Underwritten by 5Star Life Insurance Company (a Baton Rouge, Louisiana Company)
Admin Offices: 909 North Washington Street, Alexandria, VA 22314
1-866-863-9753 • www.afba.com

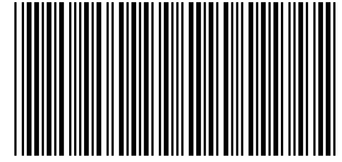
Agent use only—Agent#

Contract Code

INTERNAL USE ONLY:

Attachments: Initials:

5Star Executive Level Plan
Individual Select Term Application



USE BLACK OR BLUE INK AND PRINT USING ALL UPPER CASE LETTERS.

Employer Information

Employer Name

Employer Tax ID # —

Applicant Information

Applicant is: ◯ Employee ◯ Spouse

Last Name

First Name M.I. D.O.B. / / (Month Day Year)

SSN — — Sex: ◯ Male ◯ Female Height FT IN Weight LBS

Mailing Address:

Street Line 1

Street Line 2

City State Zip —

Daytime Phone — —

Employee Information (To be completed if Spouse is Applicant; otherwise leave blank)

Last Name

First Name M.I. D.O.B. / / (Month Day Year)

SSN — — Sex: ◯ Male ◯ Female

Coverage and Rates

Individual Select Term: ◯ 10 Year ◯ 15 Year ◯ 20 Year ◯ 30 Year

Coverage Amount $,

Monthly Premium $.

Rate Class: ◯ Ultra Preferred* ◯ Preferred* ◯ Standard Non-Tobacco** ◯ Tobacco User**

* Attach a Preferred Checklist.
** Tobacco user is one who has used any tobacco product in the past 12 months.

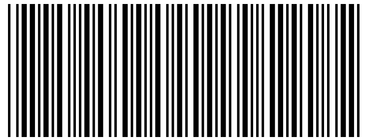
Beneficiary(ies)

I designate my beneficiary(ies) to receive benefits as indicated below. Check here ☐ if you would like an additional beneficiary form sent to you.

Primary ____________________
Last Name MI First Name Relationship DOB SSN

Secondary ____________________
Last Name MI First Name Relationship DOB SSN

Other Insurance



Do you have any existing individual life insurance or annuity contracts? ◯ Yes ◯ No
If yes, and you live in AL, AZ, CO, HI, IA, LA, MD, MS, MT, NH, NJ, NM, NC, OR, RI, VT or WV, please complete the Replacement Notice.
If yes, do you intend to replace them? ◯ Yes ◯ No
If yes, complete the applicable state Replacement Notice.

Statement of Health

Answer each question and initial in box to acknowledge you've read and understood each question.
Circle the specific condition and give full details to any "yes" answers on a separate 8 1/2 x 11 piece of paper.

Initial Here ____

	Yes	No
I. In the last 10 years, has the Applicant under this application for coverage:		
A. Had a life or health insurance application declined, postponed, modified or rated?	◯	◯
B. Had or been treated by a physician or consulted with a health advisor for any of the following:		
1. High blood pressure, chest pain, heart attack, or other heart or blood vessel disorder?	◯	◯
2. Disorder of the kidney, bladder, urinary tract, genital tract, or reproductive system?	◯	◯
3. Diabetes, thyroid disease, pituitary or other gland disorder?	◯	◯
4. Ulcers, hepatitis, colitis, severe indigestion, disorder of pancreas, liver, esophagus (gullet), stomach, intestines or colon?	◯	◯
5. Cancer or other malignant disease?	◯	◯
6. Disorder of the blood, lymph glands or connective tissue disease?	◯	◯
7. Disorder of the lungs or respiratory system, asthma, tuberculosis, chronic cough or shortness of breath?	◯	◯
8. Mental health problems, nervous system disorder, significant depression, loss of consciousness, paralysis, multiple sclerosis, or convulsive seizures?	◯	◯
9. Alcoholism or advised to reduce or discontinue the use of alcohol for health reasons; or been convicted for driving under the influence of alcohol or while intoxicated?	◯	◯
C. Used marijuana, cocaine, heroin, barbiturates, hallucinogens, or amphetamines unless on prescription of a physician?	◯	◯
D. Been diagnosed by a physician as having Human Immunodeficiency Virus (HIV), ...Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or AIDS-related conditions?*	◯	◯
II. A. In the past 5 years had any treatment and/or evaluation, except routine physicals, by a physician or other health care practitioner?	◯	◯
B. Is any such treatment or evaluation contemplated?	◯	◯
III. Have you used any tobacco or nicotine products (including nicotine patch, gum or spray) in the past 12 months?	◯	◯
IV. Did mother or father of Applicant die before age 60 of cardiovascular disease?	◯	◯

V. List each prescribed medication you are now taking on a regular or frequent intermittent basis: ____________________

* The applicant need not reveal HIV test results received from an anonymous counseling and testing site or the results of a home test kit.

Conditions Relating to this Application

Agreement: I represent that all statements and answers in this application are complete, true and correctly recorded to the best of my knowledge and belief. I agree that: 1) if this application is approved 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 subject to the health relating to the applicant 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, I will be notified that it will become void and all premiums paid will be refunded. **Authorization:** I hereby authorize any licensed physician; medical practitioner; hospital; clinic or other medical facility; insurance company; employer; Medical Information Bureau; Motor Vehicle Administration; or other organization or persons that have any records or knowledge of me or my 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 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 am, or my authorized representative is, entitled to receive a copy of this authorization. As employee, my signature authorizes payroll deduction of premium from my employer for coverage applied for.

Signatures must be personal:

Sign Here

Employee ____________________ Date ________

Applicant ____________________ Date ________
(If other than Employee)

Owner ____________________ Date ________
(If other than Applicant)

Owner's Name (Please Print) ____________________

Owner's SSN ☐☐☐-☐☐-☐☐☐☐

Owner's Address ____________________

Signed at (City, State) ____________________

Agent Certification: I certify that I asked all the questions and had the Applicant sign in my presence.
Is Applicant 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.

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, 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

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.