

SERFF Tracking Number: FIVE-125711891 State: Arkansas
Filing Company: 5 Star Life Insurance Company State Tracking Number: 39427
Company Tracking Number: 608G
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-125711891

SERFF Status: Closed

Co Tr Num: 608G

Co Status:

Author: Mildred Hunt

Date Submitted: 06/26/2008

State: ArkansasLH

State Tr Num: 39427

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 06/27/2008

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: 06/27/2008

State Status Changed: 06/27/2008

Corresponding Filing Tracking Number:

Filing Description:

G-Term App R608: Group Level Term Enrollment Form

BANG App R608: Better Alternative Level Term Enrollment Form

DoD App R608: DoD Contractors Enrollment Form

ESP App R608: Emergency Service Personnel Enrollment Form

Gov't App R608: Government Employees Enrollment Form

PREFMED R608: Preferred Checklist Form

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

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Group Market Type: Association

Deemer Date:

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Company and Contact

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$140.00
 Retaliatory? No
 Fee Explanation: Applications filed separately from policy: \$20.00 x 7 = \$140.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
5 Star Life Insurance Company	\$140.00	06/26/2008	21107590

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	06/27/2008	06/27/2008

SERFF Tracking Number: FIVE-125711891 *State:* Arkansas
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Disposition

Disposition Date: 06/27/2008

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		No
Supporting Document	Cover Letter		Yes
Form	Group Level Term Enrollment Form		Yes
Form	Better Alternative Level Term Enrollment Form		Yes
Form	DoD Contractors Enrollment Form		Yes
Form	Emergency Service Personnel Enrollment Form		Yes
Form	Government Employees Enrollment Form		Yes
Form	Preferred Checklist		Yes
Form	Part B - Statements to Company's Medical Examination		Yes

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Form Schedule

Lead Form Number: G-Term App R608

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	G-Term App R608	Application/ Enrollment Form	Group Level Term Enrollment Form	Initial			G-Term App R608 (Generic).pdf
	BANG App R608	Application/ Enrollment Form	Better Alternative Level Term Enrollment Form	Initial			BANG App R608 (Generic).pdf
	DoD App R608	Application/ Enrollment Form	DoD Contractors Enrollment Form	Initial			DoD App R608 (Generic).pdf
	ESP App R608	Application/ Enrollment Form	Emergency Service Personnel Enrollment Form	Initial			ESP App R608 (Generic).pdf
	Gov't App R608	Application/ Enrollment Form	Government Employees Enrollment Form	Initial			Gov't 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 Examination	Initial			ALCMF-100 (R608) (Generic).pdf



GT 2 608

Employment Information (DoD Contractors or Applicants Enrolling for Coverage Amounts Over \$250,000)

Current Employer: _____ Yrs with Employer: _____ Occupation: _____

Duties: _____

Owner (If other than Applicant)

Payor

SSN --

Name: _____

Address: _____

City, State, Zip _____

Relationship to Applicant _____ Phone No. _____

Owner Applicant Other (Complete all info below)

SSN --

Name: _____

Address: _____

City, State, Zip _____

Phone Number _____

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. The right to change the beneficiary is reserved to the Owner unless otherwise stated. Children's beneficiary is the Applicant unless otherwise stated.

Beneficiary:

Primary --
Name SSN Relationship DOB

Secondary --
Name SSN Relationship DOB

Coverage and Contributions

Price class applying for:*

- Ultra Preferred (GS Only)
- Preferred (GS & GH Only)
- Standard Non-Tobacco
- Tobacco User

Initial contribution by credit card?

- Yes
- No

Recurring Contribution Value

(Please choose only one.)

- | | | | | |
|--|---|--|----|-----------------------------------|
| <input type="radio"/> Monthly Credit Card | 1 | <input type="radio"/> Semi-Annual Bill | 6 | <input type="radio"/> List Bill |
| <input type="radio"/> Monthly Checkmatic | 2 | <input type="radio"/> Annual Bill | 12 | <input type="radio"/> Monthly 1 |
| <input type="radio"/> Monthly Military Allotment | 2 | <input type="radio"/> Gov't 1199 | 2 | <input type="radio"/> Bi-weekly 2 |
| <input type="radio"/> Quarterly Bill | 3 | | | <input type="radio"/> Weekly 4 |

* 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.

