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

Ins Prod Number:

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:

Individual Level Term Programs
Application

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

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

◯ Individual Select Term (IS) — Select One

◯ 10 Yr ◯ 15 Yr ◯ 20 Yr ◯ 25 Yr with 10 Yr Guarantee ◯ 30 Yr with 10 Yr Guarantee

Applicant's Information

Rank/ Prefix Last Name ◯ Male ◯ Female

First Name M.I. D.O.B. Month / Day / Year

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

Employment Information

Current Employer: Yrs with Employer: Occupation:

Duties:

Check most recent affiliation, if applicable:

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

Duty Status:

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

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Other Insurance

◯ Check if you want to cancel current group coverage underwritten by 5Star Life if new coverage is approved.
If so, specify certificate or account number: _____

Do you have an existing individual life insurance or annuity contract with another company? ◯ Yes ◯ No

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? _____.

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. .

Beneficiary:

Primary _____ ☐☐☐-☐☐-☐☐☐☐ _____ _____
First Name | Last Name | SSN | Relationship | DOB

Secondary _____ ☐☐☐-☐☐-☐☐☐☐ _____ _____
First Name | Last Name | SSN | Relationship | DOB

Coverage and Premiums

Price class applying for:*

◯ Ultra Preferred (IS Only)
◯ Preferred
◯ Standard Non-Tobacco
◯ Tobacco User

Payment Method
(Please choose only one.)

◯ Monthly Credit Card	0	◯ Semi-Annual Bill	6
◯ Monthly Checkmatic	0	◯ Annual Bill	12
◯ Monthly Military Allotment	2	◯ Non-Military Allotment	2
◯ Quarterly Bill	3	◯ Monthly List Bill	1

* 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. Price class subject to other underwriting criteria based on health.

Coverage Amount $ ☐,☐☐☐,☐☐☐ Monthly Premium $ ☐☐☐.☐☐ x **Recurring Premium** Value ____ = Amount payable to 5Star Life $ ☐☐☐☐.☐☐

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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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.

Height ☐ Ft ☐☐ In Weight ☐☐☐ Lbs

	Yes	No
I. In the last 10 years, has the Applicant:		
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:		
A. Been treated by a physician or medical facility or received professional counseling for alcohol or drug dependency or been advised by a physician 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 a physician?	○	○
III. Has the Applicant ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for cancer, tumors, cysts, masses, polyps or growths of any type?	○	○
IV. Has the Applicant 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 takes regularly or frequently: _____		
VI. In the past 12 months, has the Applicant used any tobacco or nicotine products (including nicotine patch, gum, or spray)?	○	○
VII. Did the Applicant's parent(s) or sibling(s) die before age 60 of cardiovascular or cerebrovascular disease or cancer?	○	○
VIII. Does the Applicant 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.	○	○

Initial Here _____

Details: _____

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Conditions Relating to this Application

Agreement: 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) except as provided or as stated in the Temporary Insurance Agreement, **insurance applied for will not become effective until approved by 5Star Life Insurance Company and is subject to the Applicant's health 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; 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 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 receipt of 5Star Life's Consumer Notice; and 5Star Life's Temporary Insurance Agreement, if the initial premium is submitted with this application.** I acknowledge that I am, 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.) Month Day Year

Print Applicant's Name _____

Payor _____ Date ☐☐/☐☐/☐☐☐☐
(If different than Applicant.) Month Day Year

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

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

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 with this application 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

Was premium submitted with application? ◯ Yes ◯ No If yes, was the Temporary Insurance Agreement provided to Applicant? ◯ 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 presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.