

New Group Dental Submission Checklist

- Completed Employer/Group Application** – Employer also needs to sign the Association and Trust Membership Agreement located on the back of the application.
- Completed Employee Enrollment Application** – (also includes refusal of coverage section)
Special Note – If the employer is applying simultaneously for a BEST Life Medical Plan and a BEST Life Dental Plan, only the Medical Plan enrollment application must be completed.
- Dependent coverage for Domestic Partners:**
 - If Employer wishes to offer coverage for Domestic Partners, please submit a letter from Employer.
 - If Employee wishes to insure Domestic Partner as a dependent, a complete "Affidavit of Domestic Partnership" must be submitted along with Employee application.
- Quarterly Wage Report** – **No wage report is needed for groups with 5 or more enrolling. Payroll is required for any size group if new company or spin-off.**

For groups with less than 5 enrolling - Please indicate on the Quarterly Wage Report which employees are full-time (FT), part-time (PT), seasonal (S), in their waiting period (WP), waiving coverage (W). Provide current payroll for all full-time eligible new hires not appearing on the wage report.
- Please Indicate** the names of eligible owners or partners who do not appear on the quarterly wage report and provide completed Owner/Partner Statements.
- Proof of Prior Coverage** – If applicable, please submit the most recent invoice indicating original effective date of coverage. For voluntary plans, please indicate each employee's original effective date.
- Completed Benefit Representative Statement** located on the back of the employer/group application
- Employer Check** payable to BEST Life and Health Company for the first month's estimated monthly cost.
- A Copy of your Dental Proposal**

Mail all the above items directly to:
Matrix Insurance Marketing, Inc.
1225 S. Weller St., Ste. 320
Seattle, WA 98144
Phone: 206-521-9451 / Fax 206-521-9554
E-mail: info@matrixinsurance.com

Case Submission Requirements

Category	Explanation / Requirements
Requirements for New Case Submission	<ol style="list-style-type: none"> 1. Completed Group Enrollment Application, with Association and Trust Membership Agreement and Benefit Representative Statement (on the back) signed by employer and broker. 2. Completed Employee Enrollment Form for all eligible employees. Special note: If the employee is applying simultaneously for a BEST Life Medical Plan and a BEST Life Dental Plan, only the Medical Plan enrollment application must be completed. 3. Quarterly Wage Report – See Quarterly Wage Report for submission criteria. 4. Proof of Ownership/Partnership – See Proof of Ownership for submission criteria. 5. Evidence of prior dental coverage, including most recent invoice with each employee’s effective date, or provide invoices for the last twelve months (for the waiver of waiting periods, if applicable). 6. Employer’s business check for first month’s premium and administration fees. Please make check payable to BEST Life and Health Insurance Co. 7. Copy of your BEST Life proposal.
Quarterly Wage Report	<p>Wage report required for groups with less than 5 employees enrolling:</p> <ul style="list-style-type: none"> • Most recent Quarterly Wage Report, including Quarterly Wage & Tax Report(s) for out-of-state employees. • All pages submitted including grand totals and summary page. • All employees marked to indicate employment status: part-time (PT), full-time (FT), terminated (T), seasonal (s), ineligible, waiting to enroll, or waiving coverage. • If there are new hires that do not appear on the Quarterly Wage Report – write their name(s), social security number(s), and date(s) of hire on the bottom of the Report.
Proof of Ownership	<p>Proof of ownership is required for all groups with 2-4 enrolling and who do not have a wage report:</p> <p>Note: Husband/Wife groups must provide separate tax or Quarterly Wage Report documentation showing they are owner or full-time employee.</p> <p>Sole Proprietorship - New business, no W-2 employees: Business License listing Owner Name or IRS Schedule C (Form 1040), Business Statement, and Employer Statement regarding no W-2 employees.</p> <p>Sole Proprietorship - New business with W-2 employees: Business License listing Owner Name or IRS Schedule C (Form 1040), Business Statement, Payroll Records, next available Wage Report and Employer Letter regarding no wage report.</p> <p>Sole Proprietorship - Existing business, no W-2 employees: Business License listing Owner Name or IRS Schedule C (Form 1040), and Employer Statement regarding no W-2 employees.</p> <p>Partnership/LLP - New and existing businesses, no W-2 employees: IRS Schedule K-1 (Form 1065) for enrolling partners or Partnership Agreement signed by all partners, and Employer Statement regarding no W-2 employees.</p> <p>Partnership/LLP - New business with W-2 employees: IRS Schedule K-1 (Form 1065) for enrolling partners or Partnership Agreement signed by all partners, Payroll Records, next available Wage Report, and Employer Letter regarding no wage report.</p> <p>Corporations - New and existing businesses, no W-2 employees: S-Corps IRS Schedule K-1 (Form 1120s) & C-Corps RS Form 1120 (pages 1 & 2) include “Schedule E”; Articles of Incorporation listing Owners’/Officers’ names or a Filed/Stamped Statement of Information listing Owners’/Officers’ names, and Employer Statement regarding no W-2 employees.</p> <p>Corporations - New business with W-2 employees: S-Corps IRS Schedule K-1 (Form 1120s) & C-Corps RS Form 1120 (pages 1 & 2) include “Schedule E”; Articles of Incorporation listing Owners’/Officers’ names or a Filed/Stamped Statement of Information listing Owners’/Officers’ names, Payroll Records, next available Wage Report, Employer Letter regarding no wage report.</p> <p>Limited Liability Company (LLC) - New and existing businesses, no W-2 employees: LLC Agreement signed by all managers/members/ parties or copies of appropriate tax returns, Employer Statement regarding no W-2 employees, Statement of Information, and Articles of Organization.</p> <p>LLC - New business with W-2 employees: will require LLC Agreement signed by all managers / members / parties or copies of appropriate tax returns, Payroll Records, Statement of Information, Articles or Organization, next available Wage Report, and Employer letter regarding no wage report.</p> <p>Religious Organizations - New and existing businesses, no W-2 employees: will require IRS Form 941, and Employer Statement regarding no W-2 employees.</p>

