

CASE ENROLLMENT FORM

FOR NEW CASES, RE-ENROLLMENTS & GUARANTEE ISSUE



909 North Washington Street, Alexandria, VA 2231 ▪ 1-800-776-2322 ▪ www.5starlifeinsurance.com

New Case **Re-Enrollment** **Take Over** **MGA:** _____

Regional Marketing Director: _____

Account Manager: _____

Questions? Please contact:

Mandy Coulter at 703-884-2104, Michelle Carney at 703-299-5798, or Josh Lehn at 402-925-4479

GENERAL INFORMATION

Employer/Group Name: _____

"Other", give details: _____

Employer/Group Address: _____

Nature of Business/SIC Code: _____ Tax ID: _____

Total Number of Eligible Lives: _____ Employer Association Union

Billing Contact: _____

Employer Billing Address: _____

Phone: _____ Fax: _____ E-mail: _____

BILLING INFORMATION

Employer Paid Voluntary Product
(If different from Requested Effective date)

Enrollment Start Date: _____ End Date: _____ Effective Date: _____

Requested Effective Date: _____ First Bill Date: _____ First Deduction Date: _____

Are multiple billing locations needed: Yes No If yes, give details: _____

Will employer pay any part of the premium? Yes No

Policies/Certificates sent to: Insured Employer Broker

How many payroll deductions will be made annually for voluntary benefits? N/A Employer paid coverage

52 48 26 24 12 Other If "Other", give details: _____

How often will the group be billed? 13 (recommended for 26 deductions) 12 Other

If "Other", give details: _____

Current Employee Benefit waiting period (benefit waiting period) for core and other:

(Must choose one) 30 Days 60 Days 90 Days

BILLING INFORMATION (CONT'D)

Who will deliver deduction information to the employer?

Broker Enrollment Company 5Star Life Insurance Company

Who will do the billing?

5Star Life Insurance Company TPA Other: _____
(If TPA - Vendor Agreement Form is required)

How will this case be billed? Bill Current Bill Arrears

ENROLLMENT INFORMATION

Enrollment Method: Paper Electronic List Enrollment

If enrolling electronically, what software? 5Star Enroll Third Party: _____

Will a call center be used? Yes No If "yes", has vendor agreement been completed? Yes No
(Call Center must be approved by Home Office)

PRODUCER INFORMATION

If FPPi, multi-state locations? Yes No If "Yes", please list states: _____

Servicing Agent Name: _____ Agent #: _____

Agency Name: _____ Agency #: _____

Phone: _____ Fax: _____ E-mail: _____

Enrollment Firm Name: _____ Contact: _____

Address: _____

Phone: _____ E-mail: _____

Are all enrollers appointed with 5Star Life Insurance Company? Yes No

(If "NO" contact your account manager for appointment. Please Note: All agents and enrollers must be licensed in the state(s) where applications for policies are solicited and must be appointed by 5Star Life Insurance Company.)

Premium Split Information This section must be received before applications can be processed.

Provider Name, Agent Number and Premium Split Percentage. (Split must equal 100% will default to 100% to writing agent if nothing listed.)

Name: _____ Agent #: _____ Percentage: _____

Name: _____ Agent #: _____ Percentage: _____

Name: _____ Agent #: _____ Percentage: _____

Name: _____ Agent #: _____ Percentage: _____

FPP Commission Structure This section must be received before applications can be processed.

Level Product(s): _____ Agent(s) #: _____

Hybrid Product(s): _____ Agent(s) #: _____

All Other Products Commission Structure This section must be received before applications can be processed.

Level Product(s): _____ Agent(s) #: _____

Hybrid Product(s): _____ Agent(s) #: _____

Heaped Product(s): _____ Agent(s) #: _____

PRODUCT INFORMATION (CONT'D)

5Star Life Insurance Company Products Offered:

FPPg (Group) - Terminal Illness

- Disability Waiver of Premium (WP) Quality of Life Rider (QOL) Other rider: _____
- 3% 4%
- Employer paid: _____

FPPi (Individual) - Terminal Illness

- Disability Waiver of Premium (WP) Auto Increase Rider (AIR) Quality of Life Rider (QOL)
- Other rider: _____ 3% 4%
- Employer paid: _____

Coverage Begin Date:

- Application Sign Date Date 1st Payment Received 1st of the Month Following Application Date

Group Critical Illness

- Employer Paid: _____ Employee Paid

- Accident** 24hr Non-Occ with Virtual Healthcare (If yes, fill out VHC section below)

Agent National Guardian Life (NGL) appointment required.

- Level 1 Class Description: _____
- Level 2 Class Description: _____
- Level 3 Class Description: _____
- Employer paid: _____ Contract Situs State: _____

New Benefits - Virtual Healthcare (VHC) for Accident

- VHC VHC + Dental VHC + Dental & Vision VHC + Vision

- Healthcare Indemnity Plan** with Virtual Healthcare (If yes, fill out VHC section below)

Agent National Guardian Life (NGL) appointment required.

- Basic Level Class Description: _____
- Level 1 Class Description: _____
- Level 2 Class Description: _____
- Level 3 Class Description: _____
- Employer paid: _____ Contract Situs State: _____

New Benefits - Virtual Healthcare (VHC) for Healthcare Indemnity

- VHC VHC + Dental VHC + Dental & Vision VHC + Vision PPO

These products require a census:

- Group Voluntary Term Life** with ADD
- Basic Group Term Life** with ADD

Special Remarks:

Agent Signature: _____