

SERFF Tracking Number: FIVE-125609004 State: Arkansas
Filing Company: 5 Star Life Insurance Company State Tracking Number: 38737
Company Tracking Number: 408
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
Product Name: SOH R408
Project Name/Number: /

Filing at a Glance

Company: 5 Star Life Insurance Company

Product Name: SOH R408

TOI: L04G Group Life - Term

Sub-TOI: L04G.500 Other

Filing Type: Form

SERFF Tr Num: FIVE-125609004

SERFF Status: Closed

Co Tr Num: 408

Co Status:

Author: Mildred Hunt

Date Submitted: 04/17/2008

State: ArkansasLH

State Tr Num: 38737

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 04/30/2008

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: 04/30/2008

State Status Changed: 04/30/2008

Corresponding Filing Tracking Number:

Filing Description:

SOH R408: Statement of Health Application

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type:

Group Market Size:

Group Market Type:

Deemer Date:

Company and Contact

Filing Contact Information

Mildred Hunt, Compliance Manager

909 North Washington Street

Alexandria, VA 22314

mhunt@afba.com

(703) 706-5975 [Phone]

(703) 224-0214[FAX]

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Filing Company Information

5 Star Life Insurance Company
909 North Washington Street

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

CoCode: 77879
Group Code: 77879

Group Name: NAIC
FEIN Number: 54-1829709

State of Domicile: Louisiana
Company Type: Life Insurance
Company
State ID Number:

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Filing Fees

Fee Required? Yes
Fee Amount: \$100.00
Retaliatory? Yes
Fee Explanation: Fee per product: 1 x \$100.00 = \$100.00
Per Company: No

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
26051	\$100.00	04/15/2008

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	04/30/2008	04/30/2008

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Disposition

Disposition Date: 04/30/2008

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	Statement of Health		Yes

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Form Schedule

Lead Form Number: SOH R408

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	SOH R408	Application/ Statement of Health Enrollment Form	Initial			SOH R408 (Generic).pdf

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 below.

- I. In the last 10 years, has the Applicant:
A. Had a life or health insurance application declined, postponed, modified or rated?
B. Been diagnosed or treated by a physician for:
1. Coronary artery disease, cardiac chest pain, heart attack, heart failure, heart murmur, or any heart disorder?
2. High blood pressure, peripheral vascular disease (plaque in arteries), or any blood vessel disorder?
3. Stroke, paralysis, seizures, epilepsy, loss of consciousness, multiple sclerosis, or any neurological disorder?
4. Skin disorder, cyst, tumor, or cancer?
5. Asthma, Chronic Obstructive Pulmonary Disease (COPD), tuberculosis, chronic cough or shortness of breath, or any disorder of the lungs or respiratory system?
6. Diabetes, thyroid, pituitary, adrenal, or hormone disorder?
7. Disorder of the kidney, bladder, urinary tract, genital tract, or reproductive system?
8. Ulcers, hepatitis, colitis, gastritis, disorder of the pancreas, liver, esophagus, stomach or intestines?
9. Rheumatoid disease, connective tissue disease, or disorder of the blood or lymph glands?
10. Schizophrenia, depression, personality disorder, or any mental health problem?
C. Had any evaluation or treatment by a physician or other health advisor, other than routine physicals?
II. In the past 5 years, has the 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 of driving under the influence of alcohol, 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 the Applicant ever 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 the Applicant takes regularly or frequently:
V. In the past 12 months, has any Applicant or Child used any tobacco or nicotine products (including nicotine patch, gum, or spray)?
VI. Did the Applicant's parent(s) or sibling(s) die before age 60 of cardiovascular or cerebrovascular disease?
VII. Does the Applicant receive disability benefits from any source?
If "Yes," provide details. If V.A. disability rating is 30% or more, provide full report, or details if report is not available.

Initial Here _____ Yes No

Details: _____

Conditions Relating to this Enrollment Form

Group Eligibility: I am eligible to apply for this group insurance coverage as a Member or Associate Member as defined in the Master Group Policy and described in the Certificate of insurance coverage. Agreement: 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 my 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 any 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.

Signature _____ Signed at (City, State) _____ 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. DC 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.

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Review Status: 04/14/2008
Satisfied -Name: Certification/Notice
Comments:
Attachment:
ARKANSAS Certificate of Readability.pdf

Review Status: 04/14/2008
Satisfied -Name: Application
Comments:
The application is submitted under the Form Schedule Tab.

Review Status: 04/14/2008
Satisfied -Name: Cover Letter
Comments:
Attachment:
ARKANSAS Cover Letter.pdf

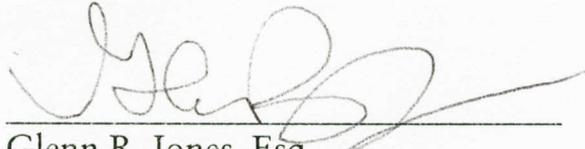


ARKANSAS INSURANCE DEPARTMENT

READABILITY CERTIFICATION

Re: *SOH R408*

The undersigned, authorized as Officer to be responsible for policy and related material filings by the officers of 5 Star Life Insurance Company, hereby certifies that the above Application's Flesch reading ease score does not meet Arizona's statutory requirement of a minimum Flesch score of 40. Because the application is one page it scored at 34.6.