Category	Explanation / Requirements
Proof of Ownership con't...	<p>Religious Organizations - New businesses with W-2 employees: will require IRS Form 941, Payroll Records, next available Wage Report, and Employer letter regarding no wage report.</p> <p>Farms - New and existing businesses, no W-2 employees: will require IRS Schedule F (Form 1040), and Employer Statement regarding no W-2 employees.</p> <p>Farms - New businesses with W-2 employees: will require IRS Schedule F (Form 1040), Payroll Records, next available Wage Report, and Employer letter regarding no wage report.</p> <p>Common Ownership: Letter stating companies with common ownership.</p>
Billing Statement / Previous Carrier Bill Requirements	<ul style="list-style-type: none"> • The most recent statement/carrier bill must include a list of employees and indicate the original effective date of coverage for each employee. • Renewal notices are not acceptable. • All terminated employees clearly marked with a T, including termination dates.
Employer Application	<ul style="list-style-type: none"> • Select plan design. • Provide answers to all questions. • Select waiting period and employer premium contribution percentage. • Sign and date the Group Enrollment Application within 30 days of the requested effective date.
Employee Enrollment Forms	<ul style="list-style-type: none"> • All eligible employees are required to submit a completed Employee Enrollment Form. • All sections of the form MUST BE COMPLETED. • Date of hire must be listed on all Employee Enrollment Forms. • All submitted Employee Enrollment Forms must be signed and dated (signed forms must be received within 30 days of requested effective date). • Employee Enrollment Forms (including waivers) must be arranged in the order of the Quarterly Wage Report or payroll records submitted with the group application materials. • Special note: If the employee is applying simultaneously for a BEST Life Medical Plan and a BEST Life Dental Plan, only the Medical Plan enrollment application must be completed. To waive coverage, employees may complete either form.
Waiver Requirements – Employee Enrollment Forms	<ul style="list-style-type: none"> • Complete Refusal of Dental Coverage or waiver forms for all eligible employees and dependents not electing to enroll. • Reason for declining must be clearly indicated. • Waiver section signed and dated within 30 days of the effective date. • Please note that voluntary groups who meet the 20% participation requirement do not need to fill out waivers.
Replacing Other Group Coverage	<ul style="list-style-type: none"> • Provide a copy of the most recent prior carrier bill that includes the employee summary. • The employer should be advised not to cancel any existing coverage until notified of approval from BEST Life Underwriting Department.
Spin Off Groups	<p>BEST Life will consider the group guarantee issue with the following:</p> <ul style="list-style-type: none"> • A letter from group or broker indicating group is enrolling as a spin off. The letter needs to include name of the group they are spinning off from. • Ownership documents showing that the company is a newly formed separate entity. • A minimum of 2 weeks payroll. If spin-off group has been in business longer than 2 weeks, payroll will be required for amount of time in business to a maximum of 6 consecutive weeks. • Dental claims will be reviewed and used along with information included on employee applications to determine rates. • A completed Group Enrollment Application, with completed Association and Trust Membership Agreement and Benefit Representative Statement (on the back), signed by employer and broker. • Completed Employee Enrollment Forms for all eligible employees. Special note: If employee is applying simultaneously for a BEST Life Medical and Dental Plan, only the Medical Plan enrollment form must be completed. • Employer’s business check for first month’s premium and administration fees. Please make check payable to BEST Life and Health Insurance Co.



