Filing at a Glance

Company: 5 Star Life Insurance Company

Product Name: Group Life - Term
TOI: L04G Group Life - Term

SERFF Tr Num: FIVE-126208270
SERFF Status: Closed-Approved-Closed

State: Arkansas
State Tr Num: 42778

Sub-TOI: L04G.500 Other
Filing Type: Form

Co Tr Num: 509

Author: Mildred Hunt
Date Submitted: 06/29/2009

State Status: Approved-Closed
Reviewer(s): Linda Bird
Disposition Date: 06/30/2009
Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
State Filing Description:

Implementation Date:

General Information

Project Name:
Project Number:
Requested Filing Mode:
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 06/30/2009

Deemer Date:
Submitted By: Mildred Hunt
Filing Description:
G-Term App R509: Group Level Term Programs Enrollment Form
G-Term App R509E: Group Level Term Programs Enrollment Form (electronic application)

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Group Market Type: Association
Explanation for Other Group Market Type:
State Status Changed: 06/30/2009
Created By: Mildred Hunt
Corresponding Filing Tracking Number:

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

5 Star Life Insurance Company	CoCode: 77879	State of Domicile: Louisiana
909 North Washington Street	Group Code: 77879	Company Type: Life Iinsurance 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:	$40.00
Retaliatory?	No
Fee Explanation:	For each form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
5 Star Life Insurance Company	$40.00	06/29/2009	28864416

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/30/2009	06/30/2009

Disposition

Disposition Date: 06/30/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FIVE-126208270*	*State:*	*Arkansas*
Filing Company:	*5 Star Life Insurance Company*	*State Tracking Number:*	*42778*
Company Tracking Number:	*509*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Group Life - Term*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Cover Letter		Yes
Supporting Document	Electronic Snapshots, PART I - Personal Information		Yes
Supporting Document	Electronic Snapshots, PART II Application Information		Yes
Supporting Document	Electronic Snapshots, PART III eSignature of Applicant		Yes
Supporting Document	Electronic Snapshots, Part IV eSignature (Agent)		Yes
Form	Group Level Term Programs Enrollment Form		Yes
Form	Group Level Term Programs Enrollment Form (Electronic)		Yes

Form Schedule

Lead Form Number: G-Term App R509

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	G-Term App R509	Application/ Enrollment Form	Group Level Term Programs Enrollment Form	Initial			G-Term App R509 (Generic).pdf
	G-Term App R509E	Application/ Enrollment Form	Group Level Term Programs Enrollment Form (Electronic)	Initial			G-TERM APP R509E (GENERIC).PDF

Underwritten by 5Star Life Insurance Company (a Baton Rouge, Louisiana Company)
Offered through Armed Forces Benefit Association (AFBA)
1-800-776-2322 • www.afba.com

Agent Number:
Agent Market Code:
Agent Level:
Source Code:

INTERNAL USE ONLY:

Pymt Enclosed: ◯ Yes ◯ No ◯ Split
Amt: $.
CC/Checkmatic Auth Rec'd: ◯ Yes ◯ No
Attachments: Initials:

Group Level Term Programs
Enrollment Form

GT 509 1

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

Coverage Plan (Select only one—All plans not available in all states.)

◯ Military Better Alternative (BA)
◯ 5Star Group Level Term (LT)
◯ Group Ultimate Select Term to 100 (GH)
◯ Group Select Term (GS) — Select One
◯ 10 Yr ◯ 15 Yr ◯ 20 Yr

Member Information

Are you a current AFBA member? ◯ Yes ◯ No

If approved for new coverage, cancel my existing AFBA group insurance. (Select all that apply)
◯ BA ◯ LT ◯ GT ◯ Other _____ ◯ All

Applicant's Information

Eligibility (Choose One):

◯ Army ◯ Marine Corps ◯ Law Enforcement ◯ Homeland Security
◯ Air Force ◯ Coast Guard ◯ Emergency Med Tech ◯ Fed/State/Local Emp
◯ Navy ◯ USPHS ◯ Deployable Gov't Contractor ◯ Dependent Spouse**
◯ NOAA ◯ Fire Dept. ◯ Non-Dep Gov't Contractor ◯ Current or Former Dependent

Duty Status:

◯ Active Duty ◯ Ready Reserve
◯ Retiree* ◯ IRR
◯ Separatee* ◯ N/A
◯ National Guard

*Approx retirement/separation date Month / Year

Rank Grade Prefix
Last Name
◯ Male ◯ Female
First Name
M.I.
D.O.B. Month / Day / Year

Address Line 1
Address Line 2

City
State
Zip –

E-Mail

Daytime Number – –
Evening Number – –

SSN – –
Driver's License #
State

Place of Birth): State
Country

Are you a United States citizen? ◯ Yes ◯ No
Are you married?** ◯ Yes ◯ No
Do you have dependent children? ◯ Yes ◯ No

** NJ & NH Residents: Married includes civil unions and civil union partners.

GT 2 509

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)

SSN ___-__-____

Name: _____

Address: _____

City, State, Zip _____

Relationship to Applicant _____ Phone No. _____

Payor

○ Owner ○ Applicant ○ Other (Complete all info below)

SSN ___-__-____

Name: _____

Address: _____

City, State, Zip _____

Phone Number _____

If Contingent Owner is desired, check here ☐ and a form will be sent to the Owner. If not, the Contingent Owner will be the Applicant.

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.)

○ Monthly Credit Card	1	○ Semi-Annual Bill	6	List Bill	
○ Monthly Checkmatic	2	○ Annual Bill	12	○ Monthly	1
○ Monthly Military Allotment	2	○ Gov't 1199	2	○ Bi-weekly	2
○ Quarterly Bill	3			○ 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: (BA & LT Only) ○ Yes ○ No

Children's Units (may not exceed 5) ☐

# of Children ☐

Applicant's Monthly Contribution ___.__

Children's Monthly Contribution–**BA/LT Only** ___.__

Total Monthly Contribution $ ___.__ x **Recurring Contribution** Value ____ = $ ____.__

Amount payable to AFBA.

GT 509 3

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 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.

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.

Initial Here _____

Height ☐ Ft ☐☐ In Weight ☐☐☐ Lbs

	Applicant Yes	Applicant No	Children Yes	Children 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? If "Yes," provide details. If V.A. disability rating is 30% or more, provide full report, or details if report is not available.	◯	◯	◯	◯
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: _____

GT 4 509

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 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 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 (30 months in VA) 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 __/__/____
(Or parent or legal guardian, if Applicant is a minor.) Month Day Year

Print Applicant's Name _____

Payor _____ Date _____
(If different than Applicant.)

Owner _____ Date __/__/____
(If different than Applicant.) 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.

Underwritten by 5Star Life Insurance Company (a Baton Rouge, Louisiana Company)
Offered through Armed Forces Benefit Association (AFBA)
1-800-776-2322 • www.afba.com

Agent Number: EVA164E

Agent Market Code

Agent Level:

Source Code:

INTERNAL USE ONLY:

Pymt Enclosed: ◯ Yes ◯ No ◯ Split

Amt: $

CC/Checkmatic Auth Rec'd: ◯ Yes ◯ No

Attachments: Initials:

Group Level Term Programs
Enrollment Form

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

Coverage Plan (Select only one—All plans not available in all states.)

- ☐ Military Better Alternative (BA)
- ☐ 5Star Group Level Term (LT)
- ☐ Group Ultimate Select Term to 100 (GH)
- ☒ Group Select Term (GS) — Select One
  - ☐ 10 Yr ☒ 15 Yr ☐ 20 Yr

Member Information

Are you a current AFBA member? ☐ Yes ☒ No

If approved for new coverage, cancel my existing AFBA group insurance. (Select all that apply)
☐ BA ☐ LT ☐ GT ☐ Other _____ ☐ All

Applicant's Information

Eligibility (Choose One)

☐ Army	☐ Marine Corps	☐ Law Enforcement	☐ Homeland Security
☐ Air Force	☐ Coast Guard	☐ Emergency Med Tech	☐ Fed/State/Local Emp
☐ Navy	☐ USPHS	☐ Deployable Gov't Contractor	☐ Dependent Spouse*
☐ NOAA	☐ Fire Dept.	☐ Non-Dep Gov't Contractor	☐ Current or Former Dependent

Duty Status:

☐ Active Duty	☐ Ready Reserve
☐ Retiree*	☐ IRR
☐ Separatee*	☐ N/A
☐ National Guard	

*Approx retirement/separation date ____ Month ____ Year

Rank Grade Prefix ____ Last Name Louisiana

☒ Male ☐ Female

First Name John M.I. P. D.O.B. 05/09/1965 (Month Day Year)

Address Line 1 909 North Washington Street

Address Line 2

City Anywhere State LA Zip 22314

E-Mail mhunt@afba.com

Daytime Number (703) 706-5975 Evening Number

SSN 456-25-9002 Driver's License # LA45689 State LA

Place of Birth): State LA Country USA

Are you a United States citizen? ☒ Yes ☐ No Are you married?* ☒ Yes ☐ No Do you have dependent children? ☒ Yes ☐ No

* NJ & NH Residents: Married includes civil unions and civil union partners.

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

Current Employer: AFBA Yrs with Employer: 12 Occupation: Compliance

Duties: Manager

Owner (If other than Applicant)

SSN

Name:

Address:

City, State, Zip

Relationship to Applicant Phone No.

Payor

☐ Owner ☒ Applicant ☐ Other (Complete all info below)

SSN 456-25-9002

Name: John P. Louisiana

Address: 909 North Washington Street

City, State, Zip Anywhere LA 22314

Phone Number (703) 706-5975

If Contingent Owner is desired, check here ☐ and a form will be sent to the Owner. If not, the Contingent Owner will be the Applicant.

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:

	Name	SSN	Relationship	DOB
Primary	Molly P. Louisiana	456-23-8975	Spouse	08/07/1969
Secondary				

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.)

☐ Monthly Credit Card	1	☐ Semi-Annual Bill	6	List Bill	
☒ Monthly Checkmatic	2	☐ Annual Bill	12	☐ Monthly	1
☐ Monthly Military Allotment	2	☐ Gov't 1199	2	☐ Bi-weekly	2
☐ Quarterly Bill	3			☐ 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 $ 300,000.00

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

Children's Units (may not exceed 5) 0

# of Children

Applicant's Monthly Contribution

Children's Monthly Contribution–**BA/LT Only**

Total Monthly Contribution $ x **Recurring Contribution** Value 1 = $ Amount payable to AFBA.

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? [X] 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 annuitieis? [X] 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.

Digitally signed by John P. Loui
2009-06-29 08:00:33 @ 12.43.255.
initial here

Height 6 Ft 5 In Weight 315 Lbs

	Applicant Yes	Applicant No	Children Yes	Children 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?		X		
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?		X		
2. High blood pressure, peripheral vascular disease (plaque in arteries), or any blood vessel disorder?		X		
3. Stroke, paralysis, seizures, epilepsy, loss of consciousness, multiple sclerosis, any neurological disorder?		X		
4. Skin disorder, cyst, tumor, or cancer?		X		
5. Asthma, Chronic Obstructive Pulmonary Disease (COPD), tuberculosis, chronic cough or shortness of breath, or any disorder of the lungs or respiratory system?		X		
6. Diabetes, thyroid, pituitary, adrenal, or hormone disorder?		X		
7. Disorder of the kidney, bladder, urinary tract, genital tract, or reproductive system?		X		
8. Ulcers, hepatitis, colitis, gastritis, disorder of the pancreas, liver, esophagus, stomach or intestines?		X		
9. Rheumatoid disease, connective tissue disease, or disorder of the blood or lymph glands?		X		
10. Schizophrenia, depression, personality disorder, or any mental health problem?		X		
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?		X		
B. Been convicted of driving under the influence of alcohol or drugs or while intoxicated?		X		
C. Used amphetamines, cocaine, heroin, hallucinogens, barbiturates, marijuana, narcotics, or any drug except as medication prescribed by physician?		X		
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)?		X		
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)?		X		
VI. Did the Applicant's or Child's parent(s) or sibling(s) die before age 60 of cardiovascular or cerebrovascular disease?		X		
VII. Does the Applicant or Child receive disability benefits from any source? If "Yes," provide details. If V.A. disability rating is 30% or more, provide full report, or details if report is not available.		X		
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.		X		

Details: _____

Conditions Relating to this Enrollment Form

Group Eligibility: I am eligible to apply for this group insurance coverage as a Member or Associate Member as defined in the Master Group Policy and described in the Certificate of insurance coverage. **Agreement:** I represent that all statements and answers in this enrollment form are complete, true and correctly recorded **TO THE BEST OF MY KNOWLEDGE AND BELIEF**. I agree that 1) upon approval of this enrollment form by 5Star Life Insurance Company, it and the Certificate of insurance coverage issued to me will describe the benefits and terms of coverage provided under the Master Group Policy; 2) **coverage applied for will not become effective until approved by 5Star Life Insurance Company and is subject to 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 Digitally signed by John P. Louisiana, Sr. 2009-06-29 08:02:16 @ 12.43.255.2 Date _____ Month Day Year

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

Print Applicant's Name John P. Louisiana, Sr.

Payor _____ Date _____

(If different than Applicant.)

Owner _____ Date _____ Month Day Year

(If different than Applicant.)

Signed at: City Anywhere State LA

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 X /is not ☐ replacing existing individual insurance.

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

Purpose of Insurance? ☐ Supplemental Coverage ☐ Family Protection ☐ Individual Protection ☐ Other _____

Agent Name Gary Anderson Agent Signature Digitally signed by Gary Anderson 2009-06-29 08:30:26 @ 12.43.255.2 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. **DCResidents: 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.

Authorization for Release of Health Related Information to 5Star Life Insurance Company

(This authorization complies with the HIPAA Privacy Rule)

John P. Louisiana, Sr.	05/09/1965	456-25-9002
Name of Proposed Insured/Patient (please print)	Date of Birth	Social Security Number

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, medications prescribed and any other protected health information concerning me to 5 Star Life Insurance Company ("5 Star Life") and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct My Providers to release and disclose my entire medical records without restriction.

This protected health information is to be disclosed under this Authorization so that 5 Star Life may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage, and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with 5 Star Life.

This Authorization shall remain in force for 30 months (24 months in IA, KS, KY, NM, OK & VT and 26 months in MN or the time period prescribed by the law of the state where you live) following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written notification to 5 Star Life at 909 North Washington St, Alexandria VA 22314 Attn: Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that 5 Star Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by 5 Star Life except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical records, 5 Star Life may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Digitally signed by John P. Louisiana, Sr.
2009-06-29 08:03:59 @ 12.43.255.2

Signature of Proposed Insured/Patient or Personal Representative or Legal Guardian (if under age 15) Date

Description of Personal Representative's Authority or Relationship to Patient: _____

AFBA Credit Card Authorization Form

AFBA USE ONLY
Application Enclosed

Payment: X Initial Month Only Recurring Monthly

List all Applicant/Insured's SSNs whose insurance coverage will be paid with this Credit Card:

1. Applicant/ Insured's SSN: 456-25-9002
2. Applicant/ Insured's SSN:
3. Applicant/ Insured's SSN:
4. Applicant/ Insured's SSN:
5. Applicant/ Insured's SSN:
6. Applicant/ Insured's SSN:
7. Applicant/ Insured's SSN:
8. Applicant/ Insured's SSN:

Payor's name as it appears on credit card:

Last Name Louisiana

First Name John M.I. P Payor's SSN: 456-25-9002

Billing Address:

Address Line 1 909 North Washington Street

Address Line 2

City Anywhere State LA Zip 22314

Only Visa/MasterCard Accepted

Credit Card Account Number: XXXXXXXXXXXX3858 Exp Date: 9 (Month) 2013 (Year)

Authorization Code (3 digit number found on the back of your card after your account number): XXX

I authorize AFBA to charge my credit card as indicated. I understand that AFBA will safeguard my credit card information. I understand that if my credit card is not accepted for payment, I have the option to pay via direct billing. If a refund is due it will be made directly to the cardholder's account. The life insurance coverage applied for will not become effective until approved and upon receipt of all monies due. I understand my account is considered paid when the credit card facility approves the transaction. I also understand that the amount to be charged will be automatically adjusted if I change my coverage, status, or the monthly contribution changes due to a birthday. This agreement will remain in effect until AFBA cancels it upon notice to me, or I notify AFBA in writing at least 10 days in advance to cancel it.

Cardholder's Signature Digitally signed by John P. Louisiana, Sr.
2009-06-29 08:05:51 @ 12.43.255.2 Date

5/05 (6/08)

Please detach and keep this portion for your records.

I authorize AFBA to charge my credit card as indicated. I understand that AFBA will safeguard my credit card information. I understand that if my credit card is not accepted for payment, I have the option to pay via direct billing. If a refund is due it will be made directly to the cardholder's account. The life insurance applied for will not become effective until approved by 5 Star Life Insurance Company and upon receipt of all monies due. I understand my account is considered paid when the credit card facility approves the transaction. I also understand that the amount to be charged will be automatically adjusted if I change my coverage, status, or the monthly contribution changes due to a birthday. This agreement will remain in effect until AFBA cancels it upon notice to me, or I notify AFBA in writing at least 10 days in advance to cancel it.

AFBA Checkmatic Authorization Form
Electronic Funds Transfer

AFBA USE ONLY
Application Enclosed

List all Applicant/Insured's SSNs whose insurance coverage will be paid with this Checkmatic:

1. Applicant/ Insured's SSN: 456-25-9002
2. Applicant/ Insured's SSN:
3. Applicant/ Insured's SSN:
4. Applicant/ Insured's SSN:
5. Applicant/ Insured's SSN:
6. Applicant/ Insured's SSN:
7. Applicant/ Insured's SSN:
8. Applicant/ Insured's SSN:

Payor's name as it appears on bank account:

Last Name Louisiana

First Name John M.I. P Payor's SSN: 456-25-9002

Address of Payor 909 North Washington Street

Address Line 2

City Anywhere State LA Zip 22314

Bank ABA No.* (First 9 digits on bottom left of check): Day of Deduction 0

Checking Savings Account Number*:

Bank's Name and Address: ,

As a convenience to me, I authorize AFBA to initiate electronic debit entries on the 5th business day of each month to my checking or savings account as indicated on the attached voided check or savings deposit slip. I also request and authorize the financial institution named on the check/deposit slip to accept and honor the same and to debit the same to my account. I understand that I have the right to receive notice of each electronic debit entry that varies in amount from the previous entry, but I elect not to receive notice if such entry is less than or equal to the amount due for my monthly payment. I also understand that the amount will be automatically adjusted if I change my coverage, status, or the monthly contribution changes due to a birthday. This agreement will remain in effect until AFBA cancels it upon notice to me, or I notify AFBA in writing and at least 10 days in advance to cancel it.

Digitally signed by John P. Louisiana, Sr.
2009-06-29 08:07:36 @ 12.43.255.2

Payor's Signature Date

***IMPORTANT:** This service is available to members with checking accounts in most U.S. banks, credit unions and savings banks. The account must be in U.S. dollars. **To start Checkmatic we must have your bank routing number and account number.** These are printed on your checks. Take a blank check from your checkbook and mark it "VOID." Return both the authorization and the voided check to the address below.

5/05 (6/08)

Please detach and keep this portion for your records.

As a convenience to me, I authorize AFBA to initiate electronic debit entries on the 5th business day of each month to my checking or savings account as indicated on the attached voided check or savings deposit slip. I also request and authorize the financial institution named on the check/deposit slip to accept and honor the same and to debit the same to my account. I understand that I have the right to receive notice of each electronic debit entry that varies in amount from the previous entry, but I elect not to receive notice if such entry is less than or equal to the amount due for my monthly payment. I also understand that the amount will be automatically adjusted if I change my coverage, status, or the monthly contribution changes due to a birthday. This agreement will remain in effect until AFBA cancels it upon notice to me, or I notify AFBA in writing at least 10 days in advance to cancel it.

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITY

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions below:

Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? _x_ Yes ___ No

Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ Yes _x_ No

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number, if available) and whether each policy or contract will be replaced or used as a source of financing:

	Insurer Name	*Contract or Policy Number*	*Insured or Annuitant*	*Replaced (R) or Financing (F)*
1.	Melody, Inc.	LA4223	Insured	Replaced
2.				None
3.				None

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because Better Rates

I certify that the responses herein are, to the best of my knowledge, accurate:

Date: _____

Digitally signed by John P. Louisiana, Sr.
2009-06-29 08:11:12 @ 12.43.255.2

Applicant's Signature

John P. Louisiana, Sr.

Applicant's Printed Name

Date: _____

Digitally signed by Gary Anderson
2009-06-29 08:34:20 @ 12.43.255.2

Producer's Signature

Gary Anderson

Producer's Printed Name

I do not want this notice read aloud to me. Digitally signed by John P. Louisiana, Sr.
2009-06-29 08:16:41 @ 12.43.255.2 ***(Applicant's must initial only if they do not want the notice read aloud.)***

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contact. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS: Are they affordable?
Could they change?
You're older - are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid, you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? (Please contact your tax advisor.)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

NOTICE TO CONSUMERS

Information regarding your insurability will be treated as confidential. 5Star Life Insurance Company or its re-insurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

5Star Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

ARKANSAS Certificate of Readability.pdf

Item Status: **Status Date:**

Bypassed - Item: Application

Bypass Reason: The paper copy and electronic version of application are attached under the Forms tab.

Comments:

Item Status: **Status Date:**

Satisfied - Item: Cover Letter

Comments:

Attachment:

ARKANSAS Cover Letter.pdf

Item Status: **Status Date:**

Satisfied - Item: Electronic Snapshots, PART I - Personal Information

Comments:

Attachment:

G-Term App R509E_Generic_ - Part I Clients & Cases.pdf

Item Status: **Status Date:**

Satisfied - Item: Electronic Snapshots, PART II Application Information

Comments:

Attachment:

G-Term App R509E_Generic_ - Part II Product Applications.pdf

Item Status: **Status Date:**

Satisfied - Item: Electronic Snapshots, PART III eSignature of Applicant

Comments:

Attachment:

G-Term App R509E_Generic_ - Part III eSignature _Applicant_.pdf

Item Status: **Status Date:**

Satisfied - Item: Electronic Snapshots, Part IV eSignature (Agent)

Comments:

Attachment:

G-Term App R509E_Generic_ - Part IV eSignature _Agent_.pdf

5STAR
LIFE INSURANCE
COMPANY

ARKANSAS INSURANCE DEPARTMENT

READABILITY CERTIFICATION

Re: *G-Term App R509: Group Level Term Programs Enrollment Form*
G-Term App R509E: Group Level Term Programs Enrollment Form
(Electronic Enrollment Form)

The undersigned, authorized as Vice President, Compliance, to be responsible for policy and related material filings by the officers of 5 Star Life Insurance Company, hereby certifies that each form in this filing meets the Flesch minimum reading ease score of 40.

Glenn R. Jones, Esq.
Vice President, Compliance

Dated: June 29, 2009

909 North Washington Street, Alexandria, VA 22314

5STAR
LIFE INSURANCE
COMPANY

Mildred E. Hunt
Compliance Manager

June 29, 2009

VIA SERFF

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

Form Number	*Description*
G-Term App R509	Group Level Term Programs Enrollment Form
G-Term App R509E	Group Level Term Programs Enrollment Form

Dear Mr. Honey:

Submitted for filing and approval are the above referenced forms. Form number G-Term App R608 was approved by the Insurance Department on June 27, 2008. The SERFF Tracking Number is FIVE-125711891. Please note that the above referenced "electronic" version (G-Term App R509E) is a clone of the G-Term App R509.

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.

This is not an illustrated product.

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

	Description
G-Term App R~~608~~ ***509***	Page 1 of 4, Applicant's Information • Eligibility Section, inserted: ***"O Homeland Security"*** Page 2 of 4, Owner (If other than Applicant)

909 North Washington Street, Alexandria, VA 22314

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

mhunt@afba.com

	• Inserted: *"If Contingent Owner is desired, □ check here and a form will be sent to the Owner. If not, the Contingent Owner will be the Applicant."* Page 3 of 4, Other Coverage • Revised line 3 to read: "If yes, and you live in *AK*, AL, AZ, CO, HI, . . ." • Deleted line 5 and inserted the following question: "~~Do you, your spouse, or children intend to replace them~~ *Will the coverage applied for replace any existing life insurance or annuities*?"

All other sections of the application remain the same.

* * *

Enclosed also are computer screen snapshots of all sections of the on-line application as viewed by the agent. The on-line application and the screen shots are substantially similar to the enclosed paper application.

Once the agent completes all information required on the application, the application is currently being e-mailed to the applicant's home e-mail address for review and signature. When this process is completed, the applicant then returns the signed application and attached forms via e-mail to the agent. The agent then affixes his signature(s) where applicable. The agent then electronically submits the entire package to 5 Star Life Insurance Company's home office for review and approval.

Please note that if the applicant does not activate the link or insert his/her signature codes within 14 days after receipt or 30 days from the first time the first party clicks the link, whichever comes later, the application will expire and all associated e-mail links or bookmarked links will cease to function. Once the parties have completed all signature requirements, *all* links will expire regardless of the time that has passed.

The signature of the applicant is digital. Parts III and IV of the enclosed screen snap shots provide an example of four digit numbers that must be inserted, where indicated. Wherever a signature is required, you

will find provided specific four digit numbers. Once these numbers are inserted and the sign button is clicked, the digital signature is generated. The signature will show the name of the applicant and/or agent, the date, and time the information was entered.

* * *

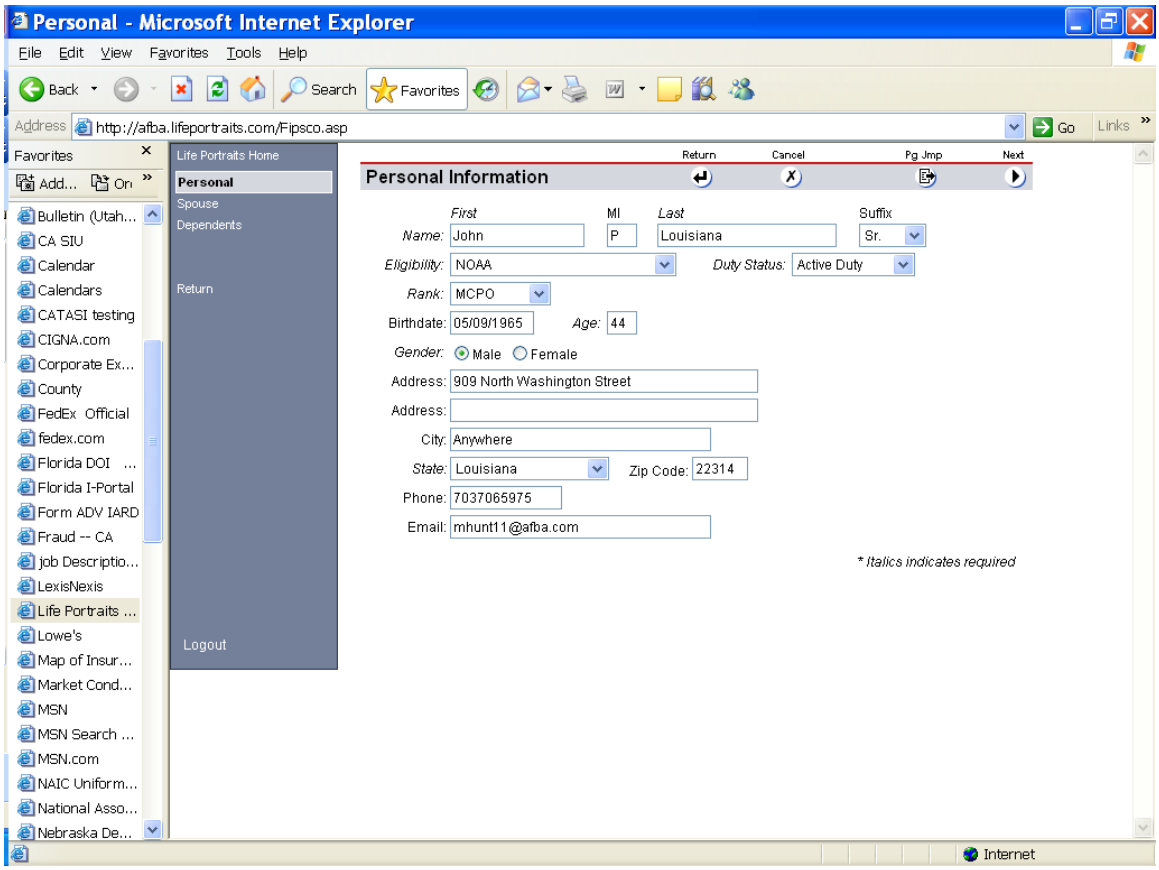
Coverage will be marketed on a direct mail basis, and via licensed agents and brokers. Once approved, 5 Star Life reserves the right to use the forms in their approved format in a variety of media, such as the Internet, with the understanding that there may be slight accommodations made for electronic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

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

Very truly yours,

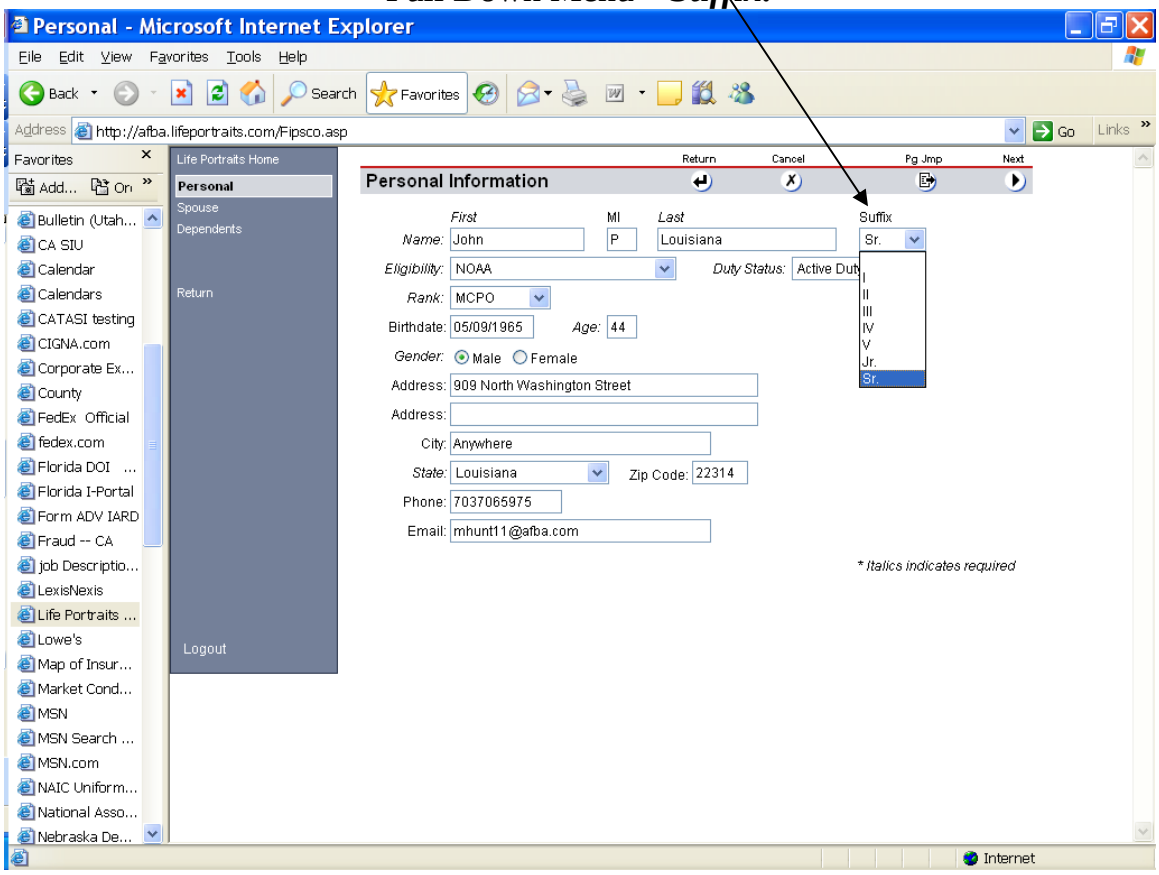
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART I – Clients and Cases

