BEST Life™
BEST Life and Health Insurance Company

Employee Request for BEST Life Vision

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

☐ New Enrollment ☐ Add Dependents ☐ Name Change

EMPLOYEE INFORMATION

Last Name	First Name	M.I.	DOB	Age	Gender ☐ M ☐ F	SSN

Residence Street Address	City	State	Zip

Name of Company	Group #, if known	Job Title	Date of F/T Hire	Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced

If changing your name, provide new name:	Do you have any eligible dependent children? ☐ Yes ☐ No If yes, how many?

Will this replace other vision insurance? ☐ Yes ☐ No Name of Carrier	☐ Group ☐ Individual ☐ Other

Policy # of Prior Coverage	Effective Date of Prior Coverage	Anticipated Termination Date of Prior Coverage

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 25. Coverage can be extended for dependent children residing: FL and NE through age 29; and OH through age 27. For FL, NE and OH residents only: if enrolling dependent children 26 and older, please indicate if they are a full-time student. Part-time students allowed in FL. All other residents can leave this column blank.

DEPENDENT INFORMATION

Qualifying Event (Select One)	Dependent Name	Relation	Full-Time Student?	Sex	SSN	Date of Birth
☐ Loss of Coverage ☐ Marriage Date:		Spouse	-	-		
☐ Loss of Coverage ☐ New Dependent			-	-		
☐ Loss of Coverage ☐ New Dependent			-	-		
☐ Loss of Coverage ☐ New Dependent			-	-		
☐ Loss of Coverage ☐ New Dependent			-	-		

I 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. 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 the Certificate of Insurance issued to me; however, if I am absent from full-time employment on such dates as the result of an accident or sickness, I agree that coverage is not effective. I determine the coverage in force and that coverage is not in force if an application for that coverage has not been made by my employer. Additionally, if I am accepted, this request for group insurance will become part of the agreement between BEST Life and Health Insurance Company and myself. I, and any enrolled family members, agree to be bound by the arbitration clause in the BEST Life and Health Insurance Company Certificate Booklet, if any, instead of trial by a court of jury. I agree that insurance does not begin until this application is approved by BEST Life and Health Insurance Company, my 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.

Your Signature in black ink	**Date**

WAIVER OF COVERAGE

Complete if you or any of your eligible dependants are declining or refusing any type of offered coverage. Check all that apply:

I waive Vision coverage for: ☐ Myself and any dependants ☐ Spouse only ☐ Spouse and dependent child(ren)

Reason for waiving coverage *(you must provide a reason for waiving coverage)* ☐ Other coverage ☐ Cost

I understand that if I desire to apply for vision insurance for myself and dependents at a later date, outside of open enrollment and any qualifying events, under the Beneficial Employees Security Trust, I/we will be eligible for no more than a total of $75 of vision benefits during the first 12 months of coverage.

Your Signature in black ink	**Date**

COBRA Electives

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

BEST Use Only	WAIVER	COBRA EE ☐ Yes ☐ No	EE _____ 1 = Employee 2 = Dependent 3 = EE & Dependent	DEP. Refusal _____ R = No Coverage O = Other Coverage	SPOUSE EE ☐ Yes ☐ No	COB ☐ Yes ☐ No	DEP 19+ FTS Y H Y

Eff. DATE	ER#	COVERAGES	PREV EE/DEP	NEW CHG	WP	#EES	LATE **L**	NEWBORN **N**	APP = A DECL= D	INITIALS

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