

Additional Children's Information



CI 2 1008

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

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
Yes No | Spouse
Yes No | Child 1
Yes No | Child 2
Yes No | Child 3
Yes No | Child 4
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"/> |
| 2. Has the proposed insured ever been <u>diagnosed or treated</u> 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"/> |

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

- | | Employee
Yes No | Spouse
Yes No |
|---|-----------------------|-----------------------|
| 3. In the last 5 (FIVE) years, has the proposed insured been <u>diagnosed with or treated</u> 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"/> |
| B. Uncontrolled high blood pressure (hypertension) and/or uncontrolled elevated cholesterol? | <input type="radio"/> | <input type="radio"/> |
| C. Lung disease requiring hospitalization, colitis, or Crohn's? | <input type="radio"/> | <input type="radio"/> |
| D. Any Skin Cancer or/and Precancerous Lesions/Tumors? | <input type="radio"/> | <input type="radio"/> |
| E. Any Human Papillomavirus (HPV), Herpes Simplex Virus (HSV), chlamydia, or gonorrhea? | <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"/> |
| 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"/> |

Conditions Relating to this Application

Agreement: I, as employee, 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. I agree that: 1) upon approval of this application by 5Star Life Insurance Company, it, the policy and any riders or endorsements will constitute the entire insurance contract; 2) 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; 3) 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. **I acknowledge that I have received and read the Accelerated Benefit Disclosure form.**

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

Agent Name _____

Agent Signature _____ Date _____

Note: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and confinement to prison.



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.

5Star Life Insurance Company

**SPECIFIED DISEASE COVERAGE
THIS CERTIFICATE PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED
TO COVER ALL MEDICAL EXPENSES**

OUTLINE OF COVERAGE

Specified disease coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it. Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.

Read Your Certificate Carefully--This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

Specified disease coverages are designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

COVERAGE AMOUNTS

Your certificate provides coverage in an amount you elect, from \$10,000.00 to \$30,000.00. Please see your enrollment form for particulars. There are three categories of conditions for which payments will be made upon first diagnosis, shown below. Payments for the three categories cannot total more than your maximum coverage amount.

**Category 1 – Covered Conditions
Percent of Initial Benefit Amount**

Heart Attack	100%
Stroke	100%
Major Organ Transplant –	
Heart or combination transplant including Heart	100%
Coronary Bypass Surgery	25%
Angioplasty	25%

Category 2 – Covered Conditions

Invasive Cancer (Diagnosis more than 30 days after effective date of coverage)	100%
Invasive Cancer (Diagnosis during the first 30 days of in force coverage)	10%
Cancer In Situ (Diagnosis more than 30 days after effective date of coverage)	25%
Cancer In Situ (Diagnosis during the first 30 days of in force coverage)	2.5%

Category 3 – Covered Conditions

Major Organ Transplant – not covered in Category 1	100%
End-Stage Renal Failure	100%
Advanced Alzheimer's disease	100%
Paralysis	100%
Occupational HIV Infection	100%

