5Star Life Insurance Company
Admin Offices: 909 North Washington Street, Alexandria, VA 22314 • 1-866-863-9753

Agent use only—Agent#

Select only one product per app:
○ FPP-CI ○ FPP-I ○ FPP-TI

INTERNAL USE ONLY:

Attachments: Initials:

5Star Family Protection Plan
Term Life Insurance to Age 100
Application

Use black or blue ink and print using all upper case letters.

FPP 1104 1

Employer Information

Employer

Employer Tax ID # —

Employee Information

Last Name

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

SSN – – Coverage Amount $, Weekly Premium $.

Mailing Address:

Street Line 1

Street Line 2

City State Zip –

Daytime Phone – – Owner is ○ Self ○ Other ____________

Spouse Information

Owner is ○ Self ○ Other ____________

Last Name

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

SSN – – Coverage Amount $, Weekly Premium $.

Children's Information (ages 0-23) — (The Owner of this policy is the Employee.)*

Child 1:

Last Name

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

SSN – – Coverage Amount $, Weekly Premium $.

Child 2:

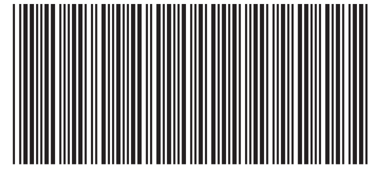
Last Name

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

SSN – – Coverage Amount $, Weekly Premium $.

* If you are applying for coverage on more than two children, please complete the "Additional Children's Information" section on the back.

Additional Children's Information



Child 3:

Name (First, MI, Last)	DOB	SSN	Sex	Coverage Amount	Weekly Premium

Child 4:

Name (First, MI, Last)	DOB	SSN	Sex	Coverage Amount	Weekly Premium

Other Insurance

Do you, your spouse or children have any existing individual life insurance or annuity contracts? ◯ Yes ◯ No

If yes, and you live in AL, CO, HI, IA, LA, MD, MS, MT, NH, NJ, NC, OR or VT, please complete the Replacement Notice.

If yes, do you, your spouse or children intend to replace them? ◯ Yes ◯ No   If yes, complete the applicable state Replacement Notice.

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.

	Last Name	First Name	MI	Relationship	DOB	SSN
Beneficiary Of Employee Coverage						
Beneficiary Of Spouse Coverage						
Beneficiary Of Child 1 Coverage						
Beneficiary Of Child 2 Coverage						
Beneficiary Of Child 3 Coverage						
Beneficiary Of Child 4 Coverage						

Statement of Health

Please answer each question and circle the specific condition.

In the last 5 years, have you had or been treated for any of the following:	Employee Yes	Employee No	Spouse Yes	Spouse No	Child 1 Yes	Child 1 No	Child 2 Yes	Child 2 No	Child 3 Yes	Child 3 No	Child 4 Yes	Child 4 No
1. Heart attack, stroke or coronary artery disease?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
2. Any form of cancer to include leukemia and Hodgkin's Disease?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
3. Chronic hepatitis, cirrhosis or other disease of the liver?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
4. Lung disease?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
5. In the last 5 years, have you had or been treated by, or consulted with, a doctor of osteopathy or a medical doctor/physician (DO or MD) or a licensed medical professional operating under such DO's or MD's direct supervision for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
6. Have you ever applied for and been rejected for life insurance?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

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 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 each person to be insured being as described in this application, 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. This authorization excludes the release of any information relating to previously administered tests for HIV antibodies, t-cell counts, AIDS or ARC, by my family-regular-attending medical doctor-physician-practitioner or care giver or any other person or entity which may be possessed of this information. In addition, I am not authorizing 5Star Life to forward the results from any new test, requested by 5Star Life, to any outside, nonaffiliated company nor to any entity not under specific contract with 5Star Life to perform underwriting services. 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 premium 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 ______________________ (If different than Employee.) SSN __________

Signed At (City, State) ______________________

Agent Certification:

Is applicant replacing existing insurance coverage? ◯ Yes ◯ No

Agent Name ______________________
Witness (Licensed Resident Agent, if required)

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.