Filing at a Glance

Company: BEST Life and Health Insurance Company

Product Name: Short Term Disability Insurance
SERFF Tr Num: BLHI-126798991
State: Arkansas

TOI: H11G Group Health - Disability Income
SERFF Status: Closed-Approved-Closed
State Tr Num: 46706

Sub-TOI: H11G.002 Short Term
Co Tr Num: BL-STD-POL-0109
State Status: Approved-Closed

Filing Type: Form
Reviewer(s): Rosalind Minor

Author: Tammy O'Connor
Disposition Date: 09/08/2010

Date Submitted: 09/02/2010
Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
Implementation Date:

State Filing Description:

General Information

Project Name: Short Term Disability Insurance
Status of Filing in Domicile:

Project Number: BL-STD-POL-0109
Date Approved in Domicile: 09/16/2009

Requested Filing Mode: Review & Approval
Domicile Status Comments:

Explanation for Combination/Other:
Market Type: Group

Submission Type: New Submission
Group Market Size: Small and Large

Overall Rate Impact:
Group Market Type: Trust

Filing Status Changed: 09/08/2010
Explanation for Other Group Market Type:

State Status Changed: 09/08/2010

Deemer Date:
Created By: Tammy O'Connor

Submitted By: Tammy O'Connor
Corresponding Filing Tracking Number:

Filing Description:

This is a short term disability product. The attached forms are new and are not intended to replace any previously approved forms, nor do they deviate from industry standards.

These forms are being submitted as a Multiple Employer Trust of Utah and was approved in our domicile state on 9/16/2009. The forms are issued to the Trustee of the Beneficial Employees Security Trust of Utah. The approved trust is attached.

These forms provide coverage for Short Term Disability for eligible employees and dependents of Subscribing Employers under a multiple employer trust. Coverage will be solicited by licensed agents and brokers.

Please note all variable items are bracketed. However, variability will not be used if it conflicts with the minimum requirements as mandated by State and/or Federal law. In addition, these forms will not be used to solicit individual policies.

Company and Contact

Filing Contact Information

Tammy O'Connor, Director, Regulatory Compliance
toconnor@bestlife.com
2505 McCabe Way
800-433-0088 [Phone] 214 [Ext]
Irvine, CA 92623

Filing Company Information

BEST Life and Health Insurance Company	CoCode: 90638	State of Domicile: Texas
2505 McCabe Way	Group Code:	Company Type:
Irvine, CA 92623	Group Name:	State ID Number:
(800) 433-0088 ext. [Phone]	FEIN Number: 95-6042390	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	Yes
Fee Explanation:	100.00 per filing in domicile state.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
BEST Life and Health Insurance Company	$100.00	09/02/2010	39213111
BEST Life and Health Insurance Company	$50.00	09/07/2010	39290984

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/08/2010	09/08/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	09/07/2010	09/07/2010	Tammy O'Connor	09/07/2010	09/07/2010

Disposition

Disposition Date: 09/08/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*BLHI-126798991*	*State:*	*Arkansas*
Filing Company:	*BEST Life and Health Insurance Company*	*State Tracking Number:*	*46706*
Company Tracking Number:	*BL-STD-POL-0109*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Short Term Disability Insurance*		
Project Name/Number:	*Short Term Disability Insurance/BL-STD-POL-0109*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Approved Trust Document	Approved-Closed	Yes
Form	Certificate	Approved-Closed	Yes
Form	Employer Enrollment Form	Approved-Closed	Yes
Form	Policy	Approved-Closed	Yes

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/07/2010
Submitted Date	09/07/2010
Respond By Date	

Dear Tammy O'Connor,

This will acknowledge receipt of the captioned filing.

Objection 1

- Certificate, BL-STD-CERT-0109 (Form)
- Employer Enrollment Form, BL-BL-STD-EE APP-0109 (Form)
- Policy, BL-STD-POL-0109 (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of150.00. Please submit an additional $50.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/07/2010
Submitted Date	09/07/2010

Dear Rosalind Minor,

Comments:
Thank you, Ms. Minor, for the heads up on the change in the filing fee process. I will make a note of it for future reference.

Response 1

Comments: I submitted the additional $50.00 at 05:17 PM today.

Related Objection 1

Applies To:

- Certificate, BL-STD-CERT-0109 (Form)
- Employer Enrollment Form, BL-BL-STD-EE APP-0109 (Form)
- Policy, BL-STD-POL-0109 (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of150.00. Please submit an additional $50.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Tammy O'Connor

Form Schedule

Lead Form Number: BL-STD-CERT-0109

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/08/2010	BL-STD-CERT-0109	Certificate	Certificate	Initial			STD Certificate.pdf
Approved-Closed 09/08/2010	BL-BL-STD-EE APP-0109	Application/Enrollment Form	Employer Enrollment Form	Initial			STD EE Enrollment Form.pdf
Approved-Closed 09/08/2010	BL-STD-POL-0109	Policy/Contract/Fraternal Certificate	Policy	Initial			STD Policy.pdf

BEST Life and Health Insurance Company
[2505 McCabe Way
Irvine, California 92614]

A STOCK COMPANY
(Herein called the Company)

BEST Life and Health Insurance Company will provide coverage to each Covered Person according to the provisions, definitions, exclusions, limitations, terms and conditions of the Group Insurance Policy. The Group Insurance Policy under which this Certificate is issued is governed under the Laws of the State of Utah.

This Certificate supersedes and replaces any which may have been issued to You previously.

PLAN EFFECTIVE DATE: [01/01/2009]

See the Schedule of Benefits for details of Your Insurance.

Signed for **BEST Life and Health Insurance Company** by its President and Secretary at [2505 McCabe Way, Irvine, California 92614.]

[ ] [ ]
President Secretary

GROUP SHORT TERM DISABILITY INCOME INSURANCE
CERTIFICATE OF COVERAGE
NON-PARTICIPATING

TABLE OF CONTENTS

PART 1 - DEFINITIONS ..... [X]

PART 2 - GENERAL PROVISIONS ..... [X]
Certificate of Coverage ..... [X]
Eligibility Date ..... [X]
When Coverage Begins ..... [X]
Absence from Work on the Date Coverage Would Normally Begin ..... [X]
Temporarily Not Working ..... [X]
Changes to Your Coverage ..... [X]
When Your Coverage Ends ..... [X]
Time Limits for Legal Proceedings ..... [X]
Statements Made in Your Application for this Coverage ..... [X]
Insurance Fraud ..... [X]
Workers' Compensation or State Disability Insurance ..... [X]
Agency ..... [X]

PART 3 - SHORT TERM DISABILITY ..... [X]
General Information ..... [X]
Benefit Information ..... [X]
Duration of Payments ..... [X]

PART 4 - CLAIM INFORMATION ..... [X]

[CERTIFICATE SECTION

[This Certificate of Coverage does not apply unless a Validation Sticker is attached below indicating the Employee's name, Policy number, effective date of coverage, Elimination Period, Maximum Period of Payment, and Waiting Period.]

VALIDATION STICKER

(Attach Validation Sticker on this page)]

SHORT TERM DISABILITY PLAN SCHEDULE OF BENEFITS

This Short Term Disability Plan provides financial protection for You by paying a portion of Your income while You are disabled. The amount You receive is based on the amount You earned before Your disability began. In some cases, You can receive disability payments even if You work while disabled.

[This Certificate of Group Coverage is validated by the attachment of a "Statement of Your Coverage Sticker" affixed to the Schedule of Benefits.]

The Policy is issued by **BEST Life and Health Insurance** to:
THE TRUSTEE OF THE BENEFICIAL EMPLOYEES SECURITY TRUST OF UTAH

EFFECTIVE DATE: [See Validation Sticker in Certificate Section] [or separate Amendment hereto] [1/1/2009]

WAITING PERIOD: [See Validation Sticker in Certificate Section or separate Amendment hereto] [12, 18, or 24 months]

ELIMINATION PERIOD: [See Validation Sticker in Certificate Section or separate Amendment hereto]

Benefits begin the day after the Elimination Period is completed.

WEEKLY BENEFIT: [40%, 50%, 60%, 67% or 70%] of Weekly Earnings to a maximum Weekly Benefit of [$250 - $2500 per week].

Your payment may be reduced by Deductible Sources of Income. Some disabilities may not be covered under this Plan.

MAXIMUM PERIOD OF PAYMENT: [See Validation Sticker in Certificate Section or separate Amendment hereto]

This Short Term Disability Plan does not cover disabilities due to an Occupational Sickness or Injury.

OTHER FEATURES: [Pre-Existing Condition Exclusion: 12/12]
[Minimum Benefit of $100]

The above items are only highlights of this Plan. For a full description of Your coverage, continue reading Your Certificate of Coverage section.

PART 1 - DEFINITIONS

Active Employment means You are working for Your Employer for earnings that are paid regularly and that You are performing the Material and Substantial Duties of Your Regular Occupation. You must be working at least the minimum number of hours as described under Eligible Class(es) in each Plan.

Your work site must be:

1. Your Employer's usual place of business;
2. an alternative work site at the direction of Your Employer; or
3. a location to which Your job requires You to travel.

Normal vacation is considered Active Employment. Temporary and seasonal workers are excluded from coverage.

Appropriate Care means that You:

1. regularly visit a Doctor as frequently as is medically required, according to standard medical practice, to effectively treat and manage Your disabling condition(s); and
2. receive Appropriate Care and treatment for the disabling condition(s), conforming to standard medical practice, by a Doctor whose specialty or experience is most appropriate for the disabling condition(s), according to standard medical practice.

Deductible Sources of Income means income from other sources listed in this Plan, under Part 3 – Short Term disability, that You receive or are eligible to receive while You are disabled. This income will be subtracted from Your Gross Disability Payment.

Doctor means all licensed practitioners of the healing arts operating within the scope of their license.

