

SERFF Tracking Number: FIVE-126035230 State: Arkansas
Filing Company: 5 Star Life Insurance Company State Tracking Number: 41571
Company Tracking Number: 209
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-126035230 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 41571

Co Tr Num: 209

Author: Mildred Hunt

Date Submitted: 02/13/2009

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 02/17/2009

Disposition Status: Approved-
Closed

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: 02/17/2009

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 02/17/2009

Created By: Mildred Hunt

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Mildred Hunt

Filing Description:

WS-UST App R209: 5Star Family Protection Plan -- Term Life Insurance to Age 100 Application

Company and Contact

Filing Contact Information

Mildred Hunt, Compliance Manager

909 North Washington Street

Alexandria, VA 22314

mhunt@afba.com

703-706-5975 [Phone]

703-224-0214 [FAX]

Filing Company Information

SERFF Tracking Number: FIVE-126035230 State: Arkansas
 Filing Company: 5 Star Life Insurance Company State Tracking Number: 41571
 Company Tracking Number: 209
 TOI: L041 Individual Life - Term Sub-TOI: L041.500 Other
 Product Name: Individual Life - Term
 Project Name/Number: /

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: \$20.00
 Retaliatory? No
 Fee Explanation: Application filing; 1 x \$20.00 = \$20.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
5 Star Life Insurance Company	\$20.00	02/13/2009	25722383

SERFF Tracking Number: FIVE-126035230 State: Arkansas
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Company Tracking Number: 209
TOI: L041 Individual Life - Term Sub-TOI: L041.500 Other
Product Name: Individual Life - Term
Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	02/17/2009	02/17/2009

SERFF Tracking Number: FIVE-126035230 *State:* Arkansas
Filing Company: 5 Star Life Insurance Company *State Tracking Number:* 41571
Company Tracking Number: 209
TOI: L041 Individual Life - Term *Sub-TOI:* L041.500 Other
Product Name: Individual Life - Term
Project Name/Number: /

Disposition

Disposition Date: 02/17/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: FIVE-126035230 State: Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Cover Letter		Yes
Form	5Star Family Protection Plan - Term Life Insurance to Age 100 Application		Yes

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Form Schedule

Lead Form Number: WS-UST App R209

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	WS-UST App R209	Application/5Star Enrollment Form	Family Protection Plan - Term Life Insurance to Age 100 Application	Initial			WS-UST App R209 (Generic).pdf

Additional Children's Information



FPP 2 209

Child 3:

Name (First, MI, Last)	DOB	SSN	Sex	Coverage Amount	Premium Amount
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Child 4:

Name (First, MI, Last)	DOB	SSN	Sex	Coverage Amount	Premium Amount
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Other Insurance

Do you, your spouse, or children have any existing life insurance or annuity contracts? Yes No

If yes, and you live in AK, 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.

Will the coverage applied for replace any existing life insurance or annuities? 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.

Beneficiary(ies)

I designate my beneficiary(ies) to receive benefits as indicated below. Check here if you would like an additional beneficiary form sent to you.

Beneficiary Of Employee Coverage _____

Last Name	First Name	MI	Relationship	DOB	SSN
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Beneficiary Of Spouse Coverage _____

Last Name	First Name	MI	Relationship	DOB	SSN
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Note: Beneficiary for Child coverage will be designated as the Employee unless otherwise noted on a separate 8.5x11 sheet of paper submitted with this application.

Statement of Health

Please answer each question and circle the specific condition.

	Employee		Spouse		Child 1		Child 2		Child 3		Child 4	
	Yes	No										
I. Has any Applicant been hospitalized in the past 90 days?.....	<input type="radio"/>											
II. In the past 10 years, has any Applicant had or been hospitalized for, been medically diagnosed, treated, or taken prescription medication for:												
A. Angina, heart attack, stroke, heart bypass surgery, angioplasty, coronary artery stenting, or coronary artery disease?.....	<input type="radio"/>											
B. Any form of cancer to include leukemia or Hodgkin's Disease (excluding non-invasive, non-melanoma skin cancer)?.....	<input type="radio"/>											
C. Chronic obstructive pulmonary disease (COPD), emphysema, or any other chronic respiratory disorder, excluding asthma?.....	<input type="radio"/>											
D. Alcoholism or drug or alcohol abuse, cirrhosis, hepatitis, or any other disease of the liver?	<input type="radio"/>											
III. Has any Applicant been diagnosed or treated by a physician, or tested positive for: Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)?.....	<input type="radio"/>											
IV. Has any Applicant ever applied for and been rejected for life insurance?.....	<input type="radio"/>											

Conditions Relating to this Application

Agreement: I, as employee, have the appropriate knowledge to answer the questions for my spouse and children. 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 health relating to each person to be insured 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 from the date below. I acknowledge that I, or my authorized representative is entitled to receive a copy of this authorization. As employee, my signature authorizes payroll deduction of premiums from my employer for myself and my family members. **I acknowledge that I have received and read the Accelerated Benefit Disclosure form. Signatures must be personal:**

Agent Certification: I certify that I asked all the questions and had the Applicant sign in my presence. To my knowledge, the Applicant has existing life insurance or annuity coverage. Yes No
 If yes, are they replacing existing coverage? Yes No
 Agent Name _____

Sign Here Employee _____ Date _____
 Owner _____ SSN _____
 (If different than Employee.)
 Signed At (City, State) _____ 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.

