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 Ins Prod Split:
Insurance Producer Market Code:
Insurance Prod Level:
Source Code:

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

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Group Level Term Programs
Enrollment Form

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

Coverage Plan (Select only one—All plans not available in all states.)

- Military Better Alternative (BA)
- 5Star Group Level Term (LT)
- Group Select Term (GS) — Select One
  - 10 Yr 15 Yr 20 Yr
  - 25 Yr with 10 Yr Guarantee
  - 30 Yr with 10 Yr Guarantee

Member Information

Are you a current AFBA member? Yes No

If approved for new coverage, cancel my existing AFBA group insurance. (Select all that apply)
BA LT GT Other All

Applicant's Information

Eligibility (Choose One):

Army	Marine Corps	Law Enforcement	Homeland Security
Air Force	Coast Guard	Emergency Med Tech	Fed/State/Local Emp
Navy	USPHS	Deployable Gov't Contractor	Dependent Spouse**
NOAA	Fire Dept.	Non-Dep Gov't Contractor	Current or Former Dependent

Duty Status:

Active Duty	Ready Reserve
Retiree*	IRR
Separatee*	N/A
National Guard	

*Approx retirement/separation date

Rank Grade Prefix
Last Name
Male Female
First Name
M.I.
D.O.B.
Address Line 1
Address Line 2
City
State
Zip
E-Mail
Daytime Number
Evening Number
SSN
Driver's License #
State
Place of Birth: State
Country

Are you a United States citizen? Yes No
Are you married?** Yes No
Do you have dependent children? Yes No

** CT, DE, HI, IL, NJ, NH, RI & VT Residents: Married includes civil unions and civil union partners.

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Employment Information (DoD Contractors or Applicants Enrolling for Coverage Amounts Over $250,000)

Current Employer: Yrs with Employer: Occupation:

Duties:

Owner (If other than Applicant)

SSN

Name: First Last

Address:

City, State, Zip

Relationship to Applicant Phone No.

Payor

○ Owner ○ Applicant ○ Other (Complete all info below)

SSN

Name: First Last

Address:

City, State, Zip

Phone Number

If Contingent Owner is desired, check here ☐ and a form will be sent to the Owner. If not, the Contingent Owner will be the Applicant.

Beneficiary(ies)

Unless you specify otherwise, payments will be shared equally by all primary beneficiaries who survive the Applicant, or if none, by all secondary beneficiaries who survive the Applicant. The right to change the beneficiary is reserved to the Owner unless otherwise stated. Children's beneficiary is the Applicant unless otherwise stated.

Beneficiary:

Primary — First Name | Last Name | SSN | Relationship | DOB

Secondary — First Name | Last Name | SSN | Relationship | DOB

Coverage and Contributions

Price class applying for:*

- ○ Ultra Preferred (GS Only)
- ○ Preferred (GS Only)
- ○ Standard Non-Tobacco
- ○ Tobacco User

Payment Method

(Please choose only one.)

○ Monthly Credit Card	0	○ Semi-Annual Bill	6	○ Bi-Weekly**	0
○ Monthly Checkmatic	0	○ Annual Bill	12		
○ Monthly Military Allotment	2	○ Non-Military Allotment	2		
○ Quarterly Bill	3	○ List Bill	1		

** Not available with all products.

* Ultra Preferred class is for those who have not used any tobacco or nicotine products in the past 60 months. Preferred class is for those who have not used any tobacco or nicotine products in the past 24 months. Standard Non-Tobacco class is for those who have not used any tobacco or nicotine products in the past 12 months.

Applicant's Coverage $,,

Children's Rider: (BA & LT Only) ○ Yes ○ No

Children's Units (may not exceed 5)

# of Children

Applicant's Monthly Contribution

Children's Monthly Contribution–**BA/LT Only**

Total Monthly Contribution $. x **Recurring Contribution** Value = $. Amount payable to AFBA.

If available for this product, I elect to receive my certificate and any associated correspondence and disclosures via electronic means. ○ Yes ○ No

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Other Coverage

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

Do you or your 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 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.

Statement of Health

Answer each question and initial in box 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 in the section below.

