Agent use only—Agent#

INTERNAL USE ONLY:

Attachments: Initials:

Group Life Insurance
Enrollment Form

NTG 1208 1

Use black or blue ink and print using all upper case letters.

○ New Enrollee ○ Late Enrollee (Statement of Health must be completed.) ○ Name Change ○ Coverage Change ○ Beneficiary Change

Employer Information

Employer Name

Employee/Applicant Information

Last Name

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

SSN ○ Male ○ Female Height ft in Weight lbs

Home Address:

Street Line 1

Street Line 2

City State Zip

Email

Daytime Phone Number

Full-Time Employment Date Month / Day / Year Coverage Effective Date Month / Day / Year

Employee Insurance Coverage

Basic Group Life Amount $, Basic Group AD&D Amount $,

Amounts requiring Evidence of Insurability are subject to Statement of Health.

Optional/Voluntary Group Life Amount $, Optional/Voluntary AD&D Amount $,

Amounts requiring Evidence of Insurability are subject to Statement of Health.

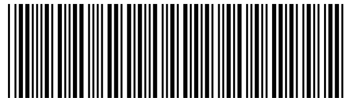
Annual Earnings $, (If coverage is earnings based) Voluntary Premium Amount $.

Voluntary/Optional Dependent Insurance Coverage

○ Life Only ○ Life and AD&D

	Name	SSN	DOB	Sex	Height	Weight	Coverage Amount	Premium Amount
Spouse								
Child 1								
Child 2								
Child 3								
Child 4								

Beneficiary Information



I designate my beneficiary(ies) to receive benefits as indicated below. The employee is the beneficiary for all dependent coverages. If more than one beneficiary is named, the beneficiaries shall share equally unless otherwise stated below.

Primary ____

Name | Address | Relationship | SSN | DOB | %

Secondary ____

Name | Address | Relationship | SSN | DOB | %

Statement of Health (To be completed only for amounts of coverage requiring evidence of insurability)

Answer each question TO THE BEST OF YOUR KNOWLEDGE AND BELIEF. Circle the specific condition and give full details to any "yes" answers in the chart below.

Yes No

I. In the past 5 years, has any Applicant been medically diagnosed or treated by a medical professional for the listed conditions:

A. Heart attack, angina (chest pain due to heart disease), congestive heart failure (CHF), 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?........ ○ ○

B. Complications of diabetes including: diabetic insulin shock or diabetic coma or diabetes not under control with current treatment or used insulin for treatment of diabetes prior to age 40?........ ○ ○

C. Any form of cancer, leukemia, lymphoma, melanoma or Hodgkin's disease (excluding basal or squamous cell skin cancer)?........ ○ ○

D. Emphysema, chronic obstructive lung disease or chronic obstructive pulmonary disease (COLD/COPD) (excluding asthma or sleep apnea)?.. ○ ○

E. Chronic hepatitis, cirrhosis of the liver or liver failure?........ ○ ○

F. Chronic kidney disease (with or without dialysis), end stage renal disease or renal insufficiency?........ ○ ○

G. Alzheimer's, dementia, neuromuscular or brain disease (including cerebral palsy, muscular dystrophy, cystic fibrosis), Lou Gehrig's disease (ALS), Huntington's disease, had an organ transplant or use oxygen equipment to assist in breathing on a daily basis?........ ○ ○

H. Sickle cell anemia , Multiple Sclerosis, Parkinson's Disease, or systematic lupus (SLE)?........ ○ ○

I. Grand mal epilepsy or seizures?........ ○ ○

J. Bipolar disorder, depression or schizophrenia?........ ○ ○

II. In the past 5 years, has any Applicant been admitted or confined to any hospital or medical treatment facility or consulted a medical professional for any disease not listed above, or been medically advised to have any surgical operation or diagnostic tests (excluding genetic tests and screenings)?........ ○ ○

III. Has any Applicant ever been medically diagnosed or treated by a medical professional as having Acquired Immunodeficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any immune deficiency related disorder (except HIV and HIV-related conditions)?........ ○ ○

IV. For each Applicant list any prescribed medication taken regularly or frequently:

____

____

For any "Yes" answers above, please complete the following. Attach additional details on an 8.5 x 11 piece of paper and submit with this enrollment form.

Ques No.	Name	Condition, injury, findings of examination or prescription	Date (Mo/Yr)	Date of Recovery	Name & Address of Hospital or Attending Physician

Continued on next page...

Conditions Relating to This Enrollment Form

Group Eligibility: I am eligible to apply for this group insurance as a full-time employee under the Group Policy issued to the Employer by 5Star Life Insurance Company. **Agreement:** I, as employee, have the appropriate knowledge to answer the statement of health questions for my dependents. 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 issued to me will describe the benefits and terms of coverage provided under the Master Group Policy; 2) c**overage applied for will not become effective until approved by 5Star Life Insurance Company and is subject to the health relating to each person to be covered being as described in this enrollment form, 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 Certificate of Insurance;** 3) if within 60 days of receipt of all required documentation this enrollment form is not approved, it will become void and any premiums paid will be refunded; I will be so notified. **Note:** Within the time limits prescribed by the law of the state where you live, no benefits will be paid and premiums will be refunded if the covered person commits suicide while sane or insane. Refer to your Certificate of Insurance for details. **Authorization:** I hereby authorize payroll deduction from my earnings of the required amount, if any, toward the cost of such insurance for myself and my family members. Authorization may be revoked by me at any time by written notice to my employer. I understand that if my employment is terminated, upon re-employment, insurance will not become effective until I apply again for insurance in accordance with the terms of the Group Policy. I hereby authorize any licensed physician; medical practitioner; hospital; clinic; insurance company; employer; financial institution; Medical Information Bureau (MIB); or Motor Vehicle Administration that may have records of my financial, 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 am entitled to receive a copy of this authorization upon request. This request may be made by me or my authorized representative. **Signature must be personal.**

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.

Sign Here

Employee's Signature__________________________________ Date __________________

Signed at (City, State) __________________________________