



BEST Life and Health Insurance Company

Submission Checklist for Group Sales

Date of Submission: _____ State: _____

Group Name: _____

Broker/Agency: _____

Phone: _____ Email: _____

ID Card Delivery: Broker Employer

Existing Group? Yes No

Group Number: _____

Plan Type (Check all that apply)

Dental Vision Life Short Term Disability

Bundling Discount: 2% 4% 5%

2 Year Rate Guarantee:

Dual Option:

Group Size: _____ Employees Enrolling: _____

Premium: _____

Effective Date Requested: _____

Sales Representative: _____

Included in this packet:

Employer Form

Employee Form

Signed Copy of Quote

Check included Check-by-fax Check mailed Check copy