Applicant's Coverage \$

Children's Rider: Yes No (BA & LT Only)

Children's Units (may not exceed 5) # of Children

Applicant's Monthly Contribution .

Children's Monthly Contribution-BA/LT Only .

Total Monthly Contribution \$.

Recurring Contribution Value

Amount payable to AFBA.

\$.



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Other Coverage

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? 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, your spouse, or children 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 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

Initial Here
Applicant Yes No Children Yes No

- I. In the last 10 years, has the Applicant or Child:
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 or Child:
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 physician?
III. Has the Applicant or Child 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 or Child 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 or Child's parent(s) or sibling(s) die before age 60 of cardiovascular or cerebrovascular disease?
VII. Does the Applicant or Child 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? If yes, please provide full details below.

Details:



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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 each covered person'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 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.

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.

[]-[]-[]

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(s) with this enrollment form 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

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.

AGENT #

Agent number input boxes

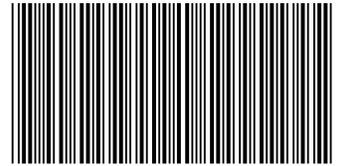
ASD: ___ YR ___ MO

AFBA USE ONLY:

Source Code: 52207

Attachments: ___ Initials: ___

Better Alternative Level Term National Guard/Reserve Enrollment Form



NGBA 608 1

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

Military Member Information

Rank Grade Prefix, Last Name, First Name, M.I., D.O.B., SSN, Height, FT, IN, Weight, LBS, Gender, Non-Tobacco*, Tobacco User*, Married, Not Married

Eligibility (Choose One):

- National Guard, Reserve

Branch:

- Army, Air Force, Navy, Marine Corps, Coast Guard

Activated?

- Yes, No

* Tobacco user is one who has used any tobacco product in the past 12 months.

Unit of Assignment:

Address Line 1, Address Line 2, City, State, Zip, E-Mail, Phone Number

Spouse Information

Last Name, First Name, M.I., D.O.B., SSN, Height, FT, IN, Weight, LBS, Gender, Non-Tobacco*, Tobacco User*

Coverage and Contributions

Military Member's Coverage, Spouse's Coverage, Children's Coverage, Children's Units

Military Member's Monthly Contribution, Spouse's Monthly Contribution, Children's Monthly Contribution, Total Monthly Contribution

National Guard/Reserve Use Only

(Please choose only one.)

- Monthly Allotment*, Monthly Checkmatic, Monthly Credit Card

* Limited Availability

Over

Beneficiary(ies)

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



NGBA 2 608

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

Other Insurance

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 any of the following: 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 intestines; 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 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 because I am currently in the National Guard, Reserve or their spouse or dependent child. Agreement: I, as military member, 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 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, 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 authority 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.

Agent Certification: I certify that I asked all the questions and had the Applicant sign in my presence.

Is Applicant replacing existing coverage? Yes No
Paramed Ordered?
Yes No

Military Member/Owner's
Signature Date
SIGNED HERE Signed at (City, State) Agent Name 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.

Statement of Health



DEF 2 608

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.

Initial Here _____

- 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, 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 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 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?

Conditions Relating to this Enrollment Form

Group Eligibility: I am eligible to apply for this group 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 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 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 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. Signatures must be personal.

Sign Here Applicant Date
Owner Date
Owner's Name (Please Print)
Owner's SSN
Owner's Address
Signed at (City, State)

Agent Certification: I certify that I asked all the questions and had the Applicant sign in my presence.
Is Applicant replacing existing coverage?
Agent Name
Agent Signature Date
Paramed Ordered?

Beneficiary(ies)



ESP 2 608

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

Beneficiary of:
Applicant
Spouse
Name SSN Relationship DOB

Other Insurance

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

Do you have any existing life insurance or annuity contracts?
Do you intend to replace them?
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 any of the following: 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 intestines; 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 each covered person'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 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. Signature must be personal.

