

Agent use only—Agent#

Agent number input boxes

Select only one product per app:

FPP-CI and FPP-TI radio buttons

INTERNAL USE ONLY:

Attachments and Initials input boxes

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



FPP 409 1

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

Employer Information

Employer Name, Tax ID # input boxes

Employee Information

Last Name, First Name, M.I., D.O.B., SSN, Coverage Amount, Premium Amount, Mailing Address, City, State, Zip, Daytime Phone, Owner is Self/Other

Spouse Information

Last Name, First Name, M.I., D.O.B., SSN, Coverage Amount, Premium Amount, Owner is Self/Other

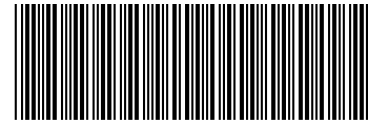
Children's Information (ages 0-23) — (The Owner of this policy is the Employee.)*

Child 1: Last Name, First Name, M.I., D.O.B., SSN, Coverage Amount, Premium Amount

Child 2: Last Name, First Name, M.I., D.O.B., SSN, Coverage Amount, Premium Amount

* 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



FPPFL 2 409

Child 3:

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

Child 4:

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

Other Insurance

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

Will the coverage applied for replace any existing life insurance or annuities? Yes No

If yes, please complete and sign the applicable state-specific Notice: Replacement of Life Insurance and Annuity.

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.

Beneficiary Of Employee Coverage Last Name First Name MI Relationship DOB SSN

Beneficiary Of Spouse Coverage Last Name First Name MI Relationship DOB SSN

Note: Beneficiary for Child coverage will be designated as the Employee unless otherwise noted on a separate 8.5x11 sheet of paper submitted with this application.

Statement of Health

Please answer each question and circle the specific condition.

Table with 7 columns (Employee, Spouse, Child 1, Child 2, Child 3, Child 4) and 2 rows (Yes, No) for each condition. Conditions include hospitalization, chronic diseases, HIV, and life insurance applications.

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) 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. 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 is guilty of a felony in the third degree.

Signatures must be personal:

Sign Here Employee Date Owner SSN 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 Date

FLORIDA SECONDARY ADDRESSEE: You have the right to designate a secondary addressee at any time the policy is in force by submitting a written notice to 5Star Life Insurance Company with the name and address of the secondary addressee.