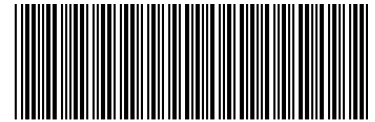




**Additional Children's Information**



FPPMA 2 209

**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

If yes, and you live in AK, AL, AZ, CO, HI, IA, KY, LA, MD, ME, MS, MT, NH, NJ, NM, NC, OH, OR, RI, TX, UT, VA, VT or WV please complete and sign the Notice: Replacement of Life Insurance and Annuity. The Notice must be **presented** and **read** to you by your agent at the time he/she takes your application.

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

If yes, and you do not live in the above listed states, 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.**

	Employee		Spouse		Child 1		Child 2		Child 3		Child 4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
I. Has any Applicant been hospitalized in the past 90 days?.....	<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"/>
II. In the past 10 years, has any Applicant had or been hospitalized for, been medically diagnosed, treated, or taken prescription medication for:												
A. Angina, heart attack, stroke, heart bypass surgery, angioplasty, coronary artery stenting, or coronary artery disease?.....	<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"/>
B. Any form of cancer to include leukemia or Hodgkin's Disease (excluding non-invasive, non-melanoma skin cancer)?.....	<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"/>
C. Chronic obstructive pulmonary disease (COPD), emphysema, or any other chronic respiratory disorder, excluding asthma?.....	<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"/>
D. Alcoholism or drug or alcohol abuse, cirrhosis, hepatitis, or any other disease of the liver? .....	<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"/>
III. Has any Applicant been diagnosed or treated by a physician, or tested positive for: Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC) (other than an anonymous result obtained under the auspices of the Alternative Testing Sites of the Mass. Dept. of Public Health or the American Red Cross)?.....	<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"/>
IV. Has any Applicant ever applied for and been rejected for life insurance?.....	<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"/>

**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. Signatures must be personal:**

**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 \_\_\_\_\_

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