Sponsor's Signature Date
Spouse's Signature Date
Agent Name Agent 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?
Paramed Ordered?
Pampered Ordered?

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.
ESP App R608 Not available in all states • Admin Office: 909 N. Washington St, Alexandria, VA 22314 • 1-800-776-2322 • www.afba.com 6/08

Beneficiary(ies)

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



GOV 2 608

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

Other Insurance

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 any of the following: 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 intestines; 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 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: 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 each covered person'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 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. Signature must be personal.

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



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, or 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-125711891 State: Arkansas
Filing Company: 5 Star Life Insurance Company State Tracking Number: 39427
Company Tracking Number: 608G
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
Product Name: Group Life - Term
Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: FIVE-125711891 State: Arkansas
Filing Company: 5 Star Life Insurance Company State Tracking Number: 39427
Company Tracking Number: 608G
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
Product Name: Group Life - Term
Project Name/Number: /

Supporting Document Schedules

Review Status: 06/26/2008

Satisfied -Name: Certification/Notice
Comments:
Attachment:
ARKANSAS Certificate of Compliance.pdf

Review Status: 06/26/2008

Satisfied -Name: Cover Letter
Comments:
Attachments:
ARKANSAS Cover Letter (Part I).pdf
ARKANSAS Cover Letter (Part II).pdf



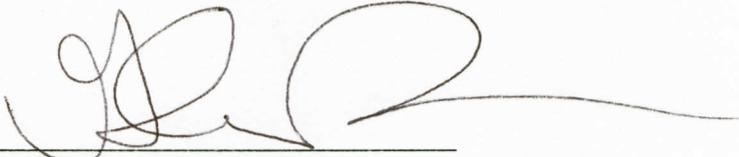
CERTIFICATION

ARKANSAS INSURANCE DEPARTMENT

Re: *G-Term App R608: Group Level Term Enrollment Form*
BANG App R608: Better Alternative Level Term Enrollment form
DoD App R608: DoD Contractors Enrollment Form
ESP App R608: Emergency Service Personnel Enrollment Form
Gov't App R608: Government Employees Enrollment Form
PREFMED R608: Preferred Checklist
ALCMF-100 (R608): Part B - Statements to Company's Medical Examination

I have reviewed or supervised the review of the above group life insurance forms and hereby certify, to the best of my knowledge and belief, that the above listed forms fully comply with Arkansas Rule 19 - Unfair Sex Discrimination in the Sale of Insurance - as well as all applicable requirements of the Arkansas Insurance Department. 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 26, 2008



Glenn R. Jones, Esq.
Vice President, Compliance



June 26, 2008

Mildred E. Hunt
Compliance Manager

VIA SERFF

Mr. Joe Musgrove
Director, Life and Health
Policy and Form Filing – 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>
G-Term App R608	Group Level Term Enrollment Form
BANG App R608	Better Alternative Level Term Enrollment Form
DoD App R608	DoD Contractors Enrollment Form
ESP App R608	Emergency Service Personnel Enrollment form
Gov't App R608	Government Employees Enrollment Form
PREFMED R608	Preferred Checklist Form
ALCMF-100(R608)	Part B – Statements to Company’s Medical Examination

Dear Mr. Musgrove:

Submitted for filing and approval are the above referenced non-certificate forms. Form numbers G-Term App R107, BANG App R107, DoD App R107, ESP App R107, Gov’t App R107, PREFMED R107, and ALCMF-100(R107) were approved by the Insurance Department on February 26, 2007. The SERFF Tracking Number is FIVE-125104831.

The applications are submitted in conjunction with the Group Level Term Insurance Policy (LT 050197) stamped approved by the Insurance Department on November 13, 1997.

909 North Washington Street, Alexandria, VA 22314

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

mhunt@afba.com

A redline depicting the deletions and the changes to various sections of the applications are outlined below: (Note: ~~Strikethroughs~~ indicate deletions, **bold**, underscore, and *italic* indicate new language.)

