5Star Group Family Protection Plan
Group Term Life Insurance to Age 121
Statement of Insurability

Section 1 - Employer Information

Employer/Group Name: ______________________________

Section 2 - Employee Information

Employee/Owner: ______________________________ SSN: ____-____-______

Section 3 - Statement of Insurability

To the best of my knowledge and belief all answers in this Statement of Insurability are true and correctly recorded, and are made as a consideration for the applied for insurance.

For **Qualified Issue** coverage answer questions **I-III**, for **Simplified Issue** Coverage answer **all** Questions.

Please answer the following questions:	**Employee**		**Spouse**	
I. In the past 5 years, has any Applicant been diagnosed, treated, or prescribed medication by a medical professional for AIDS, AIDS related complex or an immune system disorder?	☐Yes	☐ No	☐Yes	☐ No
II. In the past 6 months, has any Applicant been unable to work or needed personal or mechanical assistance in walking, bathing or dressing or been confined at home, been hospitalized* due to injury or sickness, excluding well-baby delivery and treatment for back pain?	☐Yes	☐ No	☐Yes	☐ No
***Hospitalized** is defined as an admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long-term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.				
III. In the past 12 months has any Applicant had diagnostic testing, surgery or hospitalization* recommended by a medical professional which has not been completed or for which the results have not been received?	☐Yes	☐ No	☐Yes	☐ No
IV. In the past 5 years, has any Applicant:				
A. Been diagnosed, treated, or prescribed medication by a medical professional for any of the following conditions: any disease or disorder of the heart, stroke, cancer, lung disease, chronic respiratory disorder (including any treatment with oxygen but excluding asthma), diabetes requiring insulin, liver or kidney disease?	☐Yes	☐ No	☐Yes	☐ No
B. Been convicted two or more times of driving under the influence of alcohol or drugs or while intoxicated?	☐Yes	☐ No	☐Yes	☐ No
C. Been treated by a medical professional or in a medical facility or received professional counseling for alcohol or drug dependency or been advised to reduce or discontinue use of alcohol?	☐Yes	☐ No	☐Yes	☐ No
V. In the last 10 years, has any Applicant ever applied for and been rejected for life insurance?	☐Yes	☐ No	☐Yes	☐ No

Section 4 - Conditions Relating to this Form

Representations

Group Eligibility: I am eligible to apply for this group level term life insurance coverage as an Employee as defined in the Master Group Policy and described in the Certificate of insurance coverage. **Agreement:** In the absence of my spouse, I, as Owner, have the appropriate knowledge to answer the questions for my spouse and children. 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 (5Star Life), it and the Benefits Summary issued to me will describe the benefits and terms of coverage provided under the Master Group Policy; 2) coverage applied for will not become effective until approved by 5Star Life and is subject to each covered person'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 Benefits Summary; 3) if within 60 days of receipt of all required documentation this application 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 insured commits suicide while sane or insane. Refer to your Benefits Summary for coverage details. **Authorization:** I hereby authorize any licensed physician; medical practitioner; hospital; clinic; insurance company; employer; financial institution; Medical Information Bureau; or Motor Vehicle Administration that may have records of my financial, physical, or mental health condition to give 5Star Life, its authorized representative, and its reinsurers any such information. 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, or my authorized representative is entitled to receive a copy of this authorization.

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.

I certify I have authorized my employer to make payroll deduction of premiums for myself and my family members. I certify I have authorized 5 Star Life Insurance Company to debit my checking account to make premium payments for myself and my family members.

Sign Here (signature must be personal.)

Employee (Certificate Owner): ______________________________ Date : ___ / ___ / ___

Signed at City: ______________________ State: ________

Spouse Signature (if spouse coverage elected): ______________________________ Date : ___ / ___ / ___

Signed at City: ______________________ State: ________