

Additional Children's Information



CIVA 2 809

Child 3:

Name (First, MI, Last)	DOB	SSN	Sex	Coverage Amount	Premium Amount
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Child 4:

Name (First, MI, Last)	DOB	SSN	Sex	Coverage Amount	Premium Amount
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Statement of Health (To be completed only for Dependent and Voluntary benefits)

Please answer each question to the BEST OF YOUR KNOWLEDGE AND BELIEF.

Please answer the following 2 questions for ALL family members applying for coverage:

- | | Employee | | Spouse or Domestic Partner | | Child 1 | | Child 2 | | Child 3 | | Child 4 | |
|--|-----------------------|-----------------------|----------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No |
| 1. Have 2 or more family members (natural parents, brothers or sisters) both before age 60 been diagnosed with or died from the same condition: of cancer, heart disease, stroke or kidney disease; or, both before age 75, of colorectal cancer, Alzheimer's or Senile Dementia? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Has the proposed insured ever been diagnosed or treated for any of the following: Heart Attack, Angioplasty, Coronary Artery Bypass, Stroke, Transient Ischemic Attack, Cancer (excluding non-invasive, non-melanoma Skin Cancer), End-Stage Renal Disease, Liver Cirrhosis, Hepatitis B or C (including Carrier), Multiple Sclerosis, Paralysis, Diabetes (other than during pregnancy), Organ or Bone Marrow Transplant, Alzheimer's or Senile Dementia, HIV, AIDS, or AIDS-Related Complex (ARC)?..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

The remaining questions need only be completed by Employees applying for coverage amounts over \$10,000 and by any Spouse (or Domestic Partner) applying for coverage:

- | | Employee | | Spouse or Domestic Partner | |
|--|-----------------------|-----------------------|----------------------------|-----------------------|
| | Yes | No | Yes | No |
| 3. In the last 5 (FIVE) years, has the proposed insured been diagnosed with or treated for any of the following: | | | | |
| A. Any heart disease (including angina) or any kidney disease except non-chronic kidney stones or infections?..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| B. Uncontrolled high blood pressure (hypertension) and/or uncontrolled elevated cholesterol?..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| C. Lung disease requiring hospitalization, colitis, or Crohn's?..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| D. Any Skin Cancer or/and Precancerous Lesions/Tumors?..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| E. Any Human Papillomavirus (HPV), Herpes Simplex Virus (HSV), chlamydia, or gonorrhea?..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. In the past 2 (TWO) years, has the proposed insured been informed by a member of the medical profession of any abnormal test results or been advised to have any diagnostic tests or procedures which have not yet been completed?..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. Has the proposed insured ever applied for and been rejected for a Critical Illness, Cancer, Heart or Stroke insurance policy? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Conditions Relating to this Application

Agreement: I, as employee, have the appropriate knowledge to answer the questions for my spouse (or domestic partner) and children. I represent that all statements and answers in this application are complete, true and correctly recorded. I agree that: 1) insurance 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 insured 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; 2) if within 60 days of receipt of all required documentation this application is not approved, it will become void and all premiums paid will be refunded; I will be so notified. **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 Insurance Company, its authorized representative, and its reinsurers any such information. I understand that this information will be used to determine my eligibility for insurance and that I may revoke this authorization and application 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. As employee, my signature authorizes payroll deduction of premiums from my employer for myself and my family members. The undersigned applicant and agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in a loss of coverage under the certificate. **Signatures must be personal:**

Sign Here Employee _____ Date _____
 Owner _____ SSN _____
(If different than Employee.)
 Signed At (City, State) _____

Agent Certification: I certify that I asked all the questions and had the Applicant sign in my presence.
 Agent Name _____
 Agent Signature _____ Date _____



To be left with the Applicant

NOTICE TO CONSUMERS

Information regarding your insurability will be treated as confidential. 5Star Life Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

5Star Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.