<i>Form Number</i>	<i>Description of Change</i>
<p>G-Term App R407 <u>608</u> BANG App R407 <u>608</u> DoD App R407 <u>608</u> ESP App R407 <u>608</u> Gov't App R407 <u>608</u></p>	<p>Page 3 of 4, Other Coverage, section</p> <ul style="list-style-type: none"> • Deleted in its entirety: Do you have any existing individual life insurance or annuity contracts? Yes No. Do you intend to replace them? Yes No. If yes to either question, complete the Replacement Notice. Inserted the following language: <i>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 NC, NH, NJ, NM, 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.</i> <p>Page 3 of 4, Statement of Health</p> <ul style="list-style-type: none"> • Question B. revised to read: "B. Had any known indication of, been <i>Been</i> diagnosed or treated by a physician for <i>the listed conditions</i>; or consulted with any health advisor for:" • Question B.1., revised to read: "1. Coronary artery disease, cardiac chest pain, heart attach, heart failure, heart murmur, or other <i>any</i> health disorder?" • Question B.2., revised to read: "2. High blood pressure, peripheral vascular disease (plaque in arteries), or other <i>any</i> blood vessel disorder?" • Question B.3., revised to read: "3. Stroke, paralysis, seizures, epilepsy, loss of consciousness, multiple sclerosis, other <i>any</i> neurological disorder?" • Question B.4., revised to read: "4. Cancer or other malignant disease <i>Skin disorder, cyst, tumor or cancer?</i>" • Question B.5., revised to read: "5. Asthma, Chronic Obstructive Pulmonary Disease (COPD), tuberculosis, chronic cough or shortness of breath, or other <i>any</i> disorder of the lungs or respiratory system?" • Question B.6., revised to read: "6. Diabetes, thyroid disease, pituitary, <i>adrenal, or hormone</i>, or other gland disorder. • Question B.8., revised to read: "6. Ulcers, hepatitis, colitis, severe indigestion, <i>gastritis</i>, disorder of the pancreas, liver, esophagus, stomach or intestine?"

- Question B.10., revised to read: “10. Schizophrenia, depression, personality disorder, or ~~other~~ any mental health problem?”
- Deleted Question C. in its entirety: ~~C. Had any evaluation or treatment by a physician or other health advisor, other than routine physicals?~~
- 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~~ or 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 of driving under the influence of alcohol or drugs or while intoxicated?”
- Question II.C., revised to read: “C. Used ~~marijuana, amphetamines,~~ cocaine, heroin, ~~barbiturates,~~ hallucinogens, ~~amphetamines,~~ barbiturates, marijuana, narcotics, or any illicit drug ~~except by physician prescription~~ as medication prescribed by a physician?”
- Question III. revised to read: “III. Has the Applicant or Child 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 (ARS)?”
- Question V. deleted in its entirety: ~~V. Is the Applicant or Child now contemplating any medical advice, consultation, or treatment for any known or suspected health condition?~~
- Question VI. renumbered “V.”
- Question VII. renumbered “VI.”, revised to read: “VI. Did the Applicant’s or Child’s parent(s) or sibling(s) die before age 60 of cardiovascular or cerebrovascular disease?”
- Question VIII. renumbered “VII.” and revised to read: “VII. Does the Applicant or Child receive disability pay benefits from any source?”
- Question IX. renumbered “VIII.” and revised to read: “~~IX. Does the Applicant intend to travel or reside outside of the United States in the next 2 years?~~ 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?”

Page 4 of 4, Conditions Relating to the Enrollment Form Section

- Lines 5 and 6, revised to read: “. . . Company and is subject to the health relating to each person’s health to be covered being as described in the enrollment form”

