

SERFF Tracking Number: FIVE-126168171 State: Arkansas  
Filing Company: 5 Star Life Insurance Company State Tracking Number: 42513  
Company Tracking Number: 609  
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other  
Product Name: Group Multiple Employer Trust  
Project Name/Number: /

## Filing at a Glance

Company: 5 Star Life Insurance Company

Product Name: Group Multiple Employer Trust SERFF Tr Num: FIVE-126168171 State: Arkansas  
TOI: L04G Group Life - Term SERFF Status: Closed-Approved- State Tr Num: 42513  
Closed

Sub-TOI: L04G.500 Other Co Tr Num: 609 State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Linda Bird  
Author: Mildred Hunt Disposition Date: 06/03/2009  
Date Submitted: 06/01/2009 Disposition Status: Approved-  
Closed  
Implementation Date: Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name: Status of Filing in Domicile: Pending  
Project Number: Date Approved in Domicile:  
Requested Filing Mode: Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Group  
Submission Type: New Submission Group Market Size: Large  
Overall Rate Impact: Group Market Type: Employer, Trust  
Filing Status Changed: 06/03/2009 Explanation for Other Group Market Type:  
State Status Changed: 06/03/2009  
Deemer Date: Created By: Mildred Hunt  
Submitted By: Mildred Hunt Corresponding Filing Tracking Number:  
Filing Description:  
G-MET App R609: 5Star Multiple Employer Trust Enrollment Form

## 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

|                                 |                                      |                                      |                       |
|---------------------------------|--------------------------------------|--------------------------------------|-----------------------|
| <i>SERFF Tracking Number:</i>   | <i>FIVE-126168171</i>                | <i>State:</i>                        | <i>Arkansas</i>       |
| <i>Filing Company:</i>          | <i>5 Star Life Insurance Company</i> | <i>State Tracking Number:</i>        | <i>42513</i>          |
| <i>Company Tracking Number:</i> | <i>609</i>                           |                                      |                       |
| <i>TOI:</i>                     | <i>L04G Group Life - Term</i>        | <i>Sub-TOI:</i>                      | <i>L04G.500 Other</i> |
| <i>Product Name:</i>            | <i>Group Multiple Employer Trust</i> |                                      |                       |
| <i>Project Name/Number:</i>     | /                                    |                                      |                       |
| 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: | Per form |
| Per Company:     | No       |

| COMPANY                       | AMOUNT  | DATE PROCESSED | TRANSACTION # |
|-------------------------------|---------|----------------|---------------|
| 5 Star Life Insurance Company | \$20.00 | 06/01/2009     | 28218603      |

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## Correspondence Summary

### Dispositions

| Status          | Created By | Created On | Date Submitted |
|-----------------|------------|------------|----------------|
| Approved-Closed | Linda Bird | 06/03/2009 | 06/03/2009     |

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*Filing Company:* 5 Star Life Insurance Company      *State Tracking Number:* 42513  
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*TOI:* L04G Group Life - Term      *Sub-TOI:* L04G.500 Other  
*Product Name:* Group Multiple Employer Trust  
*Project Name/Number:* /

## **Disposition**

Disposition Date: 06/03/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: FIVE-126168171 State: Arkansas  
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| Schedule            | Schedule Item                                 | Schedule Item Status | Public Access |
|---------------------|---|----------------------|---------------|
| Supporting Document | Flesch Certification                          |                      | Yes           |
| Supporting Document | Application                                   |                      | Yes           |
| Supporting Document | Cover letter                                  |                      | Yes           |
| Form                | 5Star Multiple Employer Trust Enrollment Form |                      | Yes           |

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## Form Schedule

### Lead Form Number: G-MET App R609

| Schedule Item Status | Form Number    | Form Type                         | Form Name                               | Action  | Action Specific Data | Readability | Attachment                   |
|----------------------|----------------|-----------------------------------|---|---------|----------------------|-------------|------------------------------|
|                      | G-MET App R609 | Application/5Star Enrollment Form | Multiple Employer Trust Enrollment Form | Initial |                      |             | G-MET App R609 (Generic).pdf |



**Beneficiary Information**



MET 2 609

I designate my beneficiary(ies) to receive benefits as indicated below. The employee is the beneficiary for all dependent coverages. If more than one beneficiary is named, the beneficiaries shall share equally unless otherwise stated below.

