

SERFF Tracking Number: FIVE-125569120 State: Arkansas
Filing Company: 5 Star Life Insurance Company State Tracking Number: 38580
Company Tracking Number: 408
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
Product Name: Group Life - Term
Project Name/Number: /

Filing at a Glance

Company: 5 Star Life Insurance Company

Product Name: Group Life - Term

TOI: L04G Group Life - Term

Sub-TOI: L04G.500 Other

Filing Type: Form

SERFF Tr Num: FIVE-125569120

SERFF Status: Closed

Co Tr Num: 408

Co Status:

Authors: Mildred Hunt, Carol Devine

Date Submitted: 04/02/2008

State: ArkansasLH

State Tr Num: 38580

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 04/11/2008

Disposition Status: Approved

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type:

Overall Rate Impact:

Filing Status Changed: 04/11/2008

State Status Changed: 04/11/2008

Corresponding Filing Tracking Number:

Filing Description:

FEBG/SEBG App R408: 5Star Group Level Term FEBG/SEBG Enrollment Form

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small

Group Market Type: Other

Deemer Date:

Company and Contact

Filing Contact Information

Mildred Hunt, Compliance Manager

909 North Washington Street

mhunt@afba.com

(703) 706-5975 [Phone]

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Alexandria, VA 22314

(703) 224-0214[FAX]

Filing Company Information

5 Star Life Insurance Company
909 North Washington Street

CoCode: 77879
Group Code: 77879

State of Domicile: Louisiana
Company Type: Life Insurance
Company

Alexandria, VA 22314
(703) 706-5975 ext. [Phone]

Group Name: NAIC
FEIN Number: 54-1829709

State ID Number:

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Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation: application x 1 = \$20.00
Per Company: No

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
25874	\$20.00	03/26/2008

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	04/11/2008	04/11/2008

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Disposition

Disposition Date: 04/11/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Cover Letter		Yes
Form	FEBG/SEBG Enrollment Form		Yes

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Form Schedule

Lead Form Number: FEBG/SEBG App R408

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	FEBG/SEB	Application/	FEBG/SEBG	Initial			FEBG SEBG
	G App	Enrollment	Enrollment Form				App R408
	R408	Form					(Generic).pdf

Beneficiary(ies)



EB 2 408

As sponsor, I designate beneficiary(ies) to receive benefits as indicated below. Spouse and children's beneficiary is the sponsor unless otherwise designated.

Beneficiary of: [] [] [] - [] [] - [] [] [] []
Sponsor Name SSN Relationship DOB
Spouse Name SSN Relationship DOB

Other Coverage

Answer only if this is an agent or broker initiated sale:

Do you have any existing life insurance or annuity contracts? Yes No

If yes, and you live in 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.

Do you intend to replace them? 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.

Statement of Health

Answer each question and initial below to acknowledge you've read and, TO THE BEST OF YOUR KNOWLEDGE AND BELIEF, 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.

I. In the last 10 years, has any Applicant under this application for coverage:
A. Had a life or health insurance application declined or rated?
B. Been diagnosed or treated by a physician for: High blood pressure, high cholesterol, cardiac chest pain, heart attack, vascular disease (plaque in arteries), or any heart or blood vessel disorder; cancer or blood disorder; stroke, seizures, progressive neuropathy, or any nervous system disease; shortness of breath, asthma, chronic obstructive pulmonary disease (COPD), or any respiratory tract disorder; ulcers, hepatitis, colitis, disorder of the pancreas, liver, esophagus, stomach or intestine; depression, schizophrenia, or any mental condition; diabetes, thyroid, pituitary, adrenal, or hormone disorder; disorder of the kidney, bladder, urinary tract, genital tract, or reproductive system; or any significant medical disorders?
II. In the past 5 years, has any Applicant:
A. Been treated by a physician or medical facility or received professional counseling for alcohol or drug dependency or been advised to reduce or discontinue the use of alcohol?
B. Been convicted for driving under the influence of alcohol or drugs or while intoxicated?
C. Used amphetamines, cocaine, heroin, hallucinogens, barbiturates, marijuana, narcotics, or any drug except as medication prescribed by a physician?
III. Has any Applicant been diagnosed or treated by a physician or tested positive for Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), or any AIDS-Related Complex (ARC)?

IV. List each prescribed medication taken regularly or frequently by any Applicant:

* Number of Children If you answer "yes" to any of the above questions regarding a child(ren), please provide the child(ren)'s name, date of birth and the question # the answer refers to on a 8 1/2 x 11 piece of paper. Initial Here

Conditions Relating to this Enrollment Form

Group Eligibility: I am eligible to apply for this group level term life insurance coverage as a Member or an Associate Member as defined in the Master Group Policy and described in the Certificate of insurance coverage. Agreement: In the absence of my spouse, I, as sponsor, have the appropriate knowledge to answer the questions for my spouse and children. 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 Applicant's health 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, it will become void and all contributions paid will be refunded; I will be so notified. 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 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 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 24 months from the date below. I acknowledge that I, or my authorized representative is entitled to receive a copy of this authorization. Signatures must be personal.

