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## New Business Checklist for

### **BEST Health Plans IndemnityPlus Dental**

\_\_\_\_\_ Completed Employer Application, Signed by agent and Company Officer.

\_\_\_\_\_ Quick Group Enrollment Form listing all enrolling employees and dependents and signed by the employer. Be sure to include the number of children they have in the column regardless of their enrollment in the plan. You can use the Employee enrollment/waiver form if you prefer.

\_\_\_\_\_ If you are using the Roster, you must have those employees waiving coverage for themselves or dependents sign a waiver and answer the questions on the form.

\_\_\_\_\_ Check for first months premium made payable to BEST Health Plans including Administration fee for groups of 2-5 only of \$20.00.

\_\_\_\_\_ If the group is under 5 lives we will need a quarterly Wage and Tax Report listing all employees, with hours, wages and tax information. Employees listed on the report and not enrolling, please indicate their status (i.e. Part-time, Seasonal, Termed, etc)

\_\_\_\_\_ If the group is 2-4 lives and the owner(s) are not listed on the wage report please have them complete the Owner/Partner Statement attached..

\_\_\_\_\_ If we are replacing prior coverage (groups of 5+ only, no takeover for groups of 2-4) we need a copy of the prior carrier's most recent billing statement listing each employees original effective date. Only groups under 25 lives must provide this.

\_\_\_\_\_ Mail All completed forms to: Northwest Marketing Resources  
PO Box 447  
Olympia, WA 98507

Requested Effective Date:  1<sup>st</sup> or  15<sup>th</sup> of the month \_\_\_\_\_, 20\_\_\_\_

Dental  Life  Vision

INDEMNITYPLUS PLAN TYPE	High Plan	Mid Plan	Basic Plan
Choose Calendar Year Maximum	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,200 <input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$750 <input type="checkbox"/> \$500
Choose Deductible	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100
Perio Option	<input type="checkbox"/> Class II <input type="checkbox"/> Class III	<input type="checkbox"/> Class II <input type="checkbox"/> Class III	<input type="checkbox"/> Class II <input type="checkbox"/> Class III
Endo Option	<input type="checkbox"/> Class II <input type="checkbox"/> Class III	<input type="checkbox"/> Class II <input type="checkbox"/> Class III	<input type="checkbox"/> Class II <input type="checkbox"/> Class III
Choose Orthodontia Option	<input type="checkbox"/> Adult & Child <input type="checkbox"/> Child Only \$1,000 <input type="checkbox"/> Child Only \$1,500	<input type="checkbox"/> Adult & Child <input type="checkbox"/> Child Only \$1,000 <input type="checkbox"/> Child Only \$1,500	<input type="checkbox"/> Child Only \$1,000 <input type="checkbox"/> Child Only \$1,500
Voluntary Option*	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Two-Year Initial Rate Guarantee Option**	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dual Option (check plans selected)**	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reimbursement Level	<input type="checkbox"/> 80 <sup>th</sup> % <input type="checkbox"/> 90 <sup>th</sup> %	<input type="checkbox"/> 80 <sup>th</sup> % <input type="checkbox"/> 90 <sup>th</sup> %	<input type="checkbox"/> 80 <sup>th</sup> % <input type="checkbox"/> 90 <sup>th</sup> %

\* Employer is contributing less than 50% for each employee..\*\*Certain requirements apply. Please see Plan Brochure for details.

### VISION PLAN TYPE

Access Vision Plan Choice	Frequency Choice	Deductible Choice	Lenses/Contacts Choice	Voluntary Option*
<input type="checkbox"/> Plan Series 1 (\$60 Exam / \$35 Single Lens / \$80 Frames/\$125 Contacts Allowance) <input type="checkbox"/> Plan Series 2 (\$60 Exam / \$45 Single Lens / \$100 Frames/\$125 Contacts Allowance) <input type="checkbox"/> Plan Series 3 (\$60 Exam / \$55 Single Lens / \$115 Frames/\$125 Contacts Allowance)	<input type="checkbox"/> Plan A (12/12/12/12) <input type="checkbox"/> Plan B (12/12/24/12) <input type="checkbox"/> Plan C (12/12/24/24) <input type="checkbox"/> Plan D (12/24/24/24)	<input type="checkbox"/> \$0 <input type="checkbox"/> \$10 <input type="checkbox"/> \$25	<input type="checkbox"/> Lenses, Frames <b>AND</b> Contacts <input type="checkbox"/> Lenses, Frames <b>OR</b> Contacts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vision PPO (EyeMed) Plan Choice	Frequency Choice		Voluntary Option*	
<input type="checkbox"/> Plan Series 1 (\$10 Exam Co-pay/ \$10 Lens Co-pay / \$130 Contact Lens Allowance) <input type="checkbox"/> Plan Series 2 (\$10 Exam Co-pay/ \$25 Lens Co-pay / \$130 Contact Lens Allowance) <input type="checkbox"/> Plan Series 3 (\$10 Exam Co-pay/\$25 Lens Co-pay / \$115 Contact Lens Allowance) <input type="checkbox"/> Materials Only Plan (\$10 Lens Co-pay/ \$130 Contact Lens Allowance)	<input type="checkbox"/> A 12/12/12/12 <input type="checkbox"/> B 12/12/24/12	For Materials Only plans: <input type="checkbox"/> A 12/12/12 (Lens/Frame/Contacts) <input type="checkbox"/> B 12/24/12 (Lens/Frame/Contacts)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