**Beneficiary:**

Primary \_\_\_\_\_  
Last Name, First Name, MI Relationship SSN DOB %

Secondary \_\_\_\_\_  
Last Name, First Name, MI Relationship SSN DOB %

**Statement of Health (To be completed only for amounts of coverage requiring evidence of insurability)**

Answer each question **TO THE BEST OF YOUR KNOWLEDGE AND BELIEF**. Circle the specific condition and give full details to any "yes" answers in the chart below.

- I. In the past 10 years, has any Applicant: Yes No
- A. Had a life or health insurance application declined, postponed, modified or rated?.....
- B. Been diagnosed, advised, or treated by a physician or health advisor for the listed conditions: Heart attack, coronary artery disease, or any heart disorder, stroke, high blood pressure, blood or circulatory disorder, diabetes, cancer, tumor, chronic obstructive pulmonary disease (COPD) or any lung or respiratory disorder, liver disorder, alcohol or drug abuse, kidney disorder, disorder of the pancreas, paralysis, epilepsy, or mental, nervous or emotional disorder? .....
- II. In the past 5 years, has any Applicant been admitted or confined to any hospital or medical treatment facility or consulted a physician or health advisor for any disease not listed above, or been advised to have any surgical operation or diagnostic tests (excluding genetic tests and screenings)? .....
- III. Has any 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. For each Applicant list any prescribed medication taken regularly or frequently:
- \_\_\_\_\_

For any "Yes" answers above, please complete the following. Attach additional details on an 8.5 x 11 piece of paper and submit with this enrollment form.

| Ques No. | Name | Condition, injury, findings of examination or prescription | Date (Mo/Yr) | Date of Recovery | Name & Address of Hospital or Attending Physician |
|----------|------|--|--------------|------------------|---|
|          |      |  |              |                  |   |
|          |      |  |              |                  |   |
|          |      |  |              |                  |   |

**Conditions Relating to This Enrollment Form**

**Group Eligibility:** I am eligible to apply for this group insurance as a full-time employee of an employer under the Group Policy issued to the Trustee, America's 5Star Multiple Employer Trust by 5Star Life Insurance Company. **Agreement:** I, as employee, have the appropriate knowledge to answer the statement of health questions for my spouse\*. 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 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 payroll deduction from my earnings of the required contribution, if any, toward the cost of such insurance for myself and my family members. I understand that if my employment is terminated, upon re-employment, insurance will not become effective until I apply again for insurance in accordance with the terms of the Group Policy. I hereby authorize any licensed physician; medical practitioner; hospital; clinic; insurance company; employer; financial institution; Medical Information Bureau; or Motor Vehicle Administration that 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 to my employer. 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.**

**Sign Here** Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

 Signed at (City, State) \_\_\_\_\_

**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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Product Name: Group Multiple Employer Trust  
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## Supporting Document Schedules

|  | Item Status: | Status Date: |
|--|--------------|--------------|
| <b>Satisfied - Item:</b> Flesch Certification<br><b>Comments:</b><br><b>Attachment:</b><br>ARKANSAS Certificate of Readability.pdf |              |              |

|  | Item Status: | Status Date: |
|--|--------------|--------------|
| <b>Satisfied - Item:</b> Application<br><b>Comments:</b><br><b>Attachment:</b><br>GMT200enr-r804.pdf |              |              |

|  | Item Status: | Status Date: |
|--|--------------|--------------|
| <b>Satisfied - Item:</b> Cover letter<br><b>Comments:</b><br><b>Attachment:</b><br>ARKANSAS Cover Letter.pdf |              |              |



ARKANSAS INSURANCE DEPARTMENT

**READABILITY CERTIFICATION**

Re: *G-MET App R609: 5Star Multiple Employer Trust Enrollment Form*

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 be 'G. Jones', written over a horizontal line.