BEST Life will not recognize You, any member of Your immediate family or a person residing in Your residence as a Doctor for a claim that You send to Us. In this context, "immediate family" means any of the following when related by blood or law:

1. The Covered Person's Spouse, father, mother, children, brothers, sisters and grandchildren;
2. The father, mother, brothers, and sisters of the Covered Person's Spouse; and
3. The Spouse of the Covered Person's child, brother, sister, mother, father, or grandparent.

Elimination Period means a period of continuous total disability that must be satisfied before You are eligible to receive benefits from BEST Life. The Elimination Period begins on the first day of Your disability.

Employee means a person who is a citizen or resident of the United States or Canada in Active Employment with the Participating Employer.

Employer or Participating Employer means the individual, company or corporation that participates under this Plan. A Participation Agreement must be completed and accepted by Us. Employer or Participating Employer includes any division, subsidiary, or affiliated company named in the Participation Agreement.

Evidence of Insurability means a statement of Your medical history that BEST Life will use to determine if You are approved for coverage. Evidence of Insurability will be provided at Your own expense.

Grace Period means the period of time following the premium due date during which premium payment may be made. The Grace Period for this Policy and for each Plan hereunder is 31 days.

Gross Disability Payment means the benefit amount before BEST Life subtracts Deductible Sources of Income and Disability Earnings.

Hospital, Health Facility or Institution means an accredited facility licensed to provide care and treatment for the condition causing Your disability.

Injury means a bodily Injury that is the direct result of an accident and not related to any other cause. Injury that occurs before You are covered under this Plan will be treated as a Sickness. Disability must begin while You are covered under the Plan.

Law or Act means the original enactments of the Law or Act and all amendments.

Material and Substantial Duties means duties that:

1. are normally required for the performance of Your Regular Occupation; and
2. cannot be reasonably omitted or modified, except that if You are required to work on average in excess of 40 hours per week, We will consider You able to perform that requirement if You are working or have the capacity to work 40 hours per week.

Maximum Period of Payment means the longest period of time that BEST Life will make payments to You for any one period of disability. Your Maximum Period of Payment is shown in Your [Certificate Validation Sticker] [Schedule of Benefits] or in a separate Amendment attached hereto.

Occupational Sickness or Injury means a Sickness or Injury that was caused by or aggravated by any employment for pay or profit.

Participation Agreement means a document:

1. executed by a Participating Employer in which the Employer agrees to be bound by the terms of the Trust;
2. by which certain benefits are requested for the Employer's Employees;
3. showing the eligible classes, the amounts of insurance and other relevant information pertaining to the Plan of insurance applied for by the Employer.

Payable Claim means a claim for which BEST Life is liable under the terms of the Policy.

Plan means a line of coverage under the Policy applicable to a Participating Employer.

Policyholder means the entity to which the Policy is issued.

Pre-Existing Condition means any condition for which You received medical treatment, consultation, care or services, including diagnostic measures or were prescribed drugs or medicines for Your condition during the given period of time stated in the Plan.

Recurrent Disability means a disability that is:

1. caused by a worsening in Your condition; and
2. due to the same cause(s) as Your prior disability for which BEST Life made a Short Term Disability payment.

Regular Occupation means the occupation You are routinely performing when Your disability begins. We will look at Your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

Reported Weekly Earnings means Your gross weekly income as reported by Your Employer at the time of application for coverage, providing such earnings have not decreased on or before Your date of disability. Gross weekly income is Your total income before taxes and any pre-tax deductions made under a qualified deferred compensation plan recognized by the Internal Revenue Service. It does not include income received from commissions, bonuses, overtime pay, or other extra compensation. It does not include income received from sources other than Your Employer.

If Your gross weekly income at the time of Your disability is less than that reported by Your Employer at the time of application, Your benefits will be based on Your actual gross weekly income on the day immediately prior to Your date of disability. If Your gross weekly income at the time of Your disability is more than that reported by Your Employer at the time of application, Your benefit will be based on Your gross weekly income as reported by Your Employer, except that once each year, at a time determined by BEST Life, Your Employer may provide BEST Life with evidence of such increased income in which case, Your disability benefit for any disability first occurring on or after the effective date of such notice, will be based upon Your gross weekly income as then reported by Your Employer. The effective date of such notice shall by July 1 of each year.

Your Reported Weekly Earnings will dictate the amount of premium that is required for this coverage. If Your Reported Weekly Earnings are increased, You will not receive an increase in benefits unless that increase has been reported to BEST Life as provided above and premium payments have been adjusted as required.

Retirement Plan means a defined contribution plan or defined benefit plan. These are plans that provide retirement benefits to Employees and are not funded entirely by Employee contributions.

Salary Continuation or Accumulated Sick Leave means continued payments to You by Your Employer of all or part of Your Reported Weekly Earnings, after You become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by Your Employer for the benefit of all Employees covered under the Policy.

Salary Continuation or Accumulated Sick Leave does not include compensation paid to You by Your Employer for work You actually perform after Your disability begins. Such compensation is considered Disability Earnings, and would be taken into account in calculating Your Weekly Payment.

Sickness means an illness, disease or physical condition. Disability resulting from Sickness must begin while You are covered under this Plan.

Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence means You are absent from Active Employment for a period of time that has been agreed to in advance in writing by Your Employer.

Your normal vacation time or any period of disability is not considered a Temporary Layoff or Leave of Absence.

Waiting Period means the continuous period of time (shown in each Plan) that You must be in Active Employment in an eligible class before You are eligible for coverage under a Plan.

Weekly Benefit means the total benefit amount for which an Employee is insured under this Plan subject to all Plan provisions.

Weekly Payment means Your payment after any Deductible Sources of Income and Disability Earnings have been subtracted from Your Gross Disability Payment.

We, Us, Our and Company means BEST Life and Health Insurance Company.

You or Your means a person who is eligible for BEST Life coverage.

PART 2 - GENERAL PROVISIONS

CERTIFICATE OF COVERAGE

This Certificate of Coverage is a written statement prepared by BEST Life and may include attachments. It tells You:

1. the coverage to which You may be entitled;
2. to whom BEST Life will make a payment; and
3. the limitations, exclusions and requirements that apply within a Plan.
4.

Eligibility Date

If You are working for Your Employer in an eligible class, the date You are eligible for coverage is the later of:

1. the Participating Employer's effective date of coverage under this Plan; or
2. the day after You complete Your Waiting Period.

When Coverage Begins

If the Participating Employer has 10 or more eligible Employees:

1. You will be insured for noncontributory insurance at 12:01 A.M. on Your effective date.
2. You will be insured for contributory insurance on the latest of these dates:
    a. At 12:01 A.M. on Your eligibility date, if You have made written application for insurance on or before this date.
    b. At 12:01 A.M. on the date You make written application for insurance, if You do it on or before the 31st day after Your eligibility date;
    c. At 12:01 A.M. on the date BEST Life gives its approval, if You
        i. make written application for insurance more than 31 days after Your eligibility date; or
        ii. terminated Your insurance while continuing to be eligible and again have made written application for insurance.

In the case of i. and ii. above, You must submit Evidence of Insurability to BEST Life for approval. This will be at Your expense.

The effective date of any initial, increased or additional insurance will be delayed if You are not in Active Employment because of a disability. The initial, increased or additional insurance will start on the date that You return to Active Employment.

Absence from Work on the Date Coverage Would Normally Begin

If You are absent from work due to Injury, Sickness, Temporary Layoff or Leave of Absence, Your coverage will begin on the date You return to Active Employment.

Temporarily Not Working

If You are on a Temporary Layoff, and if premium is paid, You will be covered only through the end of the month that immediately follows the month in which Your Temporary Layoff begins.

If You are on a Leave Of Absence, and if premium is paid, You will be covered only through the end of the month that immediately follows the month in which Your Leave of Absence begins. If You are on a Family and Medical Leave of Absence as defined by the federal Family and Medical Leave Act of 1993, and any amendments, and if premium is paid, Your coverage will continue as though You were in Active Employment. Coverage will continue up to the greater of the leave period required under the:

1. Federal Family and Medical Leave Act of 1993, and any amendments; or
2. applicable State Law.

Changes to Your Coverage

Once Your coverage begins, any increased or additional coverage will take effect immediately if You are in Active Employment or if You are on a Temporary Layoff or Leave of Absence not due to Sickness or Injury. If You are not in Active Employment due to Injury or Sickness, any increased or additional coverage will begin on the date You return to Active Employment.

Any decrease in coverage will take effect immediately but will not affect a Payable Claim that occurs prior to the decrease.

When Your Coverage Ends

Your coverage under the Policy or a Plan ends on the earliest of:

1. the date the Policy or a Plan is terminated;
2. the date the Employer's participation terminates;
3. the date You no longer are in an eligible class;
4. the date Your eligible class is no longer covered;
5. the last day of the period for which You made any required contributions; or
6. the last day of the month You are in Active Employment except as provided under the Temporary Layoff or Leave Of Absence provision.

BEST Life will provide coverage for a Payable Claim that occurs while You are covered under the Policy or Plan.

Entire Contract; Changes

This Group Policy, the Group Policyholder application, any endorsements, riders or papers, the Subscribing Employer's application, the Certificate(s) and the Certificateholder enrollment forms are the entire contract between the Group Policyholder and Us. We will consider any statement made by an Insured Person, Subscribing Employer or the Group Policyholder, in the absence of fraud, to be a representation and not a warranty.

No change in this Group Policy will be effective until it is approved by one of Our executive officers. This approval must be noted on or attached to this Group Policy. No agent may change this Group Policy or waive any of its provisions. Any rider, endorsement or application which modifies, limits or excludes coverage must be signed by the Group Policyholder to be effective.

Time Limits for Legal Proceedings

You can start legal action regarding Your claim 60 days after proof of claim has been given and up to 2 years from the time proof of claim is required, unless otherwise provided under State Law.