BEST Life and Health Insurance Company

Requested Effective Date: 1st or 15th of the month _____, 20_____

Dental Life Vision

Table with 4 columns: INDEMNITYPLUS PLAN TYPE, High (100/90/60) Plan, Mid (100/80/50) Plan, Basic (80/80/50) Plan. Rows include: Choose Calendar Year Maximum, Choose Deductible, Perio Option, Endo Option, Choose Orthodontia Option, Voluntary Option*, Two-Year Initial Rate Guarantee Option**, Dual Option (check plans selected)**, Reimbursement Level.

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

VISION PLAN TYPE

Table with 5 columns: Access Vision Plan Choice, Frequency Choice, Deductible Choice, Lenses/Contacts Choice, Voluntary Option*. Rows include: Plan Series 1, 2, 3; Vision PPO (EyeMed) Plan Choice; Plan Series 1, 2, 3; Materials Only Plan.

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?
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:
 1st 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 _____ 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 of the Dental Plan
IDP0309

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, and if additional employees are not enrolled and active for coverage within 2 months, 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

<p style="text-align: center;">(Please Print)</p> <p>Name _____</p> <p>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.</p> <p>Your Agency Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Who Should Receive the Service Fees? <input type="checkbox"/> Benefit Representative <input type="checkbox"/> Company/Firm</p> <p>Social Security Number - - - Federal Tax ID _____</p> <p>Date of Birth / / License No. _____ State _____</p> <p>Phone No. _____ FAX No. _____</p> <p>E-mail Address _____</p> <p>Please list any special handling needed for this client: _____</p>	<p style="text-align: center;">(Please Complete)</p> <p style="text-align: center;">Special Instructions to BEST Health Plans</p> <ol style="list-style-type: none"> May we contact the client if we need additional information? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this your first case with BEST Health Plans? <input type="checkbox"/> Yes <input type="checkbox"/> No This is: <input type="checkbox"/> an existing client <input type="checkbox"/> a new client with my company The 'New Client Kit' (certificate book, claim forms, etc.) should be sent to: <input type="checkbox"/> The benefit representative <input type="checkbox"/> The client The underwriter assigned to my case should contact me? <input type="checkbox"/> Yes <input type="checkbox"/> No <p>General Agent (GA): Matrix Insurance Marketing, Inc. 1225 S Weller St, Suite 320 Seattle, WA 98144 Ph: 206-521-9451 or 800-929-6123 Fax: 206-521-9554 Email: info@matrixinsurance.com</p>
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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:

- This firm is a bona fide business establishment and participation requirements are being met.
- I have advised my client not to terminate any existing coverage until this coverage is approved.
- Coverage, eligibility provisions, 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 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: _____
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BEST Life and Health Insurance Company
Matrix Insurance Marketing • Phone: (800) 929-6123

Please submit completed forms to:
Matrix Insurance Marketing, Inc.
1225 S. Weller St., Ste. 320
Seattle, WA 98144
Phone: 206.521.9451 / Fax 206-521-9554
E-mail: info@matrixinsurance.com

**Employee Request for
BEST Life Dental/Vision**

New Enrollment Add Dependents Name Change

EMPLOYEE INFORMATION

Last Name	First Name	M.I.	DOB	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	SSN
Residence Street Address			City	State	Zip	
Name of Company	Group #, if known	Job Title	Date of F/T Hire	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
If changing your name, provide new name:			Do you have any eligible dependent children? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many?			
Will this replace other dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				Name of Carrier <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> 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 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

