



# 5Star Family Protection Plan

## Individual Term Life Insurance

### to Age 100 Application

Underwritten by 5Star Life Insurance Company (a Lincoln, Nebraska company)  
 Not available in all states • Admin Office: 777 Research Dr., Lincoln, NE 68521 • 1-866-863-9753

<b>Agent use only.</b>	<b>First Bill Date:</b> _____
Commission Split	
Agent # _____ % _____	Agent # _____ % _____
Agent # _____ % _____	Agent # _____ % _____
Select only one product per app: FPP-CI <input type="checkbox"/> FPP-TI <input type="checkbox"/>	

Insurance Representative Assisted:  Self Completed:

#### Section 1 - Employer Information

Employer/Group Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

#### Section 2 - Employee

Employee/Owner: \_\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Gender:  M  F  
 Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Are you actively at work?\*  Y  N Date of Hire: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Email Address: \_\_\_\_\_@\_\_\_\_\_

Coverage Amount	Premium
\$ _____	\$ _____

- Riders to be added (FPP-TI only)**
- Disability Waiver of Premium (WP)
  - Auto Increase Rider (AIR)
  - Quality of Life Rider (QOL)
  - Other: \_\_\_\_\_

\* "Actively at Work" means that you are an eligible employee/member of the employer/affiliation through which you are applying for this individual insurance; you are able to work and to perform the normal activities of a person of like age and gender; and you are not confined in a hospital, at home or elsewhere due to injury or sickness on the date you signed this application.

#### Beneficiary

Primary: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Contingent: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

#### Section 3 - Spouse

The employee will be the owner unless otherwise stated.  
 Spouse's Name: \_\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Gender:  M  F Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Coverage Amount	Premium
\$ _____	\$ _____

During the prior 6 months, other than for routine medical care, has your spouse been diagnosed or treated by a member of the medical profession in a hospital or any other medical facility?  Y  N  
 (If yes, complete the questions in Section 6)

- Riders to be added (FPP-TI only)**
- Disability Waiver of Premium (WP)
  - Auto Increase Rider (AIR)
  - Quality of Life Rider (QOL)
  - Other: \_\_\_\_\_

Has your spouse been disabled\*\* in the prior 6 months or received disability payments?  Y  N  
 Mailing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Email Address: \_\_\_\_\_@\_\_\_\_\_

\*\* "Disabled" means that a person is unable to work, to attend school, or to perform the normal activities of a person of like age and gender or that a person is confined in a hospital, at home or elsewhere due to injury or sickness.

#### Beneficiary

Primary: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Contingent: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

#### Section 4 - Children's Information (ages 14 days - 23 years)

The employee will be the owner and the beneficiary unless otherwise stated.

##### Child 1

Name (First, MI, Last): \_\_\_\_\_  
 SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Gender:  M  F Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Coverage Amount	Premium
\$ _____	\$ _____

##### Child 2 (Additional Children can be shown on a separate sheet of 8.5" x 11" paper.)

Name (First, MI, Last): \_\_\_\_\_  
 SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Gender:  M  F Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\$ _____	\$ _____
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**A person who feloniously and intentionally kills, conspires to kill, or procures the killing of the insured and who is a named beneficiary of a life insurance policy on the insured is not entitled to a benefit under the policy.**

<b>Total Employee Premium</b>	\$ _____	<b>Total Premium</b>
<b>Total Spouse Premium</b>	\$ _____	
<b>Total Children Premium</b>	\$ _____	

**Section 5 - Other Insurance**

Do you, your spouse, or children have any existing life insurance or annuity contracts?  Y  N

Will the coverage applied for replace any existing life insurance or annuities?  Y  N

Please list the amount, if any, of other life insurance coverage on the life of the minor that is in force or pending at this time: \$ \_\_\_\_\_

If you answered "yes" to either question please complete and sign the Notice of Replacement.

**Section 6 - Statement of Health**

**Please answer the following Statement of Health questions for all applicants:**

	<b>Employee</b>	<b>Spouse</b>	<b>Child 1</b>	<b>Child 2</b>
I. Has any Applicant been diagnosed or treated by a member of the medical profession, or tested positive for: Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Complete ONLY if applying for Simplified Issue amounts:**

II. Has any Applicant ever applied for and been rejected for life insurance?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
III. Has any Applicant been hospitalized in the past 90 days? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
IV. In the past 5 years, has any Applicant been hospitalized for, been diagnosed or treated by a member of the medical profession or taken prescription medication for:				
A. Angina, heart attack, stroke, heart bypass surgery, angioplasty, coronary artery stenting, or coronary artery disease? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Any form of cancer to include leukemia or Hodgkin's Disease (excluding non-invasive, non-melanoma skin cancer)? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Chronic obstructive pulmonary disease (COPD), emphysema, or any other chronic respiratory disorder, excluding asthma? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Alcoholism or drug or alcohol abuse, cirrhosis, hepatitis, or any other disease of the liver? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section 7 - Conditions Relating to this Application**

**Representations**

I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the applied for insurance . I understand that 5Star Life Insurance Company (5Star Life) will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured(s). 5Star Life may rescind the policy in accordance with the Contestability provision of the Policy due to any material misrepresentation of fact made in this application. Insurance is effective under the policy only when it is delivered to the owner, and then only if the full first premium is paid and all of the statements in this application remain correct and complete.

**Authorization**

I authorize 5Star Life to collect medical information or investigation reports about proposed insureds named in this application. I authorize those with such information or reports to release them to 5Star Life. I give 5Star Life permission to send such information or reports to MIB, Inc. ("MIB"), reinsurers, the Insurance Representative who solicited the application, and any third parties who administer the policies issued by 5Star Life. I authorize 5Star Life, or its reinsurers, to make a brief report of health information to MIB. This authorization shall remain in effect for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, but in no event more than 30 months from the date I sign below.

**Acknowledgments**

I acknowledge that I have received or will receive (in the case of solicitation by direct response methods) the Accelerated Benefit Disclosure form(s).

**Note:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Sign Here**

Employee (Policy Owner): \_\_\_\_\_ Date : \_\_\_ / \_\_\_ / \_\_\_  
(Parent, step-parent, legal guardian)

Signed at City: \_\_\_\_\_ State: \_\_\_\_\_

I certify I have authorized my employer to make payroll deduction of premiums for myself and my family members. Signed: \_\_\_\_\_

**Insurance Representative Certification (when Insurance Representative assisted in completion of the application):** I certify that I reviewed all questions on this application, and that the answers have been recorded accurately. I know of nothing affecting the insurability of the proposed insured(s) which is not fully recorded on this application.

To my knowledge, the Applicant has existing life insurance or annuity coverage.  Yes  No If yes, are they replacing existing coverage?  Yes  No

Insurance Representative Name: \_\_\_\_\_

Insurance Representative Signature: \_\_\_\_\_ Date : \_\_\_ / \_\_\_ / \_\_\_

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