Statements Made in Your Application for this Coverage

BEST Life considers any statements You or Your Employer make in a signed application for coverage or Evidence of Insurability form a representation and not a warranty. If any of the statements You or Your Employer make are not complete and/or not true at the time they are made, We can:

1. reduce or deny any claim; or
2. terminate Your coverage from the original effective date.

We will use only statements made in a signed application, a copy of which has been provided to You or Your Employer, as a basis for doing this. The validity of the coverage under the Plan will not be contested after it has been in force for 2 years except for fraudulent misrepresentations.

If the Participating Employer gives Us information about You that is incorrect, We will:

1. use the facts to decide whether You have coverage under the Plan and in which amounts; and
2. make a fair adjustment of the premium.

Insurance Fraud

BEST Life wants to ensure that You and Your Employer do not incur additional insurance costs as a result of the effects of insurance fraud. We promise to focus on all means necessary to support detection, investigation, and prosecution.

It is a crime if You knowingly, and with the intent to injure, defraud or deceive Us, or provide any information, including filing an application for coverage or a claim, which contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of Your claim, and are subject to prosecution and punishment to the full extent under State and/or Federal Law. We will pursue all appropriate legal remedies in the event of insurance fraud.

Workers' Compensation or State Disability Insurance

The Policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

Agency

For purposes of the Policy, the Participating Employer acts on its own behalf or as Your agent. Under

no circumstances will the Participating Employer be deemed the agent of BEST Life.

PART 3 - SHORT TERM DISABILITY

GENERAL INFORMATION

Class of Employees Eligible for Coverage

The eligible class working at least [30] hours per week. Employees must be citizens or residents of the United States or Canada.

Waiting Period

Your Waiting Period is different than Your Elimination Period. Your Waiting Period refers to the amount of time You must be employed with a Participating Employer before You are eligible to apply for this coverage. The Elimination Period refers to the amount of time You must be continuously and totally disabled before benefits become available, after satisfying the Waiting Period.

Cost of Coverage

The coverage provided by this Policy may be contributory in which case You will be required to pay for all or a portion of the premium or non-contributory in which case Your Employer will pay the premium.

BENEFIT INFORMATION

Definition of Disability

You are disabled when BEST Life determines that:

1. You are unable to perform the Material and Substantial Duties of Your Regular Occupation due to Your Sickness or Injury; and
2. You are not working in any occupation.

You must be under the Appropriate Care of a Doctor in order to be considered disabled. The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require You to be examined by a Doctor, other medical practitioner and/or vocational expert of Our choice. BEST Life will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require You to be interviewed by an authorized BEST Life Representative.

Your failure to comply with this request may result in denial or termination of benefits.

Elimination Period

You must be continuously totally disabled through Your Elimination Period. Your Elimination Period is as indicated on Your [Certificate Validation Sticker] [Schedule of Benefits] or separate Amendment hereto. The days that You are not disabled will not count toward Your Elimination Period.

When You Receive Payments

You will begin to receive payments when We approve Your claim, providing the Elimination Period has been met and You are disabled. We will send You a payment each month for any period for which BEST Life is liable.

Amount of Payment

We will follow this process to figure Your payment:

1. Multiply Your Reported Weekly Earnings by [40%, 50% 67 % or 70%].

2. The maximum Weekly Benefit is [$250 - $2500 per week].
3. Compare the answer from Item 1 with the maximum Weekly Benefit. The lesser of these two amounts is Your Gross Disability Payment.
4. Subtract from Your Gross Disability Payment any Deductible Sources Of Income.

The amount figured in Item 4 is Your Weekly Payment.

After the Elimination Period, if You are disabled for less than 1 month, We will send You 1/7th of Your payment for each day of disability.

Deductible Sources of Income

BEST Life will subtract from Your Gross Disability Payment the following Deductible Sources of Income:

1. [The amount that You receive or are eligible to receive under:
   a. a Workers' Compensation Law;
   b. an occupational disease Law; or
   c. any other Act or Law with similar intent.

2. The amount that You receive, or are eligible to receive, as disability income payments under any:
   a. state compulsory benefit Act or Law;
   b. automobile liability insurance policy; or
   c. other group insurance Plan.

3. The amount You receive:
   a. as a result of any action brought under Title 46, United States Code Section 688 (The Jones Act);
   b. from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise, not to exceed 50% of the [net] [gross] settlement
   c. under the mandatory portion of any "no fault" motor vehicle plan; or
   d. under any Salary Continuation or Accumulated Sick Leave plans or any similar Employer-sponsored paid time off plan where You receive income from Your Employer.

4. The amount that You:
   a. receive as disability payments under Your Employer's Retirement Plan;
   b. voluntarily elect to receive as retirement payments under Your Employer's Retirement Plan;
   c. are eligible to receive as retirement payments when You reach the later of age 62 or normal retirement age, as defined in Your Employer's Retirement Plan.]

Disability payments under a Retirement Plan will be those benefits that are paid due to disability and do not reduce the retirement benefit that would have been paid if the disability had not occurred.

Retirement payments will be those benefits that are paid based on Your Employer's contribution to the Retirement Plan. Disability benefits that reduce the retirement benefit under the Plan will also be considered as a retirement benefit.

Regardless of how the retirement funds from the Retirement Plan are distributed, BEST Life will

consider the Participating Employer and Employee contributions to be distributed simultaneously throughout Your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible Retirement Plan. BEST Life will use the definition of eligible Retirement Plan as defined in Section 402 of the Internal Revenue Code including any future amendments that affect the definition.

With the exception of retirement payments, BEST Life will only subtract Deductible Sources of Income which are payable as a result of the same disability.

Non-Deductible Sources of Income

We will not subtract from Your Gross Disability Payment income You receive from, but not limited to, the following:

1. [401(k) plans;
2. profit sharing plans;
3. thrift plans;
4. tax-sheltered annuities;
5. stock ownership plans;
6. credit disability insurance;
7. non-qualified plans of deferred compensation;
8. pension plans for partners;
9. military pension and disability income plans;
10. franchise disability income plans;
11. individual disability plans paid by the Employee;
12. a Retirement Plan from another Employer;
13. individual retirement accounts (IRA).]

Minimum Benefit

The minimum weekly payment is [$10 - $50 per week]. BEST Life may apply this amount toward an outstanding overpayment.

You May Qualify for Deductible Income Benefits

When We determine that You may qualify for benefits under items 1, 2, or 4 in the Deductible Sources of Income section, We will estimate Your entitlement to these benefits. We can reduce Your payment by the estimated amounts if such benefits:

1. have not been awarded; and
2. have not been denied; or
3. have been denied and the denial is being appealed.

Your Short Term Disability payment will NOT be reduced by the estimated amount if You:

1. apply for the disability payments under items 1, 2, or 4 in the Deductible Sources of Income section and appeal Your denial to all administrative levels BEST Life feels are necessary; and
2. sign BEST Life's payment option form. This form states that You promise to pay Us any overpayment caused by an award.

If Your payment has been reduced by an estimated amount, Your payment will be adjusted when We receive proof:

1. of the amount awarded; or
2. that benefits have been denied and all appeals BEST Life feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to You.

If You receive a lump sum payment from any Deductible Sources of Income, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a monthly basis to the end of the Maximum Period of Payment.

DURATION OF PAYMENTS

BEST Life may send You a payment each month up to the Maximum Period of Payment. Your Maximum Period of Payment is based on the Plan Your Employer has selected. Your specific Maximum Period of Payment will be either [13, 26 or 52 weeks], as indicated on Your [Certificate Validation Sticker] [Schedule of Benefits] or as provided in a separate Amendment attached hereto.

We will stop sending You payments and Your claim will end on the earliest of the following:

1. the end of the Maximum Period of Payment;
2. the date You are no longer disabled under the terms of this Plan;
3. the date Your Disability Earnings exceed the amount allowable under the Plan;
4. the date You fail to provide proof of continuing disability; or
5. the date You die.

Disabilities Not Covered Under Your Plan

Your Plan does not cover any disabilities caused by, contributed to by, or resulting from Your:

1. loss of professional license, occupational license, or certification;
2. participation in a felony;
3. intentionally self-inflicted injuries;
4. attempted suicide, regardless of mental capacity;
5. active participation in a riot;
6. Pre-Existing condition;
7. attempting to commit or commission of a crime for which You have been convicted under Federal or State Law;
8. voluntarily electing a surgical procedure except when required due to Injury or Sickness;
9. elective cosmetic or plastic surgery except when required due to Injury or Sickness; or
10. Occupational Sickness or Injury .

Your Plan will not cover a disability caused by, contributed to by or resulting from war, declared or undeclared, or any act of war.

BEST Life will not pay a benefit for any period of disability during which You are incarcerated.

[Pre-Existing Condition

You have a Pre-Existing condition if:

1. the disability begins in the first 12 months after Your effective date of coverage; and
2. You received medical treatment, consultation, care, or services, including diagnostic measures, or took prescribed drugs or medicines in the 12 months just prior to Your effective date of coverage.

Benefits will not be paid for any disability caused or contributed to by a Pre-Existing condition unless Your disability starts after You have been continuously covered under the Plan for 12 consecutive months.]

Recurring Disability

If, following Your return to Active Employment, You have a Recurrent Disability the Company will treat Your disability as part of Your prior claim and You will not have to complete another Elimination Period if:

1. You were continuously insured under the Plan for a period between Your prior claim and Your Recurrent Disability; and
2. Your Recurrent Disability occurs within 14 days of the end of Your prior claim.

Your Weekly Benefit will be based on Your Reported Weekly Earnings as of the date of Your initial claim.

Your disability, as outlined above, will be subject to the same terms of the Plan as Your prior claim.

Any disability that occurs after 14]days from the date Your prior claim ended will be treated as a new claim. The new claim will be subject to all of the Plan provisions.

