



Northwest Marketing Resources, Inc

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## **New Business Checklist for**

### **BEST Health Plans Stand Alone Vision**

- \_\_\_\_\_ Completed Employer Application, Signed by agent and Company Officer.
- \_\_\_\_\_ Quick Group Enrollment Form listing all enrolling employees and dependents and signed by the employer
- \_\_\_\_\_ Check for first months premium made payable to BEST Health Plans including Administration fee of \$15.00.
- \_\_\_\_\_ Quarterly Wage and Tax report for groups of 2-4 only.
- \_\_\_\_\_ Mail All completed forms to: Northwest Marketing Resources  
PO Box 447  
Olympia, WA 98507



# Stand Alone Vision Employer-Sponsored Employer Application

Requested Effective Date:

This firm has selected:  PLAN A 12/12/12/12  PLAN B 12/12/24/12  PLAN C 12/12/24/24  PLAN D 12/24/24/24

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
1<sup>st</sup> or 15<sup>th</sup> of month only

Co-Pay:  \$0  \$10  \$25

## CALCULATION OF MONTHLY COST—Complete this section, or you may attach a BEST Health Plans Quote

Additional Case Size Discounts/Charges **A**

\$ \_\_\_\_\_ X \_\_\_\_\_ = \$ \_\_\_\_\_  
Vision Rate Number of Employees Only

\$ \_\_\_\_\_ X \_\_\_\_\_ = \$ \_\_\_\_\_  
Vision Rate Number of Employees + One

\$ \_\_\_\_\_ X \_\_\_\_\_ = \$ \_\_\_\_\_  
Vision Rate Number of Employees + Family

**Subtotal** \_\_\_\_\_

**Additional Discounts/Charges** (From Box A) X **Subtotal** = \$ \_\_\_\_\_  
Total First Month's Remittance Payable to BEST Health Plans = \$ \_\_\_\_\_

## Benefit Representative Report

(Please Print)

Name \_\_\_\_\_  
It is not necessary to complete the following information if you are currently receiving services fees from BEST Health Plans unless changes in address, etc. need to be made. Just sign and date the form below.

Your Agency Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Who Should Receive the Service Fees?

Benefit Representative  Company/Firm

Social Security Number \_\_\_\_\_ Federal Tax ID \_\_\_\_\_

Date of Birth \_\_\_\_\_ License No. \* \_\_\_\_\_ State \_\_\_\_\_

Phone No. \_\_\_\_\_ FAX No. \_\_\_\_\_

E-mail Address \_\_\_\_\_

(Please Complete)

### Special Instructions to BEST Health Plans

- May we contact the client if we need additional information?  Yes  No
- This is my first case with BEST Health Plans  Yes  No
- This is:  an existing client  a new client with my company
- The 'New Client Kit' (Certificate Book, claim forms, etc.) should be sent to:  
 The Benefit Representative  The Client
- Have the Underwriter assigned to my case call me?  Yes  No
- Please list any 'special handling' needed for this client:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby certify that I hold a valid Life, Accident & 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 I know nothing unfavorable about this firm or any individual applying for insurance, unless fully described in this application material. Furthermore, I certify that:

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

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.

**X**

Agent Signature

Agent: Print Name

Date

\*For first case please include a current copy of your State Life and Health license(s). If your state charges an appointment fee, it will be deducted from your service fee check.

# EMPLOYER ACKNOWLEDGEMENT & ASSOCIATION AND TRUST MEMBERSHIP APPLICATION

Employer Name \_\_\_\_\_ Employer Federal Tax Number \_\_\_\_\_

( ) - ( ) -

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Billing Address P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ E-Mail \_\_\_\_\_

Nature of Firm's Business \_\_\_\_\_ SIC Code \_\_\_\_\_ Person at Firm to Contact for Service and Administration \_\_\_\_\_

I certify that I have read the General Information section, understand it, and have enrolled all eligible employees and their dependents in accordance with information on the General Information page. I have discussed coverages, eligibility, and the expenses not covered with the Producer and understand them fully.

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.

Employer Contribution for Employees: \_\_\_\_\_%, (Minimum employer contribution is 50%) For Dependent Coverage: \_\_\_\_\_%.

**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 of 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.

Yes  No Are all full-time employees enrolled in the plan?

Yes  No Are any employees applying for coverage receiving extended benefits under COBRA? If yes, please list names:

Yes  No Waiting Period is waived for Present Employees?

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

1 Full Calendar Month (standard)  2 Full Calendar Months  3 Full Calendar Months  4 Full Calendar Months

Description of Classes not Eligible \_\_\_\_\_

Number of Total Employees on Payroll \_\_\_\_\_

## 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 less than 2 employees for more than 90 consecutive days, all of my selected insurance coverage will be cancelled.

## IMPORTANT PLAN INFORMATION

The undersigned Employer understands that by adopting one or more BEST Plans, it is establishing an employee welfare benefit plan for its employees. The Employer's plan is funded through the BEST Trust, which the Employer joins. The insurance company(s) issue group insurance policies to the Trustee of the BEST Trust. These policies provide the coverage selected by the Employer.

The B.E.S.T Trust receives payments from participating employer(s) and remits these payments to the insurance companies. One of the insurance carriers is BEST LIFE and Health Insurance Company. The insurance companies may contract with a third party administrator to provide administrative services on their behalf. One of these third party administrators is Beneficial Administration Company, Inc. (BAC). Beneficial Administration Company and BEST LIFE and Health Insurance Company receive a portion of the employer payments as compensation for services each performs. The managing trustor of the B.E.S.T. Trust is a party in interest in Beneficial Administration Company, Inc. and BEST LIFE and Health Insurance Company.

