Underwritten by 5Star Life Insurance Company (a Baton Rouge, Louisiana Company)
Administrative Office: 909 North Washington Street, Alexandria, VA 22314
1-800-776-2322 • www.afba.com

Agent Number: Split %
Split Agent: Split %

IP 912 1

INTERNAL USE ONLY:
Pymt Enclosed: Yes No Split
Amt:
CC/Checkmatic Auth Rec'd: Yes No
Attachments: Initials:

Individual Silver Premier Whole Life
Application

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

Plan Type: Preferred Graded Interview #:

Applicant's Information

Last Name Male Female
First Name MI TIN/ SSN
D.O.B. Place of Birth: State Country
Address Line 1
Address Line 2
City State Zip
E-Mail
Daytime Phone Cell Phone

Owner (If other than Applicant)

TIN/ SSN
Name:
Address:
City, State, Zip
Relationship to Applicant Phone No.

Payor

Applicant Policy Owner Other (Complete all info below)
TIN/ SSN
Name:
Address:
City, State, Zip
Phone No.

Coverage and Premium Amounts

Payment Mode:
(Please choose only one.)
- Monthly Credit Card
- Monthly Checkmatic
- Monthly Bill*
- Quarterly Bill
- Semi-Annual Bill
- Annual Bill

***Personal checks only**

Applicant's Coverage $

Applicant's Modal Premium $ + Modal Policy Fee $ = Amount payable to 5Star Life. $

Automatic Premium Loan

Automatic Loan Provision
Loan from your cash value if premium missed.

Amount paid with application $

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Beneficiary(ies)

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

	First Name	Last Name	Relationship	SSN (If available)	DOB	%
Primary						
Primary						
Secondary						

Statement of Health

Height ft in Weight lbs ○ Non-Tobacco ○ Tobacco User

Answer each question TO THE BEST OF YOUR KNOWLEDGE AND BELIEF.

	Yes	No
In the past 12 months, have you used any type of tobacco product or any product containing nicotine?	○	○

Section One

	Yes	No
1. Are you currently confined to a wheelchair, your home, a hospital, rehab or psychiatric facility, nursing home, long term care facility or correctional facility, or been advised in the past 5 years by a member of the medical profession to receive hospice care, or do you require use of a home hospital care agency or need assistance with two or more of the normal activities of daily living (for example: eating, bathing, dressing, taking medications, toileting, transference or moving about), or have you had an amputation due to disease?	○	○
2. Have you been diagnosed by a member of the medical profession with a terminal medical condition or end stage disease defined as any illness that is expected to result in death within 12 months?	○	○
3. Have you ever been diagnosed by a member of the medical profession, treated for, medically advised to have treatment for, or taken medication for: chronic kidney disease (with or without dialysis), renal insufficiency, cirrhosis of the liver, liver disease or liver failure, Lou Gehrig's disease (ALS), Huntington's disease, had a kidney or organ transplant, or do you use oxygen equipment (for any condition excluding sleep apnea) to assist in breathing on a daily basis?	○	○
4. Have you ever been diagnosed by a member of the medical profession, treated for, medically advised to have treatment for, or taken medication for: Alzheimer's disease, dementia, neuromuscular or brain disease (including cerebral palsy, muscular dystrophy, cystic fibrosis), sickle cell anemia, or un-operated heart defects?	○	○
5. In the past 12 months have you been diagnosed by a member of the medical profession as having, been treated for, been medically advised to have treatment for, or taken medication for cardiomyopathy, congestive heart failure (CHF)?	○	○
6. In the past 24 months have you been diagnosed by a member of the medical profession as having, treated for, medically advised to have treatment for, or taken medication for any form of cancer, leukemia, lymphoma, melanoma or Hodgkin's disease (excluding basal or squamous cell skin cancer)?	○	○
7. In the past 12 months have you been diagnosed by a member of the medical profession as having, or hospitalized for heart attack, angina (chest pain due to heart disease), stroke, or transient ischemic attack (TIA/mini-stroke), uncontrolled high blood pressure, heart or circulatory surgery including coronary artery bypass, pacemaker, heart valve replacement, aneurysm, blood clot, angioplasty, or vascular stent placement, or any procedure to improve circulation to the heart or brain?	○	○
8. Have you ever been medically treated for or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)?	○	○

If any question in **section one** is answered **yes**, applicant is **not** eligible for 5Star Life Insurance.