Screen #1 – Personal Information



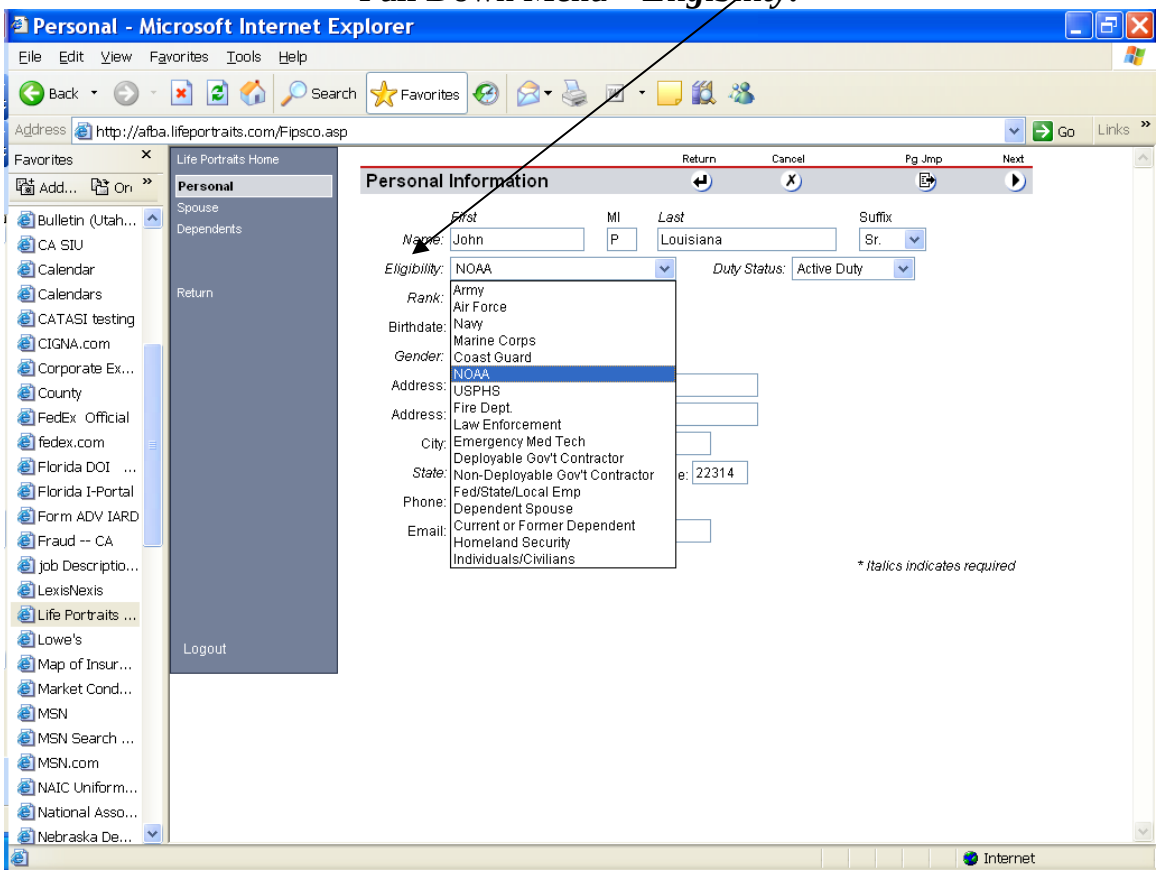
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART I – Clients and Cases

Screen #1 – Personal Information (Cont'd)
Pull Down Menu – ***Suffix:***



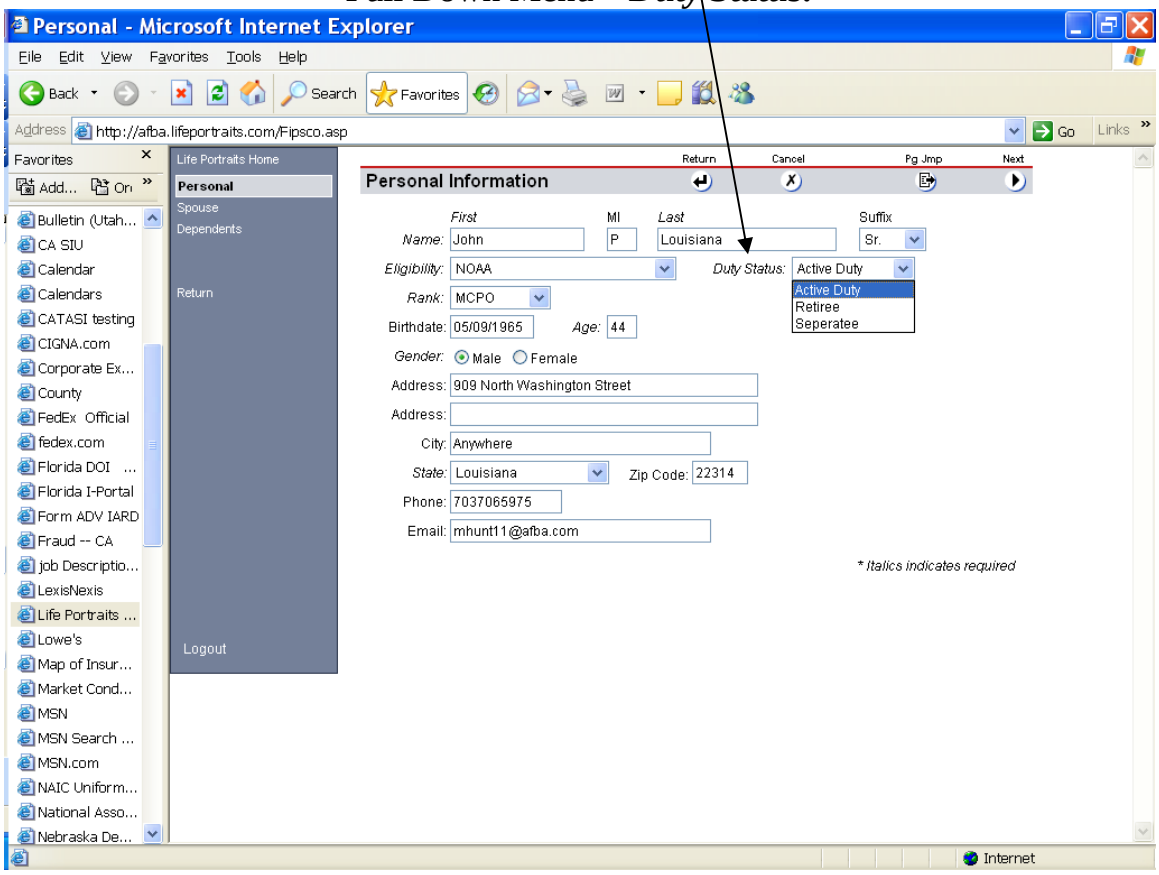
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART I – Clients and Cases

Screen #1 – Personal Information (Cont'd)
Pull Down Menu – ***Eligibility:***



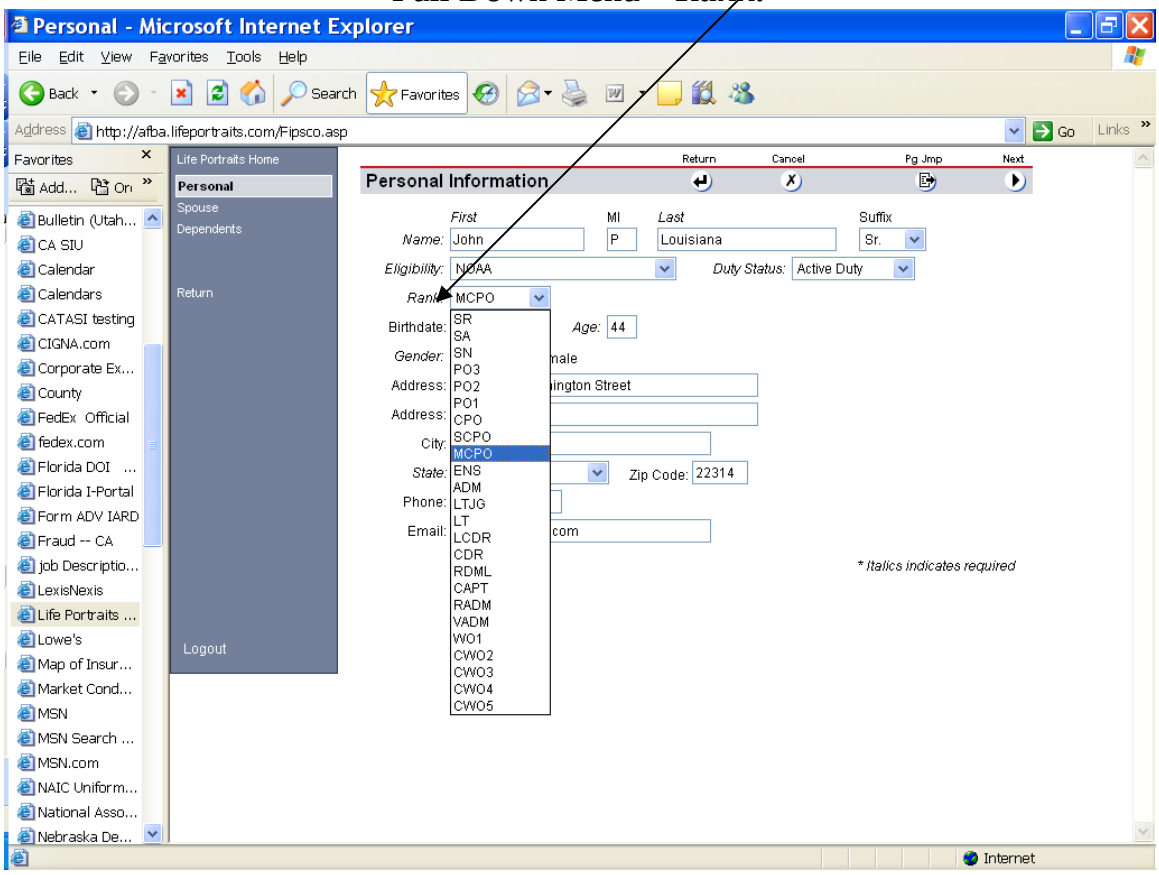
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART I – Clients and Cases

Screen #1 – Personal Information (Cont'd)
Pull Down Menu – ***Duty Status:***



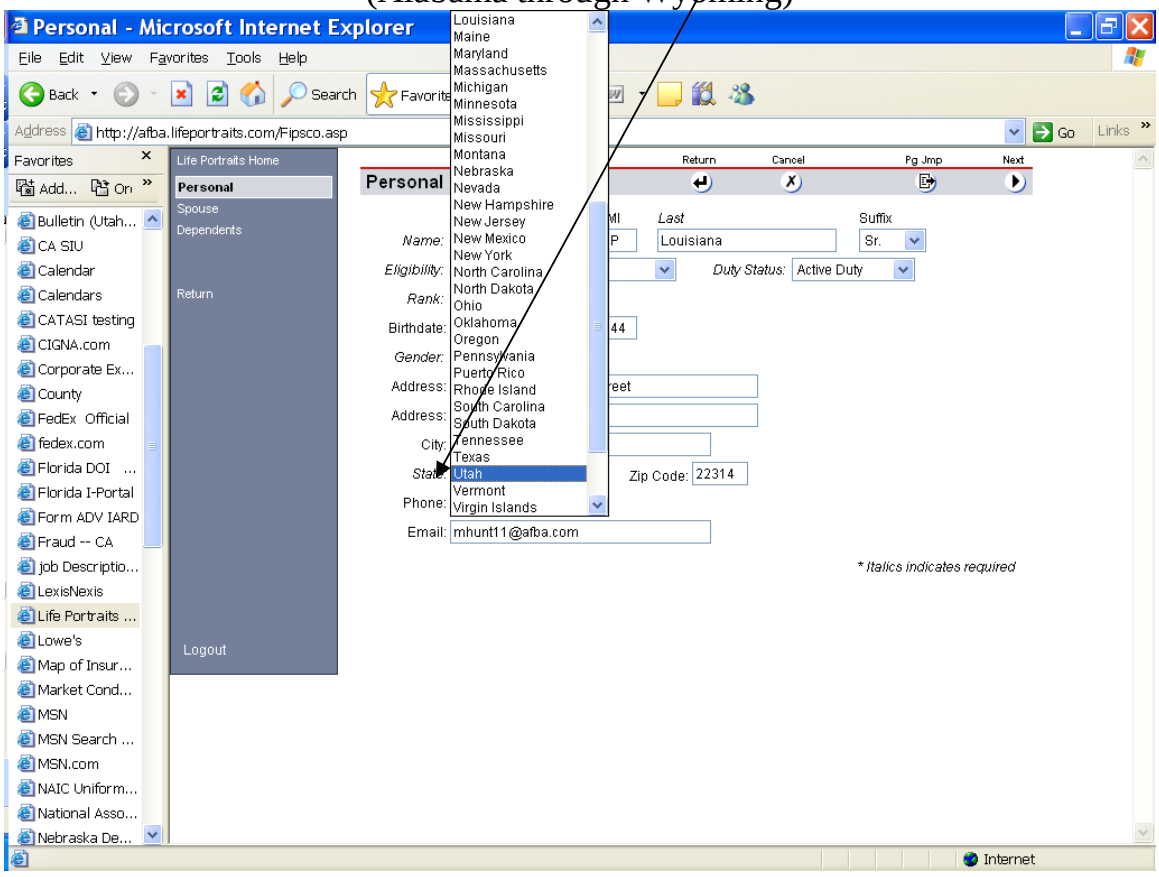
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART I – Clients and Cases

Screen #1 – Personal Information (Cont'd)
Pull Down Menu – ***Rank:***



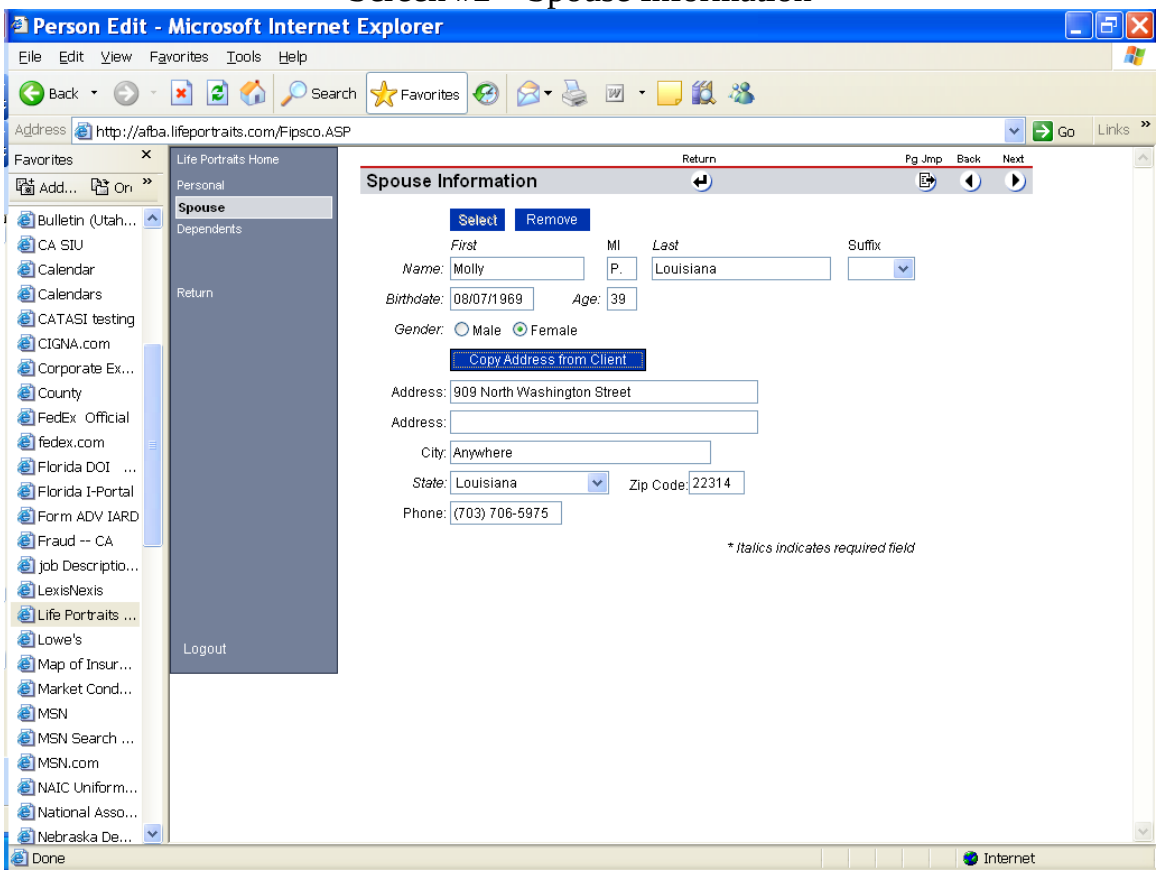
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART I – Clients and Cases

Screen #1 – Personal Information (Cont'd)
Pull Down Menu – ***State:***
(Alabama through Wyoming)



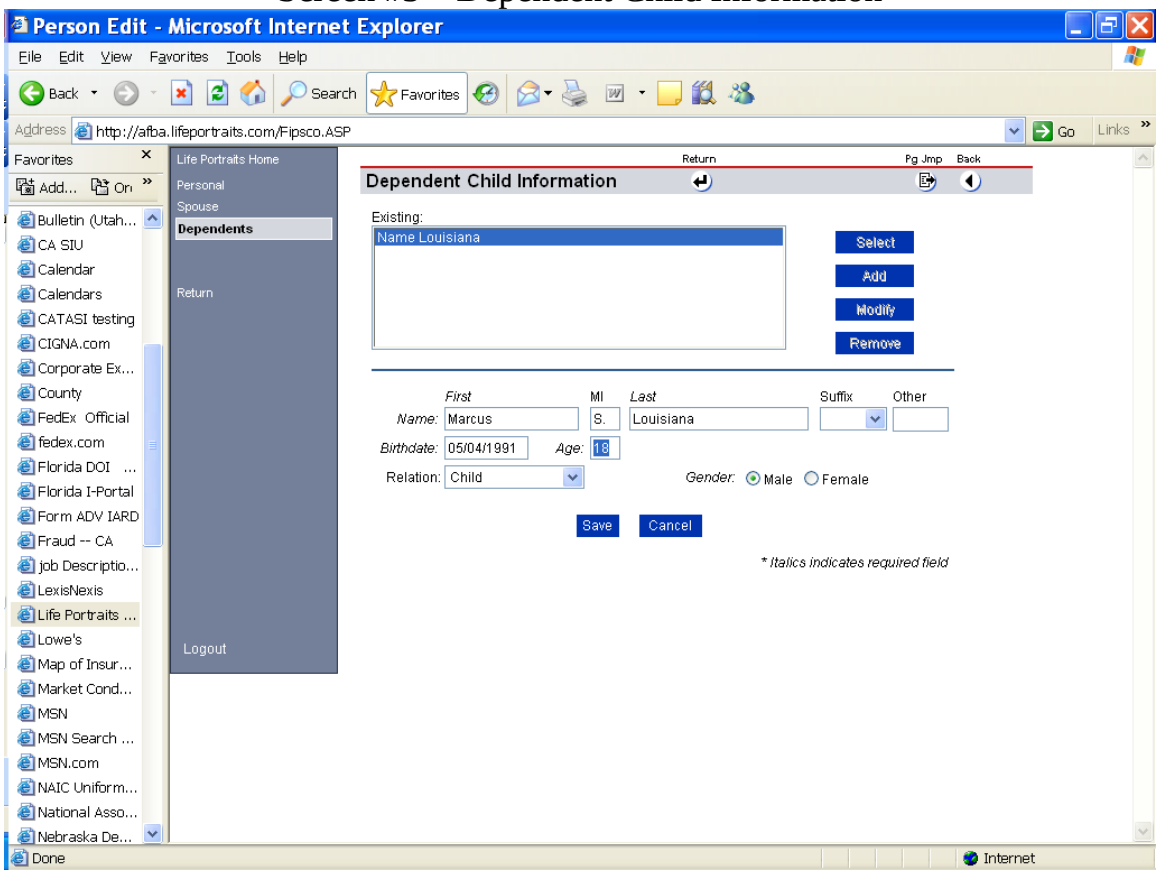
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART I – Clients and Cases

Screen #2 – Spouse Information



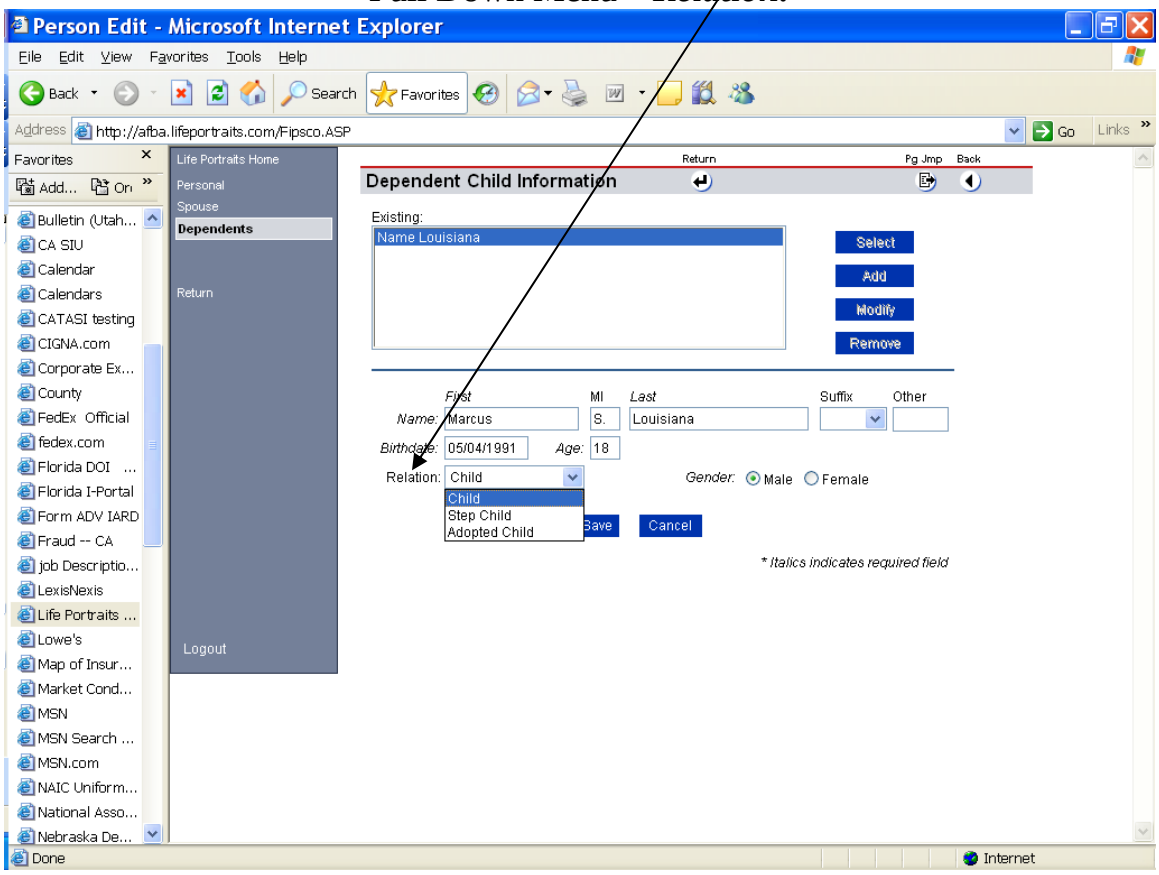
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART I – Clients and Cases

Screen #3 – Dependent Child Information



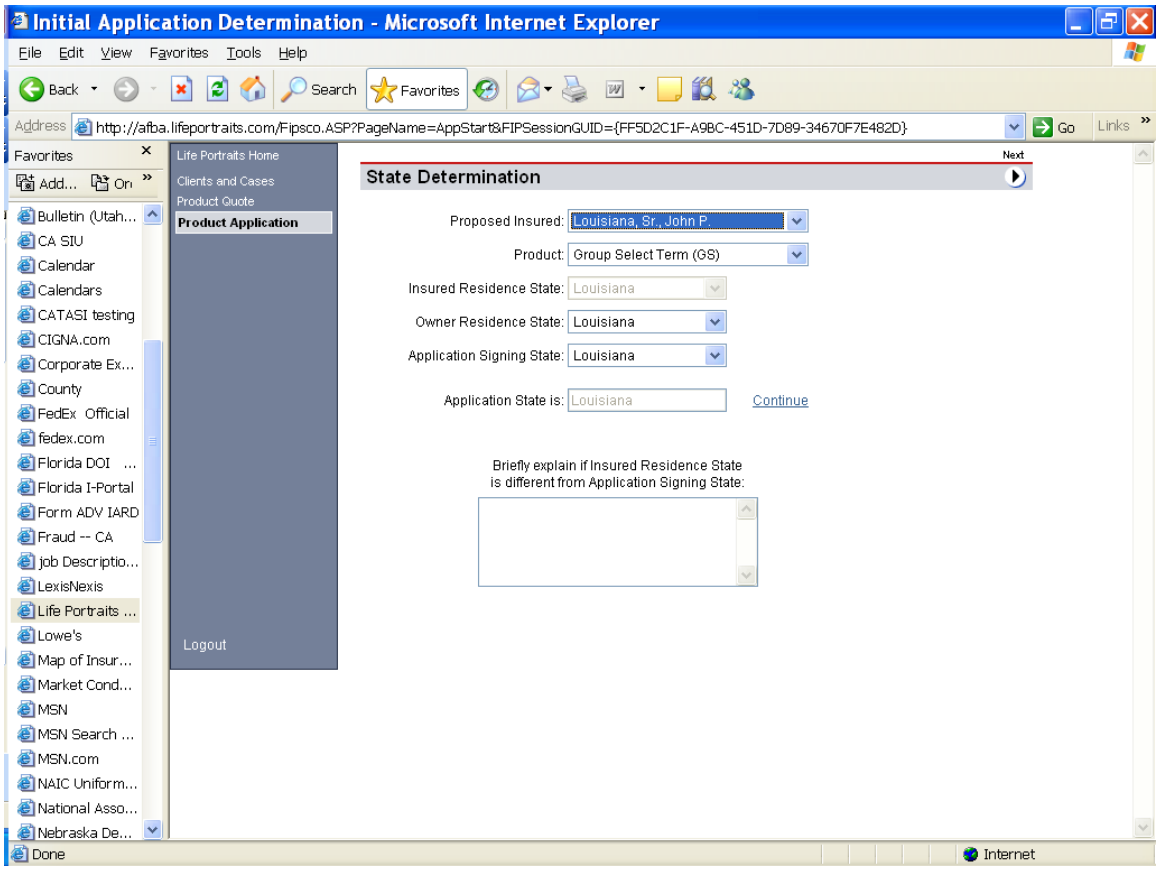
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART I – Clients and Cases

Screen #3 – Dependent Child Information (Cont'd)
Pull Down Menu – ***Relation:***



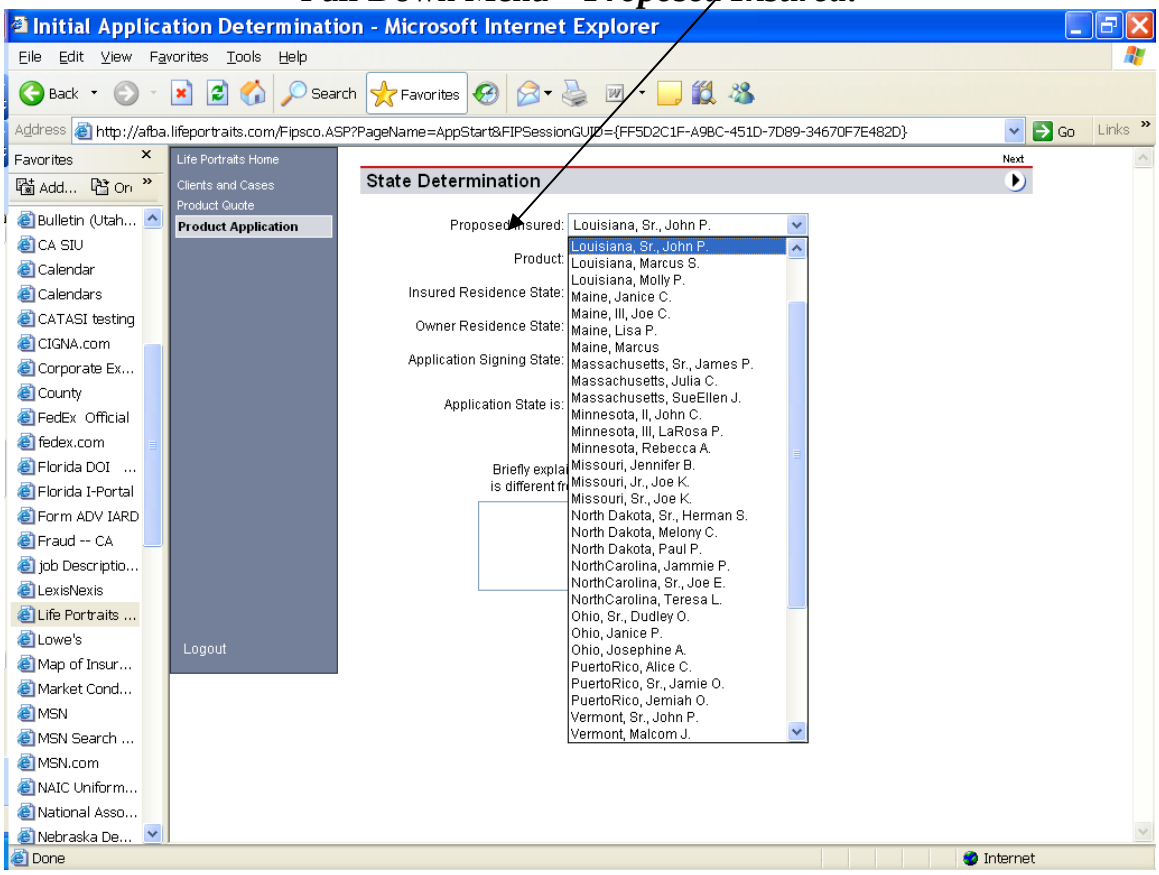
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #1 – State Determinations



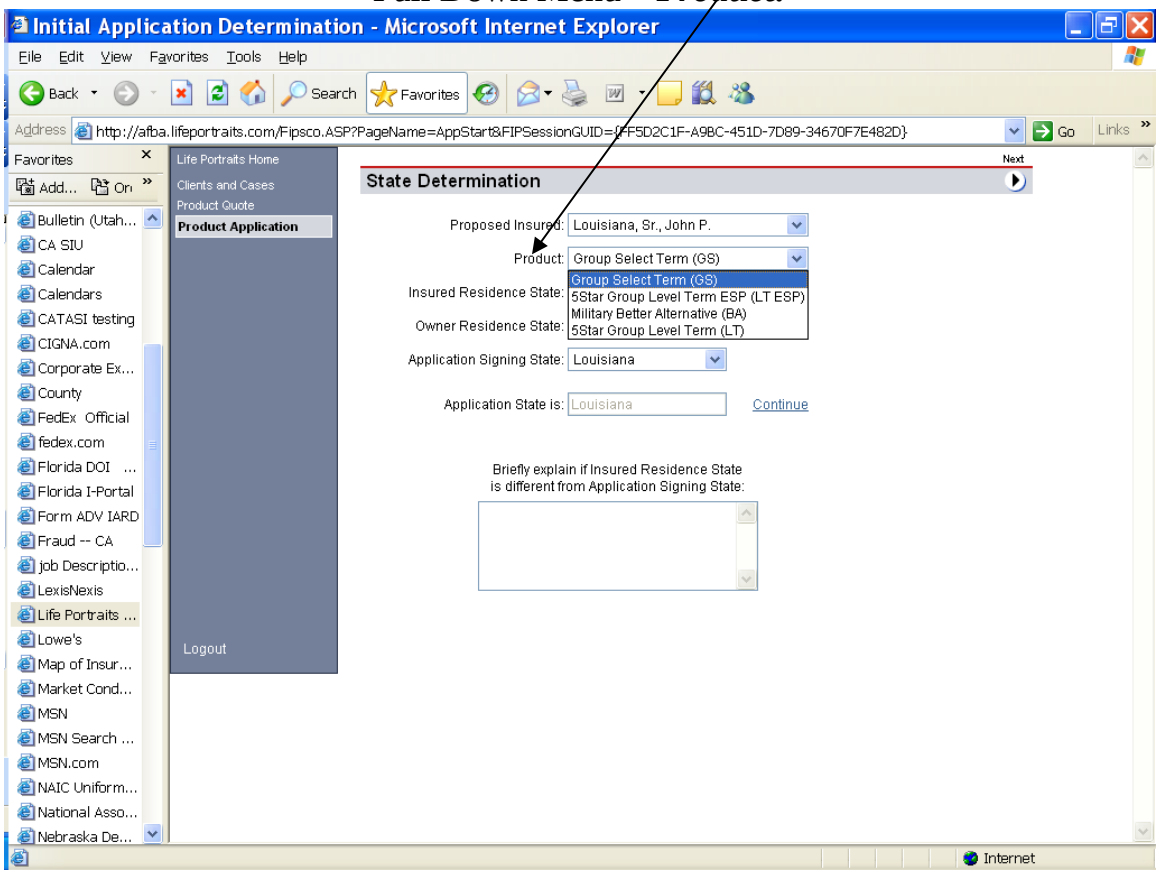
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #1 – State Determination (Cont'd)
Pull Down Menu – ***Proposed Insured:***



