

SERFF Tracking Number: FIVE-125697395 State: Arkansas  
Filing Company: 5 Star Life Insurance Company State Tracking Number: 39319  
Company Tracking Number: 608  
TOI: L04I Individual Life - Term Sub-TOI: L04I.500 Other  
Product Name: Individual Life - Term  
Project Name/Number: /

## Filing at a Glance

Company: 5 Star Life Insurance Company

Product Name: Individual Life - Term

TOI: L04I Individual Life - Term

Sub-TOI: L04I.500 Other

Filing Type: Form

SERFF Tr Num: FIVE-125697395

SERFF Status: Closed

Co Tr Num: 608

Co Status:

Author: Mildred Hunt

Date Submitted: 06/16/2008

State: ArkansasLH

State Tr Num: 39319

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 06/19/2008

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: New Submission

Overall Rate Impact:

Filing Status Changed: 06/19/2008

State Status Changed: 06/19/2008

Corresponding Filing Tracking Number:

Filing Description:

I-Term App R608: Individual Level Term Application

WS-ILT App R608: Individual Select Term Application

PREFMED R608: Preferred Checklist

ALCMF-100 (R608): Part B - Statements to Company's Medical Examiner

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

## Company and Contact

SERFF Tracking Number: FIVE-125697395 State: Arkansas  
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 TOI: L04I Individual Life - Term Sub-TOI: L04I.500 Other  
 Product Name: Individual Life - Term  
 Project Name/Number: /

**Filing Contact Information**

Mildred Hunt, Compliance Manager mhunt@afba.com  
 909 North Washington Street (703) 706-5975 [Phone]  
 Alexandria, VA 22314 (703) 224-0214[FAX]

**Filing Company Information**

5 Star Life Insurance Company CoCode: 77879 State of Domicile: Louisiana  
 909 North Washington Street Group Code: 77879 Company Type: Life Insurance  
 Company  
 Alexandria, VA 22314 Group Name: NAIC State ID Number:  
 (703) 706-5975 ext. [Phone] FEIN Number: 54-1829709  
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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$80.00  
 Retaliatory? No  
 Fee Explanation: Per form filed w/o policy: 4 x \$20.00 = \$80.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
5 Star Life Insurance Company	\$80.00	06/16/2008	20924904

SERFF Tracking Number: FIVE-125697395 State: Arkansas  
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TOI: L04I Individual Life - Term Sub-TOI: L04I.500 Other  
Product Name: Individual Life - Term  
Project Name/Number: /

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	06/19/2008	06/19/2008

SERFF Tracking Number: FIVE-125697395 State: Arkansas  
Filing Company: 5 Star Life Insurance Company State Tracking Number: 39319  
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TOI: L04I Individual Life - Term Sub-TOI: L04I.500 Other  
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Project Name/Number: /

## Disposition

Disposition Date: 06/19/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: FIVE-125697395 State: Arkansas  
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 Product Name: Individual Life - Term  
 Project Name/Number: /

<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice		Yes
<b>Supporting Document</b>	Application		No
<b>Supporting Document</b>	Life & Annuity - Acturial Memo		No
<b>Supporting Document</b>	Cover Letter		Yes
<b>Form</b>	Individual Level Term		Yes
<b>Form</b>	Individual Select Term		Yes
<b>Form</b>	Preferred Checklist		Yes
<b>Form</b>	Part B - Statements to Company's Medical Examiner		Yes

SERFF Tracking Number: FIVE-125697395 State: Arkansas  
 Filing Company: 5 Star Life Insurance Company State Tracking Number: 39319  
 Company Tracking Number: 608  
 TOI: L041 Individual Life - Term Sub-TOI: L041.500 Other  
 Product Name: Individual Life - Term  
 Project Name/Number: /

## Form Schedule

**Lead Form Number:** I-Term App R608

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	I-Term App R608	Application/ Individual Level Enrollment Form	Initial				I-Term App R608 (Generic).pdf
	WS-ILT App R608	Application/ Individual Select Enrollment Term Form	Initial				WS-ILT App R608 (Generic).pdf
	PREFMED R608	Other	Preferred Checklist	Initial			PREFMED R608 (Generic).pdf
	ALCMF-100(r608)	Other	Part B - Statements to Company's Medical Examiner	Initial			ALCMF-100 (R608) (Generic).pdf





IT 2 608

Other Insurance

Check if you want to cancel current group coverage underwritten by 5Star Life if new coverage is approved. If so, specify certificate or account number:

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

Do you, your spouse, or children have any existing life insurance or annuity contracts? 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. Do you, your spouse, or children intend to replace them?