If You become entitled to payments under any other Group Short-Term dDisability Plan that replaces this Plan, You will not be eligible for payments under the BEST Life Plan.

PART 4 - CLAIM INFORMATION

Notice of Claim

You must notify Us of Your claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of a claim should be sent within 30 days after the date Your disability begins.

The claim form is available from Your Employer, or You can request a claim form from Us. If You do not receive the form from BEST Life within 15]days of Your request, send BEST Life written proof of claim without waiting for the form.

You must notify Us immediately when You return to work in any capacity.

Filing a Claim

You and Your Employer must fill out Your own sections of the claim form and then give it to Your attending Doctor. Your Doctor should fill out his or her section of the form and send it directly to BEST Life.

Proof of Your Claim

Your proof of claim must show:

1. that You are under the Appropriate Care of a Doctor;
2. the date Your disability began;
3. the cause of Your disability;
4. the appropriate documentation of Your Reported Weekly Earnings and Your activities;
5. the extent of Your disability, including restrictions and limitations preventing You from performing Your Regular Occupation;
6. the name and address of any Hospital, Health Facility or Institution where You received treatment, including all attending Doctors; and
7. documentation of prior disability coverage, if applicable.

We may request that You send proof of continuing disability indicating that You are under the Regular Care of a Doctor. This proof must be received within [45 days w/ERISA][30 days w/o ERISA] of a request by Us.

You may be required to give BEST Life authorization to obtain additional medical information. You may also be asked to provide non-medical information as part of Your proof of claim, or proof of continuing disability. We will deny Your claim, or stop sending You payments, if the appropriate information is not submitted within [45] days of Our request.

If a claim is not denied for valid reasons within 30 days of the date BEST Life receives proof of claim, or within 20 days for a claim that is resubmitted with supporting documentation requested by BEST Life, We will pay interest at the rate of one and one-half percent per month for the first weekly payment that We make to You. Interest will be credited from the date You have provided all information required for proof of claim to the date We make the first payment.

Likewise, We will pay interest on any weekly payment that is not paid within 30 days of the date it is due to be paid as explained in "Making Payments". Interest will be paid at the rate as indicated by State Law. In any event, if BEST Life fails to pay benefits when due, You may bring an action to recover the benefits plus any interest accrued and other damages as allowed by applicable Law.

Making Payments

Once Your claim has been approved, We will send You a payment at the end of each month for any period for which BEST Life is liable.

Overpaid Claims

BEST Life has the right to recover any overpayments due to:

1. fraud;
2. administrative errors BEST Life makes in processing a claim; or
3. Your receipt of Deductible Sources of Income.

BEST Life will enforce all rights and provisions set forth in the Policy and Certificate forms.

You must reimburse Us in full. We will work with You to develop a reasonable method of repayment if You are financially unable to repay Us in a lump sum.

BEST Life will not recover more money than the amount We paid You. However, We reserve the right to recover any prior or current overpayment from a disability claim under this Plan.

Claim Review

Your claim will be administered, when applicable, in accordance with the ERISA regulations, including but not limited to the following:

If Your claim is denied, You will be given written notice of:

1. the reason for denial; and
2. the Policy provision that relates to the denial; and
3. Your right to ask for a review of Your claim; and
4. any additional information that might allow Us to change Our decision.

BEST Life shall have authority and full discretion to determine all questions arising in connection with the Plan benefits, including but not limited to eligibility, beneficiaries, interpretation of Plan language, and findings of fact

with regard to any such questions. The actions, determinations, and interpretations of BEST Life with respect to all such matters shall be conclusive and binding. This means that should there be any question concerning how the Plan applies to:

1. any claim for benefits;
2. an Employee's eligibility for Plan benefits;
3. the determination of beneficiaries; or
4. any other question or issue, whether one of fact or one of Plan interpretation.

BEST Life is deemed to have the exclusive right and authority to resolve all such questions in the exercise of BEST Life's sole discretion.

You may, upon written request, read any reports that are not confidential. We will make copies of those reports for Your use and We may charge a fee for this service. .

Appeals Procedure

Prior to filing any lawsuit and not more than 180 days after denial of a claim, You or Your beneficiary must appeal any denial of benefits under the Policy by making a written request for review of the denial.

GROUP SHORT TERM DISABILITY INCOME INSURANCE
CERTIFICATE OF COVERAGE
NON-PARTICIPATING

Underwritten by BEST Life Insurance Company
Irvine, CA

OFFICE USE ONLY		A ____ D ____ E ____
/ / Effective Date	Employee Number	Coverage Code
Adjustment		

Request for Short Term Disability Plan Participant Enrollment Form

Name of Company Where Employed | Date of F/T Employment / /

Employee Name: Last | First | M.I.

Employee Home Address | City | State | Zip

Home Phone ( ) - | Social Security Number - - | Date of Birth / / | Age | Sex

Height | Weight | Marital Status | Job Title | Monthly Earnings

Do you have or are you applying for other disability income coverage? ☐ Yes ☐ No If yes, indicate carrier and monthly benefit:

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 each certificate of insurance issued to me. However, if I am absent from full-time employment on such date(s) as the result of an accident or sickness I agree that coverage is not effective. I understand that my employer's application will determine the coverages in force and that coverage is not in force if an application for that coverage has not been made by my employer. I understand that BEST Life reserves the right to decline anyone or all persons listed on this request for group insurance.

Employee Signature | Date

CONFIDENTIAL MEDICAL INFORMATION

The following information is submitted as evidence of my insurability, if required.

1. Have you in the past 10 years (other than for routine examination, check-ups, immunizations) consulted or been treated by a physician/practitioner, or been confined or treated in a hospital or similar institution, or been advised to have an operation which has not been performed or to enter a treatment program you are not currently receiving? ☐ Yes ☐ No

2. Have you had or been told of , or consulted with a physician/practitioner for, or been treated for any of the following: High blood pressure, heart trouble or murmur, disorder of the blood or vessels; Alcohol or drug abuse; Tuberculosis; Kidney/bladder prostate or reproductive organs; Cancer, tumor, cyst or growth; Brain disorder; Spine, back disorder, chronic pain or fatigue, fibromyalgia, arthritis, rheumatism, gout, or any other bone, joint or muscle disorder; Diabetes, blood or sugar in the urine, thyroid or other glandular disorder; Mental or nervous disorder or epilepsy; Ulcer, colitis or other digestive system disorder; hernia or liver disorder (including hepatitis)? ☐ Yes ☐ No

3. Have you:
   (a) treatment from a physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No
   (b) been diagnosed by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No

4. Are you under regular medical care or taking medication of any disease or disorder? ☐ Yes ☐ No

We pay all benefits according to the law of the State in which the policy was written.

If you answered "yes" to any of the above health questions, please provide full details below. Include date of onset, diagnosis, all details of condition, routine exams, and names and addresses of Physicians and Hospitals. Attach an additional sheet if necessary.

Nature of Illness or Injury and Date and Duration of Medical Attention	Recovery Complete (Yes/No)	Names and Addresses Physicians/Hospitals

FRAUD WARNING: AS REQUIRED BY LAW, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH MAY BE CONSIDERED A CRIME.

I'm applying to BEST Life and Health Insurance Company for group short-term disability insurance coverage. The answers on this application, a copy of which will be a part of my insurance certificate if issued, are given to obtain this coverage. I hereby certify that I have read the statements contained on this application or that they have been read to me and that all statements made by me on this application are true and complete to the best of my knowledge and belief. I understand that misstatements or omissions in the application may be used to contest the validity of insurance, reduce coverage or deny a claim. I authorize my employer to deduct from my earnings any required contribution toward the premium. I further authorize any physician, hospital, clinic, insurer, or other organization or person having any records or knowledge concerning me to give this information to BEST Life and Health Insurance Company. This authorization expires 24 months from the date of the Applicant's signature. A photocopy of this authorization will be as valid as the original.

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.

Date: _____ Signature of Applicant ***X*** _____

BEST LIFE and Health Insurance Company
[2505 McCabe Way
Irvine, California 92614]

A STOCK COMPANY
(Herein called the Company)

BEST Life and Health Insurance Company will provide coverage to each Covered Person according to the provisions, definitions, exclusions, limitations, terms and conditions of the Group Insurance Policy. The Group Insurance Policy is issued is governed under the Laws of the State of Utah.

PLAN EFFECTIVE DATE: [01/01/2009]

Signed for **BEST Life and Health Insurance Company** by its President and Secretary at [2505 McCabe Way, Irvine, California 92614.]

[ ]
President

[ ]

Secretary

GROUP SHORT TERM DISABILITY INCOME INSURANCE POLICY

NON-PARTICIPATING

POLICYHOLDER: Trustee of the Beneficial Employees Security Trust of Utah

GROUP POLICY NO: [STD-PC-2002]

POLICY EFFECTIVE DATE: [December 1, 2008]

POLICY ANNIVERSARY DATE: [December 1st}

GOVERNING JURISDICTION: Utah

TABLE OF CONTENTS

GENERAL PROVISIONS [X]

PREMIUM PROVISIONS [X]

TERMINATION PROVISIONS [X]

PART 1 – GENERAL PROVISIONS

COST OF SHORT TERM DISABILITY INSURANCE

The initial premium for each Plan is based on the rate(s) in effect at the time the Policy is issued. These rates are subject to change at any time at the sole discretion of BEST Life. BEST Life will notify the Policyholder in writing at least 31 days before a premium rate is changed. A change may take effect on an earlier date when both BEST Life and the Policyholder agree.

SHORT TERM DISABILITY RATE GUARANTEE

A change in premium rate will not take effect until [1] year after the Policy Effective Date. Notwithstanding the above, a change in premium rate will not occur more often than once in a 12 month period except that BEST Life may change premiums at any time for reasons which affect the risk assumed, including those reasons shown below:

1. A change occurs in this plan design;
2. A division, subsidiary or affiliated Company is added or deleted;
3. The number of Insureds changes by [25]% or more; or
4. A new Law or a change in any existing Law is enacted which applies to this Plan.