	<ul style="list-style-type: none">• Line 8, "enrollment form is not approved, I will be notified that it will become void and any contributions paid will be refunded; <i>I will be so notified.</i>• Lines 11 and 12 revised to read: "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 . . ."• Inserted Signature block: <u>Payor Date</u> <p>Page 4 of 4, Agent Certification</p> <ul style="list-style-type: none">• Deleted the following reference: In FL Only: FL Agent License #
ALCMF-100(107608)	<ul style="list-style-type: none">• Question 2.d., revised to read: "d. Cardiac chest pain, palpitation, high <u>High</u> blood pressure, <u>coronary artery disease</u>, rheumatic fever, heart murmur, heart attack, <u>heart failure, heart murmur</u>, or other <u>any</u> disorder of the heart or blood vessels?"• Question 2.e., revised to read: "e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other <u>any</u> disorder of the stomach, intestines, liver or gallbladder?"• Question 2.f., revised to read: "f. Sugar, albumin, blood or pus in urine, venereal disease; stone or other <u>any</u> disorder of kidney, bladder, prostate, reproductive organs or breasts?"• Question 2.g., revised to read: "g. Diabetes; thyroid, <u>pituitary, adrenal or hormone</u> or other endocrine disorders?"• Question 2.h., revised to read: "h. Neuritis, sciatica; rheumatism, arthritis, gout, <u>rheumatoid disease, amputation</u> or disorder of the muscles or bones, including spine, back or <u>and</u> joints?"• Question 2.i., deleted in its entirety: i. Deformity, lameness or amputation?• Question 2.j., renumbered "<u>i.</u>"• Question 2.k., renumbered "<u>j.</u>" and revised to read: "j. Allergies, anemia, <u>Anemia</u> or other <u>any</u> disorder of the blood?"• Question 3.a., revised to read: "a. Had any <u>Been treated by a physician or medical facility for</u> alcohol or drug dependency?"• Question 3.b., revised to read: "b. Used amphetamines, cocaine, <u>heroin, hallucinogens, barbiturates</u>, marijuana, narcotics, or any other drugs, except as medication prescribed by a physician?"

	<ul style="list-style-type: none">• Question 4. revised to read: "4. Now under treatment or taking any prescription drug <i>prescribed medication</i>?"• Question 6. revised to read: "6. Other than above, <i>Within</i> the past 5 years:"• Question 6.c., revised to read: "c. Been a patient in a hospital, clinic, sanatorium, or other <i>any</i> medical facility?" <p>Authorization and Acknowledgment</p> <ul style="list-style-type: none">• Lines 1, 2 and 3 revised to read: "I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, <i>employer; financial institution;</i> the Medical Information Bureau; <i>or Motor Vehicle Administration</i> or other organization, institution, or person that may has any have records or knowledge regarding each of my, and any children of the undersigned, financial, physical, or mental health condition the undersigned and any children of the undersigned if proposed for insurance to give to the 5Star Life Insurance Company, <i>its authorized representatives,</i> or"• Line 7 revised to read: "rization shall be valid for 24 months from the date above. A Photostat <i>photocopy</i> of this authorization is <i>shall be</i> as valid as this the original."
PREFMED R907 <u>608</u>	<ul style="list-style-type: none">• Question 3. revised to read: "3. Do you have a record of conviction for driving while intoxicated (DWI) or driving under the influence of alcohol (DUI) <i>or drugs</i> in the last 10 years, or for any moving violation in the last 5 years?"• Question 6. revised to read: "6. Did either parent or any sibling die of a heart attack (i.e., myocardial infarction, coronary artery disease) or congestive heart failure <i>or stroke</i> before age 60?"• Question 7. deleted in its entirety: 7. If 5Star Life is unable to offer you the price class you applied for will you accept another price class for an additional cost?

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

Form ALCMF-100 (R608) is used for evidence of insurability purposes and is to be used in other products.

Mr. Joe Musgrove

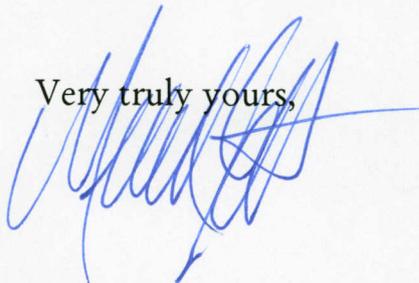
June 26, 2008

Page -6-

Form PREFMED R608 and Form ALCMF-100 (R608) are also intended for use as applicable with other products underwritten by 5 Star Life which the Department of Insurance has approved.

Should you require additional information, please do not hesitate to contact the undersigned.

Very truly yours,

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