Section Two

	Yes	No
1. Have you ever been diagnosed by a member of the medical profession as having or in the past 5 years been an inpatient or outpatient in a hospital for: chronic hepatitis, chronic bronchitis, emphysema, chronic obstructive lung disease or chronic obstructive pulmonary disease (COLD/COPD) or any chronic lung disorder (excluding asthma or sleep apnea)?	○	○
2. Have you ever been diagnosed by a member of the medical profession as having congestive heart failure (CHF) or cardiomyopathy?	○	○
3. In the past 12 months, have you required use of home oxygen equipment (for any condition excluding sleep apnea) more than 2 times per week but less than daily to assist in breathing?	○	○

"Statement of Health" continued on page 3

Statement of Health (continued)

	Yes	No
4. In the past 18 months, have you been diagnosed by a member of the medical profession as having or taken medication for angina (chest pain due to heart disease)?	○	○
5. In the past 24 months have you:		
a. Been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as: Multiple Sclerosis, Parkinson's Disease, or systemic lupus (SLE)?	○	○
b. Been diagnosed by a member of the medical profession as having or in the past 24 months been an inpatient or outpatient in a hospital for grand mal epilepsy or seizures?	○	○
c. Been diagnosed by a member of the medical profession as having, or in the past 24 months been an inpatient or outpatient in a hospital for angina, heart attack, stroke,or transient ischemic attack (TIA/mini-stroke), uncontrolled high blood pressure, heart or circulatory surgery including coronary artery bypass, pacemaker, heart valve replacement, aneurysm, blood clot, angioplasty, or vascular stent placement, or any procedure to improve circulation to the heart or brain?	○	○
d. Received or been advised by a physician to seek medical treatment or counseling for alcohol or drug abuse, bipolar disorder, depression, or schizophrenia?	○	○
e. Been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as: diabetic insulin shock, or diabetic coma, Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve, circulatory) disorder, or have you used insulin for treatment of diabetes prior to age 40?	○	○

If any question in **section two** is answered **yes**, applicant is eligible for **5Star Life Graded Insurance.**

If all questions in **section one and two** are answered **no**, applicant is eligible for **5Star Life Preferred Insurance.**

Other Insurance

Do you have any existing life insurance or annuity contracts with another company? ○ Yes ○ No

If approved, will this coverage replace any existing life insurance or annuity contracts? ○ Yes ○ No

If yes, what is the company name, address, and policy number of your existing coverage?

If yes, and if required, please complete and sign the applicable state-specific Notice: Replacement of Life Insurance and Annuity.

Conditions Relating to this Application

Agreement: I have read the completed application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. I agree that this application will be the basis for, and will become part of, the policy that is issued. The above representations are true **TO THE BEST OF MY KNOWLEDGE AND BELIEF**. I agree the policy shall not be in effect until it has been issued by 5Star Life Insurance Company and all premiums have been paid. I understand that the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the policy's incontestability provision. I understand that the agent has no authority to approve the application, change the policy, or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met. I understand that the USA Patriot Act requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and taxpayer identification number allows us to verify your identity. Our verification process may include the use of third-party sources to verify the information provided. I acknowledge receipt of a copy of the Information Practices Notice, MIB Pre-Notice, and Fair Credit Reporting Act Notice.

Authorization. I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, Medical Insurance Bureau, Inc. (MIB, Inc), pharmacy benefit manager, pharmacy, insurance laboratory, a consumer reporting agency, my employer, or any other person or organization that has any record of information about me to give 5Star Life Insurance Company, its reinsurers or its authorized representatives information about my health, prescription records, other insurance coverage, employment, age, general character, participation in hazardous activities, medical care or advice about any physical or mental condition including information about drugs, alcoholism, or other information 5Star Life Insurance Company requires to determine insurability or eligibility of benefits. I authorize 5Star Life Insurance Company, or its reinsurers, to make a report of health information to MIB. I further authorize the sources listed above except for MIB, Inc. to give such information to a consumer reporting agency acting on behalf of 5Star Life Insurance Company. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent 5Star Life Insurance Company has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to 5Star Life Insurance Company at its administrative address. I agree that a copy of this authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for 30 months from the date signed.

"Conditions Relating to this Application" continued on page 4

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Conditions Relating to this Application (continued)

HIPAA Authorization for Release of Health Related Information. This Authorization complies with the HIPAA Privacy Rule. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, benefit manager, medical facility, insurance company, insurance support organization (such as MIB, Inc., or any of its members or affiliates), or other health care provider that has provided payment, treatment or services to me (collectively, "My Providers") to disclose the entire medical record, prescription records, and any other protected health information concerning me to the company referenced on this authorization ("the Company") and their agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction for use in underwriting risk selection purposes. This protected health information is to be disclosed under the Authorization at my request, as permitted by § 164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule"). This authorization shall remain in force for 36 months following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company addressed, Attention: 5Star Life Insurance Company, Policyholder Service Department, 909 North Washington Street, Alexandria, VA 22314. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies. I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signatures must be personal:

Sign Here

Applicant _____ Date _____

Policy Owner _____ Date _____

(If different from Applicant)

Signed at (City) _____ (State) ☐☐

Insurance Producer Certification: I certify that the information recorded on this application is true and accurate to the best of my knowledge. I further certify that I have asked all the required questions on the application and I witnessed the signing of the application by the Applicant and the Proposed Policy Owner if different than the Applicant. To my knowledge, the Applicant is ◯ / ◯ is not replacing any existing life insurance or annuities.

Ins Prod Name _____

Ins Prod Signature _____

Date _____

Temporary Insurance Acknowledgment: Complete this section if full first premium or checkmatic/credit card authorization is submitted with application:

Insurance Producer: I provided the client with the Temporary Insurance Agreement ◯ Yes ◯ No

Fraud Statement

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.