### Please answer the following questions:

1. **Employer Contribution for Employees** (for employer-contributory plans, the Employer must pay at least 50% for each employee.): \_\_\_\_\_ %, For Dependent Coverage: \_\_\_\_\_ %.

Number of Total Employees on Payroll: \_\_\_\_\_ Number of Full-Time Employees: \_\_\_\_\_ Description of Classes not Eligible: \_\_\_\_\_

2.  Yes  No

**Does the employer now have or has the employer had a comparable group dental plan in force during the past twelve (12) consecutive months?**  
 For employer-contributory: 12-month wait on Major and Ortho services is waived for employees who have had 12 consecutive months of comparable prior group coverage and who are in a group with 5-9 employees enrolling with proof of continuous and comparable prior group coverage; all employees in a group 10+ employees enrolling.  
 For voluntary: 12-month wait on Major and Ortho services is waived for employees who have had 12 consecutive months of comparable prior group coverage and who are in a group with 5-9 employees enrolling with proof of continuous and comparable prior group coverage; all employees in a group with 10-24 employees enrolling and 50% participation with proof of comparable prior group coverage; if 50% participation is not met, waiver will only apply to employees who have proof of 12 consecutive months of prior group coverage (proof must be provided); all employees in a California group with 10+ employees enrolling; all employees in a group with 25+ employees enrolling.  
**A copy of your most recent dental bill listing the covered employees and their effective dates must accompany this application.**

3.  Yes  No

**Are all full-time employees enrolling in the group dental plan?**

4.  Yes  No

**Are any employees enrolling in the policy currently receiving extended benefits under COBRA?** If yes, please list names: \_\_\_\_\_

5.  Yes  No

**Waiting Period is waived for Present Employees.**

6. **Waiting Period for New Employees:** First of the Month following continuous full time employment of:

1<sup>st</sup> of the month following date of hire  1 Full Calendar Month (standard)  2 Full Calendar Months  3 Full Calendar Months  4 Full Calendar Months

### EMPLOYER ACKNOWLEDGEMENT & ASSOCIATION AND TRUST MEMBERSHIP APPLICATION

Employer Name	Employer Federal Tax Number		
Street Address	City	State	Zip
Billing Address P.O. Box	City	State	Zip
Nature of Firm's Business	SIC Code	Person at Firm to Contact for Service and Administration of the Dental Plan	

**Employer Name**

I understand and agree that the insurance hereby applied for is not effective until this application and the full initial premium is delivered to, received by and approved by BEST Life and Health Insurance Company.

I certify that this is a bona fide business with a legitimate business purpose and which has a true employer-employee relationship with the individuals designated as employees. I understand that any false statements made in this application constitute the legal basis for termination or cancellation of coverage retroactive to the effective date and denial of all claims incurred.

**Termination of Coverage**—Employee coverage and dependent coverage will terminate on the earliest of the following dates: (1) the date the employee ceases to be an eligible employee or the date the dependent is no longer eligible as a dependent under the plan; (2) the date the plan is terminated; (3) the date the employer terminates the coverage by failing to pay the required premium; (4) the date the group policy is terminated; (5) the date the group no longer meets minimum participation requirements. The benefits are subject to all the conditions and limitations of the plan.

Eligible dependent coverage terminates on the earliest of the following: when the dependent no longer meets the definition of a dependent; on the first day of the month in which premiums were not paid, or when the member terminates coverage.

**FIRM ELIGIBILITY:**

A firm or employer must be an active business operation to request coverage. The business must continue on an active basis to retain eligibility for coverage. Coverage will be terminated on the effective date the business ceases active operation. I understand that if my firm drops in size to 1 employee for more than 90 consecutive days, all of my selected insurance coverage will be cancelled.

**IMPORTANT PLAN INFORMATION**

The undersigned Employer understands and agrees that by adopting one or more BEST plans, it is establishing an employee welfare benefit plan for its employees. The employer further understands and agrees that the general definition of an employee is a person who usually works at least 30 hours per week at the firm's business location with federal, state and social security tax withheld from their salary. The Employer's plan is funded through the Beneficial Employees Security Trust of Utah ("B.E.S.T.") to which the Employer subscribes. The insurance companies issue group insurance policies to the Trustee of B.E.S.T. These policies provide the coverage(s) the Employer selects.