Qualifying Event (Select One)	Dependent Name	Relation	Full-Time Student?	Sex	SSN	Date of Birth
<input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Marriage Date:		Spouse	Yes/No	M/F		
<input type="checkbox"/> Loss of Coverage <input type="checkbox"/> New Dependent			Yes/No	M/F		
<input type="checkbox"/> Loss of Coverage <input type="checkbox"/> New Dependent			Yes/No	M/F		
<input type="checkbox"/> Loss of Coverage <input type="checkbox"/> New Dependent			Yes/No	M/F		
<input type="checkbox"/> Loss of Coverage <input type="checkbox"/> New Dependent			Yes/No	M/F		

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 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.

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
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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. 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.

Your Signature in black ink	Date
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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 <input type="checkbox"/> Yes <input type="checkbox"/> No	EE _____ 1 = Employee 2 = Dependent 3 = EE & Dependent	DEP. Refusal _____ R = No Coverage O = Other Coverage	SPOUSE EE <input type="checkbox"/> Yes <input type="checkbox"/> No	COB <input type="checkbox"/> Yes <input type="checkbox"/> 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

DVC0509



New Case Acceptance Unit

EMPLOYER STATEMENT

Date:.....

Group Name:.....

We wish to offer domestic partner coverage for our employees and their domestic partners.

Thank you.

Signature of Company Representative

Date

Title

Please Return Completed Form To:
Matrix Insurance Marketing, Inc.
1225 So. Weller St., Suite 320
Seattle, WA 98144
Phone: 206.521.9451
Fax: 206.521.9554
Email: info@matrixinsurance.com



BEST Life and Health Insurance Company

Affidavit of Domestic Partnership

Part 1 – Affirmation of Domestic Partnership

We, the undersigned, declare that we are domestic partners, and that we:

1. Are both at least eighteen (18) years of age.
2. Share a close personal relationship and are responsible for each other’s common welfare.
3. Are unmarried and have not had another domestic partner within the prior year;
4. Are not related by blood to a degree that would prohibit a spousal relationship;
5. Are legally competent to consent to contract;
6. Have jointly shared the same regular and permanent residence for at least six (6) months and intend to continue to do so indefinitely;
7. Are jointly financially responsible for basic living expenses defined as the cost of food, shelter, and any other expenses of maintaining a household.

Part 2 – Declaration of Member

1. I understand that my domestic partner is eligible for enrollment:
 - a. at the time of my hire, or
 - b. during any open enrollment period
2. I understand that the children of my domestic partner are not eligible.
3. I understand that my domestic partner is not eligible for COBRA upon termination.

Part 3 – Declaration of Partner

1. We understand and agree that a civil action may be brought against us for any losses, including reasonable attorney fees and court costs, because of willful falsification of information contained in this Affidavit of Domestic Partners.
2. We further understand and agree that, under applicable federal income tax law, payments for dental coverage of a domestic partner may not be eligible for pre-tax treatment.
3. We understand and agree that this affidavit is part of an enrollment for insurance benefits, and, as such, any person who knowingly or willfully provides false, incomplete or misleading information on this affidavit commits a fraudulent insurance act which is a crime and subject to criminal penalties.

We certify under penalty of perjury that the foregoing is true and accurate to the best of our knowledge.

Signature of Covered Member

Signature of Domestic Partner

Print Name

Print Name

Date

Date



BEST Life and Health Insurance Company

New Case Acceptance Unit

OWNER/PARTNER STATEMENT

Company Name:

I, _____, attest that while I do not appear on the State Quarterly Wage report of this company:

1. I am actively engaged at the business on a full-time, permanent basis of at least 30 hours per week;
2. I draw wages, dividends or other distributions from the company on at least a monthly basis and do not derive substantial earned income from any other employment;
3. I am otherwise eligible for benefits as outlined by the rules of the Trust;
4. I have satisfied the designated waiting period before insurance coverage is to become effective.

Owner/Partner's Signature	Date
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Percentage of Stock Ownership or Partnership Interest (Corporation)	(Partnership)
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Owner/Partner's Name (Please Print)	Title
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Please Return Completed Form To:
 Matrix Insurance Marketing, Inc.
 1225 So. Weller St., Suite 320
 Seattle, WA 98144
 Phone: 206.521.9451
 Fax: 206.521.9554
 Email: info@matrixinsurance.com