Glenn R. Jones, Esq.  
Vice President of Compliance

Dated: May 28, 2009

Agent use only—Agent#  
 [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
**INTERNAL USE ONLY:**  
 Attachments: [ ] [ ] Initials: [ ] [ ]

# 5Star Multiple Employer Trust Group Life Insurance Enrollment Form



Use black or blue ink and print using all upper case letters.

- New Enrollee    
  Late Enrollee (Statement of Health must be completed.)    
  Name Change    
  Coverage Change    
  Beneficiary Change

### Employer Information

Employer Name ABC COMPANY  
 Employer Tax ID # 123456789

### Employee/Applicant Information

Last Name DOE  
 First Name JOHN M.I. [ ] D.O.B. 10/01/1958  
 SSN 123-45-6789  Male  Female Height 5 ft 190 lbs

**APPROVED**

Home Address:  
 Street Line 1 123 ANY STREET JAN 21 2005  
 Street Line 2 [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
 City ANYWHERE State AR Zip 12345-6789

**LIFE AND HEALTH  
 ARKANSAS INSURANCE DEPARTMENT**

Daytime Phone Number 222-333-4444  
 Full-Time Employment Date [ ]/[ ]/[ ] Coverage Effective Date [ ]/[ ]/[ ]

### Employee Insurance Coverage

Basic Group Life Amount \$ XX,XXX Basic Group AD&D Amount \$ [ ] [ ] [ ] [ ]  
 Voluntary Group Life Amount \$ [ ] [ ] [ ] [ ] Voluntary AD&D Amount \$ [ ] [ ] [ ] [ ]  
 Earnings \$ [ ] [ ] [ ] [ ] (If coverage is earnings based) Voluntary Premium Amount \$ [ ] [ ] [ ] [ ]

### Voluntary/Optional Dependent Insurance Coverage

| Spouse  | Name | SSN | DOB | Sex | Height | Weight | Coverage Amount | Premium Amount |
|---------|------|-----|-----|-----|--------|--------|-----------------|----------------|
| Child 1 | Name | SSN | DOB | Sex | Height | Weight | Coverage Amount | Premium Amount |
| Child 2 | Name | SSN | DOB | Sex | Height | Weight | Coverage Amount | Premium Amount |
| Child 3 | Name | SSN | DOB | Sex | Height | Weight | Coverage Amount | Premium Amount |
| Child 4 | Name | SSN | DOB | Sex | Height | Weight | Coverage Amount | Premium Amount |





Mildred E. Hunt  
Compliance Manager

May 28, 2009

VIA SERFF

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

| <i>Form Number</i> | <i>Description</i>                            |
|--------------------|---|
| G-MET App R609     | 5Star Multiple Employer Trust Enrollment Form |

Dear Mr. Honey:

Submitted for filing and approval is the above referenced enrollment form. The previous application assigned form number GMT200ENR-R804 was stamped approved by the Insurance Department on January 21, 2005.

The application is submitted in conjunction with the Group Multiple Employer Trust Certificates (GMTCERT-EEAR, GMTCERT-EE(OPT)AR, GMTCERT-DEP(OPT)) stamped approved by the Insurance Department on February 28, 2003; GMTCERT-ADD-AR stamped approved by the Insurance Department on October 19, 2003; and GMTCERT-VGT-AR stamped approved by the Insurance Department on November 9, 2004.

This is not an illustrated product.

