

Application for Excess Amount of Guaranteed Issue
Portable Life Insurance Trust underwritten by BEST Life and Health Insurance

- I wish to apply for coverage under the Voluntary Insurance Plan.
 I am covered under the Voluntary Insurance Plan and want to increase my coverage.

EMPLOYEE-SPOUSE DATA

1. EMPLOYER: _____

2. EMPLOYEE NAME: _____ 3. SOCIAL SECURITY: _____ - _____ - _____

4. HOME ADDRESS: _____
City State Zip

5. BIRTH DATE: _____ BIRTH PLACE: _____ 6. BASIC SALARY: Weekly
 Monthly

7. AMOUNT APPLIED FOR: _____ (\$10,000 to \$300,000—Limited to 5 times annual earnings) Monthly
 Annually

8. BENEFICIARY*: _____ RELATIONSHIP: _____
*If no beneficiary is selected, your benefits will be paid according to the laws of your state.

9. I WISH TO APPLY FOR LIFE INSURANCE FOR MY SPOUSE.

SPOUSE NAME _____ BIRTH DATE _____ BIRTH PLACE _____

AMOUNT APPLIED FOR: _____ (\$10,000 to \$50,000—limited to 50% of #7 above.)

10. SPOUSE BENEFICIARY _____ RELATIONSHIP _____

11. I wish to cover my child(ren) for Life Insurance. \$5,000 %10,000

NAME _____	BIRTH DATE ____/____/____	NAME _____	BIRTH DATE ____/____/____
NAME _____	BIRTH DATE ____/____/____	NAME _____	BIRTH DATE ____/____/____

COMPLETE 12-14 IF THE ANSWER TO 7, 9 OR 11 IS MORE THAN THE GUARANTEED AMOUNT

12. EMPLOYEE:	SPOUSE:	CHILD:	CHILD:	CHILD:
HEIGHT _____	HEIGHT _____	HEIGHT _____	HEIGHT _____	HEIGHT _____
WEIGHT _____	WEIGHT _____	WEIGHT _____	WEIGHT _____	WEIGHT _____

13. Are you or your spouse/children in good health and free from impairment? Yes No

14. Have you or your spouse/child(ren):

A. Been hospitalized or been treated by a physician in the past five years? Yes No

B. Ever had, or been advised to have, or contemplated any surgical operation? Yes No

C. Ever had diagnosis of, or treatment for:

1. Disease or disorder of lungs, stomach, gall bladder, kidneys, reproductive organs? Yes No

2. Brain, nerves, heart, high blood pressure, cancer, diabetes? Yes No

3. Obesity? Yes No

4. Any other physical or mental disease or severe injury? Yes No

D. Smoked in the past 12 months? Yes No

E. Ever had any disorder of the Immune System including AIDS (Acquired Immune System Deficiency Syndrome) or ARC (AIDS Related Complex)? Yes No

GIVE FULL DETAILS ON THE REVERSE SIDE FOR EACH "YES" ANSWER. LIST PROPER QUESTION NUMBER IN FIRST COLUMN

THIS SECTION TO BE COMPLETED BY EMPLOYER'S INSURANCE/PERSONNEL DEPARTMENT

Waiting Period? Yes No

If "Yes": 1st of month following date of hire. 30 days 60 days 90 days 120 days 180 days

Date of full-time employment: _____ Group Insurance Eligibility Date: _____

Signed _____

Title _____

**DETAILS FROM "YES" ANSWERS TO 14(A-E) ON REVERSE SIDE
COMPLETE ONLY IF APPLYING FOR AMOUNTS GREATER THAN THE GUARANTEED ISSUE AMOUNT**

Yes. No.	Name of Individual	Description & Details of Illness	Date of Onset	Degree of Recovery	Names & Addresses of Physical & Hospitals
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		

ALL APPLICANTS PLEASE READ AND SIGN BELOW

I understand that the insurance for which I applied shall not become effective until this application is accepted and approved by BEST Life and Health Insurance and that the first premium must be paid prior to the death of any proposed insured. I represent that all statements and answers recorded on this application are true, complete and made to obtain the insurance for which I applied.

I hereby authorize the deduction by my employer from my earnings of amounts necessary to cover the cost of the insurance issued as indicated above. I declare that all of the statements contained in this application are, to the best of my belief and knowledge, true and correct and that no material information has been withheld or omitted concerning the past and present state of my health and that any willful mis-statements shall make any insurance based upon this application void at the option of BEST Life and Health Insurance.

Applicant's Signature **X** _____ Date _____
All Applicants must sign here and date.

Spouse's Signature **X** _____ Date _____
All Applicants must sign here and date.

AUTHORIZATION TO OBTAIN INFORMATION WHEN APPLYING FOR MORE THAN BASIC GUARANTEED ISSUE AMOUNT

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical related facility, insurance company, the Medical Information Bureau, consumer reporting agency or employer to release to BEST Life and Health Insurance, its reinsurer(s) or its legal representative any information they may have as to diagnosis, treatment and prognosis of any physical or mental condition including drug and/or alcohol abuse and/or other information of me, my minor children or my spouse.

I UNDERSTAND that any information obtained will be used to determine eligibility for insurance and will not be released by BEST Life and Health Insurance to any person or organization EXCEPT its reinsurer(s), the Medical Information Bureau, and any other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required, or as I may further authorize. I also understand that I may revoke this authorization as it applies to drug and/or alcohol abuse information at anytime, except to the extent it will not affect any action taken or information released prior to the revocation.

I KNOW that I may request to receive a copy of this Authorization and the Disclosure Notice to Applicants for Insurance.

I AGREE that a photographic copy of this authorization shall be as valid as the original and 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 Company, insurance certificate is issued, and the first premium is paid.

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.

BOTH EMPLOYEE AND SPOUSE MUST SIGN APPLICATION WHEN BOTH ARE APPLYING FOR COVERAGE

Applicant's Signature **X** _____ Date _____
All Applicants must sign here and date.

Spouse's Signature **X** _____ Date _____
All Applicants must sign here and date.