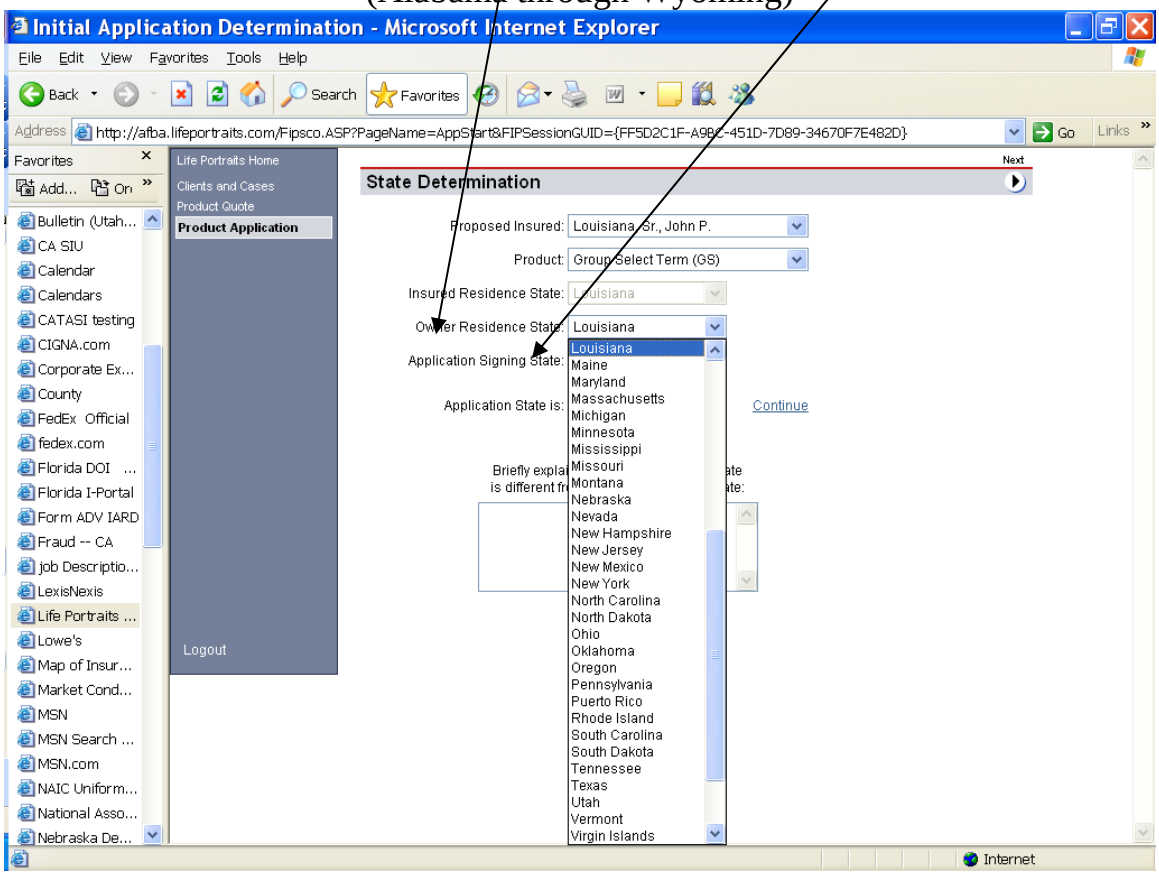
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #1 – State Determination (Cont'd)
Pull Down Menu – ***Product:***



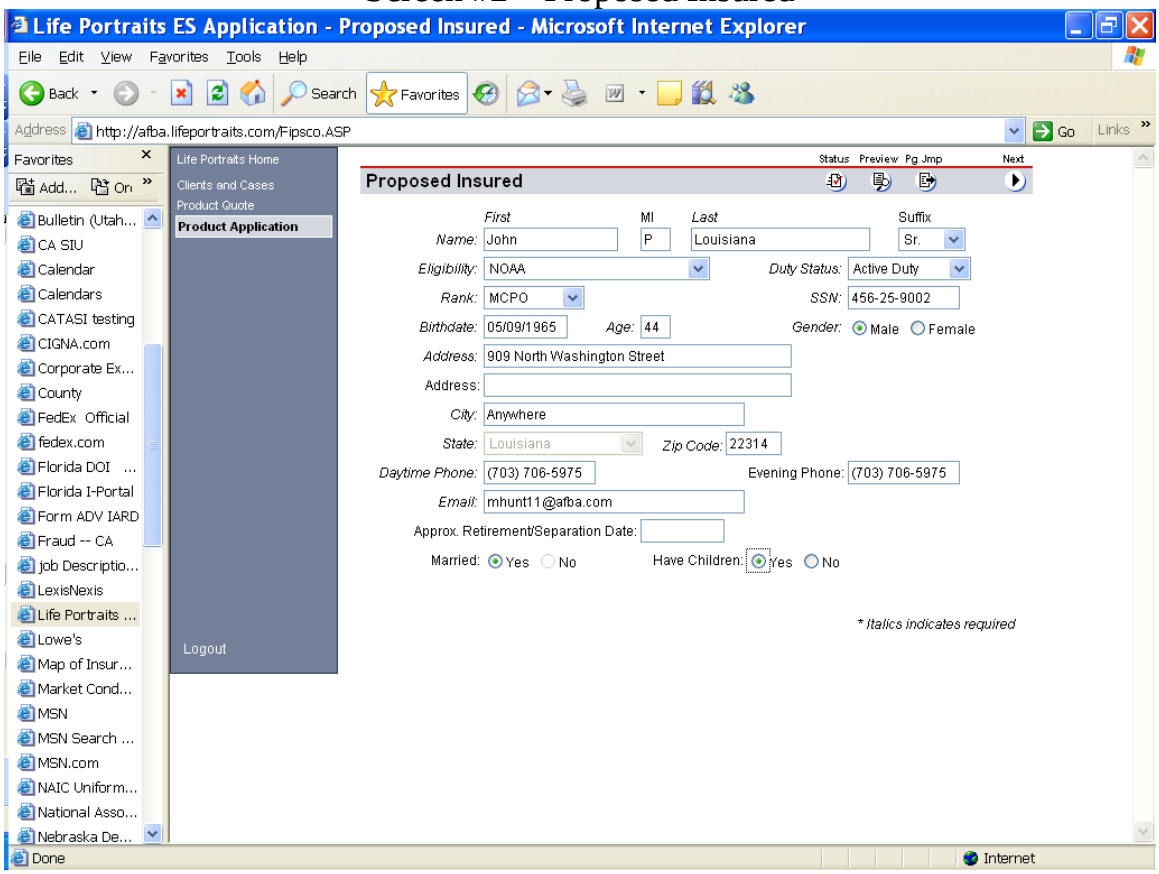
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #1 – State Determination (Cont'd)
Pull Down Menu – ***Owner Residence & Application Signing State:***
(Alabama through Wyoming)



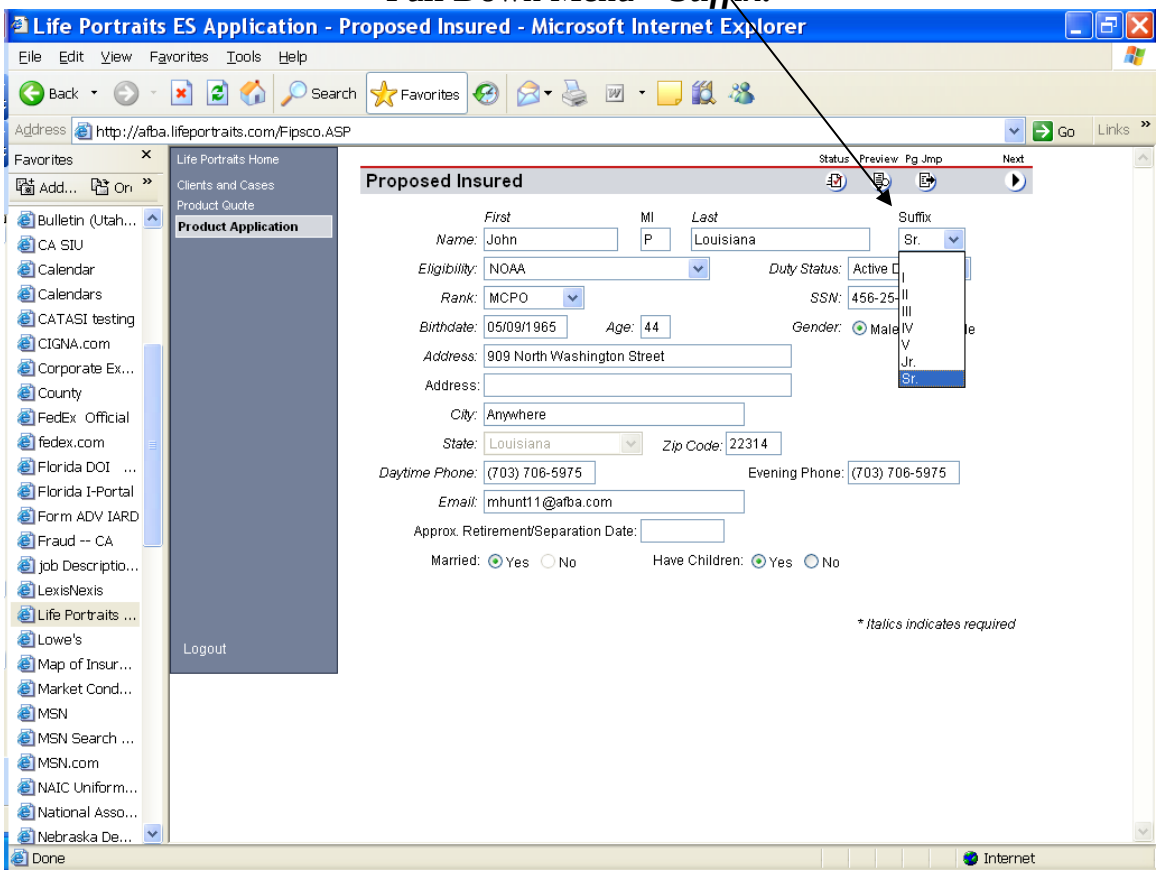
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #2 – Proposed Insured



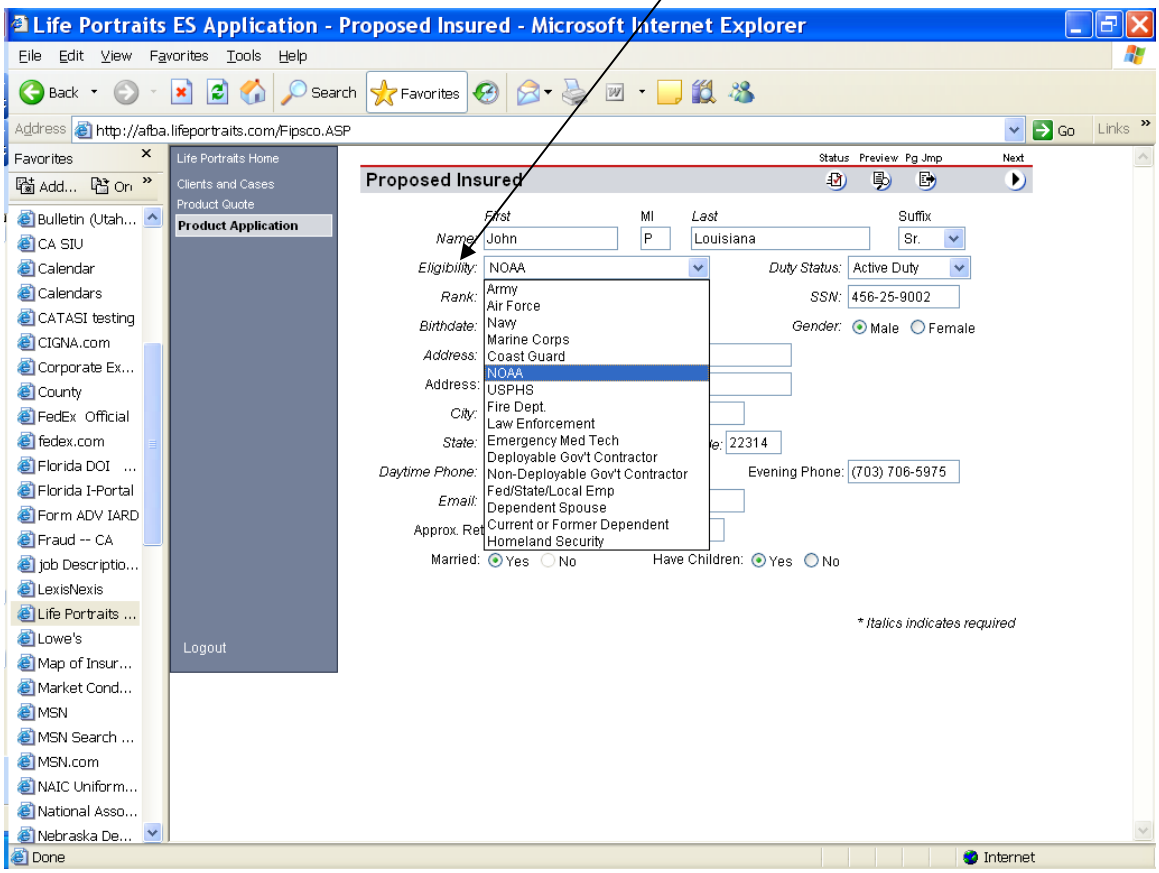
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #2 – Proposed Insured (Cont'd)
Pull Down Menu – ***Suffix:***



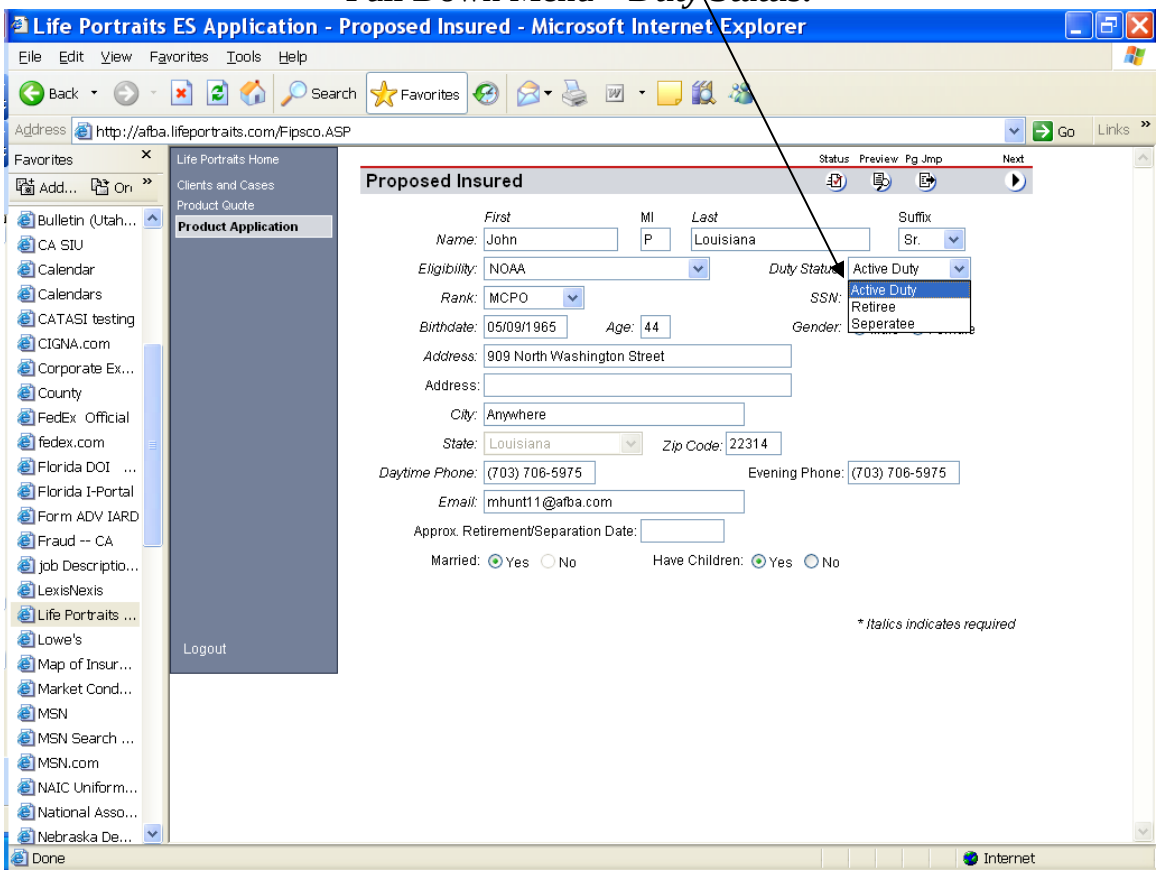
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #2 – Proposed Insured (Cont'd)
Pull Down Menu – ***Eligibility:***



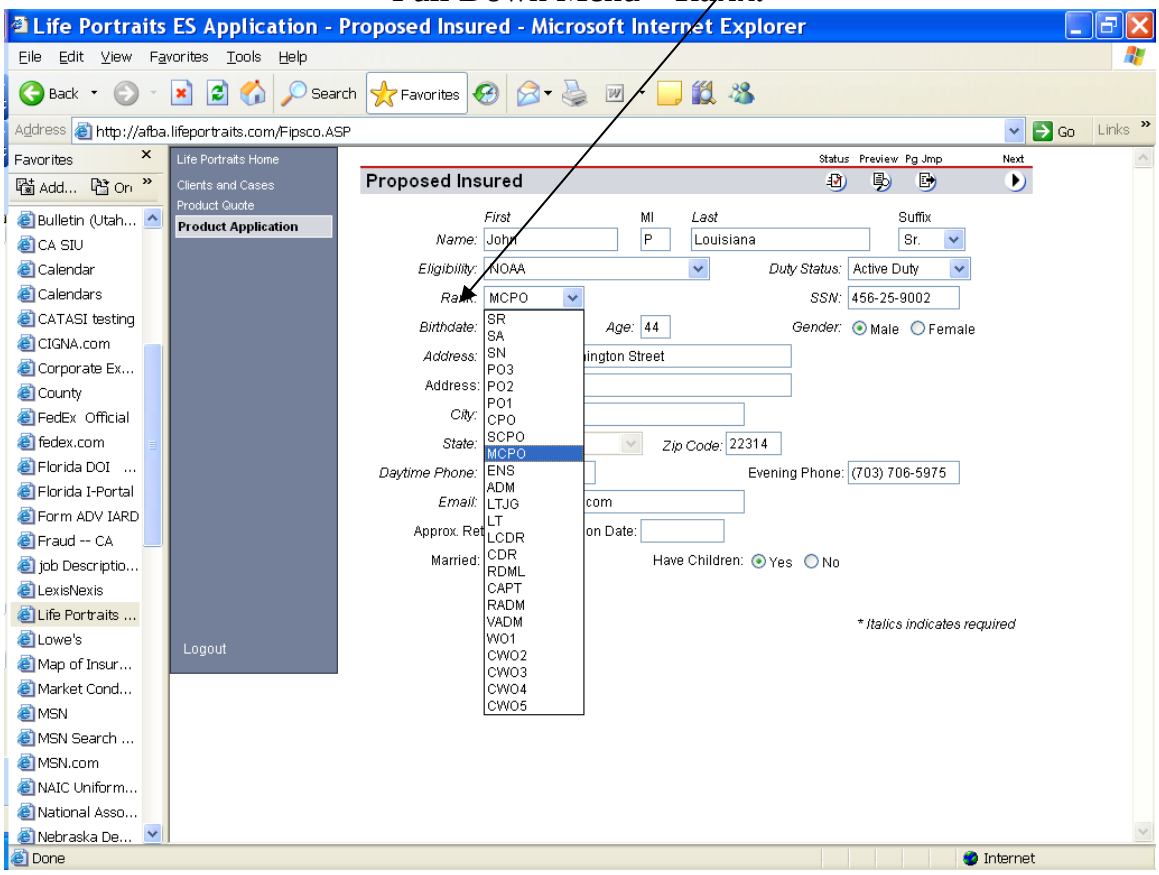
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #2 – Proposed Insured (Cont'd)
Pull Down Menu – ***Duty Status:***



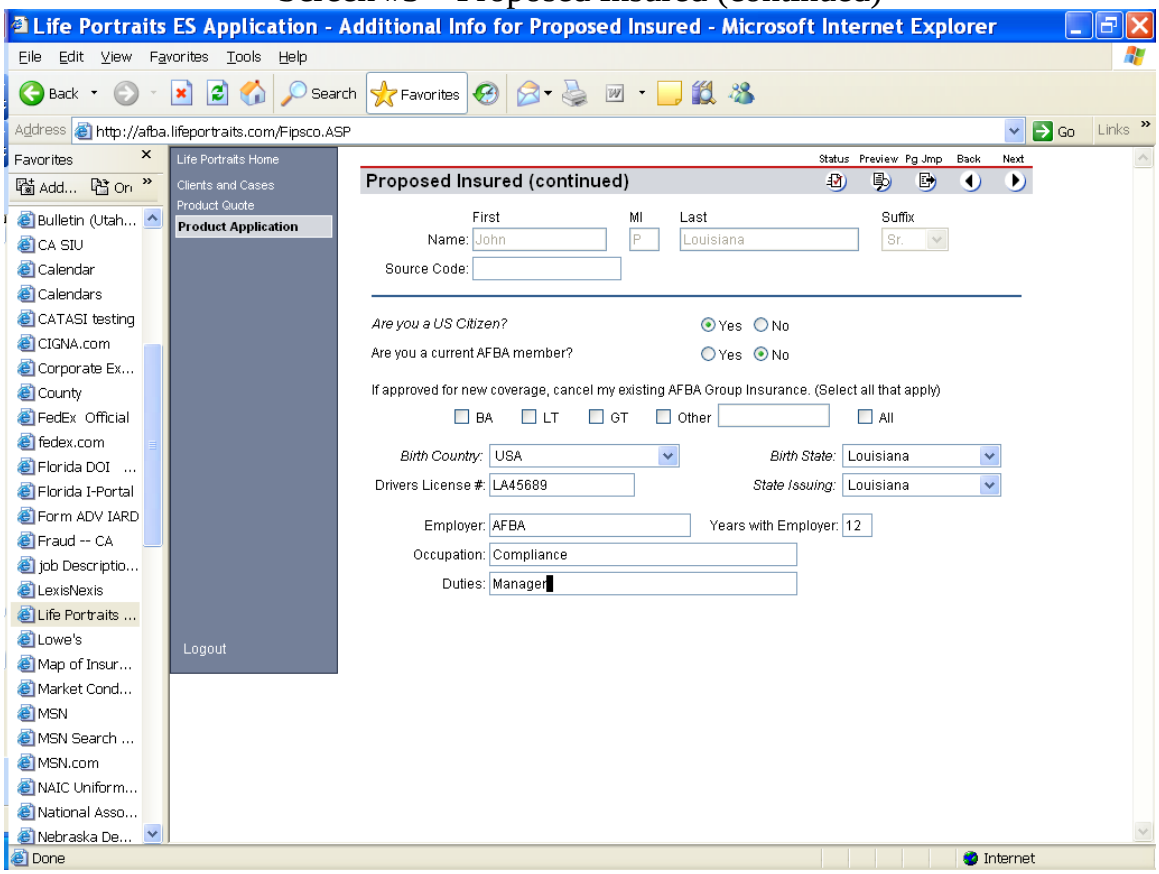
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #2 – Proposed Insured (Cont'd)
Pull Down Menu – ***Rank:***



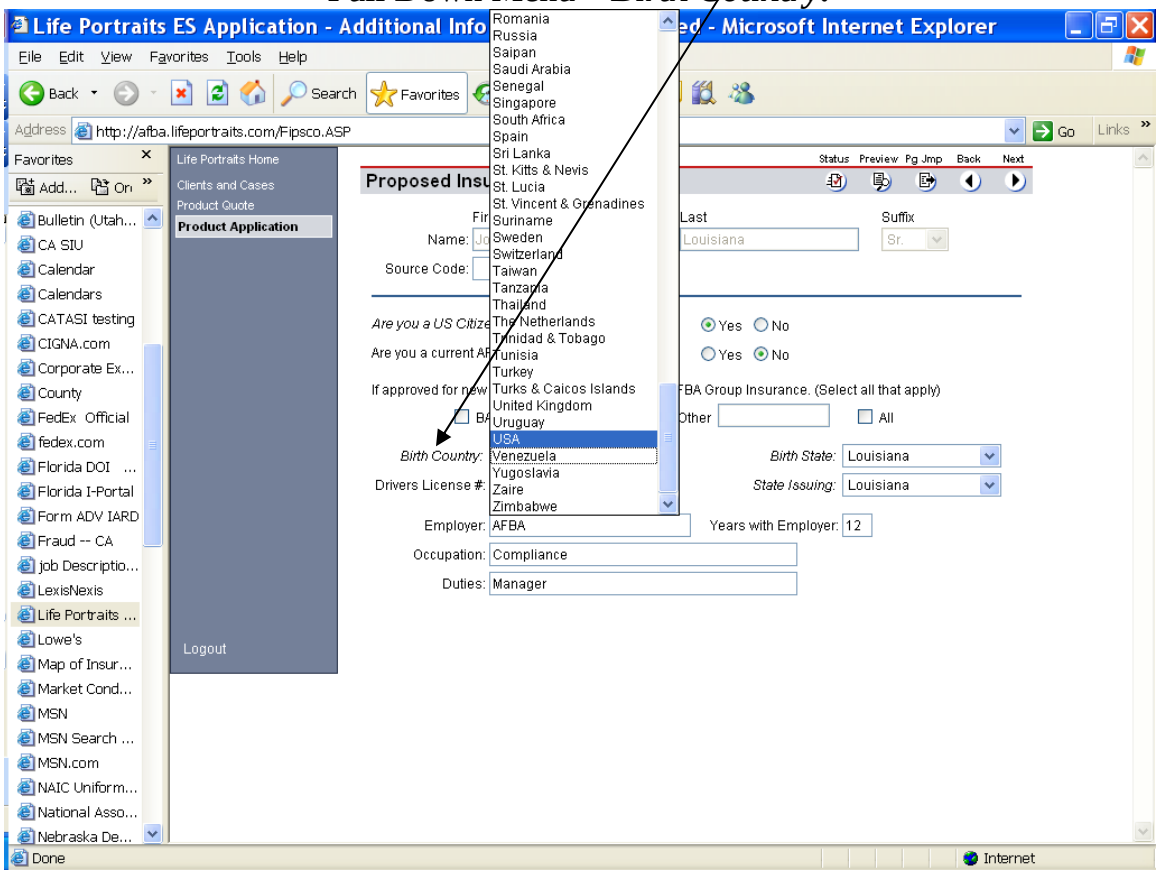
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #3 – Proposed Insured (continued)



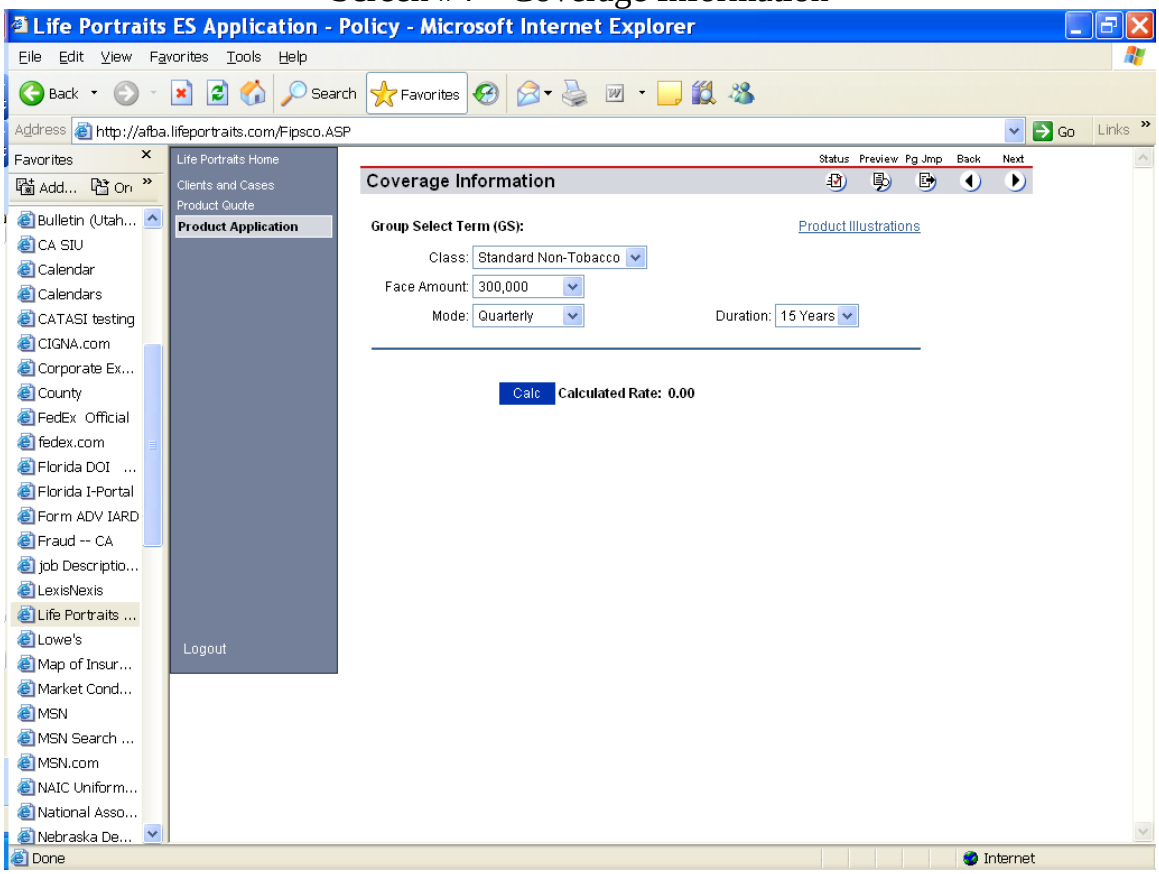
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #3 – Proposed Insured (continued) (Cont'd)
Pull Down Menu – ***Birth Country:***



