5Star Life Insurance Company
Admin Offices: 909 North Washington Street, Alexandria, VA 22314 • 1-800-776-2322 • www.afba.com

Agent use only—Agent#

INTERNAL USE ONLY:

Attachments: Initials:

5Star Multiple Employer Trust
Group Life Insurance Enrollment Form

MET 1004 1

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

○ New Enrollee ○ Late Enrollee (Statement of Health must be completed.) ○ Name Change ○ Coverage Change ○ Beneficiary Change

Employer Information

Employer Name

Employer Tax ID # –

Employee/Applicant Information

Last Name

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

SSN – – ○ Male ○ Female Height ft in Weight lbs

Home Address:

Street Line 1

Street Line 2

City State Zip –

Daytime Phone Number – –

Full-Time Employment Date / / (Month Day Year) Coverage Effective Date / / (Month Day Year)

Employee Insurance Coverage

Basic Group Life Amount $, Basic Group AD&D Amount $,

Amounts requiring Evidence of Insurability are subject to Statement of Health.

Voluntary Group Life Amount $, Voluntary AD&D Amount $,

Amounts requiring Evidence of Insurability are subject to Statement of Health.

Earnings $, (If coverage is earnings based) Voluntary Premium Amount $.

Voluntary/Optional Dependent Insurance Coverage

	Name	SSN	DOB	Sex	Height	Weight	Coverage Amount	Premium Amount
Spouse								
Child 1								
Child 2								
Child 3								
Child 4								

Beneficiary Information

I designate my beneficiary(ies) to receive benefits as indicated below. The employee is the beneficiary for all dependent coverages. If more than one beneficiary is named, the beneficiaries shall share equally unless otherwise stated below.

Primary ____
Name Address Relationship SSN DOB %

Secondary ____
Name Address Relationship SSN DOB %

Statement of Health (To be completed only for amounts of coverage requiring evidence of insurability)

Answer and initial each question. Please circle the specific condition and give full details to any "Yes" answers in the chart below.

Initials Yes No

1. In the past 10 years, have you or your spouse had a life or health insurance application declined or risk rated?............................. ____ ◯ ◯
2. In the past 10 years, have you or your spouse had or been treated by a physician or consulted with a health advisor for any of the following: disorder of the blood or circulatory system; high blood pressure; heart disorder; heart attack; chest pain; hepatitis; diabetes; disorder of the kidney; disorder of the digestive system; liver disorder; disorder of the lungs or respiratory system; asthma; tuberculosis; mental, nervous or emotional disorder; paralysis or stroke; multiple sclerosis; glandular disorder; cancer; tumor; or alcohol or drug abuse?............................. ____ ◯ ◯
3. Have you or your spouse been diagnosed or treated by a physician as having tested positive for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or AIDS-related condition?.......................... ____ ◯ ◯
4. During the past 5 years, have you or your spouse taken any prescription medication or been advised to do so by a physician?...... ____ ◯ ◯
5. During the past 5 years, have you or your spouse consulted a physician for any disease not listed above, or been advised to have any treatment, operation, or diagnostic test?............................. ____ ◯ ◯
6. During the past 5 years, have you or your spouse been admitted or confined to any hospital or medical care facility?.................... ____ ◯ ◯

For any "Yes" answers above, please complete the following. Attach additional details on an 8.5 x 11 sheet of paper and submit with this enrollment form.

Ques No.	Name	Condition, injury, findings of examination or prescription	Date (Mo/Yr)	Date of Recovery	Name & Address of Hospital or Attending Physician

Conditions Relating to This Enrollment Form

Group Eligibility: I am eligible to apply for this group insurance as a full time employee of an employer under the Group Policy issued to the Trustee, America's 5Star Multiple Employer Trust by 5Star Life Insurance Company. **Agreement:** I, as employee, have the appropriate knowledge to answer the statement of health questions for my spouse. I represent that all statements and answers in this enrollment form are complete, true and correctly recorded to the best of my knowledge and belief. I agree that 1) upon approval of this enrollment form by 5Star Life Insurance Company, it and the Certificate of Insurance Coverage issued to me will describe the benefits and terms of coverage provided under the Master Group Policy; 2) coverage 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 covered being as described in this enrollment form, and upon receipt of the full first contribution, in which case the coverage shall take effect as of the effective date as shown in the Certificate of Insurance Coverage; 3) if within 60 days of receipt of all required documentation this enrollment form is not approved, I will be notified that it will become void and any contributions paid will be refunded. **Note:** Within the time limits prescribed by the law of the state where you live, no benefits will be paid and contributions will be refunded if the covered person commits suicide while sane or insane. Refer to your Certificate of Insurance Coverage for details. **Authorization:** I hereby authorize payroll deduction from my earnings of the required contribution, if any, toward the cost of such insurance for myself and my family members. Authorization may be revoked by me at any time by written notice to my employer. I understand that if my employment is terminated, upon re-employment, insurance will not become effective until I apply again for insurance in accordance with the terms of the Group Policy. 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 coverage and that I may revoke this authorization and enrollment form 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 30 months (24 months in IA, KS, KY, NM, OK & VT and 26 months in MN or the time period prescribed by the law of the state where you live) from the date below. I acknowledge that I, or my authorized representative is entitled to receive a copy of this authorization. **Signature must be personal.**

Sign Here

Employee's Signature ______________________ Date ______________

Signed at (City, State) ______________________

WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Not available in all states • Underwritten by 5Star Life Insurance Co. (a Baton Rouge, Louisiana Co.) • Admin Offices: 909 N. Washington St., Alexandria, VA 22314 6/05