Owner (If other than Applicant)

Payor

Form for Owner and Payor information including SSN, Name, Address, City, State, Zip, Relationship to Applicant, and Phone No.

Beneficiary(ies)

Unless you specify otherwise, payments will be shared equally by all primary beneficiaries who survive the Applicant, or if none, by all secondary beneficiaries who survive the Applicant.

Form for Beneficiary information including Name, SSN, Relationship, and DOB for Primary and Secondary beneficiaries.

Coverage and Premiums

Form for Coverage and Premiums including Price class applying for, Initial premium by credit card, and Recurring Premium Value options.

\* Ultra Preferred class is for those who have not used any tobacco or nicotine products in the past 60 months. Preferred class is for those who have not used any tobacco or nicotine products in the past 24 months. Standard Non-Tobacco class is for those who have not used any tobacco or nicotine products in the past 12 months.

Form for Coverage Amount and Monthly Premium calculation: Coverage Amount \$ x Monthly Premium \$ x Recurring Premium Value = Amount payable to 5Star Life \$



IT 608 3

Statement of Health

Answer each question and initial in box 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 in the section below.

Height [ ] Ft [ ] [ ] In Weight [ ] [ ] [ ] Lbs

- 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 the listed conditions:
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, 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?
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 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 the Applicant ever been diagnosed or treated by a physician or tested positive for Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)?
IV. List each prescribed medication the Applicant takes regularly or frequently:
V. In the past 12 months, has the Applicant 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?
VIII. Is the Applicant planning to reside outside of the United States for at least 180 days and establish residence in the next 2 years?

Initial Here [ ]

Details: \_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_



IT 4 608

Conditions Relating to this Application

Agreement: 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) except as provided or as stated in the Temporary Insurance Agreement, insurance 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 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 (30 months in VA) from the date below. I acknowledge receipt of 5Star Life's Consumer Notice; and 5Star Life's Temporary Insurance Agreement, if the initial premium is submitted with this application. I acknowledge that I am, or my authorized representative is, entitled to receive a copy of this authorization. Signatures must be personal:

Sign Here



Applicant (Or parent or legal guardian, if Applicant is a minor.)

Date [Month]/[Day]/[Year]

Print Applicant's Name

Payor (If different than Applicant.)

Date

Owner (If different than Applicant.)

Date [Month]/[Day]/[Year]

Signed at: City [ ] State [ ]

For Select Term Applicants Only:

If there is a second Applicant living in the same household who is also applying for Select Term coverage, please enter their SSN below.

SSN [ ]-[ ]-[ ]

Best time to contact for medical interview (if applicable): [ ]:[ ] am pm - [ ]:[ ] am pm

Best day/time of week for paramedical exam (if applicable): [ ] Mon [ ] Tues [ ] Wed [ ] Thurs [ ] Fri [ ] Sat [ ] am [ ] pm

Agent Certification: I assisted the Applicant with this application and to the best of my knowledge the questions are answered truthfully.

To the best of my knowledge, the Applicant is [ ]/is not [ ] replacing existing individual insurance.

Paramed Ordered? [ ] Yes [ ] No Deployed? [ ] Yes [ ] No If checkmatic or credit card, did you attach the appropriate form? [ ] Yes [ ] No

Was premium submitted with application? [ ] Yes [ ] No If yes, was the Temporary Insurance Agreement provided to Applicant? [ ] Yes [ ] No

Purpose of Insurance? [ ] Supplemental Coverage [ ] Family Protection [ ] Individual Protection [ ] Other [ ]

Agent Name [ ] Agent Signature [ ] Date [ ]

Special Instructions: [ ]

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. New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Not available in all states • Admin Office: 909 N. Washington St, Alexandria, VA 22314 • 1-800-776-2322 • www.afba.com

**Agent use only—Agent#**

Contract Code

**INTERNAL USE ONLY:**

Attachments: Initials:

# 5Star Executive Level Plan Individual Select Term Application



ES 608 1

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

## Employer Information

Employer Name

Employer Tax ID #

## Applicant Information

Applicant is:  Employee  Spouse

Prefix Last Name  Male  Female

First Name M.I. D.O.B. / /

Address Line 1

Address Line 2

City State Zip

E-Mail

Daytime Number Evening Number

SSN Driver's License # State

Place of Birth: State Country

Are you a United States citizen?  Yes  No

## Employee Information (To be completed if Spouse is Applicant; otherwise leave blank)

Last Name

First Name M.I. D.O.B. / /

SSN Sex:  Male  Female



ES 2 608

Other Insurance

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

Do you, your spouse, or children have any existing life insurance or annuity contracts? ... Do you, your spouse, or children intend to replace them? ...

