5Star Life Insurance Company Family Protection Plan (FPPi)

Individual Term Life Insurance to Age 121 Application

Agent use only. **First Bill Date:** ____________
Commission Split
Agent # ____________ % ______ Agent # ____________ % ______
Agent # ____________ % ______ Agent # ____________ % ______

Insurance Representative Assisted: ☐ Self Completed: ☐

Section 1 - Employer Information

Employer/Group Name: ______________________________ Group Number: ____________

Section 2 - Employee

Coverage Amount $ ____________ **Premium** $ ____________

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: ____________________ @ ____________________

☐ Weekly
☐ Bi-Weekly
☐ Semi Monthly
☐ Monthly

Riders to be added
☐ Auto Increase Rider (AIR)
☐ Disability Waiver of Premium (WP)
☐ 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

Coverage Amount $ ____________ **Premium** $ ____________

The employee will be the owner unless otherwise noted.

Spouse's Name: ______________________ SSN: ____ - ____ - ______ Gender: ☐ M ☐ F

Birth Date: ___/___/___ 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, you must complete all questions in Section 6.

Has your spouse been disabled** in the prior 6 months or received disability payments? ☐ Y ☐ N
**"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.

Riders to be added
☐ Auto Increase Rider (AIR)
☐ Disability Waiver of Premium (WP)
☐ Quality of Life Rider (QOL)
☐ Other: ____________________

Mailing Address: ______________________________ City: ______________ State: ______ Zip Code: ____________

Email Address: ____________________ @ ____________________

Beneficiary

Primary: ______________________ Relationship: __________ Age: ____ Birth Date: ___/___/___ SSN: ____ - ____ - ______

Contingent: ______________________ Relationship: __________ Age: ____ Birth Date: ___/___/___ SSN: ____ - ____ - ______

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

Coverage Amount **Premium**

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

Child 1

Coverage Amount $ ____________ Premium $ ____________

Name (First, MI, Last): ______________________________

SSN: ____ - ____ - ______ Gender: ☐ M ☐ F Birth Date: ___/___/___

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

Coverage Amount $ ____________ Premium $ ____________

Name (First, MI, Last): ______________________________

SSN: ____ - ____ - ______ Gender: ☐ M ☐ F Birth Date: ___/___/___

Total Employee Premium $ ____________ **Total Spouse Premium** $ ____________ **Total Children Premium** $ ____________ **Total Premium** $ ____________

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

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

Section 6 - 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.

Question	Employee	Spouse	Child 1	Child 2
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	☐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? ***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.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
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	☐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	☐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	☐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	☐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	☐Yes ☐No	☐Yes ☐No

Section 7 - Acknowledgement, Authorization and Signature

By signing below:
I attest that 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 application are complete, true and correctly recorded TO THE BEST OF MY KNOWLEDGE AND BELIEF without assistance, direction or assurances regarding my eligibility for coverage from anyone. The statements and answers in the application are the basis for any policy issued and no information about me shall be considered to have been given to 5Star Life Insurance Company (5Star Life) unless it is stated in the application, and I will notify 5Star Life of any changes in the statements or answers given in the application between the time of application and delivery of the policy. I agree that 1) upon approval of this application by 5Star Life, it and the Policy issued to me will describe the benefits and terms of coverage ; 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 Policy; 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:** No benefits will be paid and premiums will be refunded if the insureds death is caused or contributed to by any attempt at suicide, or intentionally self inflicted injury, while sane or insane. Refer to your Policy for coverage details.

I authorize any physician, hospital, clinic, pharmacy, other medical facility, insurance or reinsuring company, the MIB, Inc., consumer reporting agency, employer or other organization, institution or person having information available as to diagnosis, treatment and prognosis with respect to any other information of me, to give to 5Star Life or our legal representative including third party administrators, any and all such information. Any information obtained will not be released by 5Star Life to any person or organization EXCEPT to reinsuring companies, MIB, Inc., other persons or organizations performing business or legal services in connection with my Application, claim, other business purposes, or as may be otherwise lawfully required or as I may further authorize. I know that I may request to receive a copy of this Authorization. A photographic copy of this Authorization shall be as valid as the original. This Authorization shall be valid for a time period, if any, permitted by applicable law in the state where the Policy is delivered or issued for delivery. The Application Date is shown below. I understand that the agent cannot accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the Application or the Policy to which it applies.

I acknowledge that I have received or will receive (in the case of solicitation by direct response methods) the Accelerated Benefit Disclosure form(s). I certify I have authorized my employer to make payroll deduction of premiums for myself and my family members.

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.

Signature of Proposed Insured: ______________________________ Application Date : ___/___/___

Signature of Proposed Insured: ______________________________ Application Date : ___/___/___

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: ______________________________ State of Solicitation: __________

Insurance Representative Signature: ______________________________ Date : ___/___/___