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: ARKANSAS Certificate of Readability.pdf		
Bypassed - Item: Application Bypass Reason: Application submitted for approval. Comments:		
Bypassed - Item: Life & Annuity - Acturial Memo Bypass Reason: Not applicable. Comments:		
Satisfied - Item: Cover Letter Comments: Attachment: ARKANSAS.pdf		



ARKANSAS INSURANCE DEPARTMENT

READABILITY CERTIFICATION

Re: *WS-UST App R209: 5Star Family Protection Plan -- Term Life Insurance to Age 100 Application*

The undersigned, authorized as Officer to be responsible for policy and related material filings by the officers of 5 Star Life Insurance Company, hereby certifies that the above forms meet Arizona's statutory requirement of a minimum Flesch score of 40.

A handwritten signature in black ink, appearing to read 'Glenn R. Jones', written over a horizontal line.

Glenn R. Jones, Esq.
Vice President of Compliance

Dated: February 13, 2009



Mildred E. Hunt
Compliance Manager

February 13, 2009

VIA SERFF

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

Re: *5 Star Life Insurance Company; NAIC No.: 77879*
Product: 5Star Family Protection Plan - Term Life Insurance
to Age 100 Application
Form Number: WS-UST App R209

Dear Mr. Honey:

Enclosed for review and approval is the 5Star Family Protection Plan - Term Life Insurance to Age 100 application. The prior application, WS-UST App R508, was approved on May 2, 2008, SERFF Tracking No.: FIVE-125626869.

This application is not to replace any other forms approved by the Department of Insurance. The application will be used in conjunction with the WS-UST100AR stamped approved by the Department on December 21, 2001.

The following redline dictates the changes made to the previous approved version of the WS-UST App R508: (Note: ~~Strikethroughs~~ indicate deletions; **bold**, underscore and *italic* words indicate new language.)

909 North Washington Street, Alexandria, VA 22314

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

mhunt@afba.com

Form Number	Description
<p>WS-UST App R508 <u>WS-UST App R209</u></p>	<p>Page 1, Agent Use Only – Agent #</p> <ul style="list-style-type: none"> Deleted reference: FPP-I <p>Page 2, Other Insurance</p> <ul style="list-style-type: none"> Line 2, revised to read: “If yes, and you live in <u>AK, AL, AZ, CO, . . .</u>” Line 4, revised to read: “Do you, your spouse, or children intend to replace them? O Yes O No <u>Will the coverage applied for replace any existing life insurance or annuities? O Yes O No”</u> <p>Page 2, Beneficiary(ies)</p> <ul style="list-style-type: none"> Delete reference to: Beneficiary Of Child 1 Coverage Delete reference to: Beneficiary Of Child 2 Coverage Inserted the following information: <u>“Note: Beneficiary for Child coverage will be designated as the Employee unless otherwise noted on a separate 8.5 x 11 sheet of paper submitted with this application.”</u> <p>Page 2, Statement of Health</p> <ul style="list-style-type: none"> Paragraph 1, revised to read: Answer each question and initial in the 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 on a separate 8 ½ x 11 piece of paper. “Please answer each question and circle the specific condition.” Question I, new insert: <u>“I. Has any Applicant been hospitalized in the past 90 days?”</u> Question I, revised to read: <u>“II. In the last 5 10 years, have you had or been treated by a member of the medical profession for any of the following <i>has any Applicant had or been hospitalized for, been medically diagnosed, treated, or taken prescription medication for:</i>”</u> Section A., revised to read: “A. <u>Angina</u>, heart attack, stroke, or heart bypass surgery, angioplasty, coronary artery <u>stenting, or coronary artery</u> disease?” Section B., revised to read: “B. Any form of cancer to include leukemia and Hodgkin’s Disease (<u>excluding non-invasive, non-melanoma skin cancer</u>)?” Section C., revised to read: “C. Chronic hepatitis, cirrhosis <u>obstructive pulmonary disease (COPD), emphysema</u>, or <u>any</u> other disease of the liver <u>chronic</u>

	<p><u>respiratory disorder, excluding asthma?</u></p> <ul style="list-style-type: none">• Section D., revised to read: “D. Lung disease? <u>Alcoholism or drug or alcohol abuse, cirrhosis, hepatitis, or any other disease of the liver?</u>”• Question II, revised to read: “II. III. <u>Has any</u> the Applicant been diagnosed”• Question III, revised to read: “III. IV. <u>Has any Applicant</u> Have you ever applied for and been rejected for life insurance?” <p>Page 2, Signature Block</p> <ul style="list-style-type: none">• Add: “<u>(If different than Employee)</u>” under Owner signature line.
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Coverage will be marketed via licensed agents and brokers. Once approved, 5 Star Life reserves the right to use the forms in their approval format in a variety of media, such as the Internet, with the understanding that there may be slight accommodations made for electronic viewing.

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

Very truly yours,