INFORMATION REQUIRED FROM THE POLICYHOLDER

The Policyholder must provide or require its Participating Employers to provide BEST Life with the following on a regular basis:

1. Information about Employees
    a. Who are eligible to become insured?
    b. Whose amounts of coverage change; and/or
    c. Whose coverage ends?
2. Occupational information, salary information and any other information that may be required to manage a claim; and
3. Any other information that may be reasonably required.

Policyholder or Participating Employer records that have a bearing, in BEST Life's opinion, on this Policy will be available for review by BEST Life at any reasonable time as determined by us.

Clerical error or omission by BEST Life will not:

1. Prevent an Employee from receiving coverage;
2. Affect the amount of an Insured's coverage; or
3. Cause an Employee's coverage to begin or continue when the coverage would not otherwise be effective.

CERTIFICATES

BEST Life will issue Certificates to the Participating Employer for distribution to each person insured under the Policy. The Certificate will describe the coverage under the Policy.

CLASS OF EMPLOYEES ELIGIBLE FOR COVERAGE

The eligible class working at least 30 hours per week. Employees must be citizens or residents of the United States or Canada.

PART 2 – PREMIUM PROVISIONS

PREMIUM DUE

Premium Due Dates: Premium is due on the Participating Employer's effective date of coverage and on the first day of each calendar month thereafter.

The Participating Employer must send all further premiums on or before their respective due date to BEST Life. The premium must be paid in United States dollars.

PREMIUM INCREASES OR DECREASES

Premium increases or decreases which take effect during a policy month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

BEST Life will only adjust premium for the current policy year and the prior policy year. In the case of fraud, premium adjustments will be made for all policy years.

PREMIUM REFUND

Upon termination of coverage, any unearned premium will be determined on a pro-rata basis. BEST Life will promptly return any unearned premium paid upon the request of the Participating Employer.

PART 3 – TERMINATION PROVISIONS

TERMINATING POLICY/PLAN

This Policy and/or any Plan issued to a Participating Employer under this Policy can be terminated as provided below:

1. By BEST Life; or
2. BY the Policyholder.

A Participating Employer's Plan or participation under this Policy may be terminated:

1. by BEST Life
2. by the Policyholder; or
3. by the Participating Employer.

If BEST Life terminates this Policy or a Participating Employer Plan for reasons other than the Employer's failure to pay premiums, a written notice will be delivered to the Policyholder or the Participating Employer at least 31 days prior to the termination date.

If any portion of the premium is not paid during the Grace Period, the Policy or Plan or a Participating Employer's participation will terminate automatically at the end of the Grace Period. The Participating Employer is liable for premium for coverage during the Grace Period. The Participating Employer must pay BEST Life all premiums due for the full period each Plan is in force.

The Policyholder may terminate this Policy or a Plan and a Participating Employer may terminate its participation by written notice delivered to BEST Life at least 31] days prior to the termination date. When both the Policyholder and BEST Life agree, this Policy or a Plan can be terminated on an earlier date, except that in the event of termination of a Participating Employer's Plan, at least 31 days

notice will be given. If BEST Life or the Policyholder terminates this Policy or a Plan, coverage will end at 12:00 midnight on the last day of coverage.

If this Policy or a Plan is terminated, the termination will not affect a Payable Claim.

TERMINATING PARTICIPATING EMPLOYER PLAN

BEST Life may terminate the Participating Employer's participation on any premium due date by giving written notice to the Participating Employer at least 31 days in advance if:

1. the number of Employees insured is less than 10; or
2. less than 100% of the Employees eligible for any noncontributory insurance are insured for it; or
3. for a Participating Employer with 10]or more Employees eligible for contributory insurance, less than 75% of the Employees are insured; or
4. the Participating Employer fails to furnish promptly any information that BEST Life may reasonably require or fails to perform any other obligation pertaining to the Plan or
5. the Participating Employer fails to pay any premium when due or within the Grace Period.

Termination may take effect on an earlier date when both the Employer and BEST Life agree.

GROUP SHORT TERM DISABILITY INCOME INSURANCE POLICY
NON-PARTICIPATING

Underwritten by BEST Life and Health Insurance Company
Irvine, CA

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/08/2010

Comments:

Attachments:

Readability Certification.pdf
AR Certificate of Compliance_STD.pdf
AR_Guaranty Association Notice.pdf
AR_Certification.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	09/08/2010

Comments:

Attachment:

STD Employer Application.pdf

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved-Closed	09/08/2010

Comments:

Attachment:

Statement of Variability.pdf

		Item Status:	Status Date:
Satisfied - Item:	Approved Trust Document	Approved-Closed	09/08/2010

Comments:

Attachment:

Utah Trust Document.pdf

Readability Certification
BEST Life and Health Insurance Company

BL-STD-POL-0109	Group Policy
BL-STD-CERT-0109	Certificate of Coverage
BL-STD-APP-0109	Employer Application Form
BL-STD-EE APP-0109	Employee Enrollment Form

I hereby certify that the above referenced form(s) have a combined Flesch score of 41.55.

Authorized Signature

Paul Peatross
Name

Sr. Vice President and General Counsel
Title

September 2, 2010
Date

CERTIFICATE OF COMPLIANCE

I hereby certify that BEST Life and Health Insurance Company will adhere to and comply with all Arkansas laws and regulations including Rule & Regulation 19 and Rule & Regulation 49.

BEST Life and Health will supply the Consumer Notice required by ACA 23-79-138 and Bulletin 11-88 .

Tammy O'Connor

(Signature)

Tammy O'Connor, Director of Regulatory Compliance
(Name and Title)

September 2, 2010
(Date)

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

- However, persons owning such policies are NOT protected by the Guaranty Association if:
- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do ~~mot~~ not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a non-affiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

Certification Regarding Compliance with Arkansas Regulation 19s10B

I, Paul Peatross, do hereby truthfully certify to the Arkansas Insurance Department that this submission including form number(s) BL-STD-POL-0109, BL-STD-CERT-0109, BL-STD-APP-0109 and BL-STD-EE APP-0109 meet the provisions of rule 19s10B as well as all applicable requirements of Arkansas laws and regulations.

Date: September 2, 2010

Sr. Vice-President and Chief Legal Counsel
BEST Life and Health Insurance Company

BEST LIFE

BEST Life and Health Insurance Company

Short Term Disability Employer Application

Application Checklist

For group enrollment for 2 or more lives

INSTRUCTIONS: To apply for group short term disability insurance, please submit the following items:

- ☐ Complete the Employer Application and obtain all signatures
- ☐ Attach Copy of Quote
- ☐ A Copy of firm's most recent state Quarterly Wage Report showing the names of all employees
- ☐ Obtain a business check for one month's estimated premium payable to BEST Life and Health
- ☐ Mail all documents and 1st month's premium check to:

BEST Life and Health Insurance Company
P.O. Box 19721
Irvine, CA 92623-9721

For additional information or assistance, contact us at:

Toll-free: 800.237.8543
Local: 949.253.4080
Fax: 949.553.0883
E-mail: info@besthealthplans.com
www.besthealthplans.com

BEST LIFE

BEST Life and Health Insurance Company

Short Term Disability Employer Application

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			
Years in Business	Number of Full-time Employees on Payroll	Number of Employees applying for Coverage	Description of any Classes Not Eligible		

Requested Effective Date:

STD Plan Elimination Period (select one): ☐ 0 day injury/7 day sickness ☐ 7 day injury/7 day sickness ☐ 14 day injury/14 day sickness ☐ 29 day injury/29 day sickness

Benefit Duration: ☐ 13 Weeks ☐ 26 Weeks (standard) ☐ 52 Weeks (only available for groups with 10+)

Monthly Benefit ☐ 40% ☐ 50% ☐ 60% ☐ 67% ☐ 70%

☐ $100 - $8000 per month ☐ $250 - $2500 per week.

Include Maternity? ☐ Yes ☐ No Waiting Period for New Employees: ☐ 3 Full Calendar Months ☐ 4 Full Calendar Months

Waiting Period is waived for present Full-time Employees: ☐ Yes ☐ No

Is this plan a takeover from another group's plan? ☐ Yes ☐ No If yes, please provide the prior carrier's certificate book or contract.

Employer Contribution (The Employer must pay at least 50% for each employee for employer-sponsored groups): _____%

☐ Contributory ☐ Non-Contributory

Please Provide Worker's Comp Name: _____

Financial Disclosure Statement

The undersigned Employer understands that by adopting one or more BEST Life 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 BEST Trust receives payments from the Employer and remits insurance premiums to the insurance carrier(s), and to affiliates of the BEST Trust providing services to Employers maintaining Welfare plans, and to the BEST Trust.

One of the entities providing services to your plan and to the BEST Trust is Beneficial Administration Company, an administrative service contractor only, and an affiliate of the BEST Trust. This company receives a portion of each premium dollar.

By signing this Trust Membership Application the Employer, if approved by the Trustee, becomes a Trustor 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.

Enrollment Participation Statement

I certify that I have read the Enrollment Guidelines, understand them, and have enrolled only eligible employees in accordance with the Participation Requirements. I have discussed coverages, eligibility, and pre-existing condition limitations 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.

Approval of enrollment and employee eligibility requirements (including Health Information when applicable) must be met before the insurance can be effective. Any in force coverage will not be cancelled until I receive written notification of such approval from BEST Life.

FRAUD WARNING: AS REQUIRED BY LAW, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH MAY BE CONSIDERED A CRIME.

I agree 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.

Company Officer-Signature _____ Title & Print Name _____ Date _____

Benefit Representative Report

(Please Print)

Name _____

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.