Glenn R. Jones, Esq.
Vice President of Compliance

Dated: April 14, 2008



Mildred E. Hunt
Compliance Manager

April 14, 2008

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: 77879; NAIC Code: 0000; FEIN: 54-1829709*

<i>Form Number</i>	<i>Description</i>
SOH 408	Statement of Health Application

Dear Mr. Honey:

Enclosed for review and approval is the above referenced non-certificate application 5 Star Life Insurance Company plans to include in a mailing to its members tentatively scheduled for May/June 2008. The SOH 408 will serve as an expedited method for our members to increase their coverage.

The form is similar in nature to the G-Term App R107 (Group Level Term Application) page 3 of 4 – the Statement of Health section and page 4 of 4 – the Conditions Relating to this Enrollment Form section. The G-Term App R107 was reviewed and approved by the Department on February 26, 2007, SERFF Tracking Number: FIVE-125104831.

The following changes have been made to the specified sections of the form: (Note: ~~Strikethrough~~ indicate deletions; **bold**, underline, and *italicized* words indicate new language.)

909 North Washington Street, Alexandria, VA 22314

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

mhunt@afba.com

<i>Form Number</i>	<i>Modifications Made</i>
<p>G-Term App R107 <u>SOH R408</u></p>	<p>Statement of Health section revised to read:</p> <ul style="list-style-type: none"> • I.B., Had any known indication of, been <i>Been</i> diagnosed or treated by a physician for or consulted with any health advisor for: • B.1., Coronary artery disease, cardiac chest pain, heart attack, heart failure, heart murmur, or other <u>any</u> heart disorder? • B.2., High blood pressure, peripheral vascular disease (plaque in arteries) or other <u>any</u> blood vessel disorder? • B.3., Stroke, paralysis, seizures, epilepsy, loss of consciousness, multiple sclerosis, other <u>any</u> neurological disorder? • B.4., <u>Skin disorder, cyst, tumor or cancer</u> Cancer or other malignant disease ? • B.5., Asthma, Chronic Obstructive Pulmonary Disease (COPD), tuberculosis, chronic cough or shortness of breath, or other any disorder of the lungs or respiratory system? • B.6., Diabetes, thyroid disease, pituitary, <u>adrenal, or hormone</u> or other gland disorder? • B.8., Ulcers, hepatitis, colitis, <u>gastritis</u>, severe indigestion, disorder of the pancreas, liver, esophagus, stomach or intestine? • B.10., Schizophrenia, depression, personality disorder, or other <u>any</u> mental health problem? • II.A., Had or been <i>Been</i> treated by a physician or medical facility or received professional counseling consulted with a health advisor for alcoholism or medically advised to reduce or discontinue the use of alcohol for health reasons <u>alcohol or drug dependency or been advised to reduce or discontinue the use of alcohol?</u> • II.B., Been convicted of driving under the influence of alcohol, <u>drugs</u> or while intoxicated? • II.C., Used marijuana, <u>amphetamines</u>, cocaine, heroin, barbiturates, hallucinogens, <u>barbiturates, marijuana, narcotics</u>, amphetamines, or any illicit drug except <u>as medication prescribed</u> by <u>a</u> physician prescription? • III., "Has the Applicant <u>ever</u> been diagnosed or treated by a physician or tested positive . . ."

	<ul style="list-style-type: none">• V. Is the Applicant now contemplating any medical advice, consultation, or treatment for any known or suspected health condition?• <u>VI.</u>, Did the Applicant's parent(s) or sibling(s) die before age 60 of cardiovascular <u>or cerebrovascular</u> disease?• <u>VII.</u>, Does the Applicant receive disability <u>benefits</u> pay from any source?• VIII. Is the Applicant planning to reside outside of the United States for at least 180 days and establish residence in the next two years? <p><u>Conditions Relating to this Enrollment Form</u> section revised to read:</p> <ul style="list-style-type: none">• Line 5, "Policy; 2) coverage the <u>my</u> health relating to each person to be covered being as described"• Line 7, "the Certificate of insurance coverage; 3) if within . . . approved, I will be notified that it will become void and <u>any all</u> contributions paid will be refunded; <u>I will be so notified.</u>"• Line 10, "ance coverage for details. <u>Authorization:</u> 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 other organization; or persons that <u>may</u> have any records or knowledge of me or my <u>financial,</u> physical or mental health condition. . . ." <p><u>Fraud Statement</u> section, added the following:</p> <ul style="list-style-type: none">• <u><i>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.</i></u>
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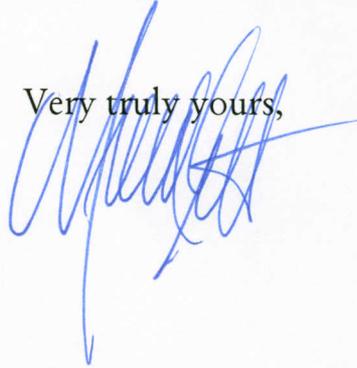
Coverage will be marketed via direct mailing. Once approved, 5 Star Life reserves the right to use the form in its approved format in a variety of

Mr. Dan Honey
April 14, 2008
Page -4-

media, such as the Internet, with the understanding that there may be slight accommodations made for electronic viewing.

Should additional information be required, please feel free to contact me.

Very truly yours,

A handwritten signature in blue ink, appearing to be "John Smith", written over the text "Very truly yours,".