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

5STAR LIFE INSURANCE COMPANY

Agent use only—Agent# ☐☐☐☐☐☐☐☐☐☐
Select only one product per app: FPP-CI ☐ FPP-TI ☒

Insurance Representative Assisted: ☒ Self Completed: ☐

Section 1 - Employer Information

Employer/Group Name: Test Case Group Number: GRP-NUM-EX123

Section 2 - Employee

Coverage Amount	Premium
$ 50,000	$ 33.25

Employee/Owner: Joe Smith SSN: 111-22-3333 Gender: ☐M ☐F

Birth Date: 1980-01-31 Are you actively at work?* ☐Y ☒N Date of Hire: None

☐Weekly ☐Bi-Weekly ☐Semi Monthly ☒Monthly

Mailing Address: 123 Sesame

City: Chicago State: IL Zip Code: 45555

Email Address: None @

Riders to be added
☐ Disability Waiver of Premium (WP)
☐ Auto Increase Rider (AIR)
☐ Chronic Illness Rider (CHR) (FPP-TI only)
☐ Other:

* "Actively at Work" means that you are an eligible employee/member of the employer/affiliation through which you are applying for this individual insurance; you are able to work and to perform the normal activities of a person of like age and gender; and you are not confined in a hospital, at home or elsewhere due to injury or sickness on the date you signed this application.

Beneficiary

Primary: None Relationship: None Age: ____ Birth Date: None SSN: None - ____ - ____

Contingent: ____ Relationship: ____ Age: ____ Birth Date: ___/___/___ SSN: ___ - ___ - ____

Section 3 - Spouse

Coverage Amount	Premium
$ NONE	$

The employee will be the owner unless otherwise stated.

Spouse's Name: ____ SSN: ___ - ___ - ____

Gender: ☐M ☐F Birth Date: ___/___/___

During the prior 6 months, other than for routine medical care, has your spouse been diagnosed or treated by a member of the medical profession in a hospital or any other medical facility? ☐Y ☐N
(If yes, complete the questions in Section 6)

Has your spouse been disabled** in the prior 6 months or received disability payments? ☐Y ☐N

Riders to be added
☐ Disability Waiver of Premium (WP)
☐ Auto Increase Rider (AIR)
☐ Chronic Illness Rider (CHR) (FPP-TI only)
☐ Other:

Mailing Address: ____

City: ____ State: ____ Zip Code: ____

Email Address: ____ @ ____

** "Disabled" means that a person is unable to work, to attend school, or to perform the normal activities of a person of like age and gender or that a person is confined in a hospital, at home or elsewhere due to injury or sickness.

Beneficiary

Primary: ____ Relationship: ____ Age: ____ Birth Date: ___/___/___ SSN: ___ - ___ - ____

Contingent: ____ Relationship: ____ Age: ____ Birth Date: ___/___/___ SSN: ___ - ___ - ____

Section 4 - Children's Information (ages 14 days - 23 years)

Coverage Amount	Premium
$	$

The employee will be the owner and the beneficiary unless otherwise stated.

Child 1

Name (First, MI, Last): ____

SSN: ___ - ___ - ____ Gender: ☐M ☐F Birth Date: ___/___/___

Child 2 (Additional Children can be shown on a separate sheet of 8.5" x 11" paper.)

Name (First, MI, Last): ____

	$	$

SSN: ___ - ___ - ____ Gender: ☐M ☐F Birth Date: ___/___/___

Total Employee Premium	$ 33.25	**Total Premium**
Total Spouse Premium	$	
Total Children Premium	$	$ 33.25

Underwritten by 5Star Life Insurance Company (a Baton Rouge, Louisiana Company)
Not available in all states • Admin Office: 777 Research Dr., Lincoln, NE 68521 • 1-866-863-9753

Section 5 - Other Insurance

Do you, your spouse, or children have any existing life insurance or annuity contracts? ☐ Y ☒ N
Will the coverage applied for replace any existing life insurance or annuities? ☐ Y ☒ N

If you answered "yes" to either question please complete and sign the Notice of Replacement.

Section 6 - Statement of Health

Please answer the following Statement of Health for all coverage:	**Employee**	**Spouse**	**Child 1**	**Child 2**
I. Has any Applicant been diagnosed or treated by a member of the medical profession, or tested positive for: Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)?	☐Yes ☒No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Complete ONLY if applying for Simplified Issue amounts:				
II. Has any Applicant ever applied for and been rejected for life insurance?	☐Yes ☒No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
III. Has any Applicant been hospitalized in the past 90 days?	☐Yes ☒No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
IV. In the past 5 years, has any Applicant been hospitalized for, been diagnosed or treated by a member of the medical profession or taken prescription medication for:				
A. Angina, heart attack, stroke, heart bypass surgery, angioplasty, coronary artery stenting, or coronary artery disease?	☐Yes ☒No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
B. Any form of cancer to include leukemia or Hodgkin's Disease (excluding non-invasive, non-melanoma skin cancer)?	☐Yes ☒No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
C. Chronic obstructive pulmonary disease (COPD), emphysema, or any other chronic respiratory disorder, excluding asthma?	☐Yes ☒No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
D. Alcoholism or drug or alcohol abuse, cirrhosis, hepatitis, or any other disease of the liver?	☐Yes ☒No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Section 7 - Conditions Relating to this Application

Representations

I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the applied for insurance . I understand that 5Star Life Insurance Company (5Star Life) will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured(s). 5Star Life may rescind the policy in accordance with the Contestability provision of the Policy due to any material misrepresentation of fact made in this application. Insurance is effective under the policy only when it is delivered to the owner, and then only if the full first premium is paid and all of the statements in this application remain correct and complete.

Authorization

I authorize 5Star Life to collect medical information or investigation reports about proposed insureds named in this application. I authorize those with such information or reports to release them to 5Star Life. I give 5Star Life permission to send such information or reports to MIB, Inc. ("MIB"), reinsurers, the Insurance Representative who solicited the application, and any third parties who administer the policies issued by 5Star Life. I authorize 5Star Life, or its reinsurers, to make a brief report of health information to MIB. This authorization shall remain in effect for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, but in no event more than 30 months from the date I sign below.

Acknowledgments

I acknowledge that I have received or will receive (in the case of solicitation by direct response methods) the Accelerated Benefit Disclosure form(s).

Note: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Sign Here

Employee (Policy Owner): _____ Date : ___/___/___

Signed at City: Chicago State: IL

I certify I have authorized my employer to make payroll deduction of premiums for myself and my family members. Signed: _____

Insurance Representative Certification (when Insurance Representative assisted in completion of the application): I certify that I reviewed all questions on this application, and that the answers have been recorded accurately. I know of nothing affecting the insurability of the proposed insured(s) which is not fully recorded on this application.

To my knowledge, the Applicant has existing life insurance or annuity coverage. ☐ Yes ☒ No If yes, are they replacing existing coverage? ☒ Yes ☐ No

Insurance Representative Name: _____

Insurance Representative Signature: _____ Date : ___/___/___