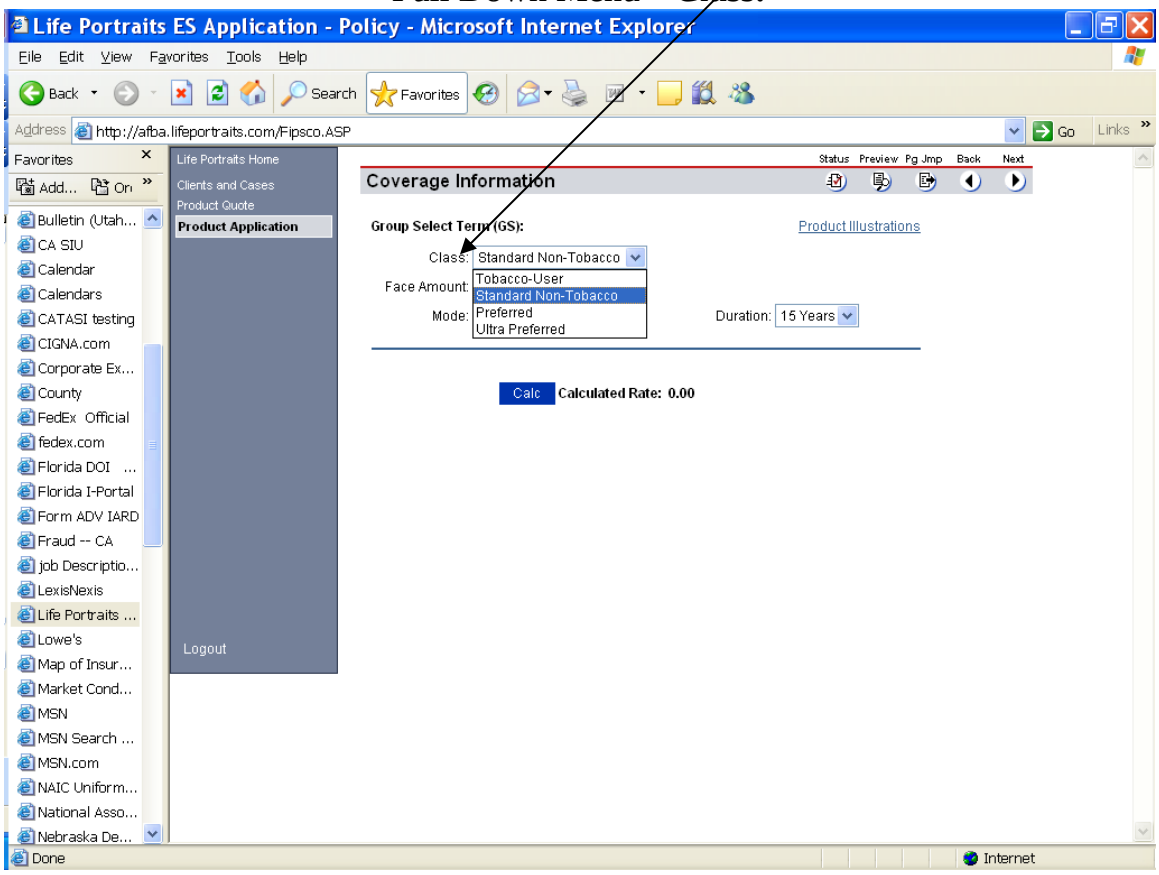
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #4 – Coverage Information



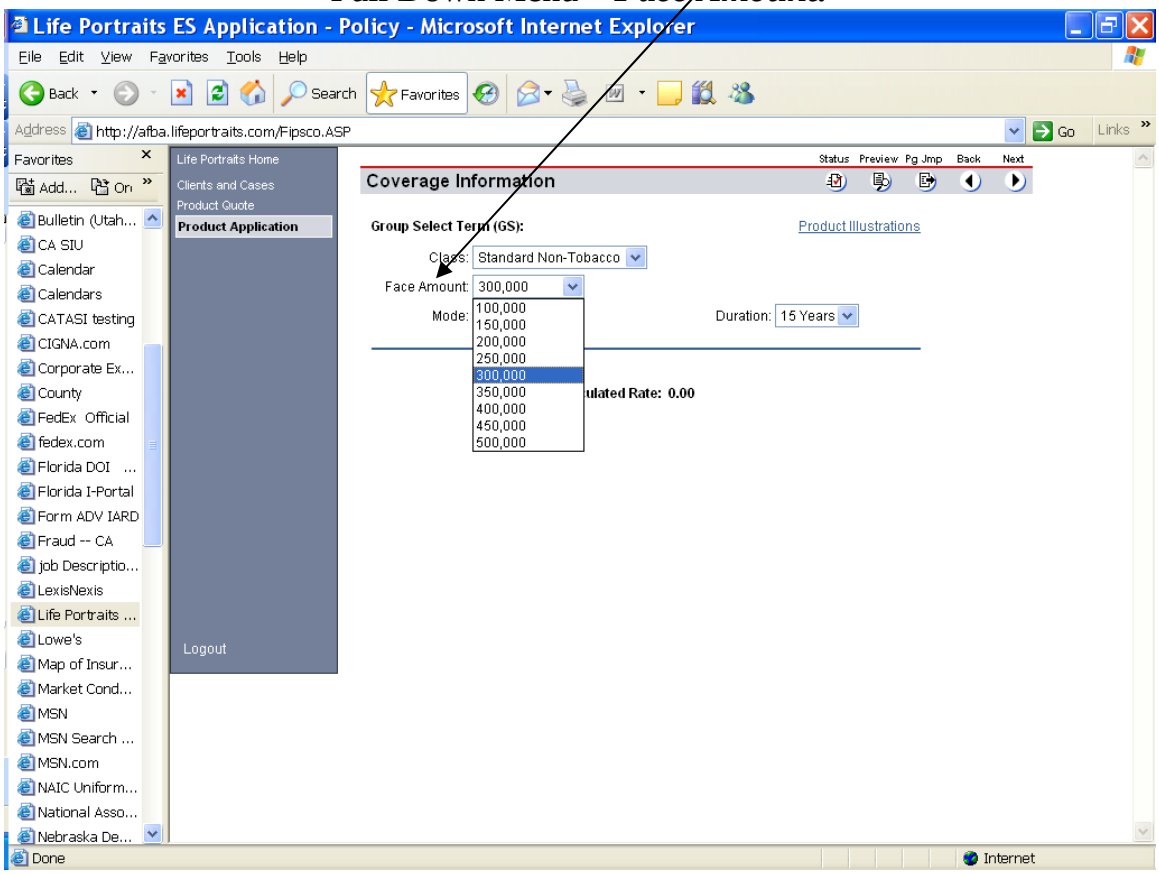
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #4 – Coverage Information (Cont'd)
Pull Down Menu – ***Class:***



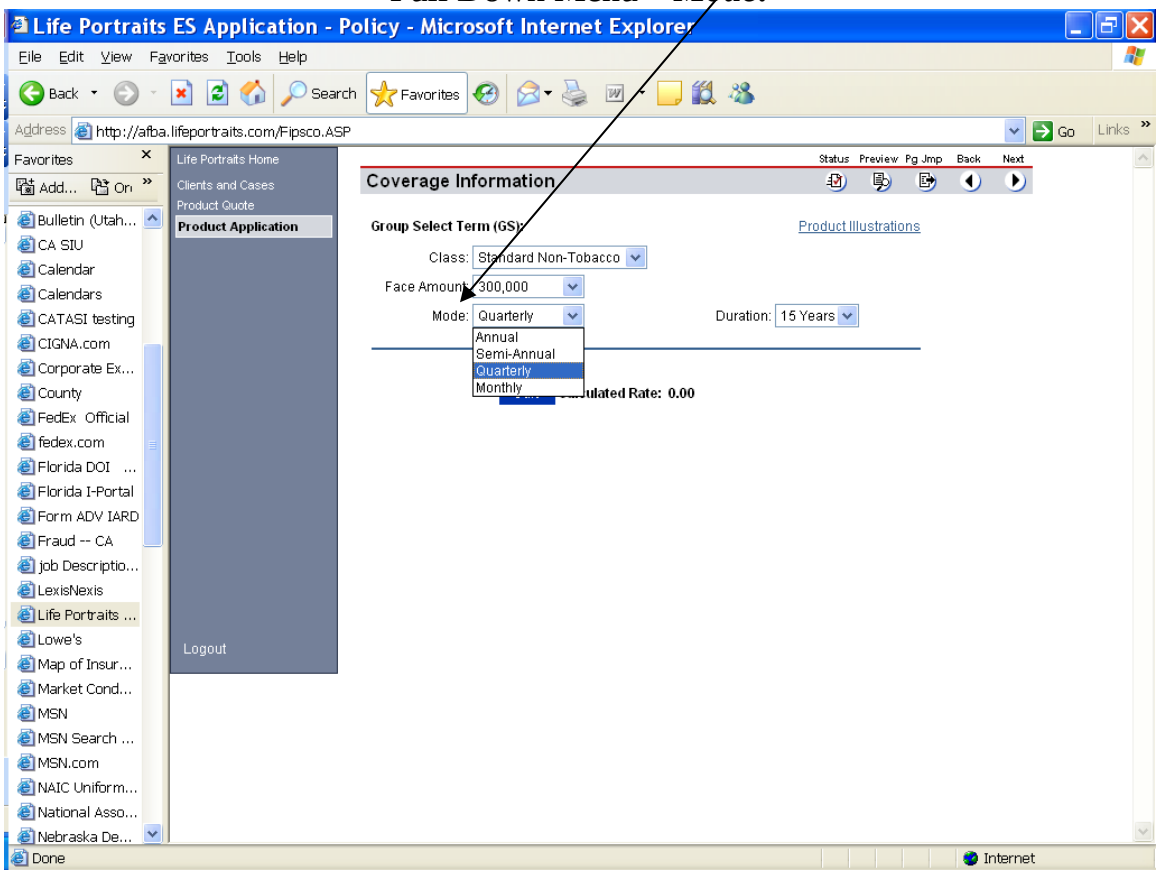
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #4 – Coverage Information (Cont'd)
Pull Down Menu – ***Face Amount:***



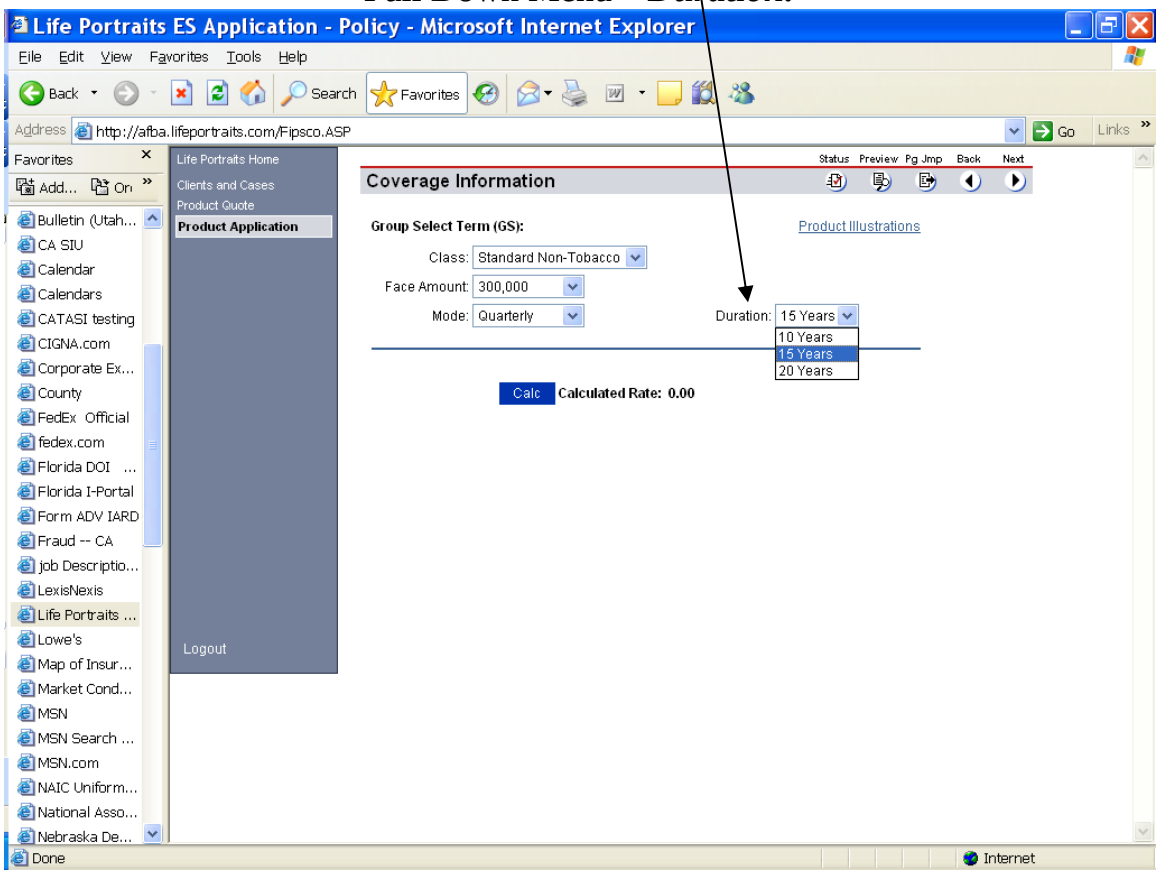
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #4 – Coverage Information (Cont'd)
Pull Down Menu – ***Mode:***



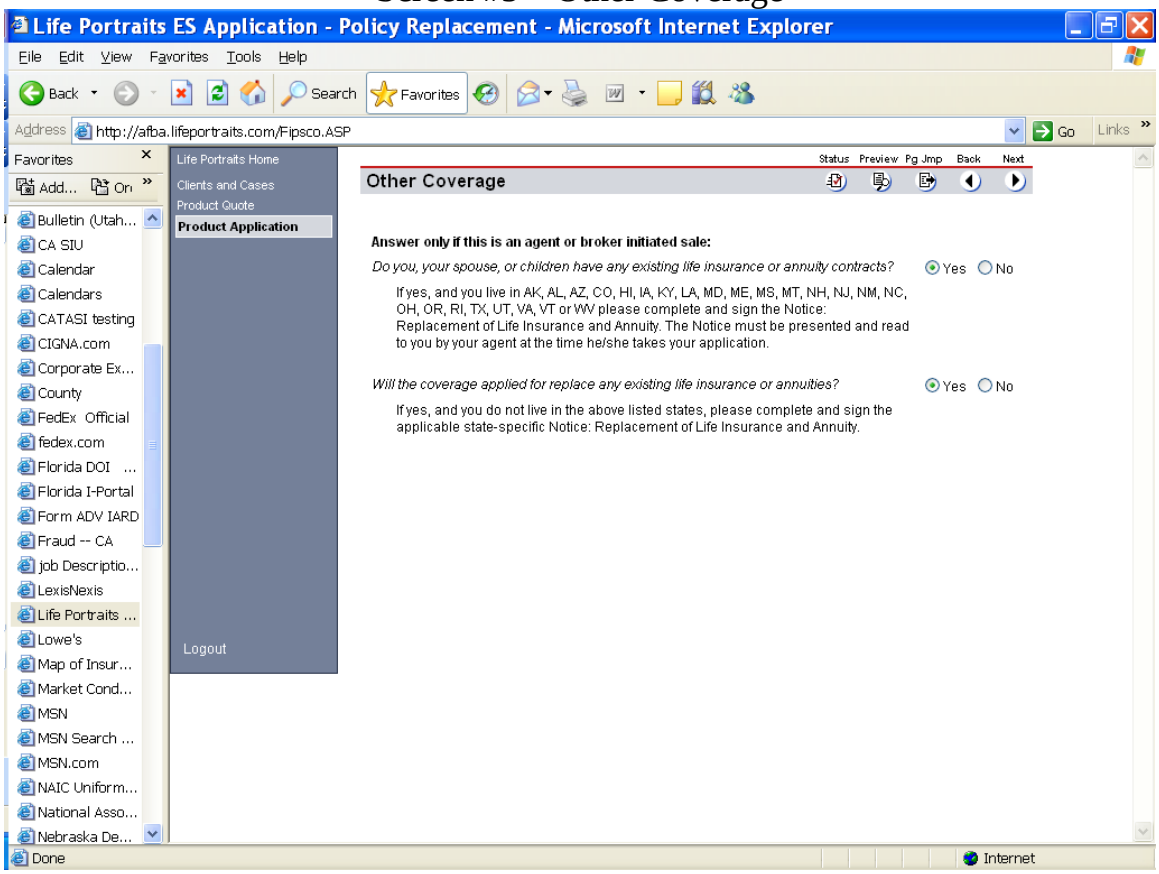
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #4 – Coverage Information (Cont'd)
Pull Down Menu – ***Duration:***



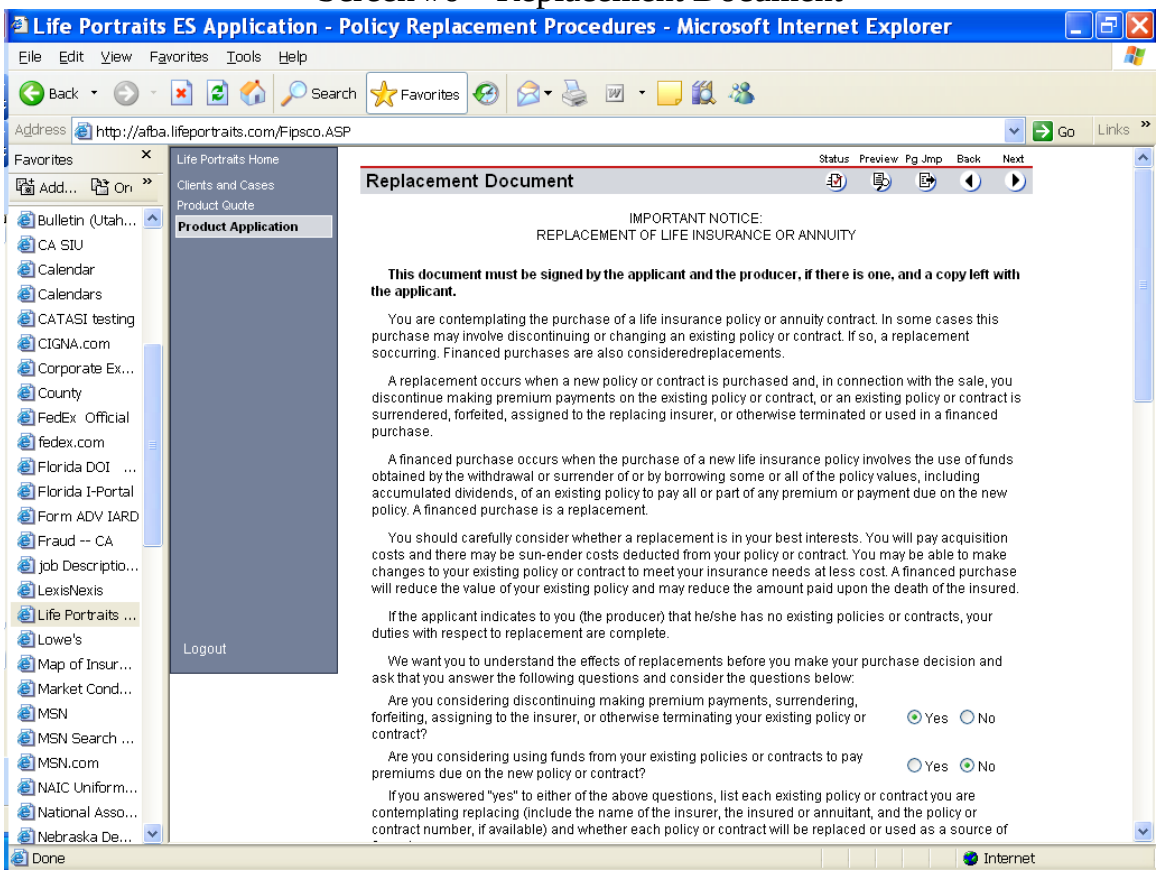
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #5 – Other Coverage



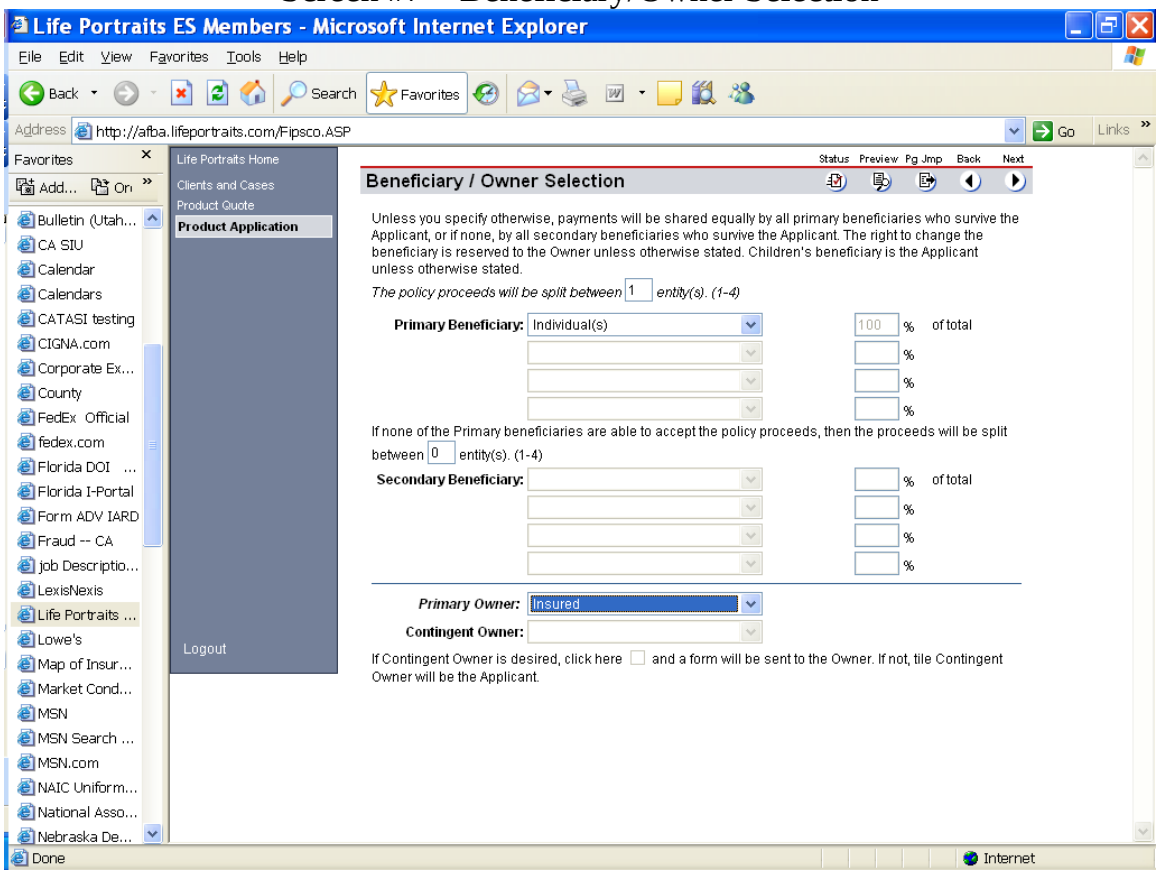
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #6 – Replacement Document



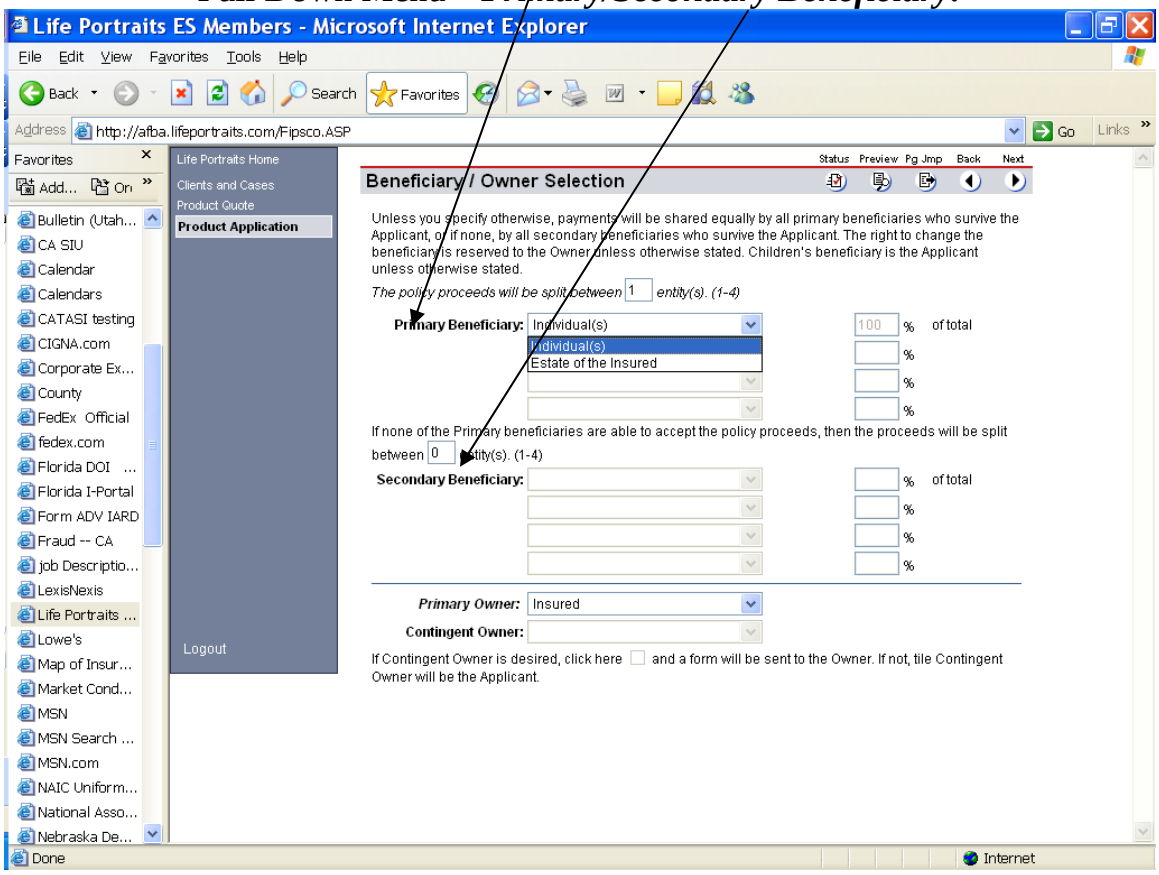
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #7 – Beneficiary/Owner Selection



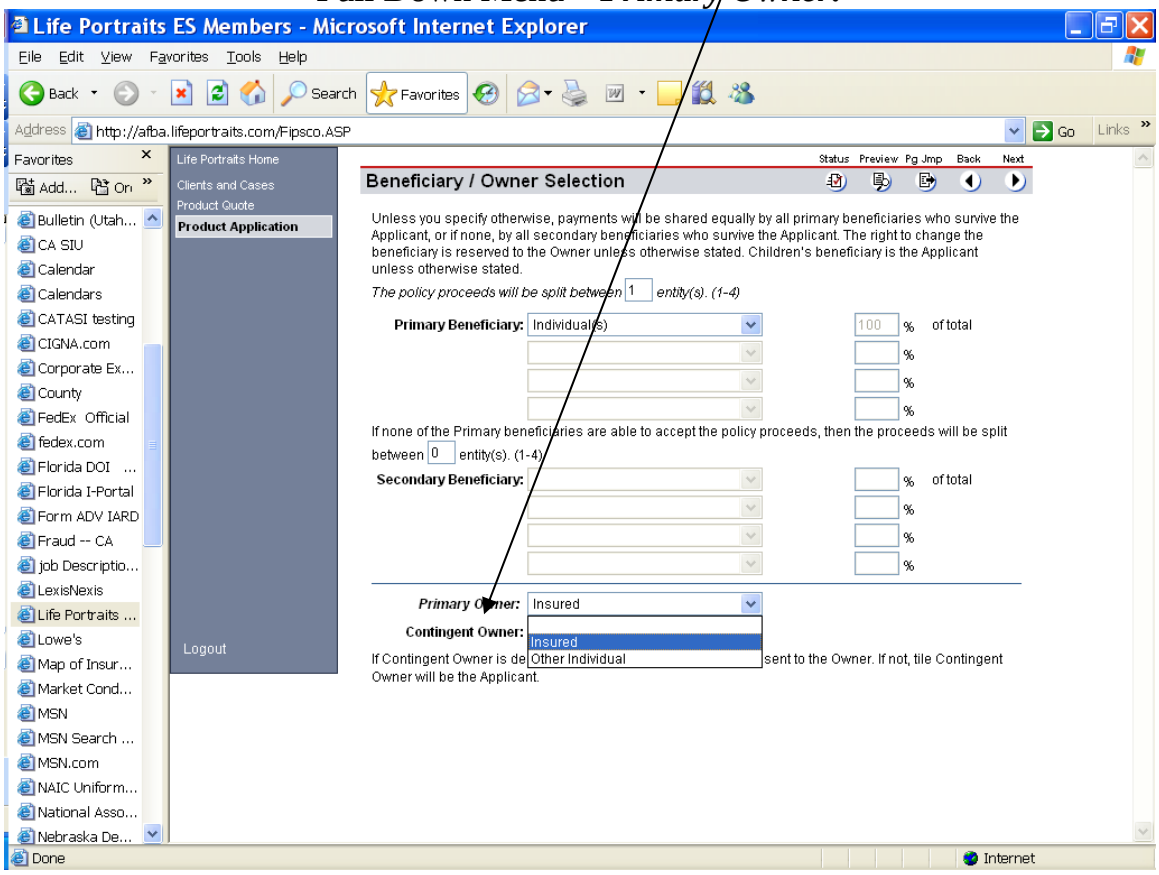
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #7 – Beneficiary/Owner Selection (Cont'd)
Pull Down Menu – ***Primary/Secondary Beneficiary:***



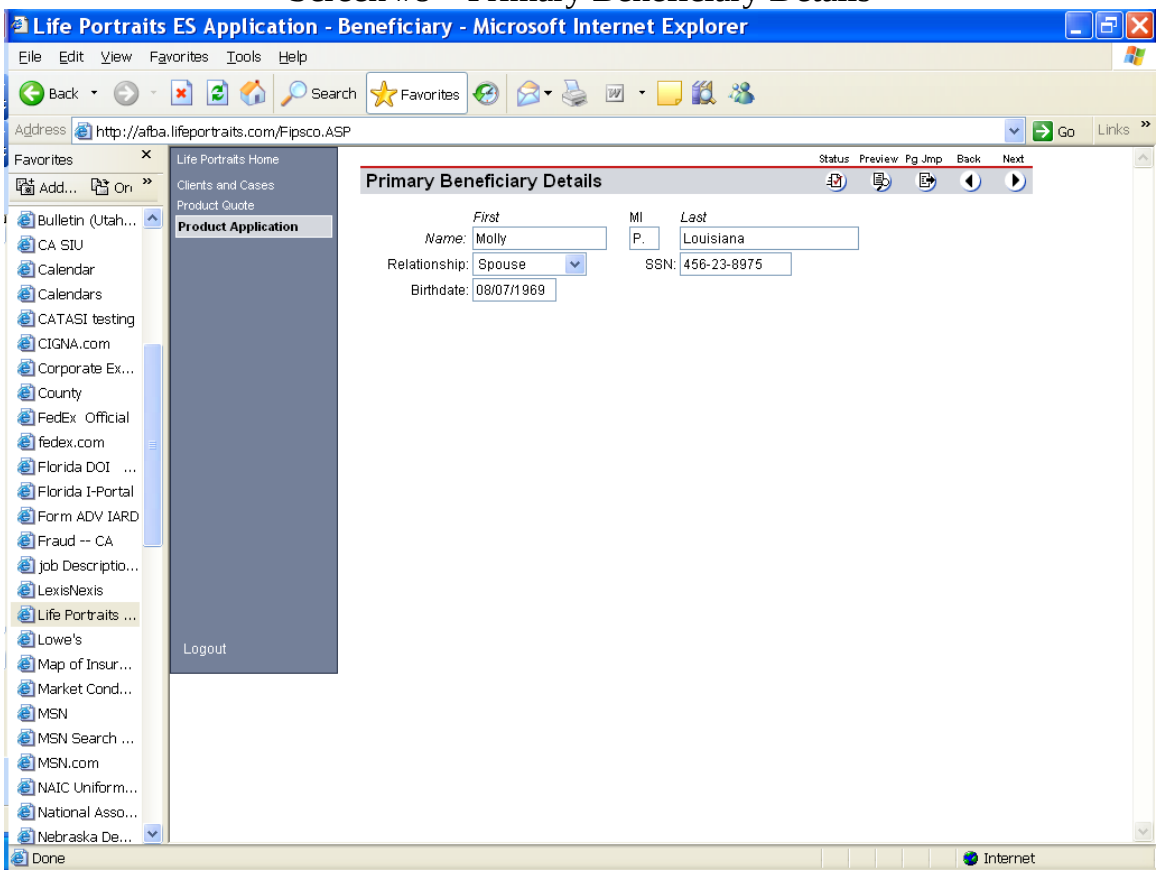
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #7 – Beneficiary/Owner Selection (Cont'd)
Pull Down Menu – ***Primary Owner:***



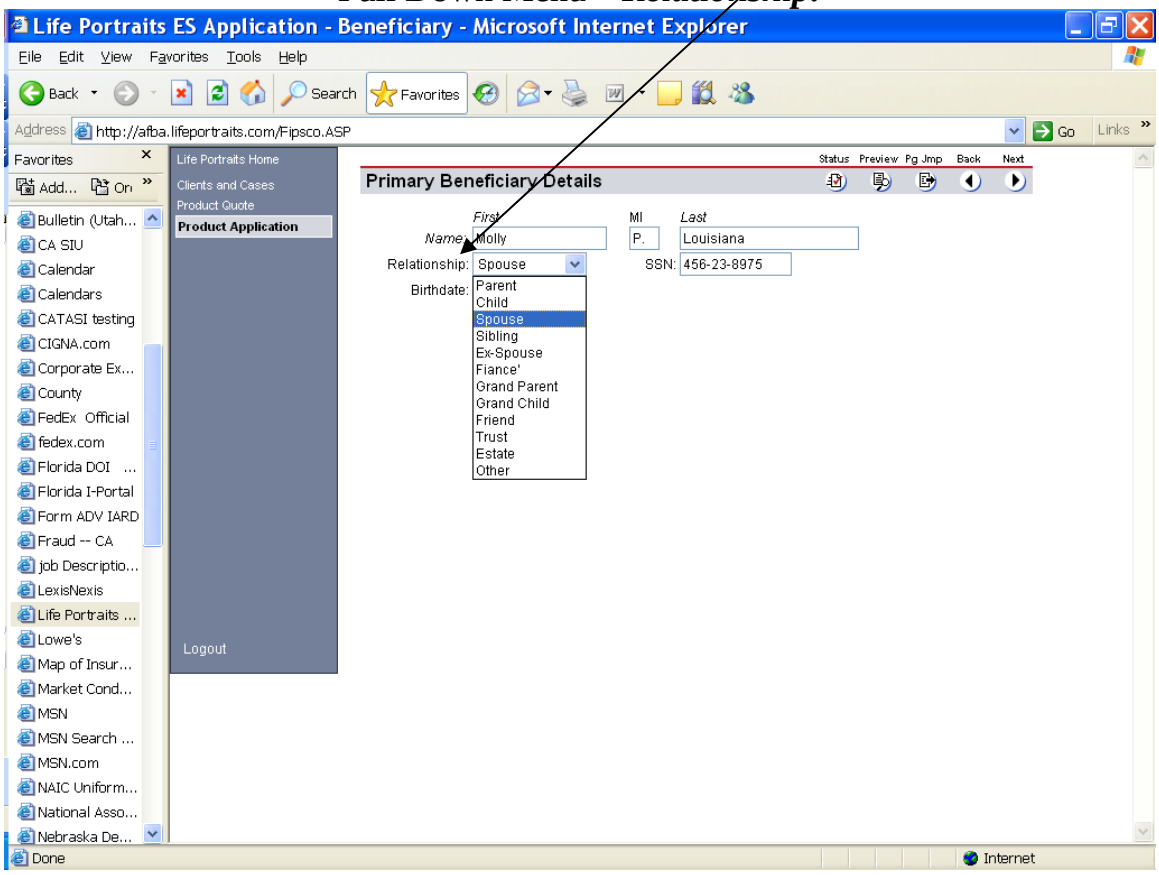
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #8 – Primary Beneficiary Details



5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #8 – Primary Beneficiary Details (Cont'd)
Pull Down Menu – ***Relationship:***



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Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #9 – Statement of Health

Life Portraits Application - Medical Questions - Microsoft Internet Explorer

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Calendars
CATASI testing
CIGNA.com
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County
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fedex.com
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Florida I-Portal
Form ADV IARD
Fraud -- CA
job Descriptio...
LexisNexis
Life Portraits ...
Lowe's
Map of Insur...
Market Cond...
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MSN Search ...
MSN.com
NAIC Uniform...
National Asso...
Nebraska De...

