M11. Ulcerative Colitis		<input type="checkbox"/> N11. Renal Failure	
<input type="checkbox"/> L12. Other (_____)		<input type="checkbox"/> M12. Other (_____)		<input type="checkbox"/> N12. Other (_____)	

Please answer the following questions for yourself and for anyone in your family applying for coverage:

- YES NO Is anyone currently pregnant or an expectant parent?
Due date: _____
 Yes No a. Has the pregnancy been confirmed by a physician or practitioner?
 Yes No b. Pregnancy complications?
 Yes No c. Multiple births expected?
- YES NO Is anyone currently, or in the past five years has anyone been, a patient in a hospital, clinic, surgi-center, urgent care facility, or other medical facility as an inpatient or outpatient?
- YES NO Does anyone currently use tobacco products, including cigarettes, pipes, cigars or chewing tobacco?
- YES NO Does anyone currently have, or in the past 12 months has anyone had, any of the following?
 abnormal test or physical results pending test results
 health condition, illness or injury that may require treatment or surgery
 tests, treatment or surgery advised unexplained weight gain/loss or fatigue
 Worker's Compensation injury or illness condition not mentioned above in Section 2

Please use this table to explain any "YES" answers or items that you marked in Section 2. You may attach additional sheets.

Question Number	Name	Diagnosis/Treatment	Diagnosis Date	Treatment Status

Section 3: Family Medications

YES NO Are you or anyone in your family applying for coverage currently taking any medications (including "over the counter" or "OTC" medicine) prescribed or recommended by a physician or practitioner?

If you answer "YES" to the question above, please use this table to explain. You may attach additional sheets.

Name	Medicine	Dosage & Frequency of Use	Date Prescribed	Date Last Taken or Ongoing	Condition(s) Being Taken For

PLEASE NOTE: If you leave out or misrepresent any information, the premium for your group coverage may change retroactive to the date the policy became effective. You or your authorized agent is entitled to receive a copy of this form.

Employee Signature: _____

Date Signed: _____