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

909 North Washington Street, Alexandria, VA 22314

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

mhunt@afba.com

| <i>Form Number</i>                             | <i>Description</i>  |
|--|---|
| GMT200ENR-R106 <u>G-MET</u><br><u>App R609</u> | <p>Page 1, Voluntary/Optional Dependent Insurance Coverage section</p> <ul style="list-style-type: none"><li>• Inserted asterisk: Spouse*</li><li>• Inserted definition of asterisk: <u>*NJ and NH Residents: Includes civil unions and partners.</u></li></ul> <p>Page 2, Beneficiary Information section</p> <ul style="list-style-type: none"><li>• Inserted: <u>"Beneficiary"</u></li></ul> <p>Page 2, Statement of Health section</p> <ul style="list-style-type: none"><li>• Revised introduction to Statement of Health section to read: "Answer each question and initial in the box to acknowledge you've read and, <u>TO THE BEST OF YOUR KNOWLEDGE AND BELIEF</u>, understood each question."</li><li>• Question I. revised to read: "In the last <u>past</u> 10 years, has the <u>any</u> Applicant <u>under this application for coverage</u>?"</li><li>• Question I.A., revised to read: "A. Had a life or health insurance application declined, <u>postponed, modified</u> or rated?"</li><li>• Question I.B., revised to read: "B. <u>Been diagnosed, advised, or</u> Had <del>any known indication of or been treated by a physician or consulted with a health advisor for any of the following</del> <u>the listed conditions</u>: High blood pressure, high cholesterol, chest pain, heart <u>Heart</u> attack, <u>coronary artery</u> vascular disease (plaque in arteries), <del>or other heart or blood vessel disorder</del>; or <u>any heart disorder</u>; cancer or blood disorder; stroke, seizures, progressive neuropathy, or other nervous system disease; shortness of breath, asthma, <u>high blood pressure, blood or circulatory disorder, diabetes, cancer, tumor</u>, chronic obstructive pulmonary disease (COPD) or <u>any lung or</u> other respiratory tract disorder; hepatitis; pancreatitis, colitis, <del>or other disorder of the stomach, liver</del> <u>disorder, pancreas, in testiness</u>;</li></ul> |

~~or digestive system; depression, schizophrenia, or other mental condition; alcoholism or alcohol or drug abuse; diabetes, thyroid disease; pituitary disorder, or other gland disorder; disorder of the kidney disorder, disorder of the pancreas, paralysis, epilepsy, or mental, bladder, urinary tract, genital tract, or reproductive system, or any other significant medical disorders nervous or emotional disorder?~~

- Question I.C., deleted in its entirety: “C. Used marijuana, cocaine, heroin, barbiturates, hallucinogens, amphetamines, or any illicit drug except by physician prescription?”
- Question II. inserted: “In the past 5 years, has any Applicant been admitted or confined to any hospital or medical treatment facility or consulted a physician or health advisor for any disease not listed above, or been advised to have any surgical operation or diagnostic tests (excluding genetic tests and screenings)?”
- Question II. revised: “III. H. Has the any 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) related condition?”
- Question III. revised: “IV. H. For each Applicant list any List each prescribed medication taken regularly or frequently by the Applicant.”
- Question IV. deleted in its entirety: “IV. In the past 5 years, has the Applicant for this coverage been admitted or confined to any hospital or medical treatment facility?”

Page 2, Conditions Relating to This Enrollment Form Agreement section:

- Line 2, revised to read: “the statement of health questions for my spouse\*. . . .”
- Line 3, revised to read: “recorded TO THE

Mr. Dan Honey

May 28, 2009

Page -4-

|  |  |
|--|--|
|  | <p><u><i>BEST OF MY KNOWLEDGE AND BELIEF. . .</i></u></p> <ul style="list-style-type: none"><li>• Line 5, revised to read: “coverage applied for will . . . <u><i>each person’s</i></u> health being as described. . . .”</li><li>• Line 7 and 8, revised to read: “the Certificate of Insurance Coverage; 3) if within 60 days . . . not approved, <del>I will be notified that . . . void</del> and any contributions paid will be refunded; <u><i>I will be so notified. . .</i></u>”</li></ul> <p>Page 2, Conditions Relating to This Enrollment Form <u><b>Authorization</b></u> section:</p> <ul style="list-style-type: none"><li>• Line 2, revised to read: “such insurance for myself and my family members. <del>Authorization may be revoked by me at any time by written notice to my employer. . . .</del>”</li><li>• Lines 4 and 5, revised to read: “per; hospital; clinic; insurance company; employer; <u><i>financial institution</i></u>; Medical Information Bureau; or Motor Vehicle Administration that have records <u><i>of my financial</i></u>, physical, or mental health condition . . . .”</li><li>• Line 7, revised to read: “ment form at any time by providing written notice <u><i>to my employer</i></u>. A photocopy . . . .”</li></ul> |
|--|--|

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.

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

Sincerely,