B.E.S.T. receives the subscribing employer's payment and remits the insurance premium to the insurance carrier(s) or to affiliates filing a common federal income tax form that provide services to Employers and to B.E.S.T. One of the insurance carriers is BEST Life and Health Insurance Company ("BEST Life").

The Employer agrees and understands that by signing this Trust Membership Application, it becomes a Subscribing Employer of the Trust. A subscribing employer of the Trust agrees to be bound by all the terms and conditions of the Trust Agreement. A subscribing employer of the Trust further agrees that the Trustee shall not be liable to any participating Employers, to any person insured, or to anyone else in connection with the operation of the Group Insurance Trust Fund.

The Master Group Policy is issued to the Trustee of B.E.S.T. To participate in the plan, each subscribing employer adopts the Trust. The Master Group Policy is governed by the laws of the state of Utah. However, to the extent that such Policy and/or Certificate of Coverage is in conflict with the laws of another demonstrating statutory governing jurisdiction over an out-of-state multiple employer trust Policy, then such Policy and/or Certificate of Coverage will be amended to comply with the minimum requirements of that state.

**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.**

**X** \_\_\_\_\_ / /  
Signature of Company Officer Print Name & Title Dated

**Benefit Representative Report**

<i>(Please Print)</i>		<i>(Please Complete)</i>	
Name _____		<b>Special Instructions to BEST Health Plans</b>	
It is not necessary to complete the following information if you are currently receiving service fees from BEST Health Plans unless changes in address, etc. need to be made. Just sign and date the form below.		1. May we contact the client if we need additional information? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Your Agency Name _____		2. Is this your first case with BEST Health Plans? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address _____		3. This is: <input type="checkbox"/> an existing client <input type="checkbox"/> a new client with my company	
City _____	State _____	Zip _____	4. The 'New Client Kit' (certificate book, claim forms, etc.) should be sent to: <input type="checkbox"/> The benefit representative <input type="checkbox"/> The client
Who Should Receive the Service Fees? <input type="checkbox"/> Benefit Representative <input type="checkbox"/> Company/Firm		5. The underwriter assigned to my case should contact me? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Social Security Number - - _____	Federal Tax ID _____		
Date of Birth / / _____	License No. _____	State _____	
Phone No. _____	FAX No. _____		
E-mail Address _____			
Please list any special handling needed for this client: _____			

I hereby certify that I hold a valid Life, Accident and Health license issued by the state in which this document was executed and that all of the information contained herein is correct, to the best of my knowledge, and that I know nothing unfavorable about this firm or any individual applying for insurance unless fully described in this application material. Furthermore, I certify that:

1. This firm is a bona fide business establishment and participation requirements are being met.
2. I have advised my client not to terminate any existing coverage until this coverage is approved.
3. Coverage, eligibility provisions, waiting periods and limitations have been fully explained to, and understood by, the Employer identified in this document.
4. I have no right to bind, modify or alter provisions of this program.

I understand and agree that the insurance applied for herein does not begin until this application is received and approved by BEST Life and Health Insurance Company, the insurance certificates are issued and the first premium is received and accepted.

Agent's Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_



BEST Life and Health Insurance Company

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

Employee Request for BEST Life Dental/Vision

New Enrollment  Add Dependents  Name Change

EMPLOYEE INFORMATION

Form with fields: Last Name, First Name, M.I., DOB, Age, Gender (M/F), SSN, Residence Street Address, City, State, Zip, Name of Company, Group #, 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), Will this replace other dental insurance? (Yes/No) Name of Carrier, 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 20, extended through age 25 if they are full-time students. Dependent children residing in: FL are covered through age 29; UT are covered through age 25; TX, WA\* and MT\* are covered through age 24; IN\*, MO, MS, TN and WV are covered through age 23. \*Does not offer extended coverage through age 25.

DEPENDANT INFORMATION

Table with 7 columns: Qualifying Event (Select One), Dependent Name, Relation, Full-Time Student?, Sex, SSN, Date of Birth. Includes checkboxes for Loss of Coverage and 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.

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Your Signature in black ink Date

WAIVER OF COVERAGE

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

Check all that apply:

I waive Dental coverage for:  Myself and any dependents  Spouse only  Child(ren) only  Spouse and dependent child(ren)

I waive Vision coverage 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

I understand that if I desire to apply for dental insurance for myself and dependents at a later date, outside of open enrolling and any qualifying events, under the Beneficial Employees Security Trust, I/we will be eligible for Class I, Preventive Procedures during the first 12 months of continuous coverage and during the second 12 months of continuous coverage, eligible for Class I, Preventive Procedures and for 50% of the benefits for Class II Basic Procedures not to exceed a maximum of \$500 during the second 12 months of continuous 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?

Table with 12 columns: 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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