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Clients and Cases
Product Quote
Product Application
Logout

Status Preview Pg Jmp Back Next

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: 6 ft 5 in *Weight:* 315 lbs

In the last 10 years, has the Applicant or Child:

Had a life or health insurance application declined, postponed, modified or rated?	○ Yes	◉ No

In the last 10 years, has the Applicant or Child been diagnosed or treated by a physician for the listed conditions:

Coronary artery disease, cardiac chest pain, heart attack, heart failure, heart murmur, or any heart disorder?	○ Yes	◉ No
High blood pressure, peripheral vascular disease (plaque in arteries), or any blood vessel disorder?	○ Yes	◉ No
Stroke, paralysis, seizures, epilepsy, loss of consciousness, multiple sclerosis, any neurological disorder?	○ Yes	◉ No
Skin disorder, cyst, tumor, or cancer?.	○ Yes	◉ No
Asthma, Chronic Obstructive Pulmonary Disease (COPD), tuberculosis, chronic cough or shortness of breath, or any disorder of the lungs or respiratory system?	○ Yes	◉ No
Diabetes, thyroid, pituitary, adrenal, or hormone disorder?	○ Yes	◉ No
Disorder of the kidney, bladder, urinary tract, genital tract, or reproductive system?	○ Yes	◉ No
Ulcers, hepatitis, colitis, gastritis, disorder of the pancreas, liver, esophagus, stomach or intestines?	○ Yes	◉ No
Rheumatoid disease, connective tissue disease, or disorder of the blood or lymph		

Done Internet

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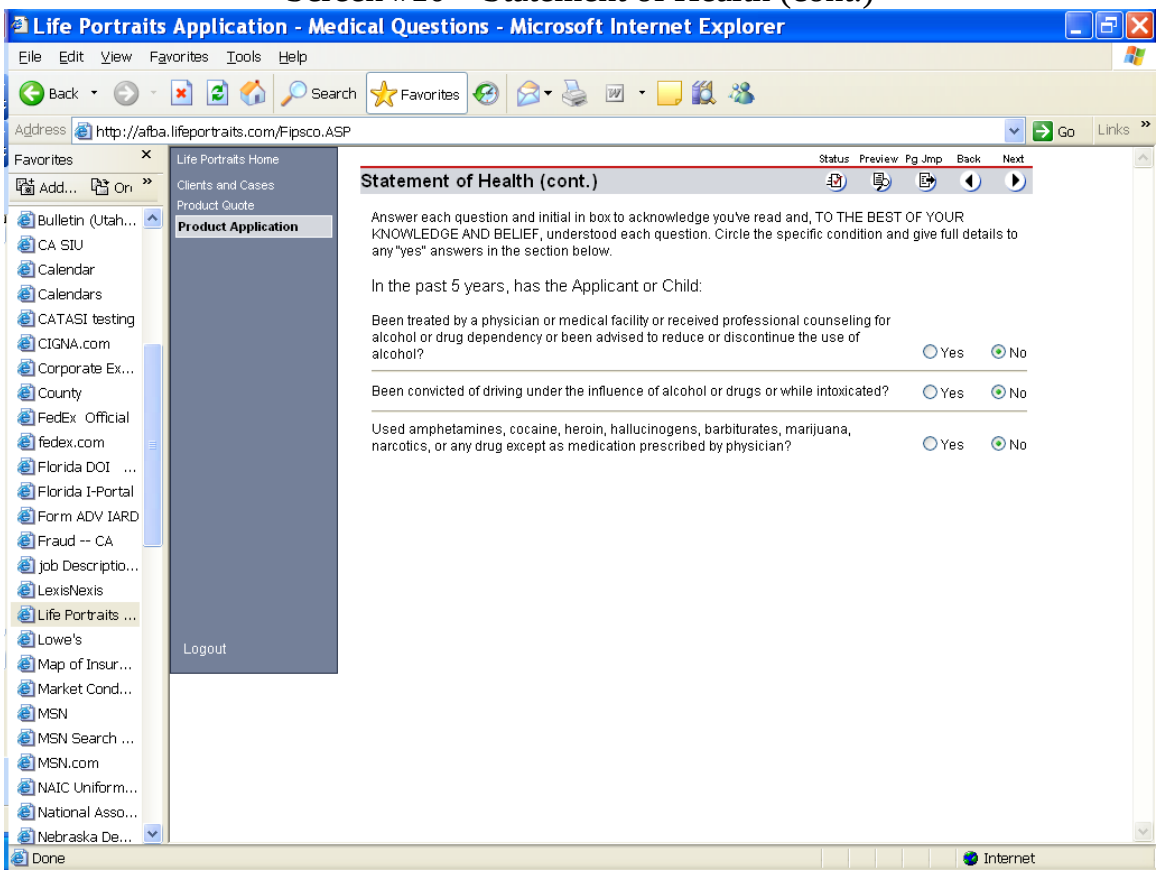
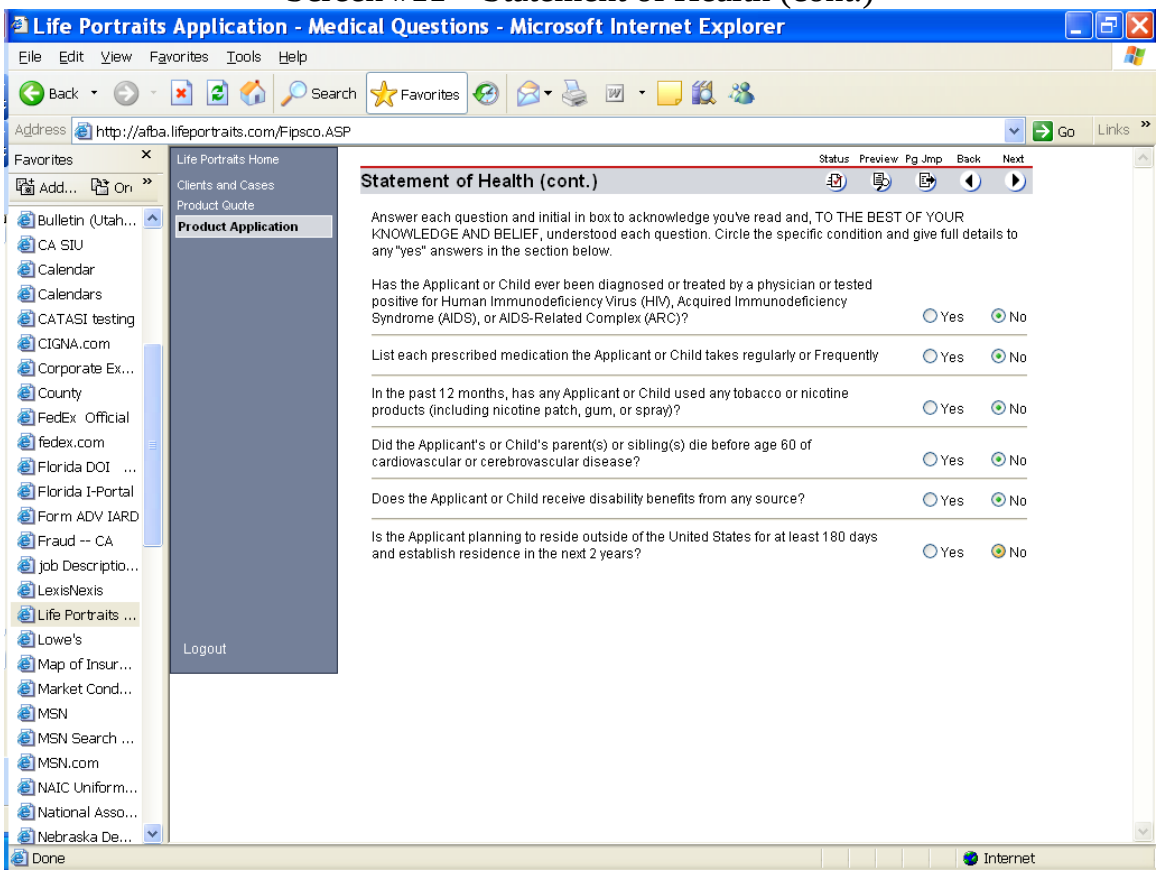
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #10 – Statement of Health (cont.)



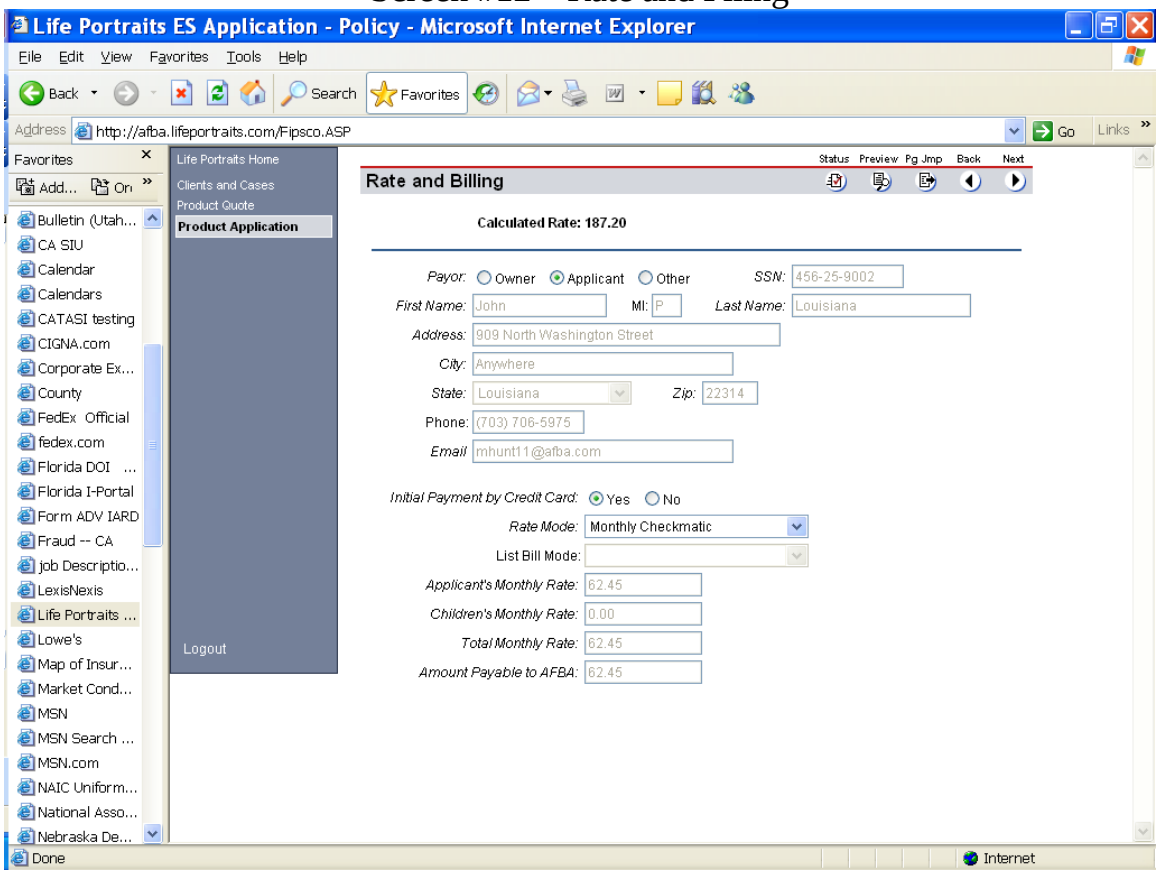
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #11 – Statement of Health (cont.)



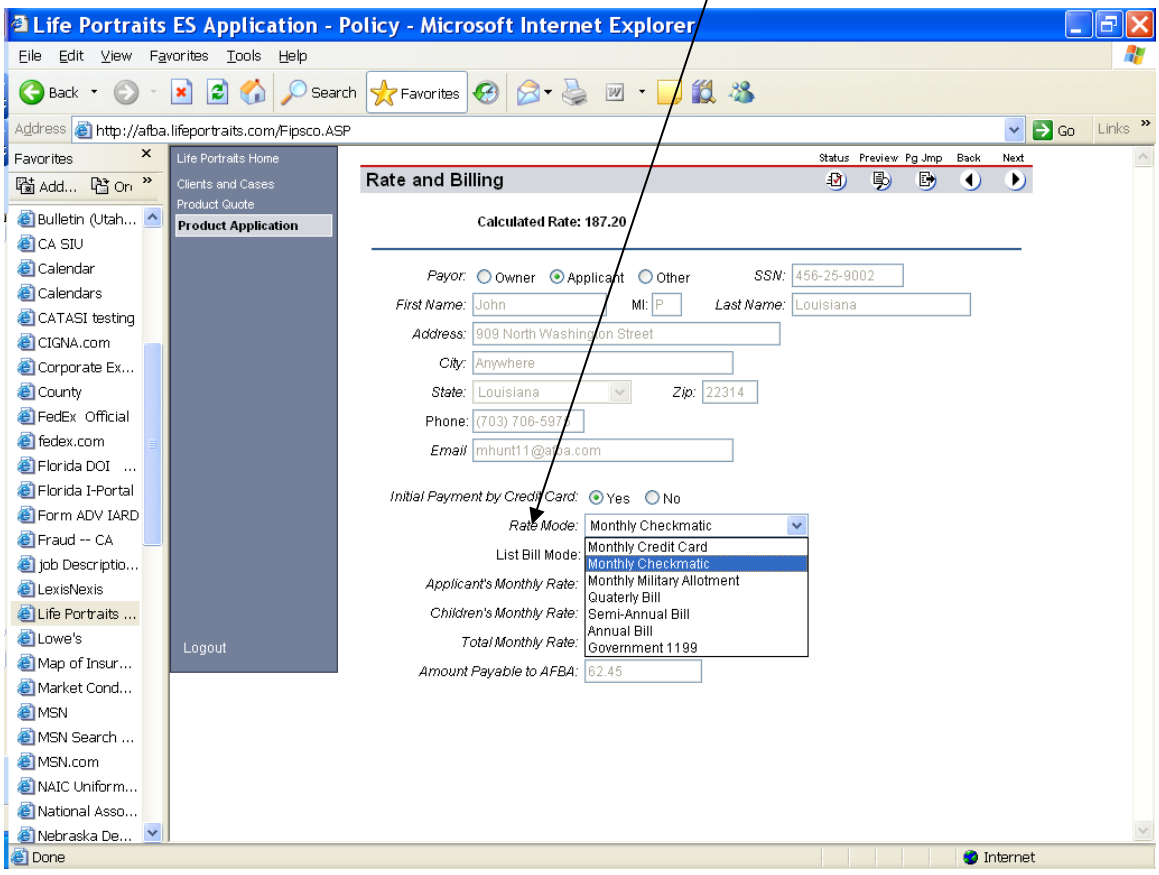
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #12 – Rate and Filing



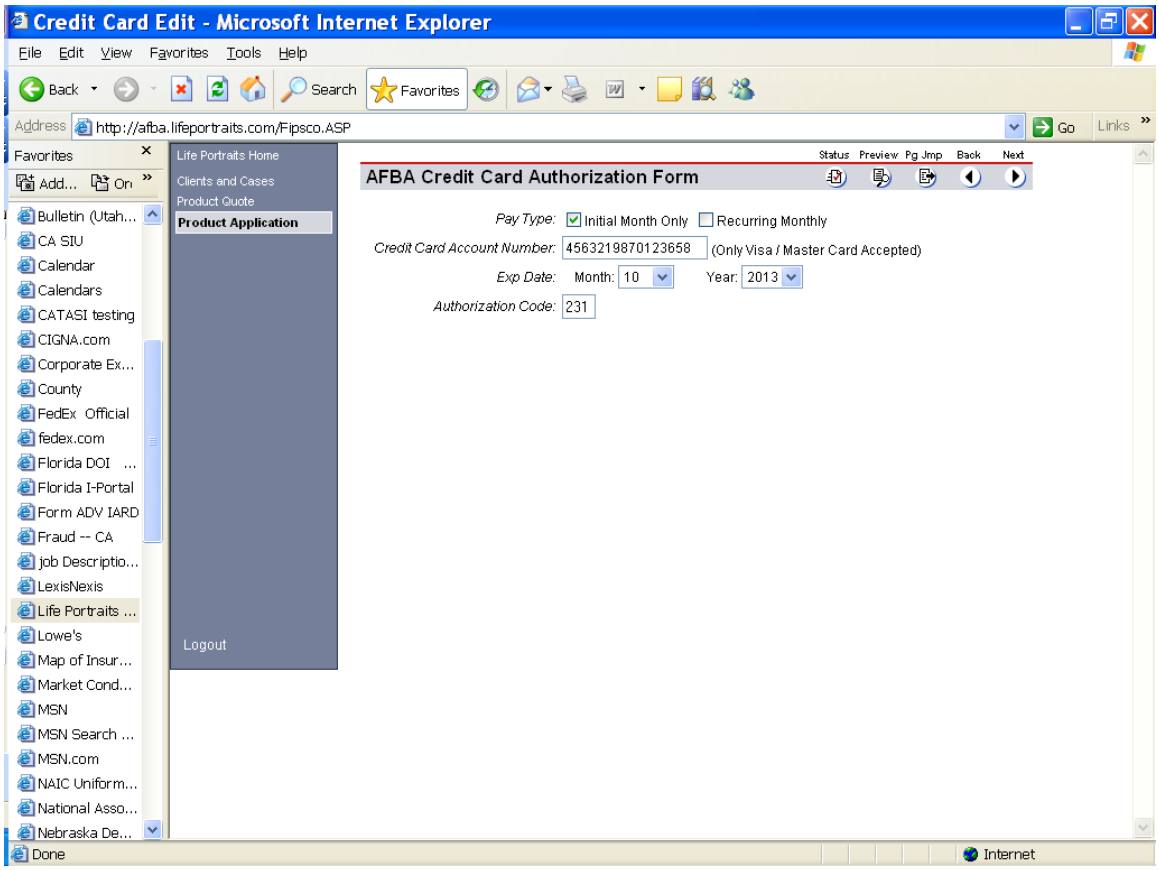
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #12 – Rate and Filing (Cont'd)
Pull Down Menu – ***Rate Mode:***



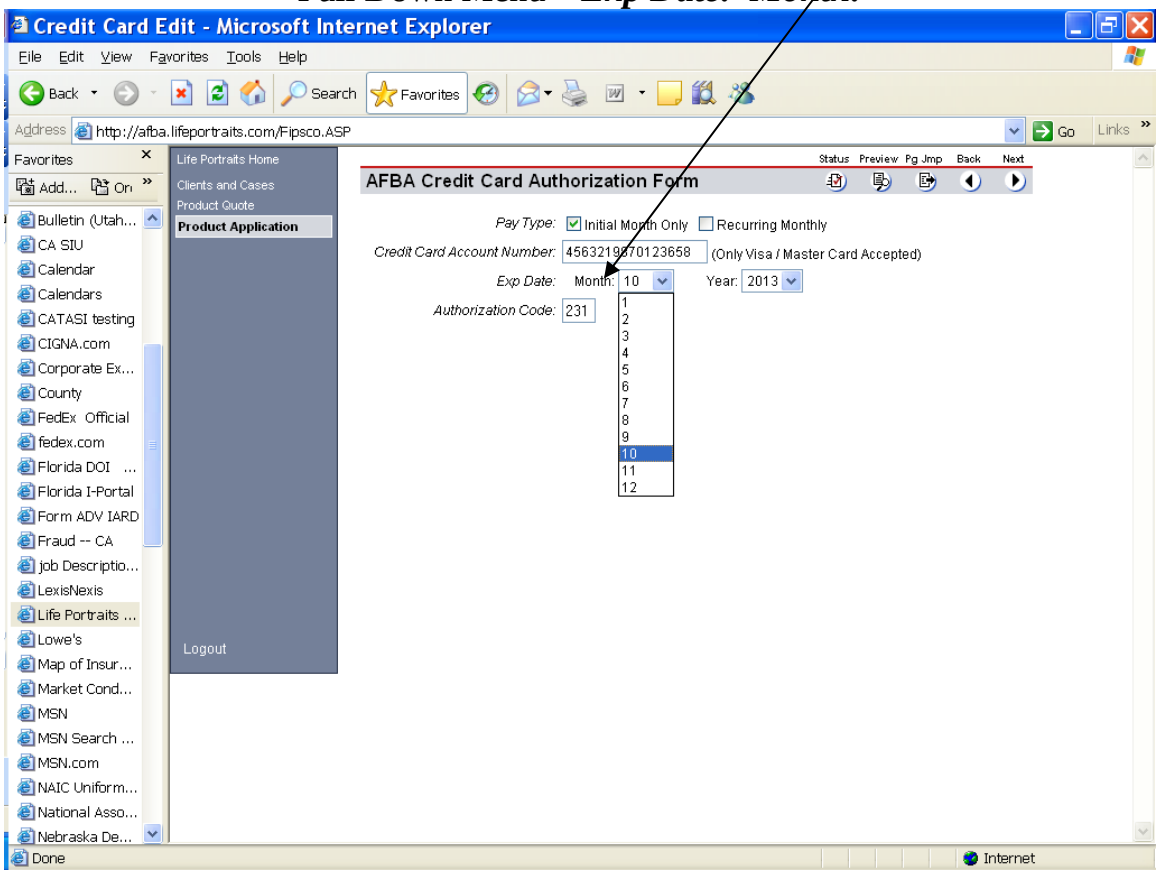
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #13 – AFBA Credit Card Authorization Form



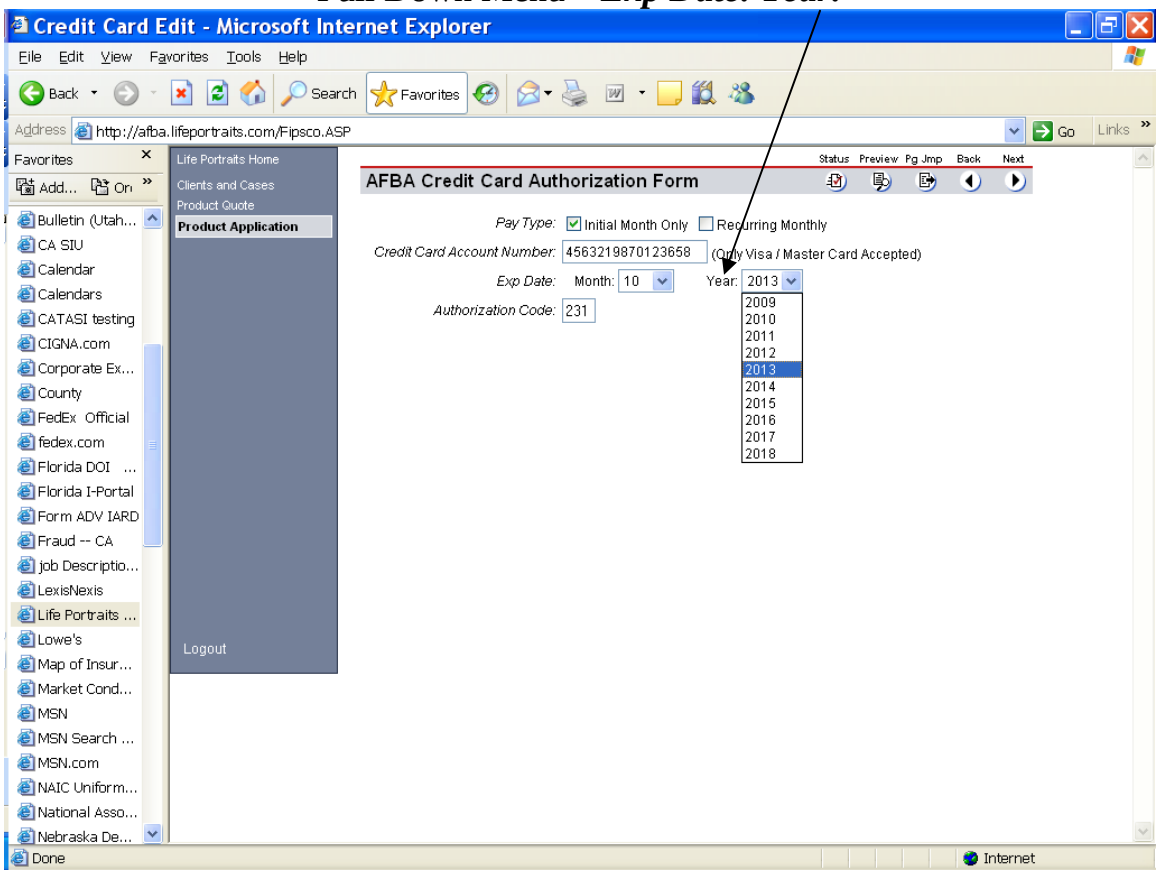
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #13 – AFBA Credit Card Authorization Form (Cont'd)
Pull Down Menu – ***Exp Date: Month:***



5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #13 – AFBA Credit Card Authorization Form (Cont'd)
Pull Down Menu – ***Exp Date: Year:***



5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART II – Product Applications

Screen #14 – Agent Certification

Life Portraits ES Application - Agent Certification - Microsoft Internet Explorer

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Corporate Ex...
County
FedEx Official
fedex.com
Florida DOI ...
Florida I-Portal
Form ADV IARD
Fraud -- CA
job Descriptio...
LexisNexis
Life Portraits ...
Lowe's
Map of Insur...
Market Cond...
MSN
MSN Search ...
MSN.com
NAIC Uniform...
National Asso...
Nebraska De...