Sponsor's Signature Date Agent Certification: I certify that I asked all the questions and had the Sponsor sign in my presence. Is Sponsor or Spouse replacing existing coverage? Yes No
Sign Spouse's Signature Date Paramed Ordered?
Here Signed at (City, State) Agent Name Yes No
Agent Signature Date

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Rate Information

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Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 03/21/2008

Comments:

Attachment:

ARKANSAS Certificate of Authority.pdf

Review Status:

Satisfied -Name: Application 03/21/2008

Comments:

The form number of the previously approved application is: FEBG/SEBG App R907

Date of Approval: 10/01/2007

Review Status:

Satisfied -Name: Cover Letter 03/21/2008

Comments:

Attachment:

ARKANSAS Cover Letter.pdf



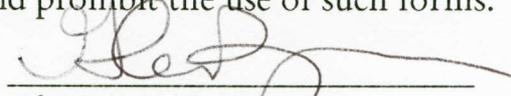
CERTIFICATION

ARKANSAS DEPARTMENT OF INSURANCE

Re: *FEBG/SEBG App R408 - Group Level Term FEBG/SEBG Enrollment Form*

I have reviewed or supervised the review of the above group life insurance enrollment form contained in this filing and hereby certify, to the best of my knowledge and belief, that the above listed form is in compliance with the applicable statutes, regulations, and bulletins of the state of Arkansas. I further certify that the above form will be revised and/or discontinued in the event of future changes in the statutes, regulations, or bulletins which would prohibit the use of such forms.

Dated: March 21, 2008



Glenn R. Jones, Esq.
Vice President, Compliance



March 24, 2008

Mildred E. Hunt
Compliance Manager

VIA SERFF

Mr. Dan Honey
Deputy Commissioner, Life and Health
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201-1904

Re: *5 Star Life Insurance Company; NAIC No.: 77879; NAIC Code: 0000; FEIN: 54-1829709*

<i>Form Number</i>	<i>Description</i>
FEBG/SEBG App R408	5Star Group Level Term FEBG/SEBG Enrollment Form

Dear Mr. Honey:

Submitted for filing and approval is the above referenced non-certificate form. Form number FEBG/SEBG App R907 was stamped accepted for information purposes by the Department on October 1, 2007. The SERFF tracking number is FIVE-125287776.

This filing is submitted to institute the following changes: (Note: ~~Strikethroughs~~ indicate deletions; **bold**, underscored, and *italicized* words indicates new language.)

<i>Form</i>	<i>Description</i>
FEBG/SEBG App R907 <u>FEBG/SEBG App R408</u>	<ul style="list-style-type: none"> Page 1 of 2, section Sponsor Information, inserted <u><i>Driver's License #</i></u> <input type="text"/> Page 2 of 2, Statement of Health section: <ul style="list-style-type: none"> Question I.B., revised to read: "B. Had any known indication of or been <u><i>Been diagnosed or</i></u> treated by a physician or consulted with a health advisor for any of the following: High blood pressure, high cholesterol, cardiac chest

909 North Washington Street, Alexandria, VA 22314

(703) 706-5975
(800) 776-2322 x2204

mhunt@afba.com

pain, heart attack, vascular disease (plaque in arteries), or ~~other~~ *any* heart or blood vessel disorder; cancer or blood disorder; stroke, seizures, progressive neuropathy, or ~~other~~ *any* nervous system disease; shortness of breath, asthma, chronic obstructive pulmonary disease (COPD), or ~~other~~ *any* respiratory tract disorder; *ulcers*, hepatitis, ~~pancreatitis~~, colitis, or ~~other disorder of the stomach, liver, pancreas, intestines, or digestive system~~ *disorder of the pancreas, liver, esophagus, stomach or intestine*; depression, schizophrenia, or ~~other~~ *any* mental condition; diabetes, thyroid ~~disease~~, pituitary, *adrenal, or hormone* disorder or ~~other gland disorder~~; disorder of the kidney, bladder, urinary tract, genital tract, or reproductive system; or any ~~other~~ significant medical disorders?"

- Question II.A., revised to read: "A. ~~Had or been~~ *Been* treated by a physician or consulted with a health advisor for alcoholism or medically advised to reduce or discontinue the use of alcohol for health reasons *medical facility or received professional counseling for alcohol or drug dependency or been advised to reduce or discontinue the use of alcohol?*"
- Question II.B., revised to read: "B. Been convicted for driving under the influence of alcohol or *drugs or* while intoxicated?"
- Question II.C., revised to read: "C. Used ~~marijuana, cocaine, heroin, barbiturates, hallucinogens, amphetamines, or any illicit drug except by physician prescription~~ *amphetamines, cocaine, heroin, hallucinogens, barbiturates, marijuana, narcotics, or any drug except as medication prescribed by a physician?*"

Page 2 of 2, Conditions Relating to this Enrollment Form section

- Agreement, line 7, ". . . 3) If within 60 days of receipt of all required documentation the

Mr. Dan Honey

March 24, 2008

Page -3-

	<p>enrollment form is not approved, I will be notified that it will become void and any <u>all</u> contributions paid will be refunded; <u>I will be so notified.</u>"</p> <ul style="list-style-type: none">• Authorization: I hereby authorize any licensed physician; medical practitioner; hospital; clinic or other medical facility; insurance company; employer; <u>financial institution;</u> Medical Information Bureau; <u>or</u> Motor Vehicle Administration or knowledge of me or my physical or mental health condition to give 5Star Life Insurance Company, . . ." <p>Fraud Statement section.</p> <ul style="list-style-type: none">• Page 2 of 2, Inserted the following statement: <u>"D.C. Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant."</u>
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Please note that the term "FEBG" means "Federal Employee Benefit Group" and the term "SEBG" means "State Employee Benefit Group."

All other parts of the above referenced forms remain the same.

Coverage will be marketed via licensed agents and brokers. Once approved, 5 Star Life reserves the right to use the forms in their approval format in a variety of media, such as the Internet, with the understanding that there may be slight accommodations made for electronic viewing.

Should you have any questions, please feel free to contact me.

Very truly yours,