Owner (If other than Applicant)

Payor

Form with fields for Owner and Payor including SSN, Name, Address, City, State, Zip, Relationship to Applicant, and Phone No.

Beneficiary(ies)

Unless you specify otherwise, payments will be shared equally by all primary beneficiaries who survive the Applicant, or if none, by all secondary beneficiaries who survive the Applicant.

Form for Beneficiary(ies) with fields for Primary and Secondary Name, SSN, Relationship, and DOB.

Coverage and Premiums

- 10 Year, 15 Year, 20 Year, 30 Year

Price class applying for: Ultra Preferred (IS Only), Preferred, Standard Non-Tobacco, Tobacco User

Initial premium by credit card? Yes, No

Recurring Premium Value (Please choose only one.) Monthly Credit Card, Monthly Checkmatic, Quarterly Bill, Semi-Annual Bill, Annual Bill, List Bill, Monthly, Bi-weekly, Weekly

\* Ultra Preferred class is for those who have not used any tobacco or nicotine products in the past 60 months. Preferred class is for those who have not used any tobacco or nicotine products in the past 24 months. Standard Non-Tobacco class is for those who have not used any tobacco or nicotine products in the past 12 months. Price class subject to other underwriting criteria based on health.

Coverage Amount \$ [ ] , [ ] , [ ] , [ ]

Monthly Premium \$ [ ] , [ ] x Recurring Premium Value = Amount payable to 5Star Life \$ [ ] , [ ]



ES 608 3

Statement of Health

Answer each question and initial in box 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 in the section below.

Height [ ] Ft [ ] [ ] In Weight [ ] [ ] [ ] Lbs

- 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 the listed conditions:
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, 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?
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 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 the Applicant ever been diagnosed or treated by a physician or tested positive for Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)?
IV. List each prescribed medication the Applicant takes regularly or frequently:
V. In the past 12 months, has the Applicant 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?
VIII. Is the Applicant planning to reside outside of the United States for at least 180 days and establish residence in the next 2 years?

Initial Here [ ]

Details: [ ]



ES 4 608

Conditions Relating to this Application

Agreement: 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 Applicant's health 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 (30 months in VA) from the date below. I acknowledge that I am, or my authorized representative is, entitled to receive a copy of this authorization. As employee, my signature authorizes payroll deduction of premium from my employer for coverage applied for, if applicable. Signatures must be personal:



Employee \_\_\_\_\_ Date [ ]/[ ]/[ ]

Applicant \_\_\_\_\_ Date [ ]/[ ]/[ ]

Print Applicant/Employee's Name \_\_\_\_\_

Payor \_\_\_\_\_ Date \_\_\_\_\_

Owner \_\_\_\_\_ Date [ ]/[ ]/[ ]

Signed at: City [ ] State [ ]

If there is a second Applicant living in the same household who is also applying for Select Term coverage, please enter their SSN below.

[ ]-[ ]-[ ]

Best time to contact for medical interview (if applicable): [ ]:[ ] am pm - [ ]:[ ] am pm

Best day/time of week for paramedical exam (if applicable): [ ] Mon [ ] Tues [ ] Wed [ ] Thurs [ ] Fri [ ] Sat [ ] am [ ] pm

Agent Certification: I assisted the Applicant with this application and to the best of my knowledge and belief the questions are answered truthfully.

To the best of my knowledge and belief, the Applicant is [ ]/is not [ ] replacing existing individual insurance.

Paramed Ordered? [ ] Yes [ ] No

Purpose of Insurance? [ ] Supplemental Coverage [ ] Family Protection [ ] Individual Protection [ ] Other \_\_\_\_\_

Agent Name \_\_\_\_\_ Agent Signature \_\_\_\_\_ Date \_\_\_\_\_

Special Instructions: \_\_\_\_\_

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. New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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## Preferred Checklist

Print Name of Applicant: \_\_\_\_\_ SSN: \_\_\_\_\_

Please answer the following questions. For any “yes” answers, please provide comments below. These questions are only one factor considered in making a determination of eligibility for a preferred price class. All applicants seeking a preferred price class will be subject to a paramedical exam, including blood and urine samples. A final decision regarding the price class will be based on our underwriting guidelines and experience.

