Underwritten by 5Star Life Insurance Company (a Baton Rouge, Louisiana Company)
Offered through Armed Forces Benefit Association (AFBA) • 1-800-776-2322 • www.afba.com

Ins Prod Number:

2nd Prod Split:

Prod Level:

Source Code: (TPA Code)

INTERNAL USE ONLY:

Pymt Enclosed: Yes No Split

Amt:

CC/Checkmatic Auth Rec'd: Yes No

Attachments: Initials:

[5Star Group Level Term Emergency Service Personnel and Government Enrollment Form]

ESP 410 1

USE BLACK OR BLUE INK AND PRINT USING ALL UPPER CASE LETTERS.

Sponsor Information

Rank Grade Prefix

Last Name

First Name M.I. D.O.B.

SSN Height FT IN Weight LBS

Male Female

Non-Tobacco* Tobacco User*

Federal Employee Non-Federal Emp

Department Code:

Choose One: Fire Department Law Enforcement Emergency Med Tech Non ESP Government

Address Line 1

Address Line 2

City State Zip

E-Mail

Phone Number

* Tobacco user is one who has used any tobacco product in the past 12 months.

Spouse Information

Last Name

Male Female

First Name M.I. D.O.B.

Non-Tobacco* Tobacco User*

SSN Height FT IN Weight LBS

Coverage and Contributions

Contribution Mode:
(Please choose only one.)

- Payroll Deduct* 1
- Monthly Credit Card 1
- Monthly Checkmatic 2
- Quarterly Bill 3
- Semi-Annual Bill 6
- Annual Bill 12
- List Bill** (Employer Tax ID required)

** Limited availability

Sponsor's Coverage $

Spouse's Coverage $

Children's Coverage: Yes No

Children's Units
(may not exceed 5)

Employer Tax ID:
(List Bill Only)

Sponsor's Monthly Contribution $

Spouse's Monthly Contribution $

Children's Monthly Contribution $

Total Monthly Contribution $

Contribution Mode

Total Amount Due $

Over

Beneficiary(ies)

As applicant, I designate beneficiary(ies) to receive benefits as indicated below. Spouse and children's beneficiary is the applicant unless otherwise designated.

Beneficiary of:

	First Name	Last Name	SSN	Relationship	DOB
Applicant					
Spouse					

Other Insurance

Answer only if this is an agent or broker initiated sale:

Do you, your spouse, or children have an existing individual life insurance or annuity contract with another company? ○ Yes ○ No

If yes, and you live in AK, AL, AR, AZ, CO, IA, KS, KY, LA, MD, ME, MS, MT, NC, NE, NH, NJ, NM, OH, OR, RI, SC, TX, UT, VA, VT, WI or WV please complete and sign the Notice: Replacement of Life Insurance and Annuity. The Notice must be ***presented*** and ***read*** to you by your agent at the time he/she takes your application.

If approved, will this coverage replace your existing life insurance or annuity contract? ○ Yes ○ No If yes, what is the company name for your existing coverage? _____. If you do not live in the above listed states, please complete and sign the applicable state-specific Notice: Replacement of Life Insurance and Annuity.

Statement of Health

Answer each question and initial below to acknowledge you've read and, TO THE BEST OF YOUR KNOWLEDGE AND BELIEF, understood each question. Circle the specific condition and give full details to any "yes" answers on a separate 8 1/2 x 11 piece of paper.

	Applicant		Spouse		Children*	
	Yes	No	Yes	No	Yes	No
I. In the last 10 years, has any Applicant under this application for coverage:						
A. Had a life or health insurance application declined, postponed, modified, or rated?	○	○	○	○	○	○
B. Been diagnosed or treated by a physician for the listed conditions: High blood pressure, high cholesterol, cardiac chest pain, heart attack, vascular disease (plaque in arteries), or any heart or blood vessel disorder; cancer or blood disorder; stroke, seizures, progressive neuropathy, or any nervous system disease; shortness of breath, asthma, chronic obstructive pulmonary disease (COPD), or any respiratory tract disorder; ulcers, hepatitis, colitis, disorder of the pancreas, liver, esophagus, stomach, or intestines; depression, schizophrenia, or any mental condition; diabetes, thyroid, pituitary, adrenal, or hormone disorder; disorder of the kidney, bladder, urinary tract, genital tract, or reproductive system; or any significant medical disorders?	○	○	○	○	○	○
II. In the past 5 years, has any Applicant:						
A. Been treated by a physician or medical facility or received professional counseling for alcohol or drug dependency or been advised to reduce or discontinue the use of alcohol?	○	○	○	○	○	○
B. Been convicted for driving under the influence of alcohol or drugs or while intoxicated?	○	○	○	○	○	○
C. Used amphetamines, cocaine, heroin, hallucinogens, barbiturates, marijuana, narcotics or any drug except as medication prescribed by a physician?	○	○	○	○	○	○
III. Has any Applicant ever been diagnosed or treated by a physician or tested positive for Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)?	○	○	○	○	○	○

IV. List each prescribed medication taken regularly or frequently by any Applicant:

*** Number of Children** ___ If you answer "yes" to any of the above questions regarding a child(ren), please provide the child(ren)'s name, date of birth and the question # the answer refers to on a 8 1/2 x 11 piece of paper.

Initial Here

Conditions Relating to this Enrollment Form

Group Eligibility: I am eligible to apply for this group level term life insurance coverage as a Member as defined in the Master Group Policy and described in the Certificate of insurance coverage. **Agreement: In the absence of my spouse, I, as sponsor, have the appropriate knowledge to answer the questions for my spouse and children.** I represent that all statements and answers in this enrollment form are complete, true and correctly recorded **TO THE BEST OF MY KNOWLEDGE AND BELIEF**. I agree that 1) upon approval of this enrollment form by 5Star Life Insurance Company, it and the Certificate of insurance coverage issued to me will describe the benefits and terms of coverage provided under the Master Group Policy; 2) **coverage applied for will not become effective until approved by 5Star Life Insurance Company and is subject to each covered person's health being as described in this enrollment form, and upon receipt of the full first contribution, in which case the coverage shall take effect as of the effective date as shown in the Certificate of insurance coverage;** 3) if within 60 days of receipt of all required documentation this enrollment form is not approved, it will become void and any contributions paid will be refunded; I will be so notified. **Authorization:** I hereby authorize any licensed physician; medical practitioner; hospital; clinic; insurance company; employer; Medical Information Bureau, Inc. (MIB, Inc.)); or Motor Vehicle Administration that may have records of my physical or mental health condition to give 5Star Life Insurance Company, its authorized representative, and its reinsurers any such information. I authorize 5Star Life Insurance Company, or its reinsurers, to make a brief report of health information to MIB, Inc.. I understand that this information will be used to determine my eligibility for coverage and that I may revoke this authorization and enrollment form at any time by providing written notice. A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for 24 months from the date below. I acknowledge that I, or my authorized representative, is entitled to receive a copy of this authorization. **Signature must be personal.**

NOTE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and confinement to prison.

Sponsor's Signature _____ Date _____

Sign Here

Spouse's Signature _____ Date _____

Signed at (City, State) _____

Insurance Producer Certification: I certify that I asked all the questions and had the Sponsor sign in my presence.

Is Sponsor or Spouse replacing existing coverage? ○ Yes ○ No

Ins Prod Name _____ Paramed Ordered? ○ Yes ○ No

Ins Prod Signature _____ Date _____