Life Portraits Home
Clients and Cases
Product Quote
Product Application
Logout

Status Preview Pg Jmp Back

Agent Certification

To the best of my knowledge, the Applicant is/is not replacing existing individual insurance. ◉ Yes ○ No
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

Signed at City: Anywhere *State:* LA

Special Instructions:

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

Best time to contact for medical interview (if applicable): From : ○ am ○ pm
To : ○ am ○ pm

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

Done Internet

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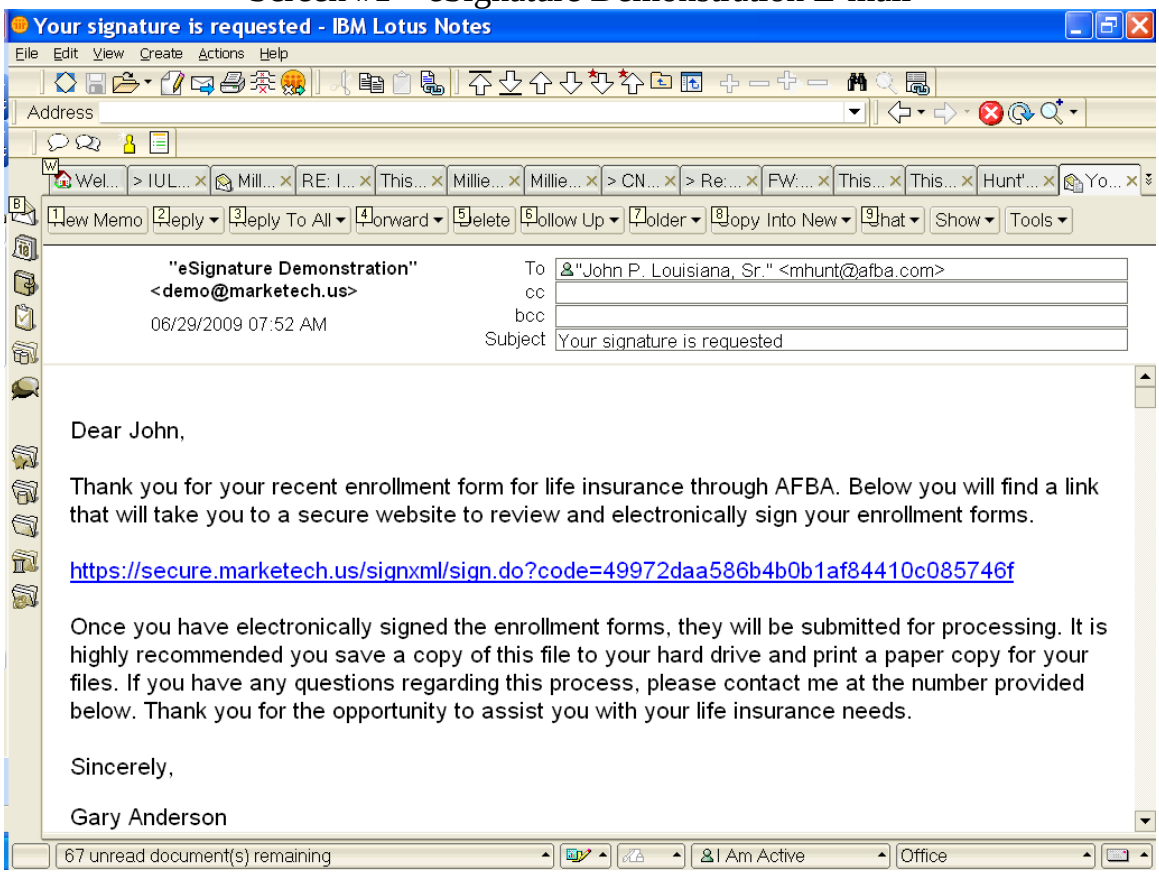
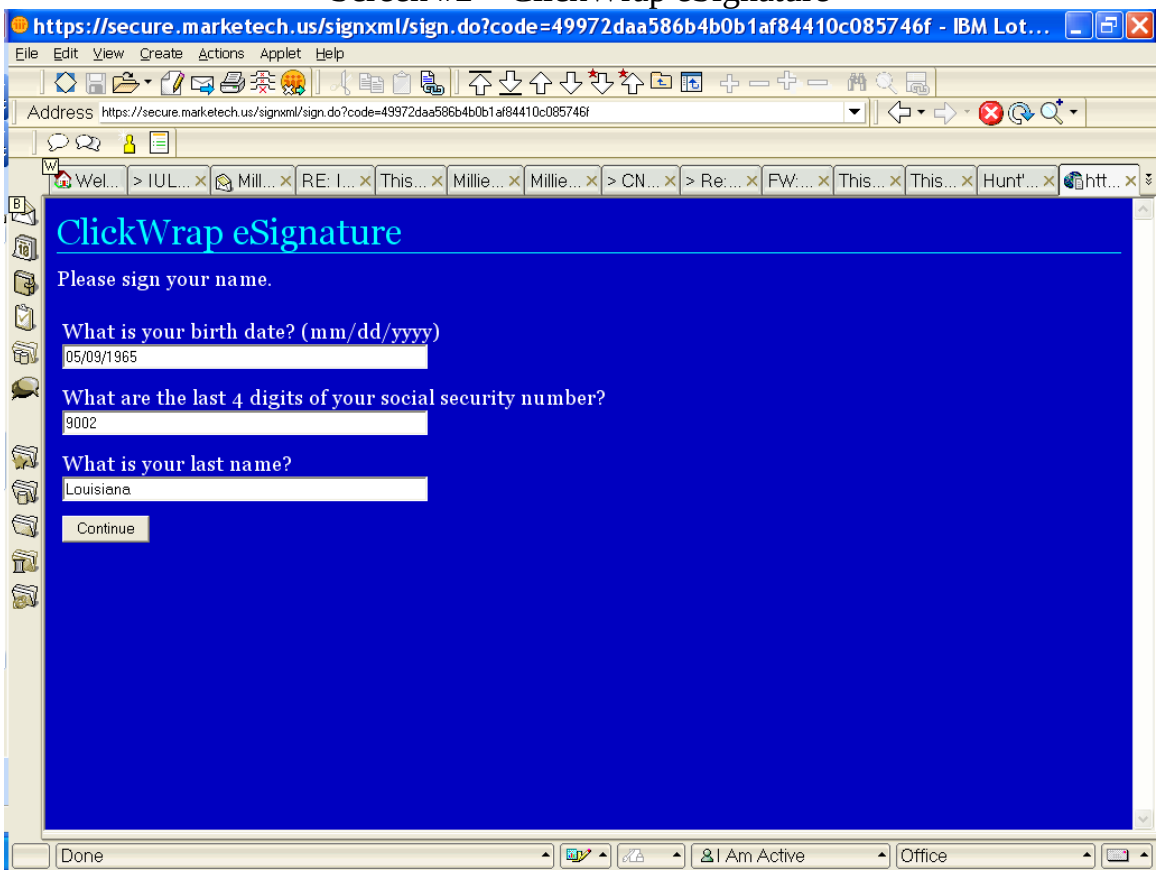
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #1 – eSignature Demonstration E-mail



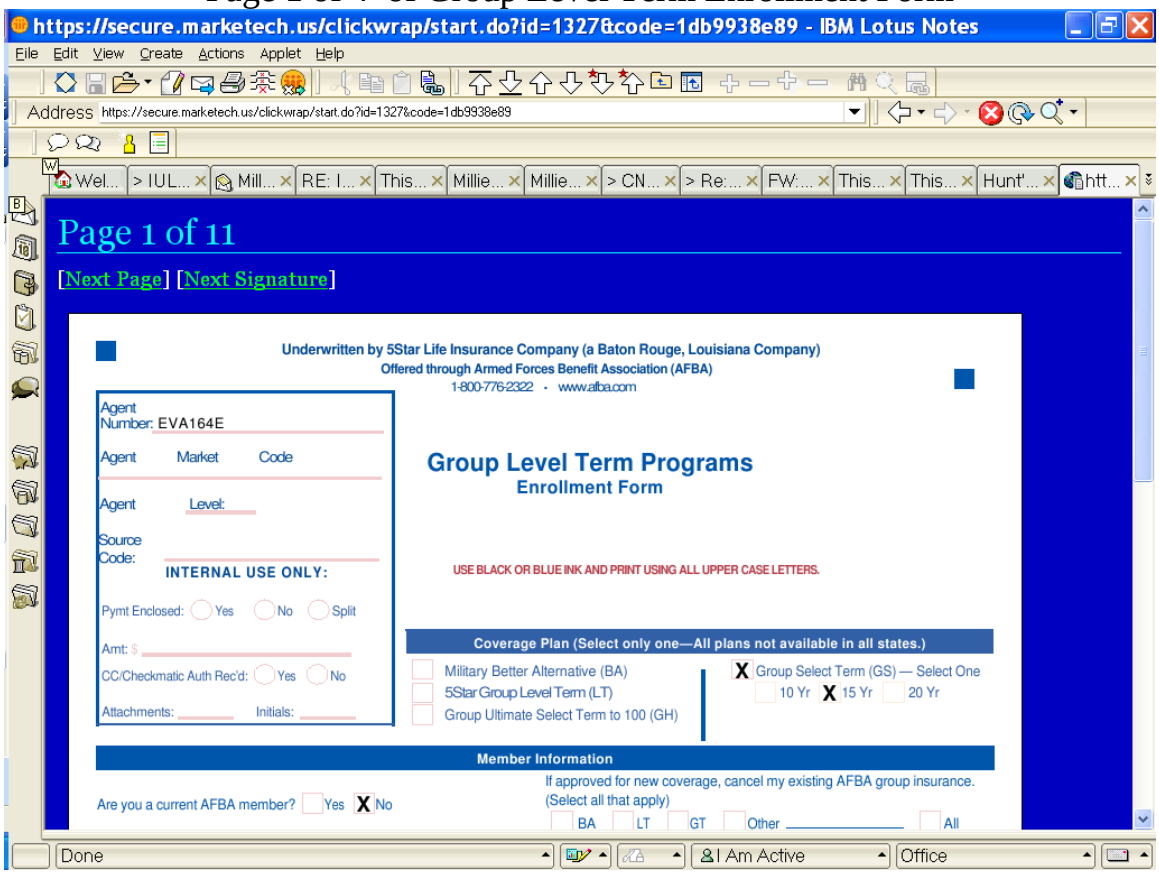
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #2 – ClickWrap eSignature



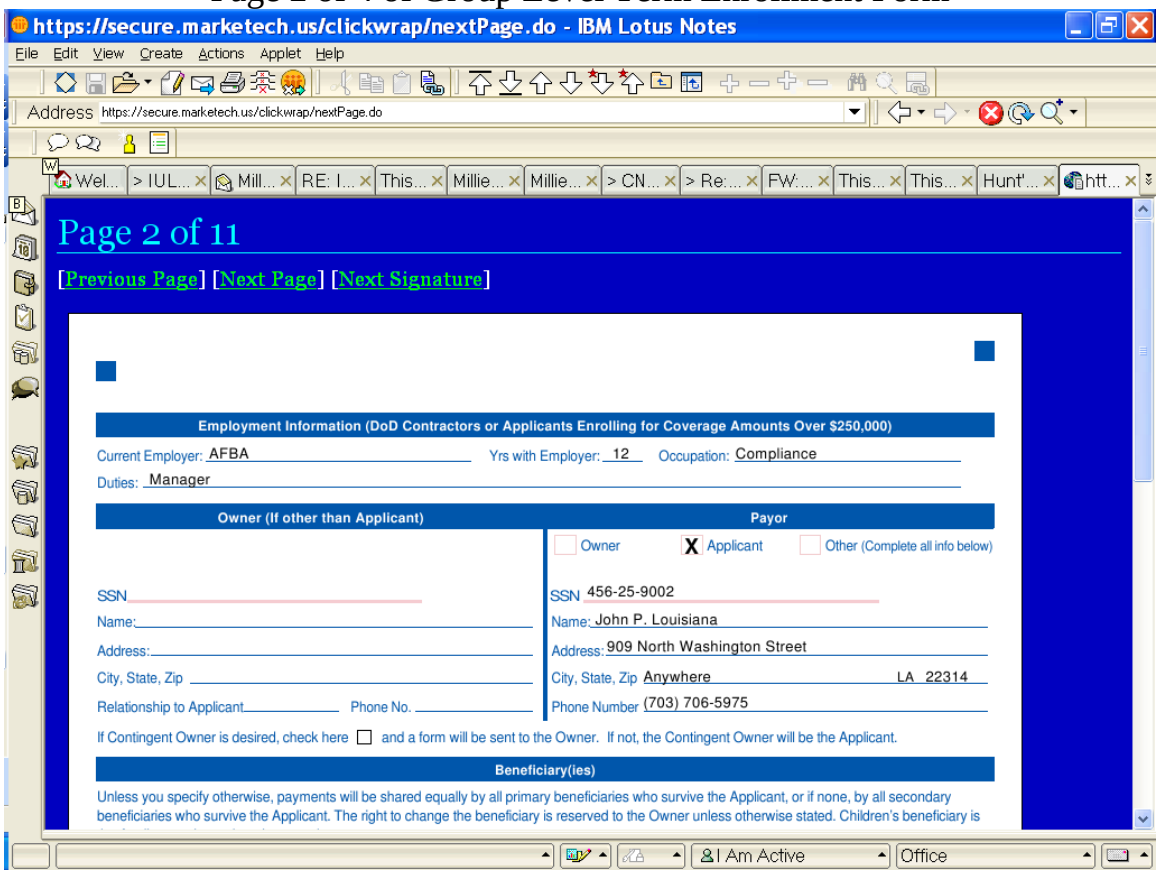
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #3 – Page 1 of 11
Page 1 of 4 of Group Level Term Enrollment Form



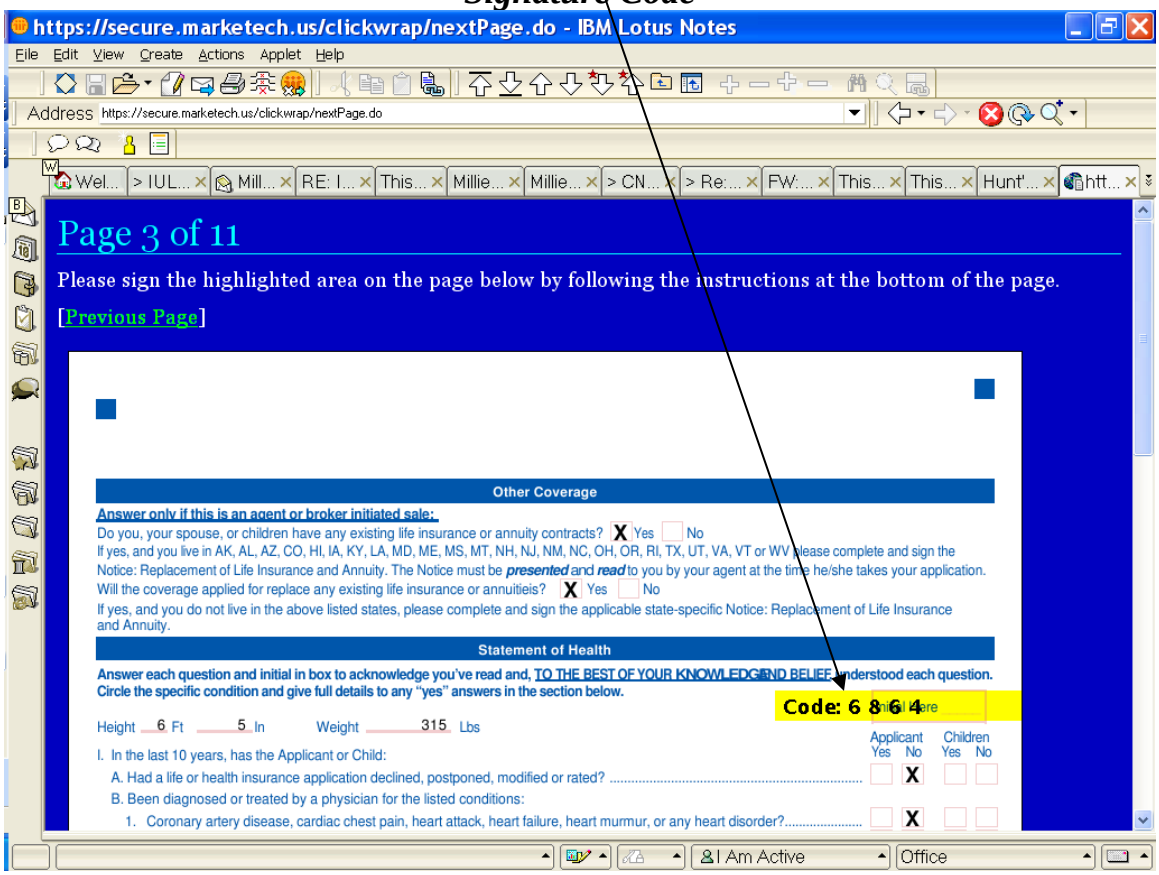
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #4 – Page 2 of 11
Page 2 of 4 of Group Level Term Enrollment Form



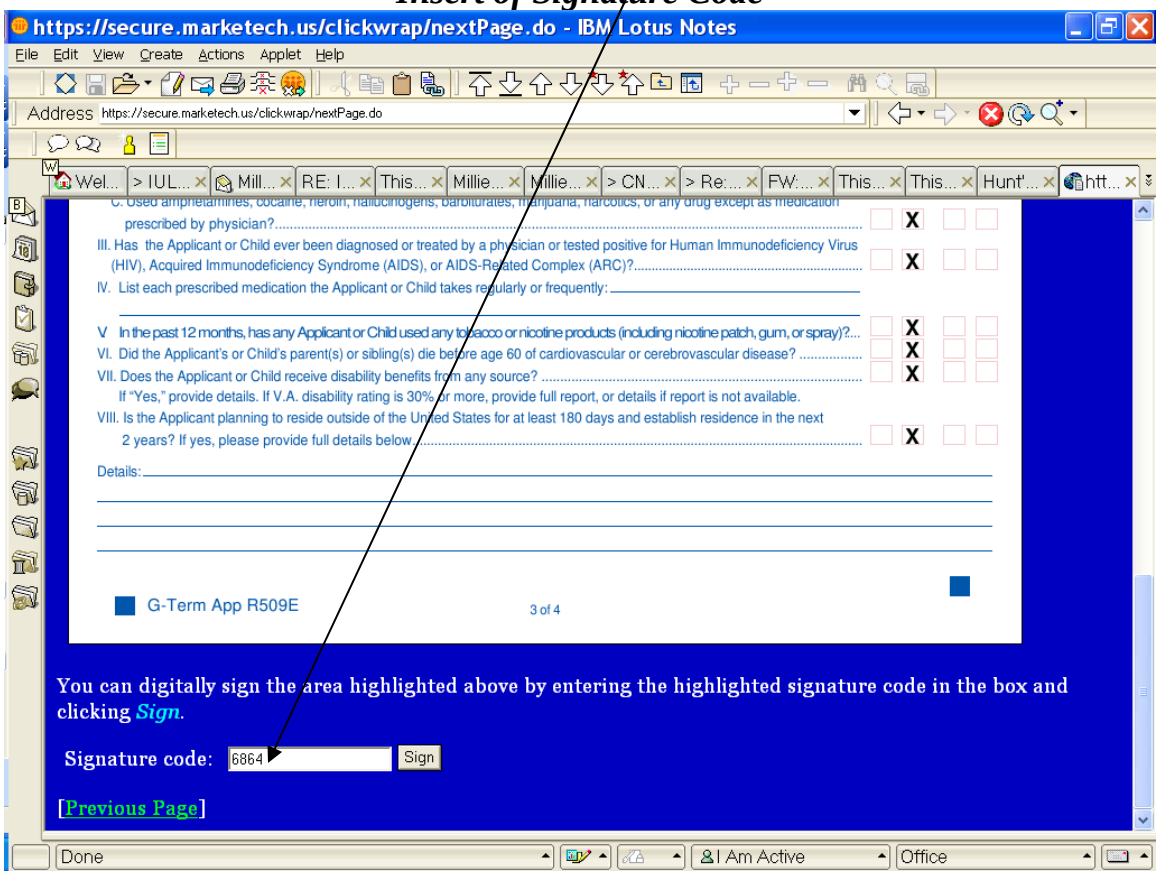
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #5 – Page 3 of 11
Page 3 of 4 of Group Level Term Enrollment Form
Signature Code



5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #5 – Page 3 of 11
Page 3 of 4 of Group Level Term Enrollment Form
Insert of Signature Code

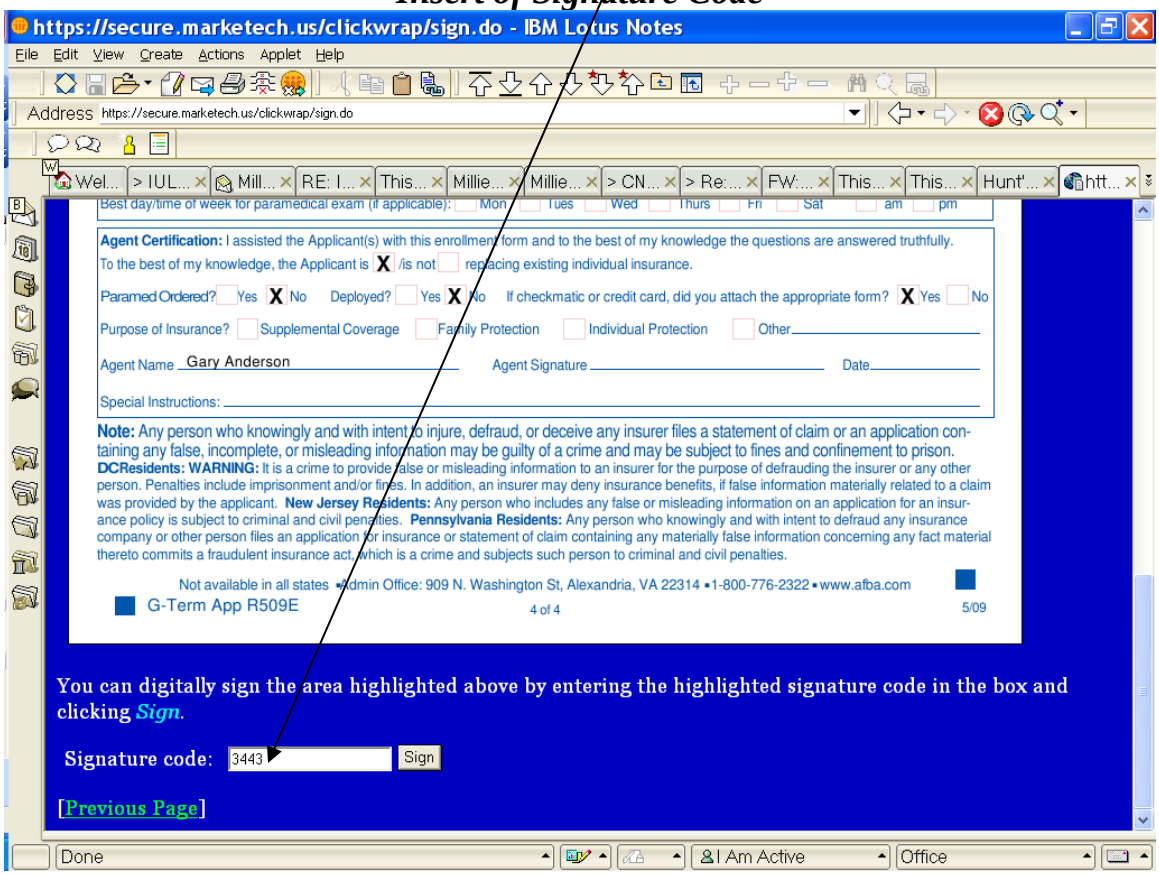


5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #6 – Page 4 of 11
Page 4 of 4 of Group Level Term Enrollment Form
Signature Code

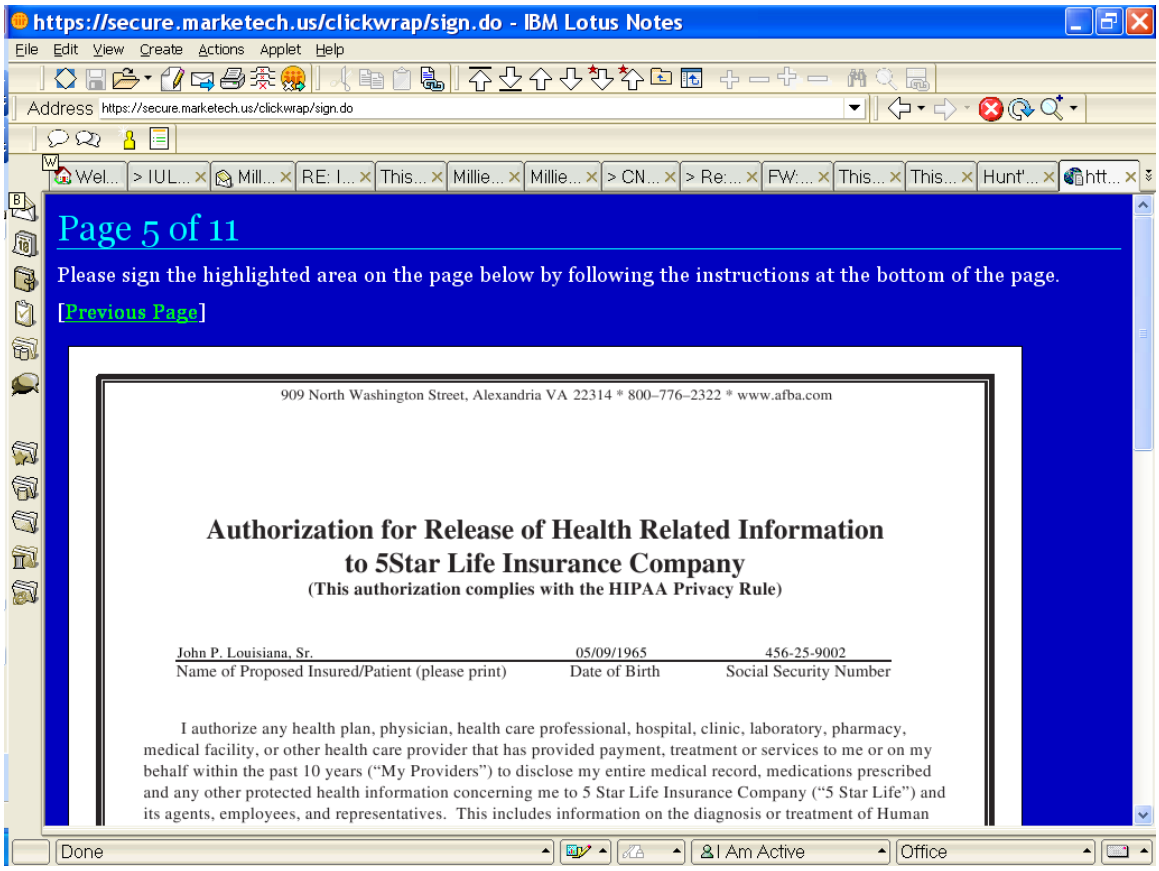
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #6 – Page 4 of 11
Page 4 of 4 of Group Level Term Enrollment Form
Insert of Signature Code



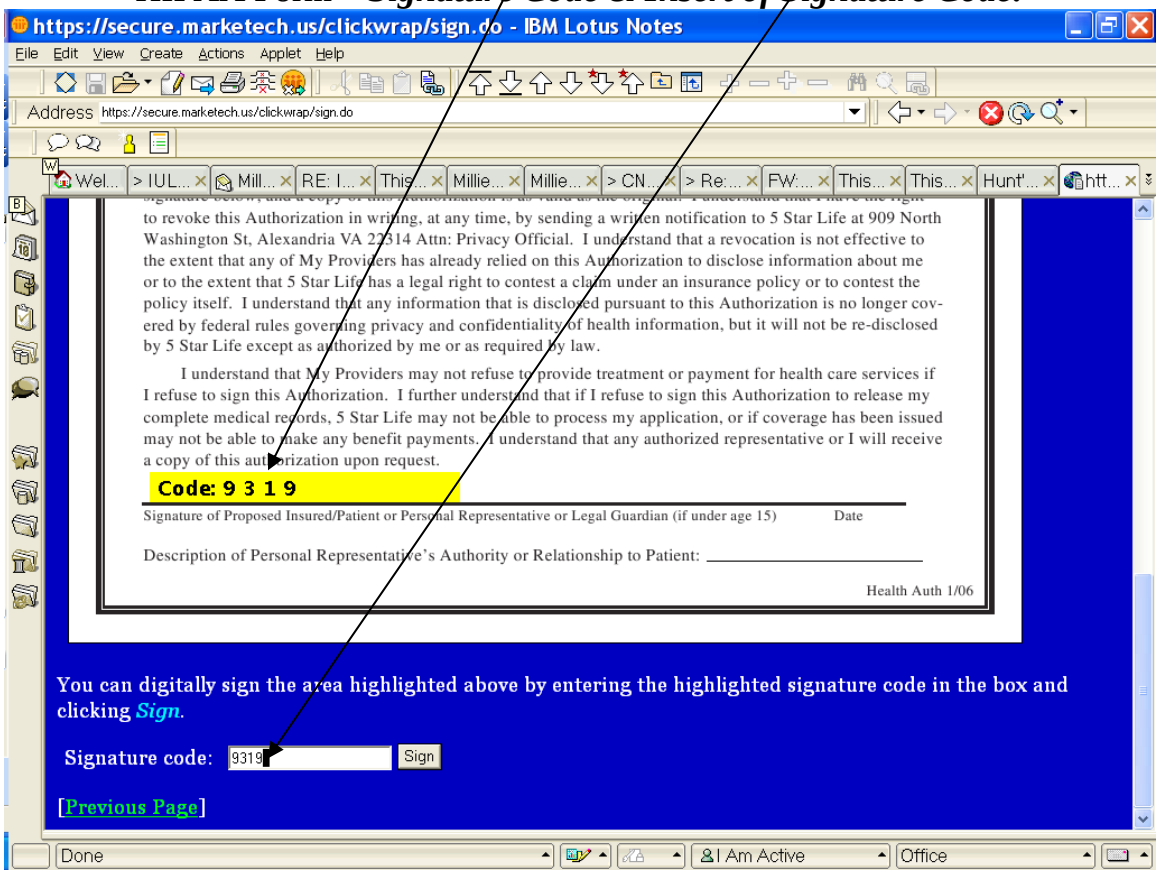
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #7 – Page 5 of 11
HIPAA Form



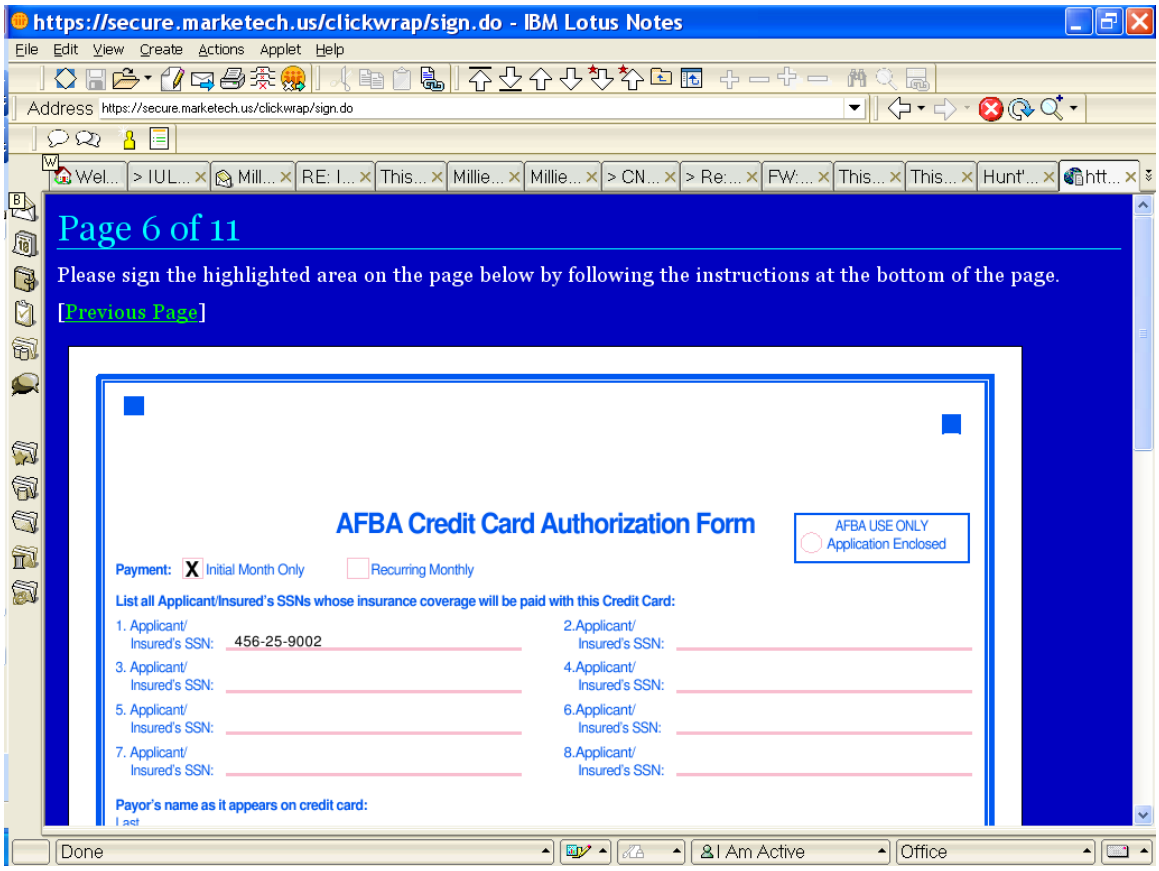
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #7 – Page 5 of 11 (Cont'd)
HIPAA Form – ***Signature Code & Insert of Signature Code:***