**Yes No**

1. Have you used any tobacco products, nicotine gum, nicotine patch, nicotine nasal spray, or similar nicotine-containing products:
  - a. In the past 5 years?.....
  - b. In the past 2 years?.....
  - c. In the past 1 year?.....
2. Have you been treated for or been medically advised to have treatment for the use of drugs or alcohol?....
3. Do you have a record of conviction for driving while intoxicated (DWI) or driving under the influence of alcohol (DUI) or drugs in the last 10 years, or for any moving violations in the last 5 years? .    
 (If “yes,” list all incidents below, giving the month, year, and offense.)
4. Have you been treated for or been medically advised to have treatment for any of the following:
  - a. Blood pressure?.....
  - b. Cholesterol?.....
  - c. Heart disease?.....
  - d. Diabetes?.....
  - e. Any cardiovascular disease?.....
  - f. Cancer (excluding non-melanoma skin cancer)?.....
5. Do you engage in any of the following hazardous activities: aviation; parachuting; hang-gliding; ultralighting; ballooning; gliding; space travel; SCUBA diving below 60 feet; cave, air-supplied or salvage diving; white water rafting or kayaking; auto, motorcycle or motorboat racing or stunting; rock or mountain climbing; bungee jumping? .....    
 (If “yes,” describe below, giving your level of expertise, frequency of participation, and level of risk. For aviation activities, give purpose of flights, crew position, type of aircraft, and number of hours flown yearly. Do not include flight in regularly scheduled commercial aircraft or any activities performed only pursuant to military, police, fire, or EMS duty.)
6. Did either parent or any sibling die of a heart attack (i.e., myocardial infarction, coronary artery disease) or congestive heart failure or stroke before age 60? .....

Comments: \_\_\_\_\_  
 \_\_\_\_\_

**AGREEMENT:** I represent that all statements and answers in this Preferred Checklist are complete, true, and correctly recorded, **TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

Signature of Applicant: \_\_\_\_\_ 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. **New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The questions and answers in 1-10 and Details of "Yes" answers apply to the following person proposed for insurance:

1. Person proposed for insurance: (PRINT)

a. \_\_\_\_\_  
 First Name M.I. Last Name

b. Birth Date (mm/dd/yy) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 SSN \_\_\_\_-\_\_\_\_-\_\_\_\_

2. In the last 10 years, have you been medically treated for or had any known indication of: **Yes No**

a. Disorder of eyes, ears, nose, or throat?

b. Dizziness, fainting, convulsions, headaches; speech defect, paralysis or stroke; mental or nervous disorder?

c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?

d. High blood pressure, coronary artery disease, heart attack, heart failure, heart murmur, or any disorder of the heart or blood vessels?

e. Jaundice, intestinal bleeding, ulcer, colitis, diverticulitis, recurrent indigestion, or any disorder of the stomach, intestines, liver or gallbladder?

f. Sugar, albumin, blood or pus in urine, venereal disease; stone or any disorder of kidney, bladder, prostate, reproductive organs or breasts?

g. Diabetes; thyroid, pituitary, adrenal, or hormone disorder?

h. Neuritis, rheumatoid disease, amputation, or disorder of the muscles or bones, including the spine, back and joints?

i. Disorder of skin, lymph glands, cyst, tumor, or cancer?

j. Anemia or any disorder of the blood?

3. In the past 5 years have you:

a. Been treated by a physician or medical facility for alcohol or drug dependency?

b. Used amphetamines, cocaine, heroin, hallucinogens, barbiturates, marijuana, narcotics, or any drugs, except as medication prescribed by a physician?

4. Now under treatment or taking any prescribed medication?

5. Any change in weight in the past year?    
 Gain \_\_\_\_ lbs. Loss \_\_\_\_ lbs.

6. Within the past 5 years:

a. Had any mental or physical disorder not listed above?

b. Had a checkup, consultation, illness, injury, surgery?

c. Been a patient in a hospital, clinic, sanatorium, **Yes No** or any medical facility?

