5STAR LIFE INSURANCE COMPANY

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

Agent use only—Agent# 26PQD
Select only one product per app: FPP-CI ☐ FPP-TI ☒

Insurance Representative Assisted: ☒ Self Completed: ☐

Section 1 - Employer Information

Employer/Group Name: Test Group 123 Group Number:

Section 2 - Employee

Coverage Amount	Premium
$ 125,000	$ 27.10

Employee/Owner: John Doe SSN: 999-88-7777 Gender: ☒M ☐F

Birth Date: 02/02/1980 Are you actively at work?* ☒Y ☐N Date of Hire: 11/11/2011

Mailing Address: 123 Main

City: Chicago State: IL Zip Code: 12345

Email Address: no@thanks.com @

☐Weekly ☒Bi-Weekly ☐Semi Monthly ☐Monthly

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: Jane Doe Relationship: Spouse Age: 32 Birth Date: 03/03/1983 SSN: 666-55-4444

Contingent: Bobby Doe Relationship: Son Age: 10 Birth Date: 05/05/2005 SSN: 555-55-5555

Section 3 - Spouse

Coverage Amount	Premium
$ 50,000	$ 10.37

The employee will be the owner unless otherwise stated.

Spouse's Name: Jane Doe SSN: 666-55-4444

Gender: ☐M ☒F Birth Date: 03/03/1983

SPOUSE POLICY OWNER: Mary Motherinlaw, 888-88-8888

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: SAME AS EMPLOYEE

City: State: Zip Code:

Email Address: SAME AS EMPLOYEE @

** "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: John Doe Relationship: Spouse Age: 35 Birth Date: 02/02/1980 SSN: 999-88-7777

Contingent: The Doe Family Trust Relationship: Trust/Estate Age: Birth Date: SSN:

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

Coverage Amount	Premium
$ 10,000	$ 2.30

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

Child 1
Name (First, MI, Last): Jimmy Doe

SSN: 333-33-3333 Gender: ☒M ☐F Birth Date: 04/04/2004

SEE ATTACHED FOR ADDITIONAL CHILDREN

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

$ 10,000	$ 2.30

Name (First, MI, Last): Suzie Doe

SSN: 444-44-4444 Gender: ☐M ☒F Birth Date: 05/05/2005

Total Employee Premium	$ 27.10	**Total Premium**
Total Spouse Premium	$ 10.37	
Total Children Premium	$ 9.20	$ 46.67

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): DocuSigned by: John Doe D88497639B8A4ED... Date: 8/7/2015

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: DocuSigned by: John Doe D88497639B8A4ED...

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: Alfred Agent

Insurance Representative Signature: DocuSigned by: Alfred Agent 7542D570FDA842C... Date: 8/7/2015

5Star Family Protection Plan Application

Supplemental Form: Children's Information

Employer/Group: Test Group 123
Employee: John Doe xxx-xx-7777

Information and Coverage

Child #	Name	SSN	Gender	Birth Date	Coverage	Premium
3	Bobby Doe	555-55-5555	M	06/06/2006	$10,000	$2.30
4	Sally Doe	666-66-6666	F	07/07/2007	$10,000	$2.30

Statement of Health

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 Chronic obstructive pulmonary disease (COPD), emphysema, or any other chronic respiratory disorder, excluding asthma?

Bobby No

Sally No

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)?

Bobby No

Sally No

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 Angina, heart attack, stroke, heart bypass surgery, angioplasty, coronary artery stenting, or coronary artery disease?

Bobby No

Sally No

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 Alcoholism or drug or alcohol abuse, cirrhosis, hepatitis, or any other disease of the liver?

Bobby No

Sally No

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 any form of cancer to include leukemia or Hodgkin's Disease (excluding non-invasive, non-melanoma skin cancer)?

Bobby No

Sally No

Has any Applicant been hospitalized in the past 90 days?

Bobby No

Sally No

Has any Applicant ever applied for and been rejected for life insurance?

Bobby	No
Sally	No

DocuSigned by:

John Doe

D8849763 9B8A4ED...

Employee

John Doe

STATE OF ILLINOIS
IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITY

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the insurance producer or company that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

List below the identification of policies which are involved in the replacement action:

Contract Number: _____
Contract Number: SEE ATTACHED
Contract Number: _____
Contract Number: _____

Date: 8/7/2015, 20__

DocuSigned by:
Alfred Agent
7542D570FDA842C...
Insurance Producer's Signature

Alfred Agent
Insurance Producer's Printed Name

5Star Family Protection Plan Application

Supplemental Form: Additional Replacement Policies

Employer/Group: Test Group 123
Employee: John Doe xxx-xx-7777

Additional Policy Information

Insurer Name	Contract or Policy Number	Insured	Replaced (R) or Financing (F)	Reason for Replacement
ABC Carrier	123456	John Doe	financing	here is a reason for financing
XYZ Carrier	6543210	Jane Doe	replaced	this is another reason for replacing
PDQ Carrier	12/3456-789	John Doe	replaced	no longer want this insurance

DocuSigned by:
John Doe
D88497639B8A4ED...
Employee