By signing this Trust Membership Application, the Employer, if approved by the Trustee becomes a subscribing employer of the Trust. The Employer thereby subscribes to and agrees to be bound by all the terms and conditions of the Trust Agreement and 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 the Beneficial Employees Security Trust of Utah, and each participating Employer unit adopts the Trust to participate in the plan. The Master Group Policy is governed by the laws of the state of Utah. In the event of dispute or litigation, I agree to be bound by the terms and conditions of the arbitration clause in the *Plan Certificate Booklet*.

Beneficial Administration Company and/or BEST LIFE reserves the right to decline any new business application which, in their opinion, does not meet sound underwriting standards or which affects the financial stability of the Trust.

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.

X

Signature of Company Officer

Print Name and Title

Dated



# Stand Alone Vision Quick Group Enrollment Form

## Dependent Information

Are you insuring dependents? If YES, please complete the section below. If enrolling Dependent Children between the ages of 20 and 25, please indicate if they are a full-time student.

Employer Name: \_\_\_\_\_

Please list employees in the order they appear on the Quarterly Wage Report.						No. Eligible Dependent Children (If none, state zero.)	Dependent Name	Relationship	M/F	Full Time Student? Y or N	Date Of Birth	
Employee SS#	Last Name, First Name MI	Date Of Birth	M/F	Marital Status (S,M,D,W)	Date of Full Time Employment	Job Title						
<i>Sample</i> 987 - 56 - 1234	<i>Smith, Todd A</i>	<i>12/19/59</i>	<i>M</i>	<i>S</i>	<i>11/03/88</i>	<i>Asst. Mgr.</i>	<i>Zero</i>	<i>Mary Smith</i>	<i>Spouse</i>	<i>F</i>	<i>Y</i>	<i>01/08/62</i>
- -		/ /	-	-	/ /		-	1. 2. 3. 4. 5.	_____ _____ _____ _____ _____	- - - - -	- - - - -	/ / / / / / / / / /
- -		/ /	-	-	/ /		-	1. 2. 3. 4. 5.	_____ _____ _____ _____ _____	- - - - -	- - - - -	/ / / / / / / / / /
- -		/ /	-	-	/ /		-	1. 2. 3. 4. 5.	_____ _____ _____ _____ _____	- - - - -	- - - - -	/ / / / / / / / / /
- -		/ /	-	-	/ /		-	1. 2. 3. 4. 5.	_____ _____ _____ _____ _____	- - - - -	- - - - -	/ / / / / / / / / /
- -		/ /	-	-	/ /		-	1. 2. 3. 4. 5.	_____ _____ _____ _____ _____	- - - - -	- - - - -	/ / / / / / / / / /

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- -		/ /	—	—	/ /		—	1. 2. 3. 4. 5.	_____ _____ _____ _____ _____	— — — — —	— — — — —	/ / / / / / / / / /
- -		/ /	—	—	/ /		—	1. 2. 3. 4. 5.	_____ _____ _____ _____ _____	— — — — —	— — — — —	/ / / / / / / / / /
- -		/ /	—	—	/ /		—	1. 2. 3. 4. 5.	_____ _____ _____ _____ _____	— — — — —	— — — — —	/ / / / / / / / / /

**EMPLOYER VERIFICATION:**  
I(We) certify and verify that all employees applying for coverage listed above are actively at work and are working at least 30 hours per week, and that all employees and dependents (if electing dependent coverage) meet all eligibility and participation requirements listed in the brochure and certificate booklet.

**FURTHER:**  
I (We) verify that this vision plan has been offered to all eligible employees. Completed waiver cards are attached for all employees and dependents electing not to participate in the plan. I (We) represent that all information on this application is correct to the best of my (our) knowledge. I (We) understand that our firm is not eligible for coverage until written confirmation is received from the insurance company. I (We) further agree to be bound by the arbitration clause in the BEST LIFE certificate booklet instead of a trial by a court or jury.  
I (we) 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.

**X** \_\_\_\_\_  
Employer Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

- ENROLLMENT REMINDERS:**
- Complete refusal cards for all employees and/or dependents not enrolling for vision plans.
  - First Month's Premium Deposit check payable BEST Health plans

SEND COMPLETED FORMS TO BEST LIFE and Health Insurance Company • P.O. BOX 19721 • Irvine, CA 92623-9721



Refusal of Vision Coverage Card

Employee Name—Last	First	Middle
Name of Firm Where Employed		BEST Health Plans Customer Number

I understand that if I desire to apply for insurance for myself and dependents at a later date 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

**I am refusing coverage for:**

Myself (and dependents, if any)

All of my dependents

My Spouse only

My Children Only

**REQUIRED Reason(s) for refusing coverage:**

Other Group Insurance

Name \_\_\_\_\_

Policy Name \_\_\_\_\_

Other Reason

Your Signature in Black Ink \_\_\_\_\_ Date Signed \_\_\_\_\_

Photocopy if more cards are required

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Refusal of Vision Coverage Card

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Policy Name \_\_\_\_\_

Other Reason

Your Signature in Black Ink \_\_\_\_\_ Date Signed \_\_\_\_\_

Photocopy if more cards are required

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