BEST Life™

BEST Life and Health Insurance Company

Electronic Group Enrollment Roster Agreement

INSTRUCTIONS: A signed copy of this form must be included with your electronic enrollment roster. Fax, email or mail a completed form to:

New Enrollments Department
BEST Life and Health Insurance Company
2505 McCabe Way
Irvine, CA 92614
Fax: (949) 724-1603.
E-mail: cs@bestlife.com

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 dental 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 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

Print Form