Underwritten by 5Star Life Insurance Company (a Baton Rouge, Louisiana Company)
Admin Offices: 777 Research Dr., Lincoln, NE 68521 • 1-866-863-9753

Agent use only—Agent#

Select only one product per app:
○ FPP-CI ○ FPP-TI

INTERNAL USE ONLY:

Attachments: Initials:

5Star Family Protection Plan
Term Life Insurance to Age 100
Application

FPP 409 1

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

Employer Information

Employer

Employee Information

Last Name

First Name M.I. D.O.B. (Month / Day / Year) ○ Male ○ Female

SSN Coverage Amount $ Premium Amount $

Mailing Address:

Street Line 1

Street Line 2

City State Zip

Email

Daytime Phone Owner is ○ Self ○ Other _____

Spouse Information

Owner is ○ Self ○ Other _____

Last Name

First Name M.I. D.O.B. (Month / Day / Year) ○ Male ○ Female

SSN Coverage Amount $ Premium Amount $

Children's Information (ages 0-23) — (The Owner of this policy is the Employee.)*

Child 1:

Last Name

First Name M.I. D.O.B. (Month / Day / Year) ○ Male ○ Female

SSN Coverage Amount $ Premium Amount $

Child 2:

Last Name

First Name M.I. D.O.B. (Month / Day / Year) ○ Male ○ Female

SSN Coverage Amount $ Premium Amount $

* If you are applying for coverage on more than two children, please complete the "Additional Children's Information" section on the back.

Additional Children's Information

FPP 2 409

Child 3:

Name (First, MI, Last) | DOB | SSN | Sex | Coverage Amount | Premium Amount

Child 4:

Name (First, MI, Last) | DOB | SSN | Sex | Coverage Amount | Premium Amount

Other Insurance

Do you, your spouse, or children have any existing life insurance or annuity contracts? ◯ Yes ◯ No

If yes, and you live in AK, AL, AZ, CO, HI, IA, KY, LA, MD, ME, MS, MT, NH, NJ, NM, NC, OH, OR, RI, TX, UT, VA, VT 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.

Will the coverage applied for replace any existing life insurance or annuities? ◯ Yes ◯ No

If yes, and you do not live in the above listed states, please complete and sign the applicable state-specific Notice: Replacement of Life Insurance and Annuity.

Beneficiary(ies)

I designate my beneficiary(ies) to receive benefits as indicated below. Check here ❒ if you would like an additional beneficiary form sent to you.

Beneficiary Of Employee Coverage _____
Last Name | First Name | MI | Relationship | DOB | SSN

Beneficiary Of Spouse Coverage _____
Last Name | First Name | MI | Relationship | DOB | SSN

Note: Beneficiary for Child coverage will be designated as the Employee unless otherwise noted on a separate 8.5x11 sheet of paper submitted with this application.

Statement of Health

Please answer each question and circle the specific condition.

	Employee		Spouse		Child 1		Child 2		Child 3		Child 4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
I. Has any Applicant been hospitalized in the past 90 days?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
II. In the past 10 years, has any Applicant had or been hospitalized for, been medically diagnosed, treated, or taken prescription medication for:												
A. Angina, heart attack, stroke, heart bypass surgery, angioplasty, coronary artery stenting, or coronary artery disease?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
B. Any form of cancer to include leukemia or Hodgkin's Disease (excluding non-invasive, non-melanoma skin cancer)?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
C. Chronic obstructive pulmonary disease (COPD), emphysema, or any other chronic respiratory disorder, excluding asthma?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
D. Alcoholism or drug or alcohol abuse, cirrhosis, hepatitis, or any other disease of the liver?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
III. Has any Applicant been diagnosed or treated by a physician, or tested positive for: Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
IV. Has any Applicant ever applied for and been rejected for life insurance?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Conditions Relating to this Application

Agreement: I, as employee, have the appropriate knowledge to answer the questions for my spouse and children. I represent that all statements and answers in this application are complete, true and correctly recorded **TO THE BEST OF MY KNOWLEDGE AND BELIEF**. I agree that: 1) upon approval of this application by 5Star Life Insurance Company, it, the policy and any riders or endorsements will constitute the entire insurance contract; 2) insurance applied for will not become effective until approved by 5Star Life Insurance Company and is subject to the health relating to each person to be insured being as described in this application, and upon receipt of the full first premium, in which case the coverage shall take effect as of the effective date as shown in the policy; 3) if within 60 days of receipt of all required documentation this application is not approved, it will become void and all premiums paid will be refunded; I will be so notified. **Authorization:** I hereby authorize any licensed physician; medical practitioner; hospital; clinic; insurance company; employer; financial institution; Medical Information Bureau; or Motor Vehicle Administration that may have records of my financial, physical or mental health condition to give 5Star Life Insurance Company, its authorized representative, and its reinsurers any such information. I understand that this information will be used to determine my eligibility for insurance and that I may revoke this authorization and application 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. As employee, my signature authorizes payroll deduction of premiums from my employer for myself and my family members. **I acknowledge that I have received and read the Accelerated Benefit Disclosure form. Signatures must be personal:**

Sign Here

Employee _____ Date _____

Owner _____ SSN _____
(If different than Employee.)

Signed At (City, State) _____

Agent Certification: I certify that I asked all the questions and had the Applicant sign in my presence. To my knowledge, the Applicant has existing life insurance or annuity coverage. ◯ Yes ◯ No

If yes, are they replacing existing coverage? ◯ Yes ◯ No

Agent Name _____

Agent Signature _____ Date _____

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.