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

1. May we contact the client if we need additional information?
   ☐ Yes ☐ No
2. Is this your first case with BEST Health Plans? ☐ Yes ☐ No
3. This is: ☐ an existing client ☐ a new client with my company
4. The 'New Client Kit' (certificate book, claim forms, etc.) should be sent to:
   ☐ The benefit representative ☐ The client
5. The underwriter assigned to my case should contact me? ☐ Yes ☐ No

General Agent (GA):

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:

*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.

VARIABILITY STATEMENT

FORM NUMBER BL-STD-CERT-0109

FACE PAGE

- The company address is bracketed to allow for a physical move.
- Plan Effective Date is bracketed to allow for various effective dates for group.
- The names of the President and Secretary are bracketed to allow for a change in management.

CERTIFICATE SECTION

- The validation sticker may be removed throughout due to administrative system changes.

SHORT TERM DISABILITY PLAN SCHEDULE OF BENEFITS

- Reference to the Validation Sticker may be removed.
- Effective date will change depending upon date of enrollment.
- Waiting period will be 12, 18, or 24 months, depending on the plan chosen by the group.
- Weekly benefit is filed as a range or percentage and will vary depending on the plan chosen by the group.
- Other Features may or may not be included depending on the plan chosen by the group.

DEFINITIONS

- Maximum Period of Payment may be shown on the Validation Sticker or on the Schedule of Benefits, depending on the administration system that is used.

SHORT TERM DISABILITY

- Amount of Payment will be 40%, 50% 67 % or 70% of the weekly earnings, depending on what is chosen by the Employer.
- The maximum Weekly Benefit will be in a range between $250 and $2500 per week, depending on what is chosen by the Employer.
- Deductible Sources of Income – Is bracketed to allow for any statutory changes.
- Deductible Sources of Income – Net and Gross are bracketed. The Certificate will contain either or, depending on the plan chosen by the group.
- Non-Deductible Sources of Income – Is bracketed to allow for any statutory changes.
- Minimum Benefit - The minimum weekly payment will be between $10 and $50 per week, depending on the benefit chosen by the Employer.
- The pre-existing provision may or may not be included.

BEST OF UTAH

AGREEMENT AND

DECLARATION OF TRUST

FOR THE SERVICE INDUSTRY

THIS AGREEMENT AND DECLARATION OF TRUST is made and entered into this first day of August, 1982, by and between PENSION ADMINISTRATORS, INC., a California corporation, with its principal office being located in Newport Beach, California (hereinafter referred to as "Settlor") and DONALD R. LAWRENZ, SR., with his principal office located in Newport Beach, California (hereinafter referred to as the "Managing Trustor"), and FIRST INTERSTATE BANK OF UTAH, a Utah corporation, with its office being locatd in Salt Lake City, Utah (hereinafter referred to as "Trustee");

WHEREAS, the Employers subscribing hereto (hereinafter referred to as "Subscribing Employers") desire to implement, through the purchase of group insurance, certain welfare plans established by them for their respective eligible Employees and the dependents of such Employees; and

WHEREAS, Settlor desires to establish this Trust in order to provide a conduit for subscribing Employers to make from time to time the periodic Payments for insurance contracts by which the benefits under the welfare plans of the respective subscribing Employers will be provided; and

WHEREAS, the Trustee and Managing Trustor have agreed to accept this Trust upon all the terms and conditions hereinafter set forth;

NOW, THEREFORE, to carry this Trust into effect, and in consideration of the premises and of the mutual convenants herein contained, it is mutually agreed as follows:

ARTICLE I

The following definitions shall govern the interpretation of this Agreement and Declaration of Trust:

1. "Subscription Agreement" shall mean the agreement signed by an Employer whereby said employer agrees to be bound by all the terms and provisions of this Trust and whereunder said employer promises to make payment on behalf of its eligible Employees and their dependents for benefits, if applicable.

2. "Subscribing Employer" shall mean any Employer who has signed a Subscription Agreement and who has been accepted as an Employer by the Managing Trustor or his designee.

3. "Employee" shall mean a person employed by a Subscribing Employer and as defined in the contract or contracts of insurance owned by the Trustee.

4. "Insurer" shall mean BEST Life Assurance Company of California with its principal offices located at 4201 Birch Street, Newport Beach, California 92660; Commercial Bankers Life Insurance Company with its principal offices located at 1401 Dove Street, Newport Beach, California 92660; and any other insurance company or companies hereafter selected pursuant to the terms of this Trust. The Insurer shall not be deemed a party to this Trust and the obligations of the Insurer shall be determined solely by the terms and conditions of the policy or policies, and any additional agreements between the Trustee and the Insurer.

5. "Agreement and Declaration of Trust", "Trust" or "Agreement" shall mean this instrument, including any amendments thereto made in conformity with the terms hereof.

6. "Fund" shall mean:

(a) as to the Trustee, only such group insurance contracts issued hereunder, and such individual insurance policies, if any, as may be, with the consent of the Trustee, either owned or held by the Trustee. Trustee is not and shall not be deemed a fiduciary, co-fiduciary, or investment manager with respect to any res, asset, chose in action, contract right, or thing of value of any kind or nature whatsoever, whether tangible or intangible, other than or in addition to the items described in the immediately preceding sentence, and particularly with respect to the items described in subparagraph (b) hereunder, and

(b) as to the Managing Trustor, the sum of all funds and things of value held by the Managing Trustor, and shall include, but not be limited to, Payments from Subscribing Employers, interest, income, or any other return thereon, insurance policies together with any premium dividends, refunds, retrospective rate credits or other sums payable to the Trustee or Managing Trustor on account of such policies, and any other property of any kind received and held by the Managing Trustor for the use and purposes declared by this Trust.

7. "Trustee" shall mean the banking association originally designatd as Trustee in this Agreement and any person, persons, association or corporation hereafter selected pursuant to the terms of this Trust.

8. "Managing Trustor" shall mean the person originally designated as Managing Trustor in this Agreement and any person, persons, association or corporation hereafter selected pursuant to the terms of this Trust.

9. "Plan" shall mean any welfare program established by the BEST Employers Association, in order to provide Benefits for

eligible Employees of Employers and their dependents through contracts of insurance issued to the Trustee or to the individual employees or their dependents.

10. "Benefits" shall mean any and all Benefits provided for eligible Employees and their dependents exclusively through contracts of insurance issued to the Trustee.

11. "Payments" shall mean amounts remitted to the Managing Trustor by Subscribing Employers from the general assets of a Subscribing Employer and from contributions of eligible Employees, which are forwarded to the Managing Trustor by a Subscribing Employer for payment of premiums on insurance policies issued to the Trustee, plus amounts remitted to the Managing Trustor by a Subscribing Employer for the costs of establishing and administering this Trust.

ARTICLE II

ESTABLISHMENT OF TRUST

There is hereby established a trust to be hereinafter known and identified as the Beneficial Employees Security Trust of Utah. Although a single trust, such trust shall be comprised of two separate and distinct funds as described and defined in ARTICLE I subparagraph 6 hereof, and nothing herein shall be construed so as to impose upon the Trustee by inference, implication or otherwise any rights, powers, duties, responsibilities or obligations of any nature whatsoever with respect to any matter or matters except those directly relating to items as defined in subparagraph (a) of paragraph 6 of ARTICLE I hereof. The purpose of the trust shall be to provide a conduit for payment by a Subscribing Employer of premiums for insurance policies to fully fund Benefits for Subscribing Employers, their eligible Employees, and their dependents.

ARTICLE III

TRUSTEE

1. The Trustee shall execute this Agreement and Declaration of Trust and such execution shall constitute an acceptance of this Trust and the office of Trustee.

2. The Trustee shall continue to serve until death, incapacity, resignation or removal as herein provided:

(a) The Trustee may resign from this Trust by delivering a written notice of resignation to the Managing Trustor. The resignation shall be effective on the date specified in the notice, which shall be a date not less than ninety (90) days from the date of delivery of the notice of resignation, unless the Managing Trustor shall consent in writing to an earlier effective date.

(b) The Trustee may be removed at any time by the Managing Trustor. The Managing Trustor shall mail or deliver to the Trustee notice of his removal to be effective thirty (30) days from the giving of notice.

(c) Upon termination of the services of a Trustee for any reason whatsoever, the Trustee or his personal representative, to the extent held by the Trustee, shall transfer and deliver to the successor Trustee the Fund and all policies, books, checks, receipts, accounts and other records of any kind or character without exception relating to the Trust, and execute all instruments necessary to effect such transfer.

3. Whenever a Trustee shall die, become incapacitated, resign or be removed, a successor Trustee shall be selected by the Managing Trustor.

4. Such selection shall be evidenced by an instrument in writing and bear the written acceptance of the successor Trustee. One executed copy of such writing shall be appended to this Agreement and a copy of such writing shall be delivered to the Insurer. The Managing Trustor shall notify such other persons and institutions that may be directly affected by such succession. The successor Trustee shall serve in the place and stead of the previously selected Trustee, and so often as a new Trustee shall be so selected, the Fund and all the powers and authorities herein granted or given to the Trustee shall vest in the successor Trustee as fully and effectively as though it had been the original Trustee hereunder.

ARTICLE IV

DUTIES AND POWERS OF THE TRUSTEE

1. The Trustee shall discharge its duties with the standard of care established by law.

2. The Trustee shall have only such duties, powers and responsibilities as are specifically allocatd to it under this Agreement. No other or future duties, powers or responsibilities shall be implied.

3. The Trustee shall have the following duties, powers and responsibilities:

(a) The Trustee shall, as directed by the Managing Trustor, apply for policies of insurance from insurance companies licensed to conduct insurance business in the State of Utah or other states as required. The Trustee shall be the legal owner of all policies, unless prohibited by law.

(b) The Trustee, unless prohibited by law, shall hold in safekeeping the policies of group insurance issued pursuant to this Agreement.