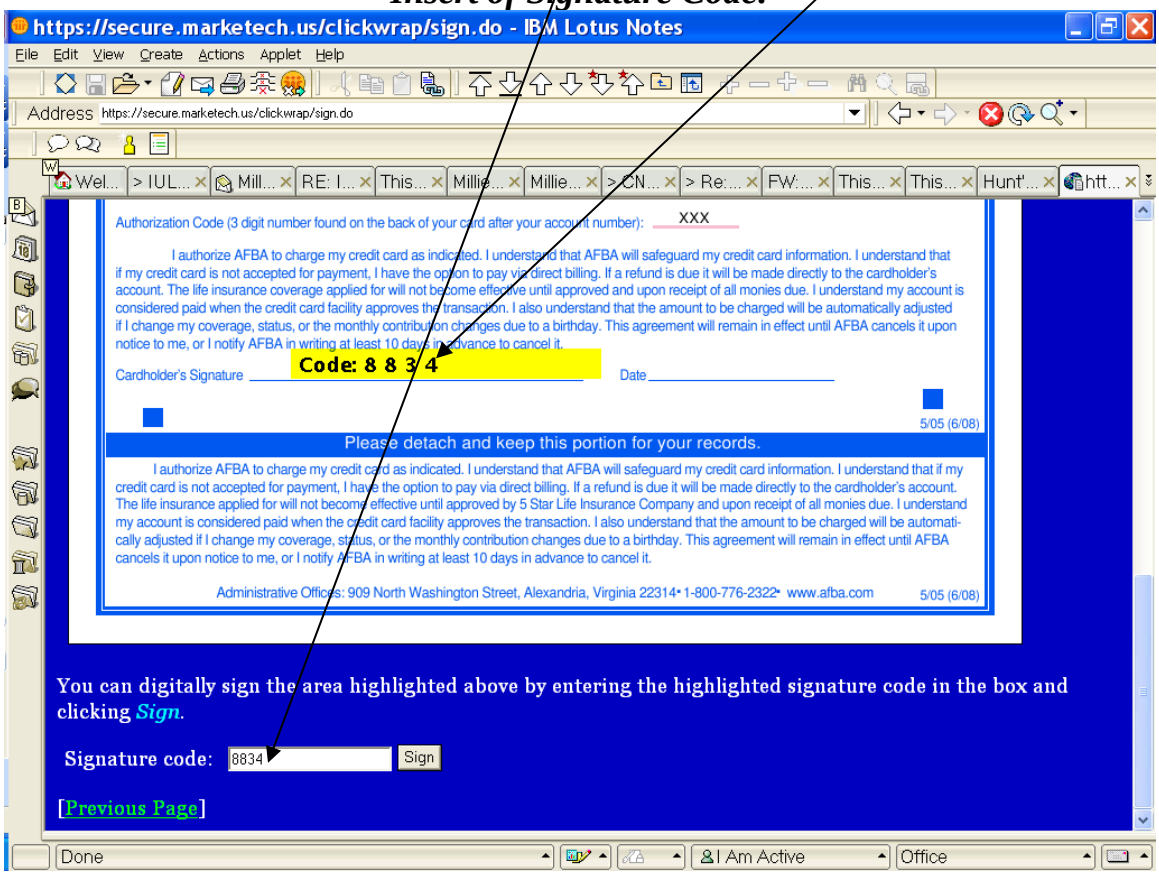
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #8 – Page 6 of 11
AFBA Credit Card Authorization Form



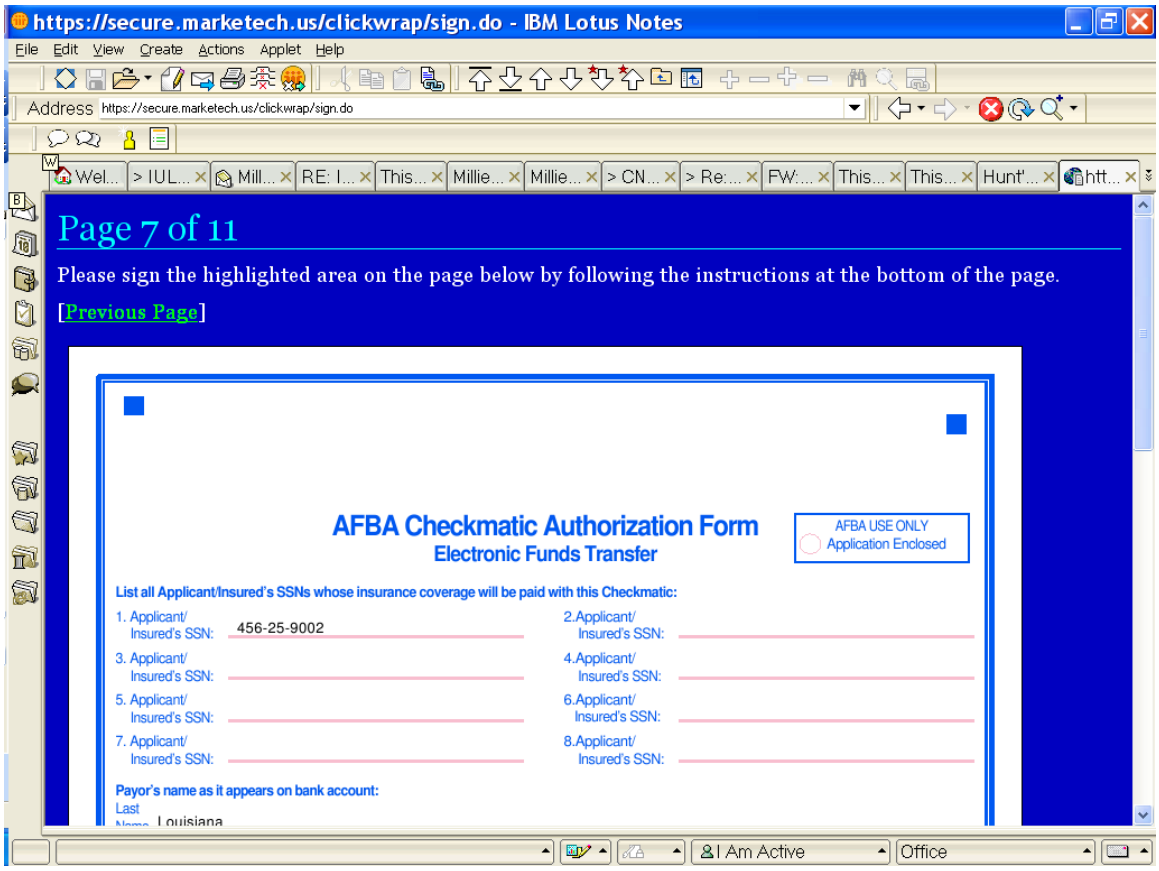
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #8 – Page 6 of 1 (Cont'd)
AFBA Credit Card Authorization Form – ***Signature Code & Insert of Signature Code:***



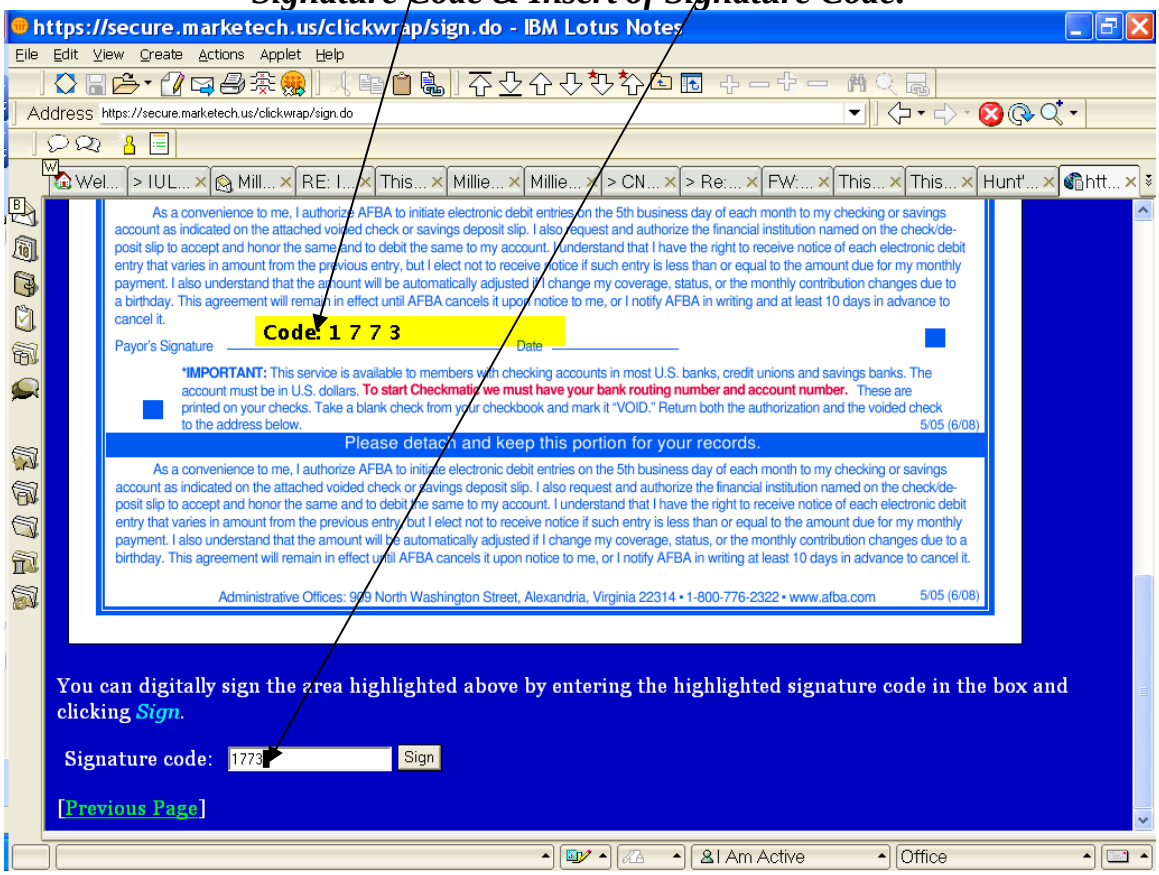
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #9 – Page 7 of 11
AFBA Checkmatic Authorization Form



5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #9 – Page 7 of 11 (Cont'd)
AFBA Checkmatic Authorization Form
Signature Code & Insert of Signature Code:



5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #10 – Page 8 of 11
Replacement of Life Insurance or Annuity

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IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITY

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

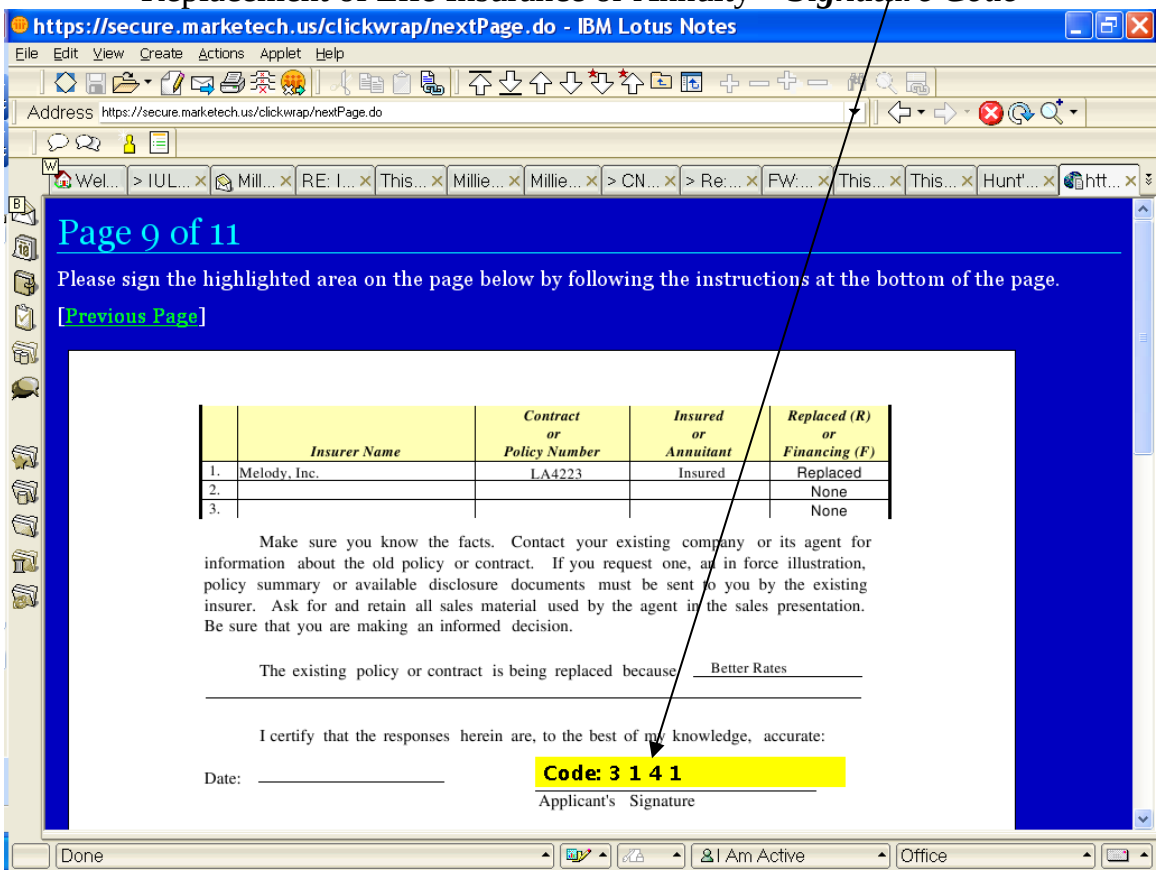
You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to

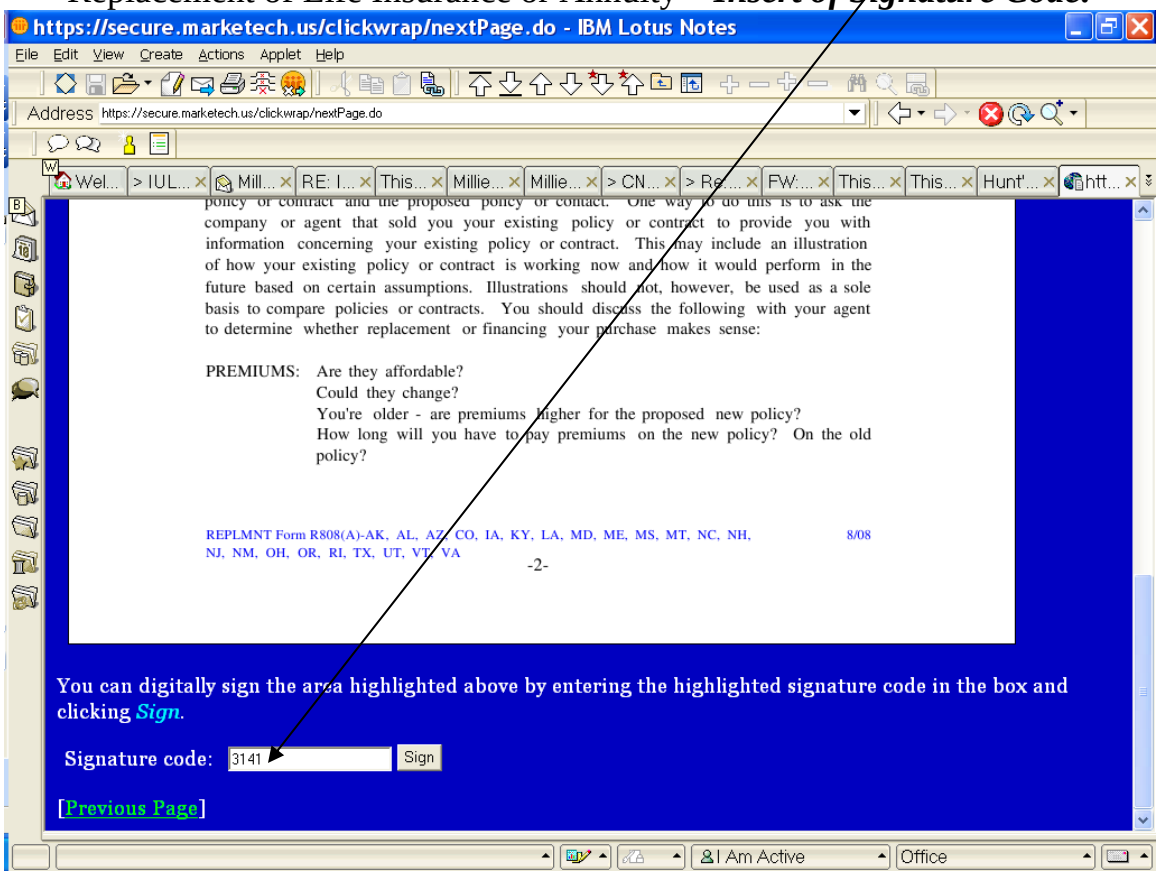
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #11 – Page 9 of 11
Replacement of Life Insurance or Annuity – ***Signature Code***



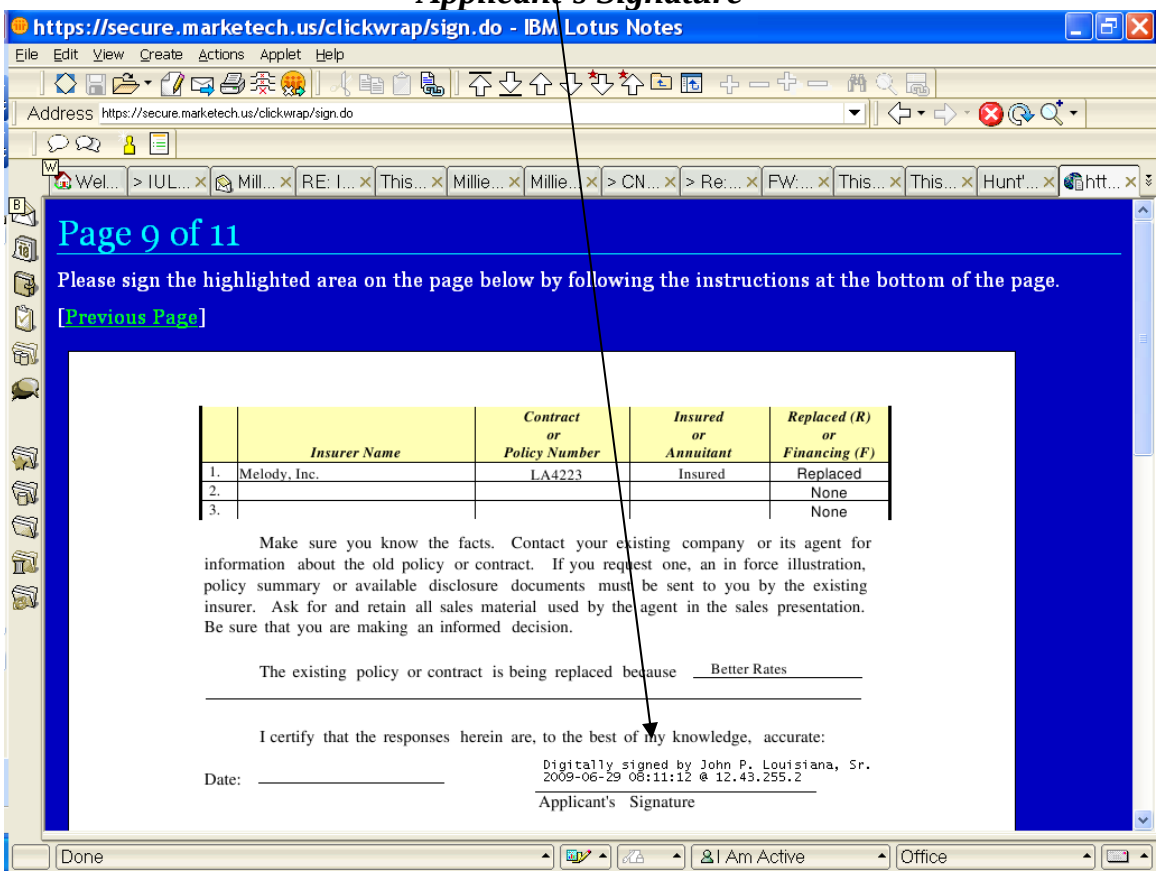
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #11 – Page 9 of 11 (Cont'd)
Replacement of Life Insurance or Annuity – ***Insert of Signature Code:***



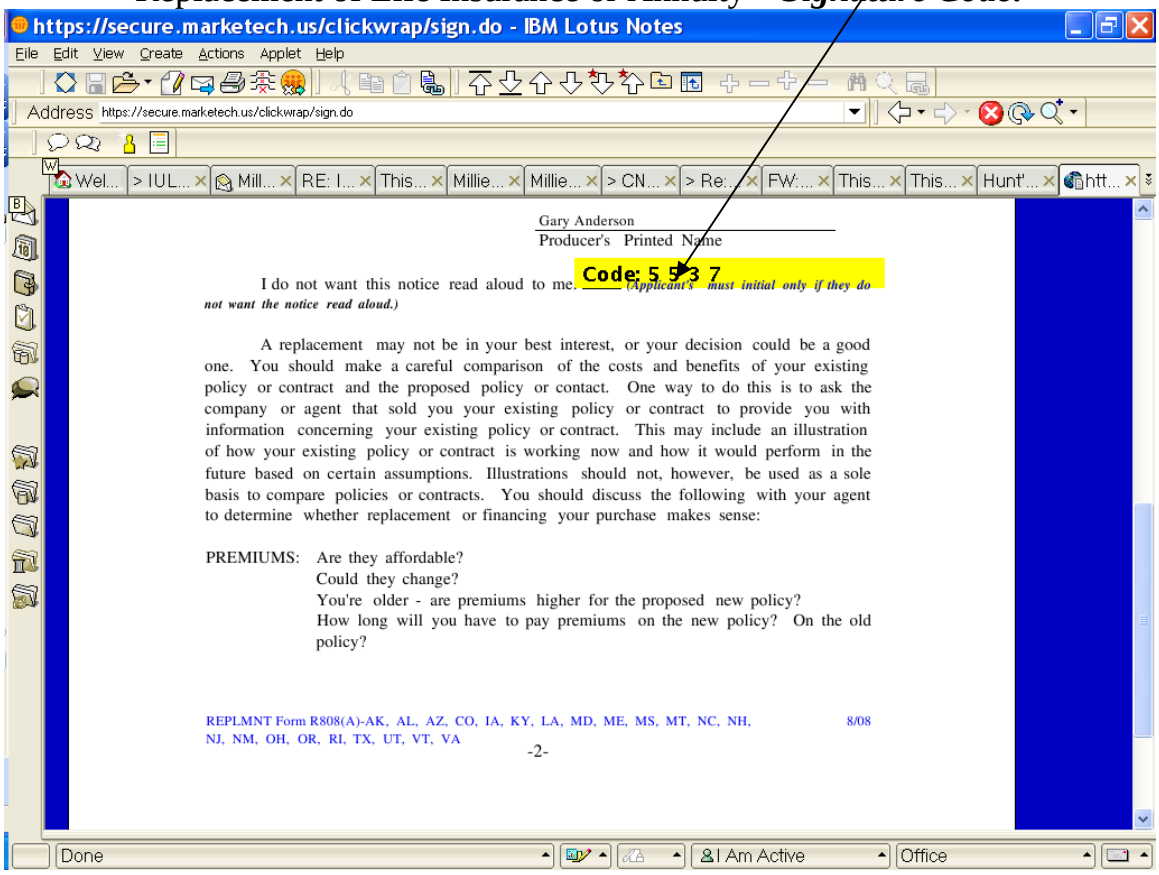
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #12 – Page 9 of 11
Replacement of Life Insurance or Annuity
Applicant's Signature



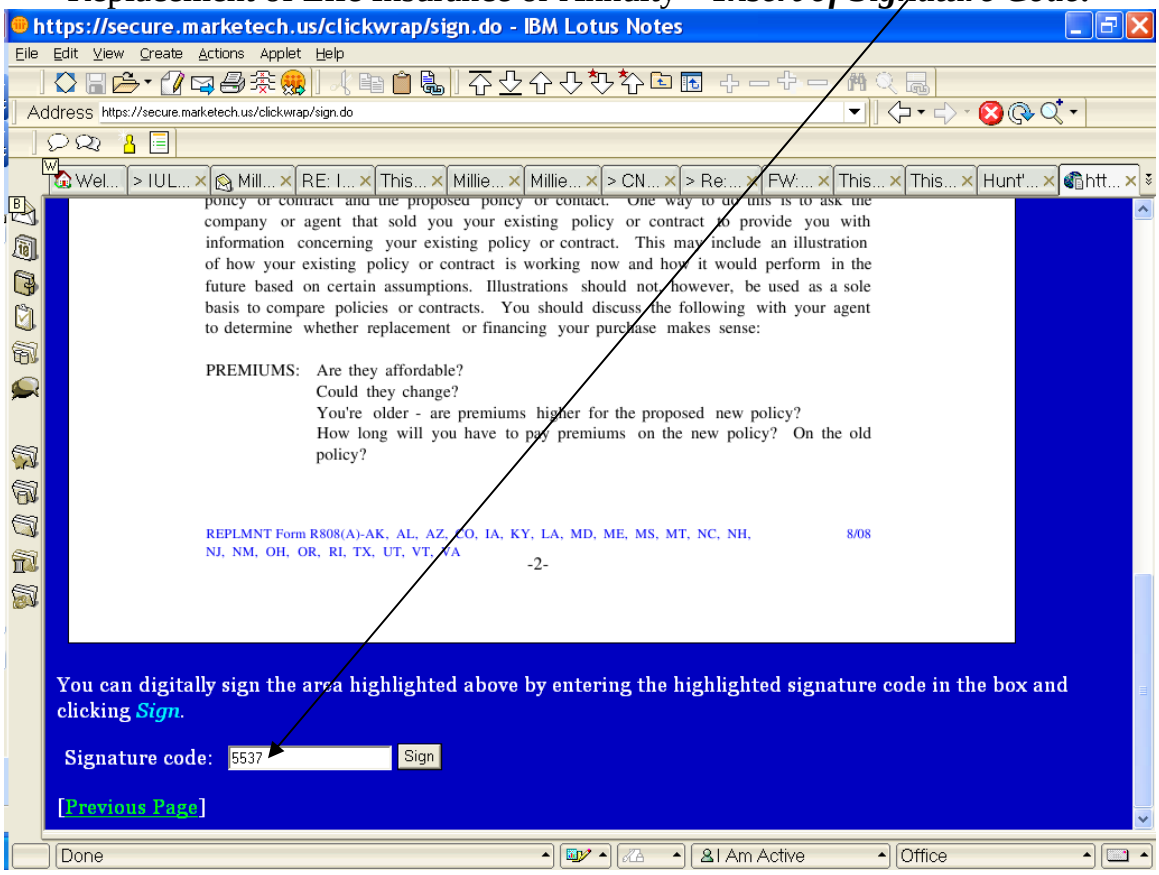
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #12 – Page 9 of 11 (Cont'd)
Replacement of Life Insurance or Annuity – ***Signature Code:***



5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #12 – Page 9 of 11 (Cont'd)
Replacement of Life Insurance or Annuity – ***Insert of Signature Code:***



5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #13 – Page 10 of 11
Replacement of Life Insurance or Annuity

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POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

Done | I Am Active | Office

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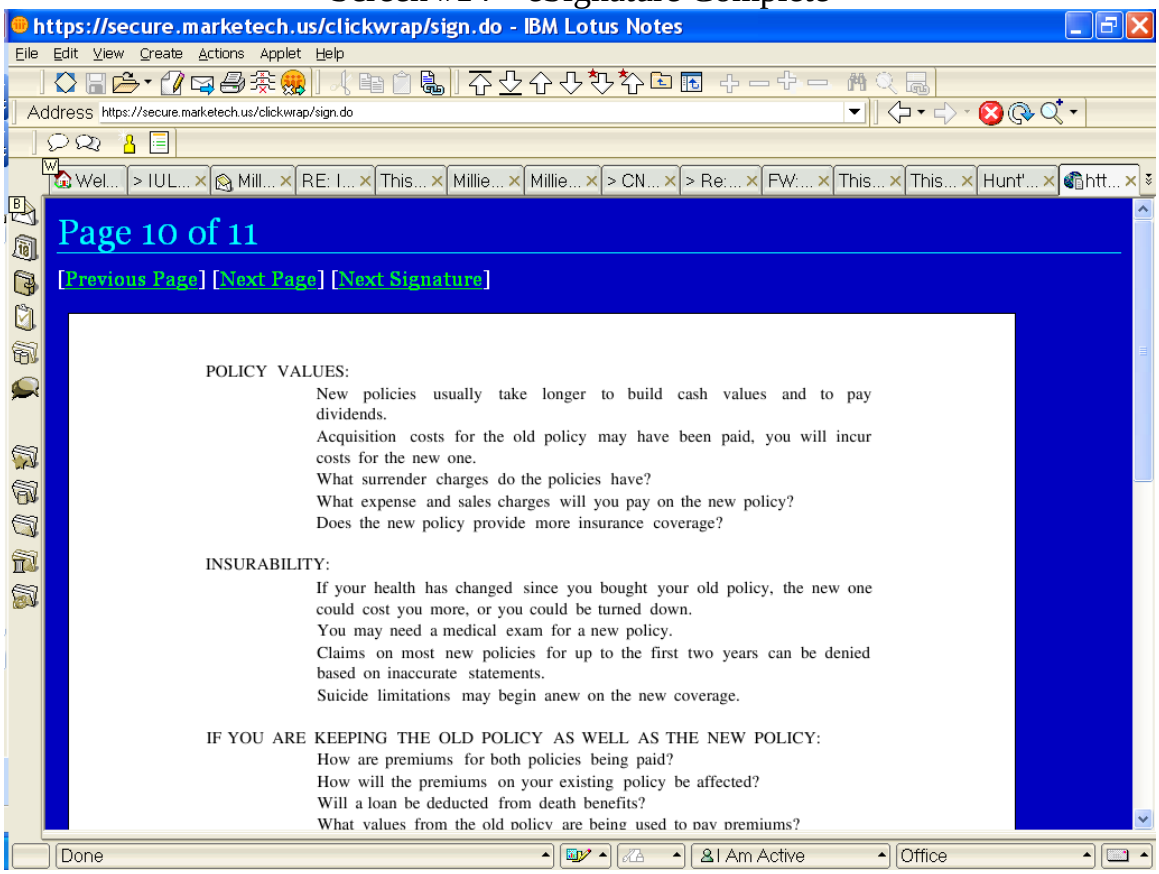
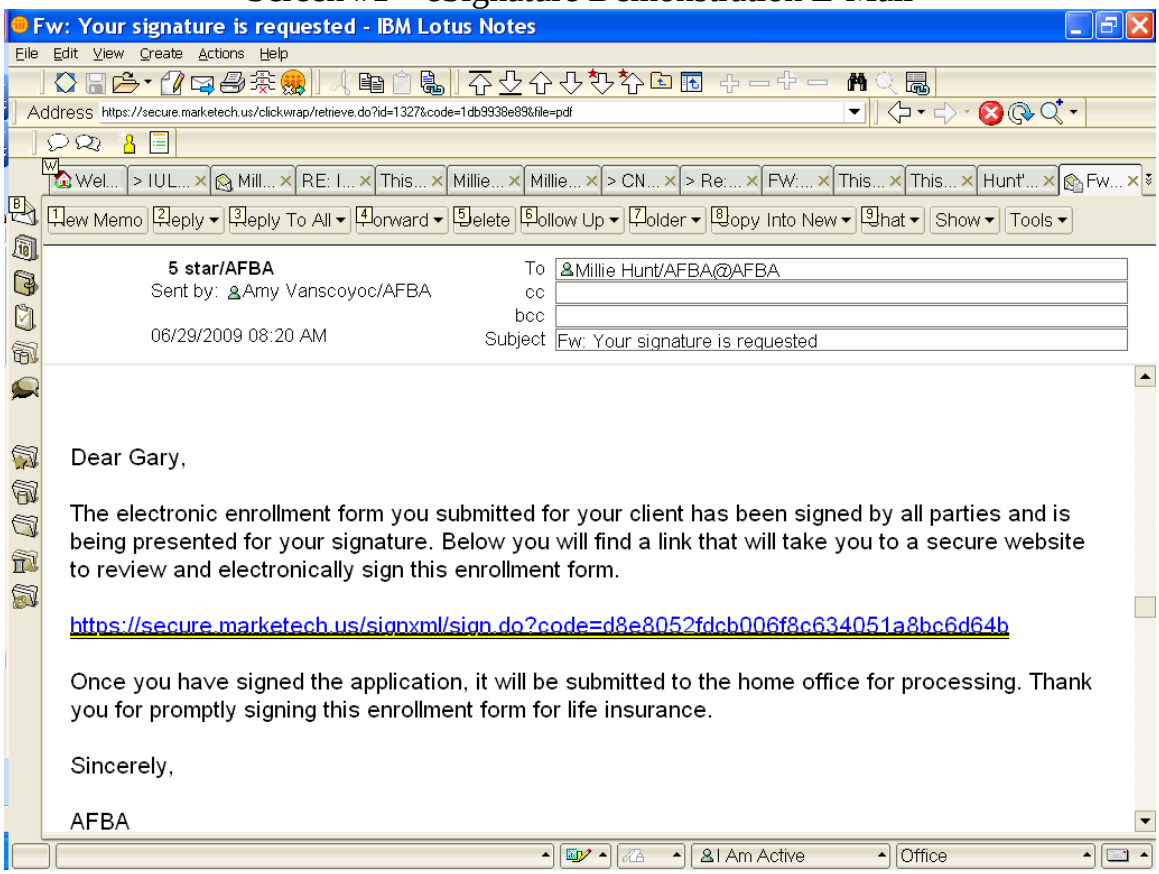
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART III – eSignature (Applicant)

