VERIFICATION OF EMPLOYMENT

Administrative Office: PO Box 83043, Lincoln, NE 68501-3043 • 866-863-9753 • www.5starlifeinsurance.com

Employer: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Employer Contact Name: _____ Phone: _____

Full Name of Employee: _____

Policy Number: _____ Policy Effective Date: _____ SSN: _____

Current Annual Salary:_____

Date employee became eligible for benefits: _____

Did the employee enroll/apply during the open enrollment period? ☐ YES ☐ NO

Was employee actively at work, performing their normal duties, and an eligible member of the group/class as defined in your plan documentation at their date of enrollment and for the policy effective date? ☐ YES ☐ NO

Deceased is: ☐ Employee, ☐ Spouse, ☐ Child

Employee's status on date of enrollment: ☐ Full Time, ☐ Retired, ☐ Other_____

Number of hours worked per week or average over the past 90 days (if full-time): _____

Employer Certification

I certify that the information provided above is true and accurate to the best of my knowledge. I understand that this information will be used to determine the employee's coverage eligibility under 5Star Life Insurance Company as of the date of enrollment.

Signed this _____ day of _____, 20____

Name/Title:_____

Signature:_____