(c) The Trustee shall receipt and hold on file any documents pertaining to the resignation, removal or appointment of a successor Managing Trustor.

(d) The Trustee shall file any tax returns and reports required of it by law on the basis of information and records furnished to Trustee by the Managing Trustor.

(e) The Trustee shall provide any bond required under law for the faithful performance of its duties.

(f) The Trustee may retain, consult with and rely upon the advice of legal counsel.

(g) The Trustee shall receive reasonable compensation from the Fund for its services as may be agreed upon from time to time by the Managing Trustor and Trustee. The Trustee shall be reimbursed by the Managing Trustor from the fund for all proper and necessary expenses reasonably incurred. To the extent not prohibited by law this shall be deemed to include but not be limited to: legal fees, costs, and legal damages suffered in connection with any action, suit or proceedings in which it may be involved by virtue of it being or having been a Trustee hereunder, except those final judgements where the Trustee is adjudged to have committed negligence or breached any fiduciary duty.

(h) The Trustee may do all things, execute all instruments and enter into all agreements and transactions as are reasonable, desirable or necessary to execute the specific powers set forth herein.

ARTICLE V

MANAGING TRUSTOR

1. The Managing Trustor shall execute this Agreement and Declaration of Trust and such execution shall constitute an acceptance of the office of Managing Trustor.

2. The Managing Trustor shall continue to serve until death, resignation, incapacity or removal as herein provided:

(a) The Managing Trustor may resign from this Trust by delivering a written notice of resignation to the Trustee and to the President of BEST Employers Association. The resignation shall be effective on the date specified in the notice, which shall be a date not less than ninety (90) days from the date of delivery of the notice of resignation, unless the President of BEST Employers Association shall consent in writing to an earlier effective date.

(b) The Managing Trustor may be removed at any time by the President of BEST Employers Association. The President of BEST Employers Association shall mail or deliver to the Managing

Trustor notice of his removal to be effective thirty (30) days from the giving of notice, and shall mail a copy to the Trustee.

(c) Upon termination of the services of a Managing Trustor for any reason whatsoever, the Managing Trustor or his personal representative, to the extent held by the Managing Trustor, shall transfer and deliver as directed by the President of BEST Employers Association to the successor Managing Trustor or the President of BEST Employers Association the Fund and all books, checks, receipts, accounts and other records of any kind or character without exception relating to the Trust, and execute all instruments necessary to effect such transfer.

3. Whenever a Managing Trustor shall die, become incapacitated, resign, or be removed, a successor Managing Trustor shall be selected by the President of BEST Employers Association, or if the President shall for any reason fail or refuse to name a successor Managing Trustor, the BEA Administrative Committee shall select a successor Managing Trustor.

4. Such selection shall be evidenced by an instrument in writing and bear the written acceptance of the successor Managing Trustor. One executed copy of such writing shall be appended to this Agreement and a copy of such writing shall be deliverd to the Insurer, the Trustee, and to the President of BEST Employers Association. The successor Managing Trustor shall notify such other persons and institutions that may be directly affectd by such succession. The successor Managing Trustor shall serve in the place and stead of the previously acting Managing Trustor and so often as a new Managing Trustor shall be so selected all the powers and authority herein granted or given to the Managing Trustor, shall vest in the successor Managing Trustor as fully and effectively as though he had been the original Managing Trustor hereunder.

ARTICLE VI

DUTIES AND POWERS OF THE MANAGING TRUSTOR

1. The Managing Trustor shall discharge his duties with the standard of care established by law.

2. The Managing Trustor shall have only such duties, powers and responsibilities as are specifically allocated to him under this Agreement. No other or further duties, powers or responsibilities shall be implied.

3. The Managing Trustor shall have the following duties and responsibilities:

(a) The Managing Trustor shall arrange for the issuance of policies of insurance to provide Benefits. The Managing Trustor shall direct the Trustee as to the exercise of all rights and privileges granted to the Trustee as policyholder

and may agree with the Insurer on any alterations, modifications or amendments of such policies, all as the Managing Trustor, in his sole discretion may deem necessary or desirable.

(b) The Managing Trustor shall collect and pay premiums for all policies issued pursuant to this Trust.

(c) The Managing Trustor shall keep the policies in force by paying from the Fund to the extent that the Fund is sufficient, the premiums required under the policies and shall direct that all reports required by Insurer are furnished.

(d) The Managing Trustor shall receive Payments from each Subscribing Employer.

4. The Managing Trustor, in order to carry out the purposes of this Trust and to discharge his obligations as Managing Trustor hereunder, shall have the following powers:

(a) To receive, hold and administer Payments from Subscribing Employers which are due and payable to the Fund; to pay or provide for payment of all reasonable and necessary expenses of administering the affairs of the Fund, including but without limitation, the employment of or contracting with administrative, legal, accounting, expert and clerical personnel; the designation and use of a depository bank; the lease of premises; and the purchase of materials, supplies and equipment; all as the Managing Trustor in his sole discretion, may find necessary or appropriate to the performance of his duties and the sound and efficient administration of the Fund.

(b) To prepare and file any tax returns or reports required of the Trustee or Managing Trustor, including but not limited to the annual report of the Plans required by the Employee Retirement Income Security Act of 1974.

(c) To pay out of the Fund such sums as may be necessary for the continuance of the Trust, including costs incurred in establishing the Trust and applicable taxes imposed upon the Fund; to pay out of the fund premiums on any liability policy purchased by Managing Trustor; and to contest the validity of any tax, levy, assessment, claim or demand which may be levied or made against the Fund.

(d) To establish and accumulate such reserve funds as the Managing Trustor may deem necessary or desirable for the proper and safe administration of the Fund, and to invest and reinvest said reserves or a portion thereof in savings accounts, or in obligations of the United States Government, or in securities which are recognized under law for the investment of the Fund.

(e) To refund to Subscribing Employers such portions of Payments as are found to be in excess of amounts due from them.

(f) To originate and maintain any and all actions or legal proceedings which may be deemed necessary for the protection of the Fund or the Trustee or Managing Trustor; to compromise, settle or release claims on behalf of or against the Fund or the Trustee or Managing Trustor on such terms as the Managing Trustor, in his sole discretion, may deem advisable or desirable; to construe the provisions hereof, and any such construction adopted in good faith by the Managing Trustor shall be binding upon all of the parties hereto.

(g) To delegate such of his powers and duties as may in the opinion of the Managing Trustor be desirable.

(h) To provide for the administration of this Trust in whole or in part, jointly with, or in cooperation with, other Trusts established for similar purposes in order to reduce the expense of administration.

(i) To keep true and accurate books and accounts and records of all transactions.

(j) To apply any dividend resulting from experience rating of the policies hereunder to a reserve to be used only for reduction of future premiums due from all Subscribing Employers. The Insurer shall accept the direction of the Managing Trustor regarding the aforesaid application and shall have no responsibility in this regard.

(k) To accumulate Trust Fund surpluses from, but not limited to, investment income, interest, and premium dividends and refunds, and to use such funds pursuant to ERISA Section 404(a)(1) for the benefit of beneficiaries of the Fund.

(l) To purchase a liability policy or policies covering the Managing Trustor for his services hereunder.

(m) To establish from time to time rules for eligibility and termination of Subscribing Employers.

(n) To terminate a Subscribing Employer's participation in the Trust if it is deemed by the Managing Trustor, or the President of BEST Employers Association, that a Subscribing Employer's continued participation in the Trust is detrimental to other Subscribing Employers and/or the financial stability of the Trust Fund; or, if it is determined that any information furnished to the Trust, or the Insurer, by a Subscribing Employer is false or misleading and such misinformation has affected the rate charged said Subscribing Employer for benefits provided to him or his employees by the Trust.

5. The Managing Trustor shall provide any bond required under law for the faithful performance of his duties.

6. The Managing Trustor shall receive reasonable compensation for his services. To the extent not prohibited by law this

shall be deemed to include but not be limited to: legal fees, costs, expenses and legal damages suffered in connection with any action, suit or proceedings in which he may be involved by virtue of his being or having been a Managing Trustor hereunder, except those final judgements where the Managing Trustor is adjudged to have committed negligence or breached any fiduciary duty.

7. The Managing Trustor may do all things, execute all instruments and enter into all agreements and transactions as are reasonable, desirable or necessary to execute the specific powers set forth herein and to facilitate the foregoing duties, powers and responsibilities.

ARTICLE VII

EMPLOYER PAYMENTS

1. To provide Benefits for its eligible Employees and their dependents, each Subscribing Employer shall pay to the Fund such Payments as are from time to time billed to them by the Managing Trustor.

2. The failure of a Subscribing Employer to make Payments as are requested by the Managing Trustor shall constitute a violation of that Subscribing Employer's obligation thereunder. The failure of a Subscribing Employer to make Payments shall not relieve any other Subscribing Employer of its obligation to make Payments and no Subscribing Employer shall be liable for the failure of any other Subscribing Employer to make its Payments. The Managing Trustor shall have no duty on behalf of any eligible Employee or his dependents to enforce the Payments required of a Subscribing Employer. No fiduciary of this Trust shall be liable for an act or omission of a Subscribing Employer to carry out its responsibility for making its Payments.

3. From time to time the Managing Trustor and/or the President of BEST Employers Association shall establish standards for payment and delinquencies. These standards may include but are not limited to penalties for late payments and suspension and/or cancellation of coverage.

4. All Subscribing Employers shall make such reports and statements to the Managing Trustor with respect to the amount and calculation of any and all Payments, or with respect to any other matter pertinent to the establishment, maintenance and administration of the Fund, as the Managing Trustor may deem necessary and desirable. The Managing Trustor may, at reasonable times and during normal business hours, cause an audit or examination by a Certified Public Accountant or other agent of the Managing Trustor, of the books and records of a Subscribing Employer which may be pertinent in connection with said Payments and reports and insofar as same may be necessary to accomplish the purpose of this Agreement.