Initial Here

Height ☐ Ft ☐☐ In Weight ☐☐☐ Lbs

	Applicant		Children	
	Yes	No	Yes	No
I. In the last 10 years, has the Applicant or Child:				
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:				
1. Coronary artery disease, cardiac chest pain, heart attack, heart failure, heart murmur, or any heart disorder?	○	○	○	○
2. High blood pressure, peripheral vascular disease (plaque in arteries), or any blood vessel disorder?	○	○	○	○
3. Stroke, paralysis, seizures, epilepsy, loss of consciousness, multiple sclerosis, any neurological disorder?	○	○	○	○
4. Asthma, Chronic Obstructive Pulmonary Disease (COPD), tuberculosis, chronic cough or shortness of breath, or any disorder of the lungs or respiratory system?	○	○	○	○
5. Diabetes, thyroid, pituitary, adrenal, or hormone disorder?	○	○	○	○
6. Disorder of the kidney, bladder, urinary tract, genital tract, or reproductive system?	○	○	○	○
7. Ulcers, hepatitis, colitis, gastritis, disorder of the pancreas, liver, esophagus, stomach or intestines?	○	○	○	○
8. Rheumatoid disease, connective tissue disease, or disorder of the blood or lymph glands?	○	○	○	○
9. Schizophrenia, depression, personality disorder, or any mental health problem?	○	○	○	○
II. In the past 5 years, has the Applicant or Child:				
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 of 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 physician?	○	○	○	○
III. Has the Applicant or Child ever had or currently have any cancer, tumors, cysts, masses, polyps, or growths of any type?	○	○	○	○
IV. Has the Applicant or Child 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)?	○	○	○	○
V. List each prescribed medication the Applicant or Child takes regularly or frequently:				
VI. In the past 12 months, has any Applicant or Child used any tobacco or nicotine products (including nicotine patch, gum, or spray)?	○	○	○	○
VII. Did the Applicant's or Child's parent(s) or sibling(s) die before age 60 of cardiovascular or cerebrovascular disease or cancer?	○	○	○	○
VIII. Does the Applicant or Child receive disability benefits from any source? If "Yes," provide details. If V.A. disability rating is 30% or more, provide full report, or details if report is not available.	○	○	○	○
IX. Is the Applicant planning to reside outside of the United States for at least 180 days and establish residence in the next 2 years? If yes, please provide full details below.	○	○	○	○

Details:

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Conditions Relating to this Enrollment Form

Group Eligibility: I am eligible to apply for this group insurance coverage as a Member as defined in the Master Group Policy and described in the Certificate of insurance coverage. **Agreement:** 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 the Applicant'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 (MIB); 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. 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.

Signatures must be personal.

Sign Here

Applicant _____ Date ☐☐/☐☐/☐☐☐☐
(Or parent or legal guardian, if Applicant is a minor.)

Print Applicant's Name _____

Payor _____ Date _____
(If different than Applicant.)

Owner _____ Date ☐☐/☐☐/☐☐☐☐
(If different than Applicant.)

Signed at: City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State ☐☐

For Select Term Applicants Only:
If there is a second applicant living in the same household who is also applying for Select Term coverage, please enter their SSN below.

☐☐☐-☐☐-☐☐☐☐

Best time to contact for medical interview (if applicable): ☐☐:☐☐ ○ am ○ pm ☐☐:☐☐ ○ am ○ pm

Best day/time of week for paramedical exam (if applicable): ○ Mon ○ Tues ○ Wed ○ Thurs ○ Fri ○ Sat ○ am ○ pm

Insurance Producer Certification: I assisted the Applicant(s) with this enrollment form and to the best of my knowledge the questions are answered truthfully.

To the best of my knowledge, the Applicant is ○ /is not ○ replacing existing individual insurance.

Paramed Ordered? ○ Yes ○ No Deployed? ○ Yes ○ No If checkmatic or credit card, did you attach the appropriate form? ○ Yes ○ No

Purpose of Insurance? ○ Supplemental Coverage ○ Family Protection ○ Individual Protection ○ Other

Insurance Producer Name _____ Insurance Producer Signature _____ Date _____

Special Instructions:

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. **DC Residents: WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant. **New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.