BEST LIFE
BEST Life and Health Insurance Company

Dental/Vision Employee Enrollment Card

Customer Service
Fax: (949) 724-1603 Phone: (800) 433-0088

☐ **New Enrollment** ☐ **Change of Status**

Company Name	Group ID#	Date of Hire / /

Employee Name – Last	First	Middle Initial	Social Security Number - -

Your Home Address	City	State	Zip

Date of Birth / /	Sex ☐ M ☐ F	No. of Eligible Dependents	Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced	Job Title

Are you insuring your dependents? ☐ Yes ☐ No. If 'Yes', please complete the section below.

Add	Remove	Dependent Name	Relationship	Full Time Student?	Sex	Date of Birth
☐	☐		**Spouse**	**Yes/No**	**Male/Female**	**/ /**
☐	☐			**Yes/No**	**Male/Female**	**/ /**
☐	☐			**Yes/No**	**Male/Female**	**/ /**
☐	☐			**Yes/No**	**Male/Female**	**/ /**

Do you, your spouse or child(ren) have any other dental insurance? ☐ Yes ☐ No. If 'Yes', please complete the section below.

Policyholder (Name) Policy Number Name and Address of Insurance Carrier

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 a 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 *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 Co., my insurance certificate is issued, and the first premium is paid. Conformity with states that may require a fraud warning – 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, is guilty of committing a fraudulent insurance act, which is a crime, and subject to criminal prosecution.

Your Signature (in black ink)	**Date**

BEST Use Only	Waiver	COBRA	EE ______ 1 = Employee 2 = Dependent 3 = EE & Dependent	DEP. Refusal ______ R = No Coverage O = Other Coverage	Spouse EE **Y / N**	COB **Y / N**	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

REFUSAL OF DENTAL/VISION COVERAGE

Employee Name - Last	First	Middle

Company Name	BEST Health Plans Customer Number

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

REQUIRED

I am refusing coverage for: ☐ Dental ☐ Vision (check one or both)

☐ Myself (and dependents, if any)
☐ All of my dependents
☐ My spouse only
☐ My child(ren) only

Reasons for refusing coverage:

☐ Other Group Insurance
Name ______
Policy Number______
☐ Other Reason ______

Your Signature (in black ink)	**Date Signed** / /

Photocopy if more cards are required

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