5. Payments to the Fund shall not constitute or be deemed to be wages. No Subscribing Employer, Trustee, Managing Trustor, Employee, or any beneficiary, nor any other person, shall have any right, title or interest in the Fund other than as specifically provided in this Trust; and no part of the Fund shall revert to the Subscribing Employers, the Trustee, Managing Trustor, any Employee or any other person. Neither an Employee, nor his beneficiary shall have the option to receive any part of the Payments to the Fund in lieu of Benefits. Neither the Fund nor any Payments to the Fund shall in any manner be liable for or subject to the debts, contracts or liabilities of the Subscribing Employers, the Trustee, Managing Trustor, or any Employee.

ARTICLE VIII

AMENDMENT, TERMINATION AND MERGER OF THE TRUST

1. The Trust may be amended by the Managing Trustor. No amendment affecting the rights, powers, or duties of the Trustee shall be effective unless and until it has been approved in writing by the Trustee. The Managing Trustor and Trustee shall execute any instrument necessary in connection therewith. The Managing Trustor shall forthwith notify the insurer and the participating current Subscribing Employers of any executed amendment.

2. This Trust shall terminate concurrently with the termination of all group policies held by the Trustee. In the event of termination, the Managing Trustor shall notify each Subscribing Employer and the Trustee. Subject to the payment of expenses for termination, the Trustee, upon direction of the Managing Trustor, shall transfer any individual policy held by the Trustee to the individual insured unless otherwise provided by law. Any balance remaining in the Fund shall be expended by the Managing Trustor for the benefit of the beneficiaries of this Trust as provided in this Agreement.

3. The parties hereto recognize that at some time or times in the future it may be in the best interest of the Fund that the Fund be merged, consolidated or joined with other trust funds, or that the Fund accept funds from other trust funds in connection with a joinder or consolidation, or inclusion in this Fund of new employers. The Managing Trustor shall have full power to investigate, evaluate and negotiate any such merger, consolidation, joinder, or similar inclusion, and to prepare and enter into agreements to consummate same.

ARTICLE IX

GENERAL PROVISIONS

1. No party dealing with the Trustee or Managing Trustor shall be obligated to see that the application of any funds or property of the Fund is proper, or to see that the terms of the Trust have been complied with or to inquire into the necessity or

(b) The BEA Administrative Committee shall serve in an advisory capacity to the Managing Trustor. Upon incapacity or resignation of the Managing Trustor, if the President of BEST Employers Association fails to appoint a successor Managing Trustor, the Administrative Committee shall select a successor Trustor by consent of a majority of its members. Upon resignation of a Managing Trustor in the absence of any action by the President of BEST Employers Association, the Administrative Committee may agree on behalf of the Trust by unanimous consent of its members to a settlement of the account of the Managing Trustor. Vacancies shall be disregarded in determining the number of members which may consent.

(c) BEA Administrative Committee shall not be liable or responsible for:

(i) Any debts, liabilities or obligations of the Trust or the Managing Trustor; or

(ii) The acts or omissions of any fiduciary (except as specifically undertaken by agreement of indemnity), or other person rendering services to the Trust Fund.

ARTICLE X

APPOINTMENT OF ADMINISTRATIVE SERVICES CONTRACTOR

1. Upon the execution of this Trust, the Managing Trustor hereby designates Beneficial Administration Company, a California corporation (hereinafter BAC), as Administrative Services Contractor, and Pension Administrators, Inc., a California corporation (hereinafter PA), as Marketing Contractor to perform such of the duties and responsibilities imposed hereunder upon the Managing Trustor for the administration and marketing of this Trust as may be mutually agreed upon by BAC, PA and the Managing Trustor pursuant to separate administrative services and marketing agreements. The Administrative Services Contractor and Marketing Contractor shall be entitled to receive a fee for their services as set forth in the administrative services and marketing agreements, and such fees shall be charged against the Fund.

2. The Administrative Services Contractor and Marketing Contractor may be removed at any time by the Managing Trustor upon giving ninety (90) days written notice to the Administrative Services Contractor or Marketing Contractor. The Administrative Services Contractor or Marketing Contractor may resign at any time upon giving ninety (90) days written notice to the Managing Trustor.

3. In the event of the resignation or removal of the Administrative Services Contractor or Marketing Contractor, the Managing Trustor may appoint a successor Administrative Services Contractor or Marketing Contractor to serve in their place.

IN WITNESS WHEREOF, this Trust has been executed as of the day and year first above written by the Managing Trustor, the Settlor by its president thereunto duly authorized, and by the Trustee by its respective officers thereunto duly authorized.

ATTEST:

PENSION ADMINISTRATORS, INC.

By: Donald R. Lawrenz, Sr.
President

ATTEST:

FIRST INTERSTATE BANK OF UTAH, N.A.

By: Edward G. Richards
Vice President and Trust Officer

ATTEST:

By: Donald R. Lawrenz, Sr.
Managing Trustor

AMENDMENT NO. 1

TO

BEST OF UTAH

AGREEMENT AND

DECLARATION OF TRUST

FOR THE SERVICE INDUSTRY

WHEREAS, there has heretofore been entered into an Agreement and Declaration of Trust, effective August 1, 1982, between PENSION ADMINISTRATORS, INC., a California Corporation, Settlor, and Donald R. Lawrenz, Sr., Managing Trustor, and FIRST INTERSTATE BANK OF UTAH, a Utah Corporation, Trustee; and

WHEREAS, ARTICLE VI, DUTIES AND POWERS OF THE MANAGING TRUSTOR, Paragraph 7., provides as follows:

> "7. The Managing Trustor may do all things, execute all instruments and enter into all agreements and transactions as are reasonable, desirable or necessary to execute the specific powers set forth herein and to facilitate the foregoing duties, powers and responsibilites."

WHEREAS, ARTICLE VIII, AMENDMENT, TERMINATION, AND MERGER OF THE TRUSTS, Paragraph 1. and Paragraph 3. provide as follows:

> "1. The Trust may be amended by Managing Trustor. No amendment affecting the rights, powers, or duties of the Trustee shall be effective unless and until it has been approved in writing by the Trustee. The Managing Trustor and Trustee shall execute any instrument necessary in connection therewith. The Managing Trustor shall forthwith notify the insurer and the participating current Subscribing Employers of any executed amendment."

> "3. The parties hereto recognize that at some time or times in the future it may be in the best interest of the Fund that the Fund be merged, consolidated or joined with other trust funds, or that the Fund accept funds from other trust funds in connection with a joinder or consolidation, or inclusion in this Fund of new

employers. The Managing Trustor shall have full power to investigate, evaluate and negotiate any such merger, consolidation, joinder, or similar inclusion, and to prepare and enter into agreements to consummate same."

NOW THEREFORE this Trust is hereby amended to delete "FOR THE SERVICE INDUSTRY" from the title of said trust and shall be merged, consolidated, and joined to form one Trust with the BEST OF UTAH.

Executed this 31 day of July, 1987, at Newport Beach, California.

Donald R. Lawrenz

DONALD R. LAWRENZ, SR.
MANAGING TRUSTOR

390/UT/S/7.87

Since 1970

Paula Knox

DATE: April 11, 2000

TO: Steve Course
David F. Friedly
Stan Hassan
Alan Koransky
Laurie Lee
Gary Lee Miller
John Vanderschraaf
Jim Voegtlin

FROM: Donald R. Lawrenz

After many years of service and because of my continuing heavy workload I have decided to resign as Managing Trustor of the Beneficial Employees Security Trusts of California and Utah. My resignation will be effective May 5, 2000.

Best Employers Association has met and convened and has elected a successor Managing Trustor, Laurie Lee.

Laurie has agreed to serve in this position effective May 5, 2000. Please adjust your records to indicate Laurie as the new Managing Trustor of the California and Utah Trusts.

In the future, all amendments, expenses, documents, new Trust issues et al will be directed to Laurie Lee for her signature.

Please join me in congratulating Laurie Lee on her new position.

Donald R. Lawrenz
Managing Trustor

P.O. Box 3100 • Newport Beach, California 92658-9027
(949) 756-1000 • (800) 854-7417 • FAX (949) 553-0883

AMENDMENT TO THE
BEST OF UTAH AGREEMENT AND DECLARATION OF TRUST

A. For purposes of this Amendment, Successor Managing Trustor:

Pursuant to the terms, conditions and mutual covenants of the BEST OF UTAH AGREEMENT AND DECLARATION OF TRUST, and the requirement to name a successor Managing Trustor in the event of the death, incapacitation, resignation or removal of the Managing Trustor, DONALD R. LAWRENZ, JR., has been named as the successor Managing Trustor, effective September 8, 1996

B. For purposes of this Amendment, the following words and phrases shall have the meanings as shown below:

1. PENSION ADMINISTRATORS, INC., a California corporation, with its principal office being located in Irvine, California (hereinafter referred to as "Settlor");

2. DONALD R. LAWRENZ, JR., with his principal office located in Irvine, California (hereinafter referred to as the "Managing Trustor"); and

3. WELLS FARGO BANK, with its office being located in Salt Lake City, Utah (hereinafter referred to as "Trustee")

Any other words or phrases that are used and not defined in this Amendment shall have the meanings ascribed to them in the Original BEST OF UTAH AGREEMENT AND DECLARATION OF TRUST.

The signature of the Managing Trustor below is evidence of the notice and acceptance of his selection as successor Managing Trustor.

ATTEST:

PENSION ADMINISTRATORS, INC.

By: _____
Donald R. Lawrenz, Jr.
President

ATTEST:

WELLS FARGO BANK, N.A.

By: _____
Vice President and Trust Officer

ATTEST:

By: _____
Donald R. Lawrenz, Jr.
Managing Trustor

GLM/1997/Ce