6. d. Had electrocardiogram, X-ray, or other diagnostic test?

e. Been medically advised to have any diagnostic test, hospitalization, or surgery which was not completed?

7. Ever:

a. Had military service deferment, rejection or discharge because of a physical or mental condition?

b. Requested or received a pension, benefits, or payment because of an injury, sickness or disability?

8. Have you ever been diagnosed or treated by a physician or tested positive for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency (AIDS) or any AIDS-Related Complex (ARC)?

9. Other Information:

a. Name and address of your personal physician: (If none, so state) \_\_\_\_\_  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_

b. In the past 5 years have you consulted your personal physician for any matter not recorded in answers to questions 2-8? If "Yes", furnish reason, details and date in "Details" space below.

10. Any family history of diabetes, cancer, high blood pressure or cholesterol, heart or kidney disease, or mental illness?

	Age if Living	Cause of Death	Age at Death
Father			
Mother			
Brothers and Sisters			
# Living _____			
# Dead _____			

**DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER. CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)**

The foregoing statements and answers are **TO THE BEST OF MY KNOWLEDGE AND BELIEF**, complete, true, and correctly recorded and are representations and not warranties.

Dated at (City, State) \_\_\_\_\_ on the month, day and year of \_\_\_\_\_

Medical Examiner \_\_\_\_\_  
 Signature of person proposed for insurance, if age 15 or over, Applicant, if person proposed is under age 15.

**TO BE COMPLETED IN EVERY CASE. DO NOT DETACH. Authorization and Acknowledgment**

Date \_\_\_\_\_

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 and any children of the undersigned to give 5Star Life Insurance Company, its authorized representatives, or its reinsurer(s) any such information, including information concerning every condition for which each has been under observation or treatment, including if the information specified contains information related to treatment for drug and/or alcohol abuse or for psychiatric and/or mental conditions, the history obtained, physical and laboratory findings, diagnosis, and treatment. The authorization shall be valid for 24 months from the date above. A photocopy of this authorization shall be as valid as the original.

\_\_\_\_\_  
 Name of proposed insured if under age 15 (PRINT) Signature of proposed insured, if age 15 or over, or Applicant, if proposed insured is under age 15.

**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. **New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

*SERFF Tracking Number:* FIVE-125697395      *State:* Arkansas  
*Filing Company:* 5 Star Life Insurance Company      *State Tracking Number:* 39319  
*Company Tracking Number:* 608  
*TOI:* L04I Individual Life - Term      *Sub-TOI:* L04I.500 Other  
*Product Name:* Individual Life - Term  
*Project Name/Number:* /

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: FIVE-125697395 State: Arkansas  
Filing Company: 5 Star Life Insurance Company State Tracking Number: 39319  
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## Supporting Document Schedules

**Review Status:** 06/16/2008  
**Satisfied -Name:** Certification/Notice  
**Comments:**  
**Attachment:**  
ARKANSAS Certificate of Compliance.pdf

**Review Status:** 06/16/2008  
**Satisfied -Name:** Cover Letter  
**Comments:**  
**Attachment:**  
ARKANSAS Cover Letter.pdf



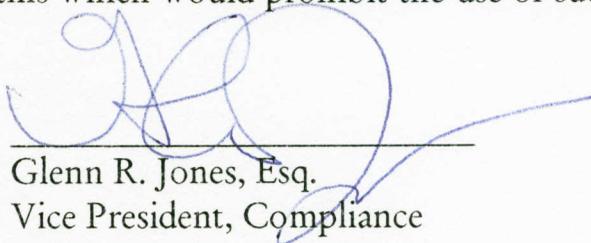
*CERTIFICATION*

ARKANSAS INSURANCE DEPARTMENT

Re: *I-Term App R608: Individual Level Term Application*  
*WS-ILT App R608: Individual Select Term Application*  
*PREFMED R608: Preferred Checklist*  
*ALCMF-100(R608): Part B - Statements to Company's Medical Examiner*

I have reviewed or supervised the review of the above individual life insurance enrollment forms contained in this filing and hereby certify, to the best of my knowledge and belief, that the above listed forms are in compliance with the applicable statutes, regulations, and bulletins of the state of Arkansas. I further certify that the above forms 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: June 16, 2008

  
Glenn R. Jones, Esq.  
Vice President, Compliance

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Attachment "ARKANSAS Cover Letter.pdf" is larger than 3MB and cannot be reproduced here.