



BEST Life and Health Insurance Company

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Employee Request for Enrollment Groups of 2 to 50 Health Solutions High Deductible Health Plan - Texas

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 #, Job Title, Weekly Hours, Date of F/T Hire, Marital Status, and beneficiary information.

OPTIONAL COVERAGES

If your employer is offering optional group coverage, which do you request?  Dental  Vision

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 dependents include spouses and unmarried dependent children. Dependent children are covered through age 24, extended through age 25 if they are full-time students.

DEPENDENT INFORMATION

Table with 8 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.

Signature and Date fields: 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?

Summary 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.

BL-EGH-ENR-1005-TX

(continued on other side, signature required)

**HEALTHCARE EVALUATION FOR ALL EMPLOYEES AND DEPENDANTS APPLYING FOR COVERAGE**

**FIRMS OF 2-50 ELIGIBLE EMPLOYEES COMPLETE THIS SECTION**

1. Has any applicant in the last five years had, been medically advised of having, been treated for, or been referred for treatment (including medications), advice or hospitalization for any of the following?) CHECK APPROPRIATE BOX(ES); PROVIDE DETAILS FOR ALL 'YES' ANSWERS BELOW. For questions A through D, CIRCLE the condition(s) that apply.

A. Any disorder/disease of the heart, lungs, liver, pancreas, colon, back, bones, muscles or joints or arthritis?  Yes  No

B. Any disorder/disease of the digestive system, urinary tract, kidneys, reproductive system?  Yes  No

C. Stroke, paralysis, leukemia, cancer, tumors, neurological or seizure disorder, or birth defect?  Yes  No

D. Any mental, nervous or behavioral disorder, chemical imbalance, alcoholism or drug abuse or addiction?  Yes  No

E. Diabetes?  Yes  No  
If 'YES', last blood sugar reading and date? Date: \_\_\_\_\_

F. High blood pressure?  Yes  No  
If 'YES', last 3 blood pressure readings and date \_\_\_\_\_  
Dates: \_\_\_\_\_

2. "Have you had or been told you had or been tested for any immune deficiency disorder, AIDS or ARC in the last 10 years?  Yes  No

3. In the past three years has any applicant had medical expenses or claims of \$5000 or more or been hospitalized?  Yes  No

4. Is the employee or dependant pregnant (whether applying for coverage or not)?  Yes  No If yes, name \_\_\_\_\_  
Anticipated due date: Any history of complications, premature birth, or C-Section?  Yes  No

5. Have you or any dependants used tobacco products in the last five years?  Yes  No

**PRESCRIPTION MEDICATION – Please list below all medications prescribed or taken by you or your dependents currently and in the past two years.**

Name of Individual	Name of Medication	Reason for Medication (Diagnosis)	How Long	Results

Please provide detail for all YES answers to the health questions above. You may have your treating provider complete this section. Print legibly and complete all columns. Attach additional paper if necessary and be sure to sign and date it.

Name of Person Treated	Name of Condition/ Diagnosis	Duration Dates From (Mo/Yr) to (Mo/Yr)	Explain Treatment, Hospitalization, Tests and Surgery	Medications	Date Last Treated	Final Results/Degree of Recovery

**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.

**A person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.**

**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.

**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