Screen #14 – eSignature Complete



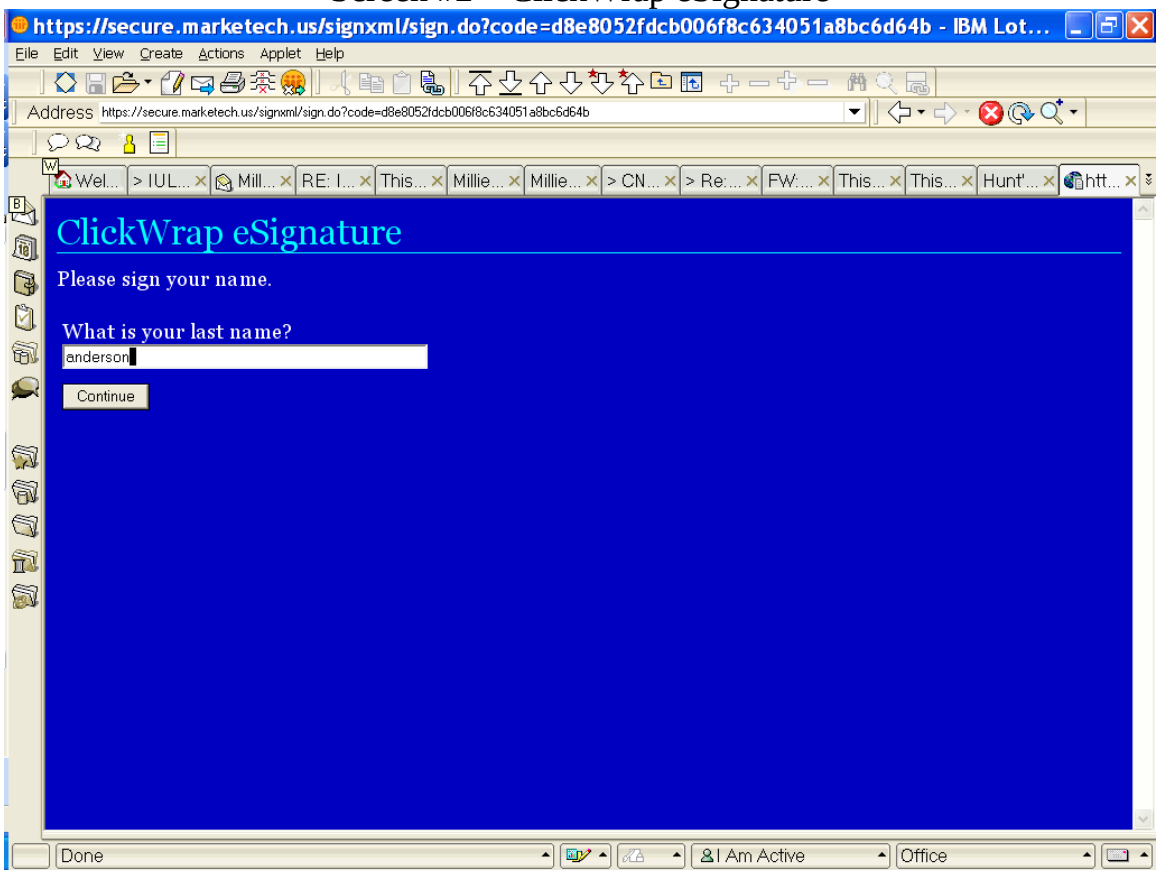
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART IV – eSignature (Agent)

Screen #1 – eSignature Demonstration E-Mail



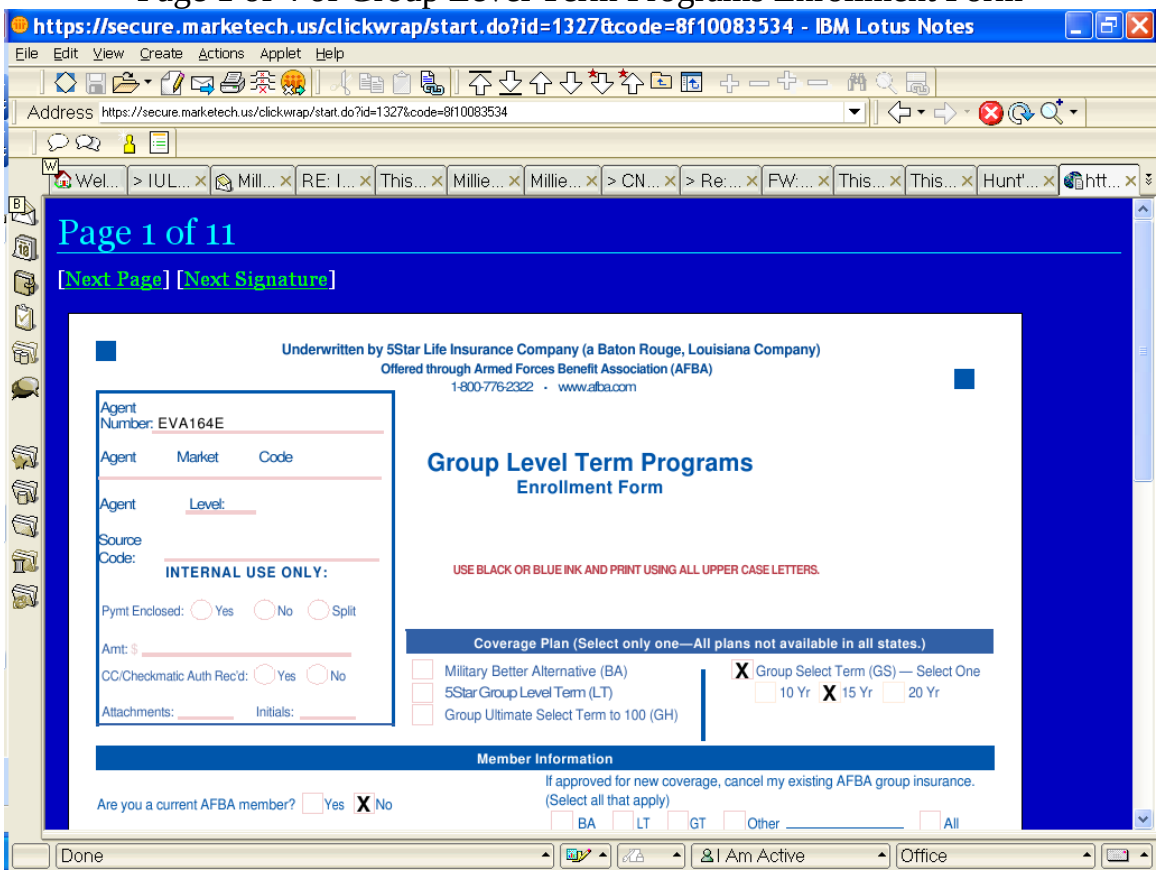
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART IV – eSignature (Agent)

Screen #2 – ClickWrap eSignature



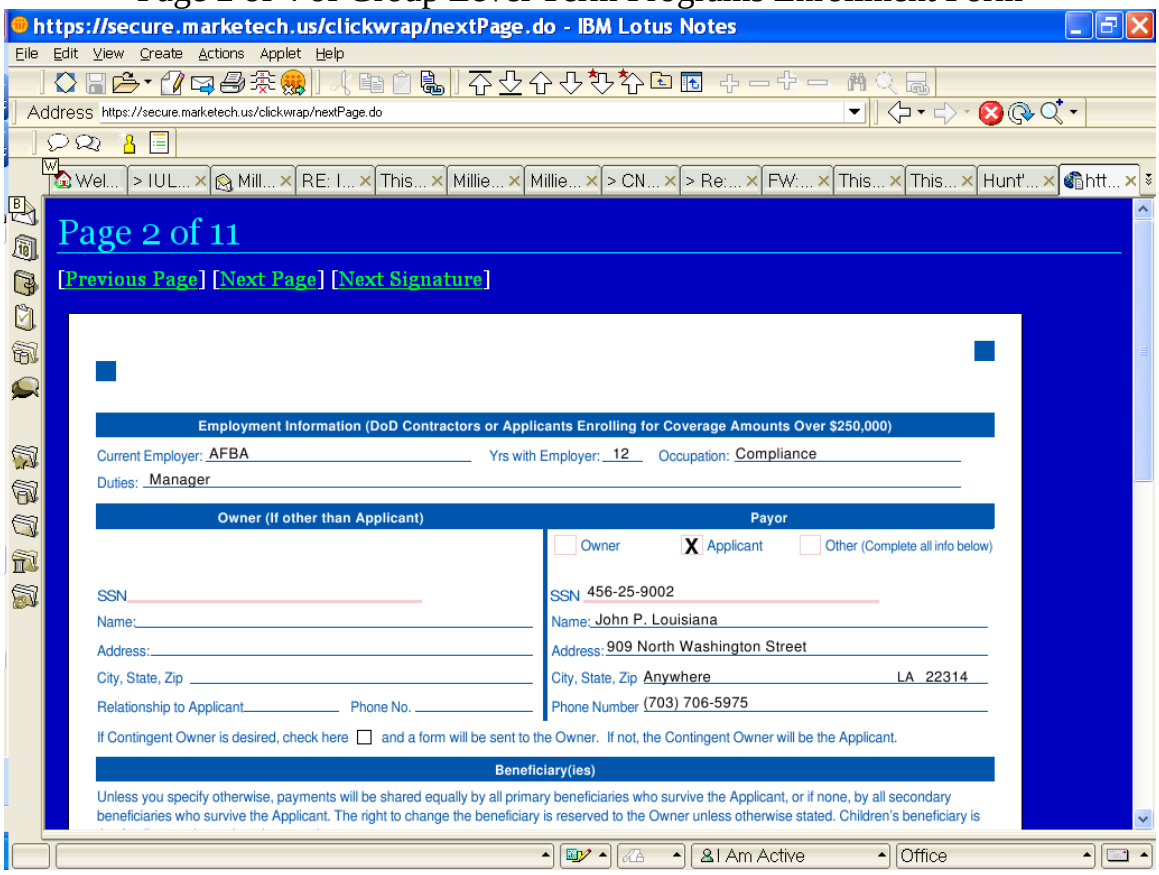
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART IV – eSignature (Agent)

Screen #3 – Page 1 of 11
Page 1 of 4 of Group Level Term Programs Enrollment Form



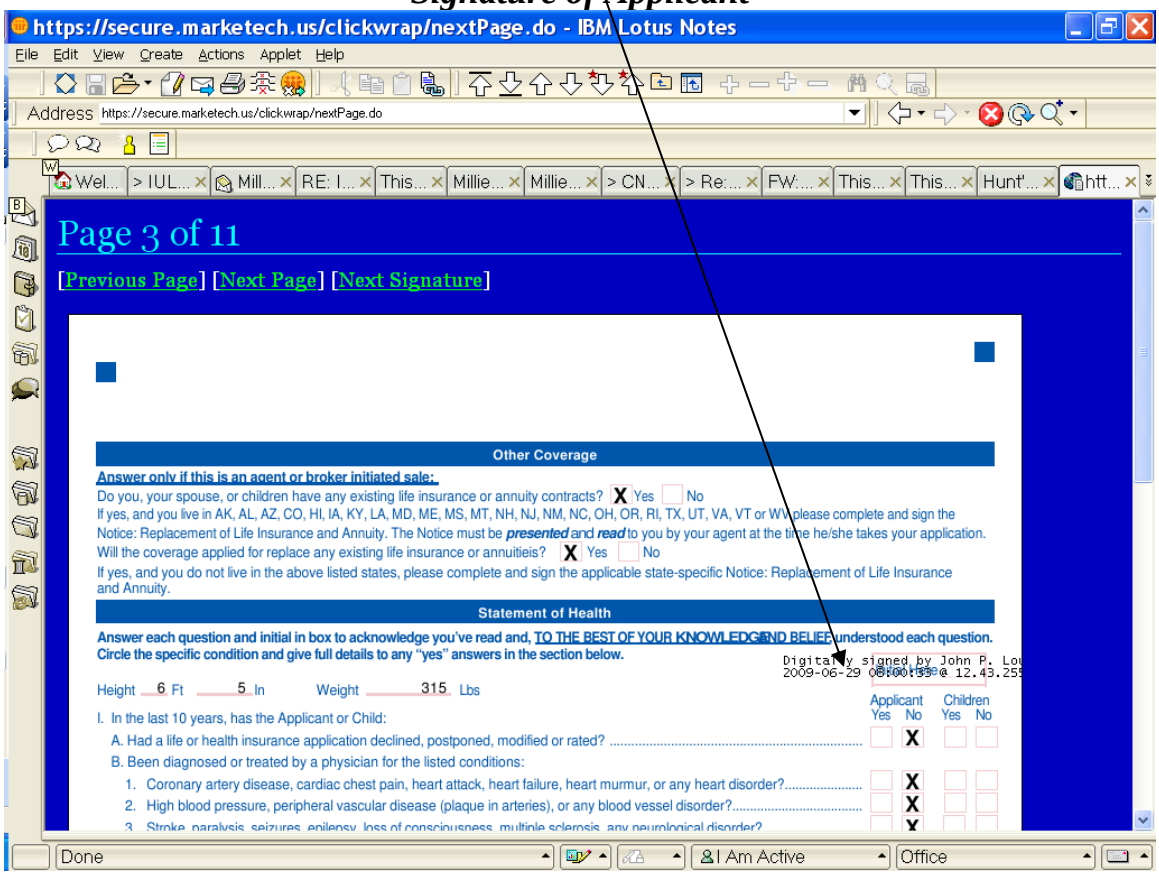
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART IV – eSignature (Agent)

Screen #4 – Page 2 of 11
Page 2 of 4 of Group Level Term Programs Enrollment Form



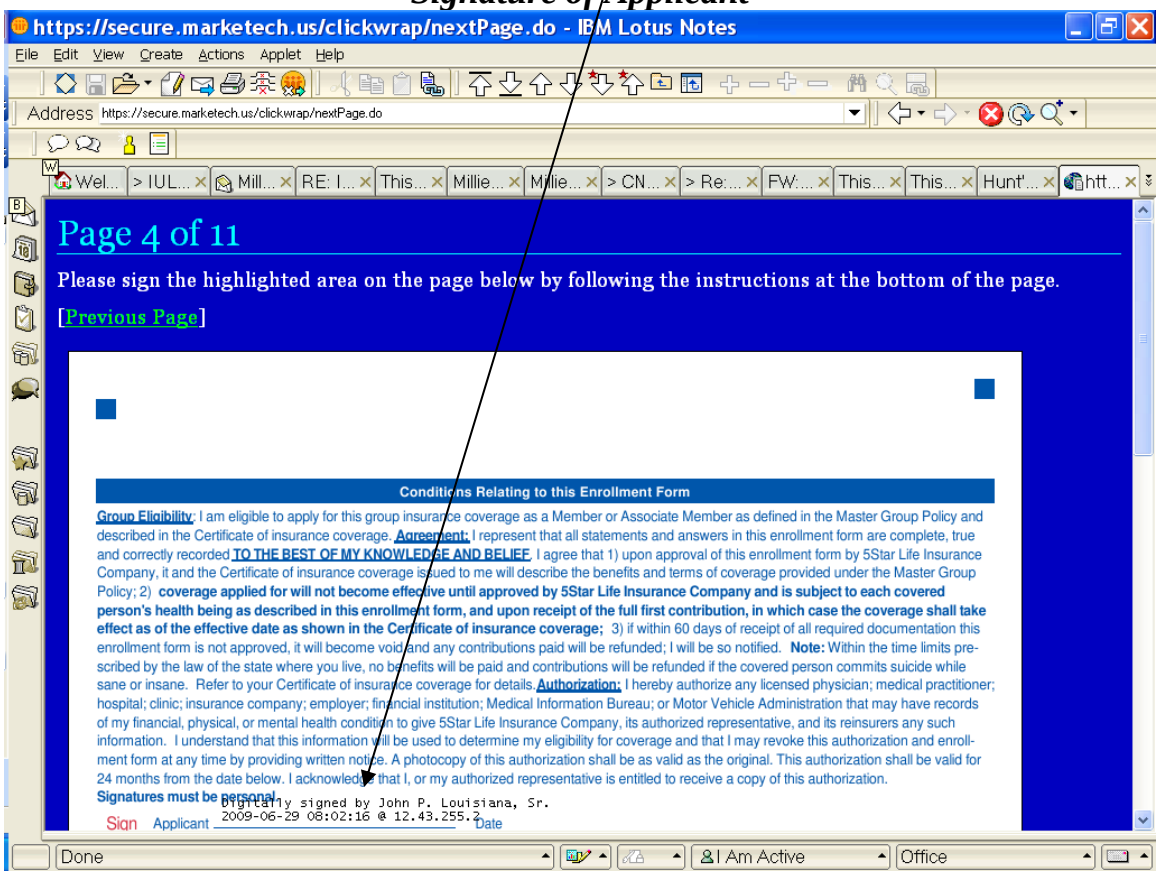
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART IV – eSignature (Agent)

Screen #5 – Page 3 of 11
Page 3 of 4 of Group Level Term Programs Enrollment Form
Signature of Applicant



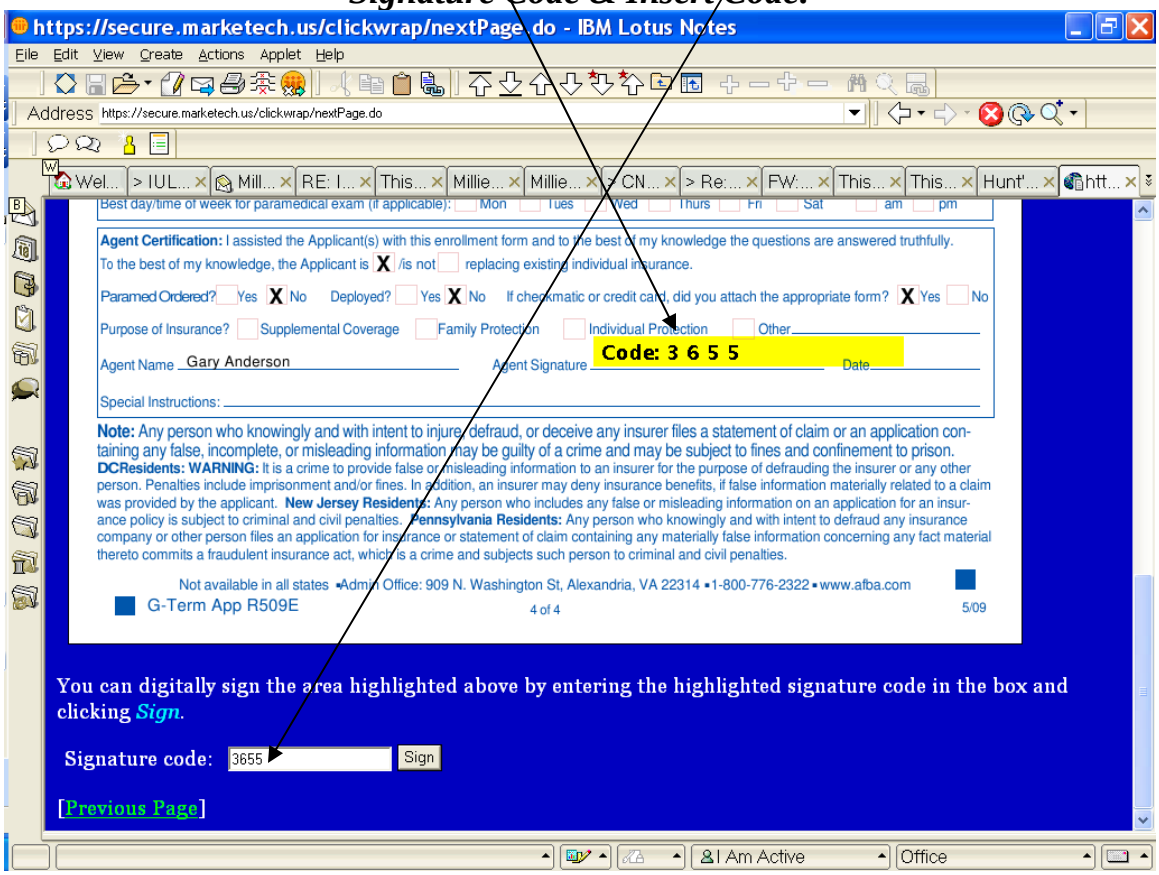
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART IV – eSignature (Agent)

Screen #5 – Page 4 of 11
Page 4 of 4 of Group Level Term Programs Enrollment Form
Signature of Applicant



5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART IV – eSignature (Agent)

Screen #5 – Page 4 of 11 (Cont'd)
Page 4 of 4 of Group Level Term Programs Enrollment Form
Signature Code & Insert Code:



5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART IV – eSignature (Agent)

Screen #6 – Page 5 of 11
HIPAA Form

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909 North Washington Street, Alexandria VA 22314 * 800–776–2322 * www.afba.com

Authorization for Release of Health Related Information to 5Star Life Insurance Company
(This authorization complies with the HIPAA Privacy Rule)

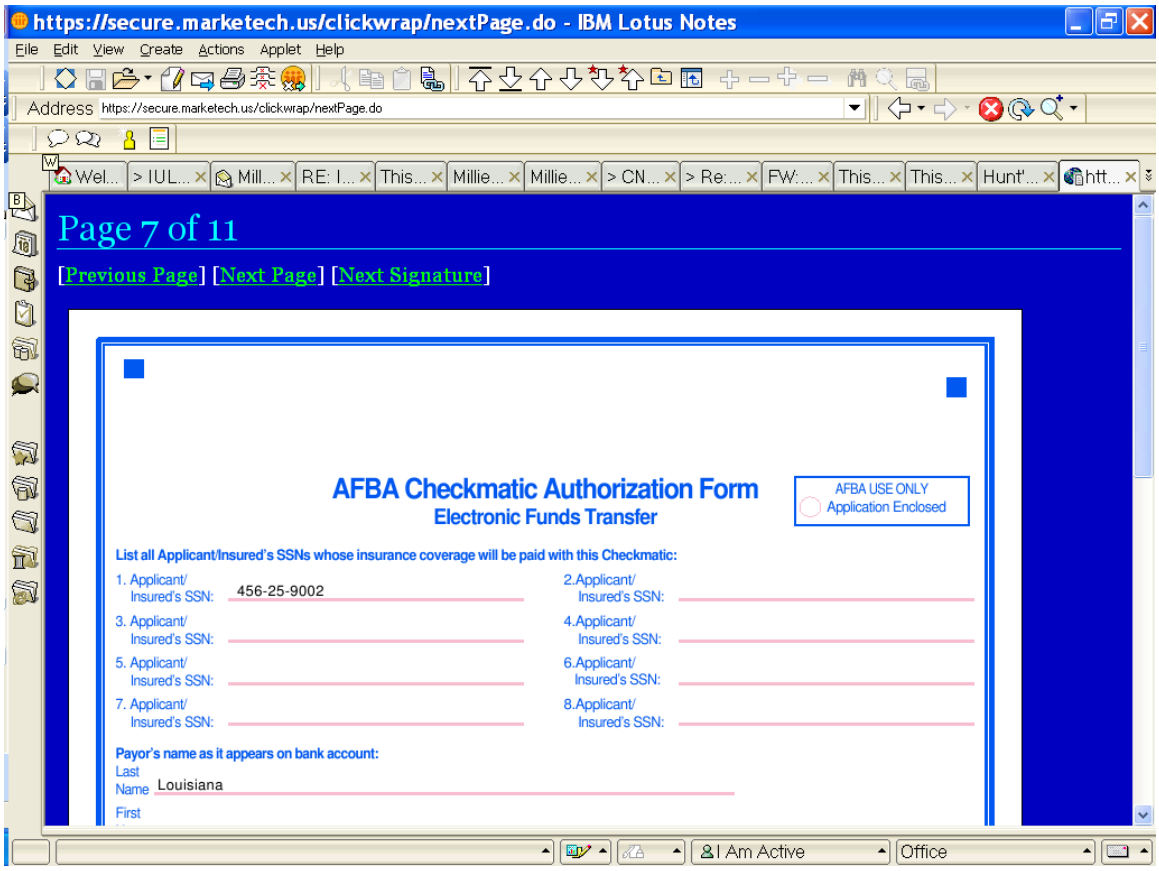
John P. Louisiana, Sr.	05/09/1965	456-25-9002
Name of Proposed Insured/Patient (please print)	Date of Birth	Social Security Number

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, medications prescribed and any other protected health information concerning me to 5 Star Life Insurance Company ("5 Star Life") and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psycho-

Done | I Am Active | Office

5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART IV – eSignature (Agent)

Screen #7 – Page 6 of 11
AFBA Checkmatic Authorization Form



5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART IV – eSignature (Agent)

Screen #8 – Page 9 of 11
Replacement of Insurance and Annuities

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Please sign the highlighted area on the page below by following the instructions at the bottom of the page.

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	Insurer Name	Contract or Policy Number	Insured or Annuitant	Replaced (R) or Financing (F)
1.	Melody, Inc.	LA4223	Insured	Replaced
2.				None
3.				None

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because Better Rates

I certify that the responses herein are, to the best of my knowledge, accurate:

Date: _____

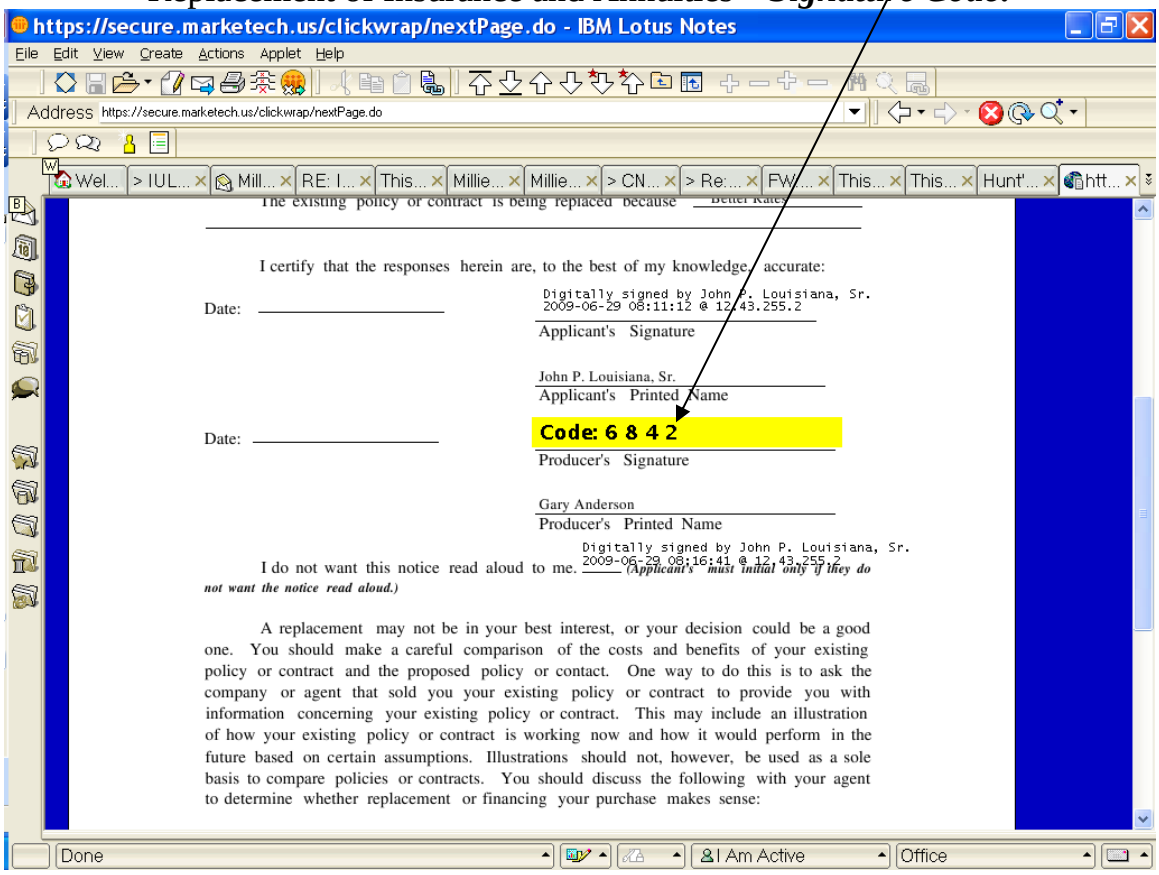
Digitally signed by John P. Louisiana, Sr.
2009-06-29 08:11:12 @ 12.43.255.2

Applicant's Signature

I Am Active Office

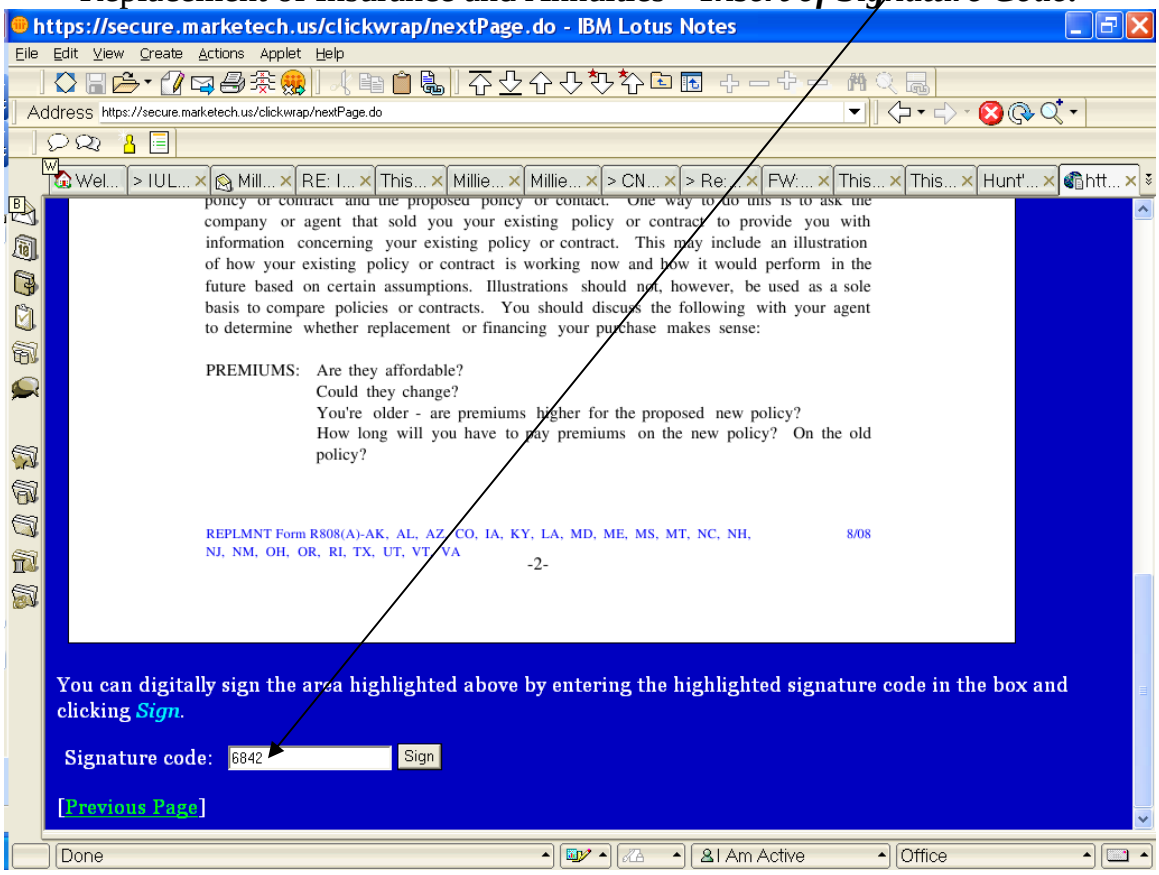
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART IV – eSignature (Agent)

Screen #8 – Page 9 of 11 (Cont'd)
Replacement of Insurance and Annuities – ***Signature Code:***



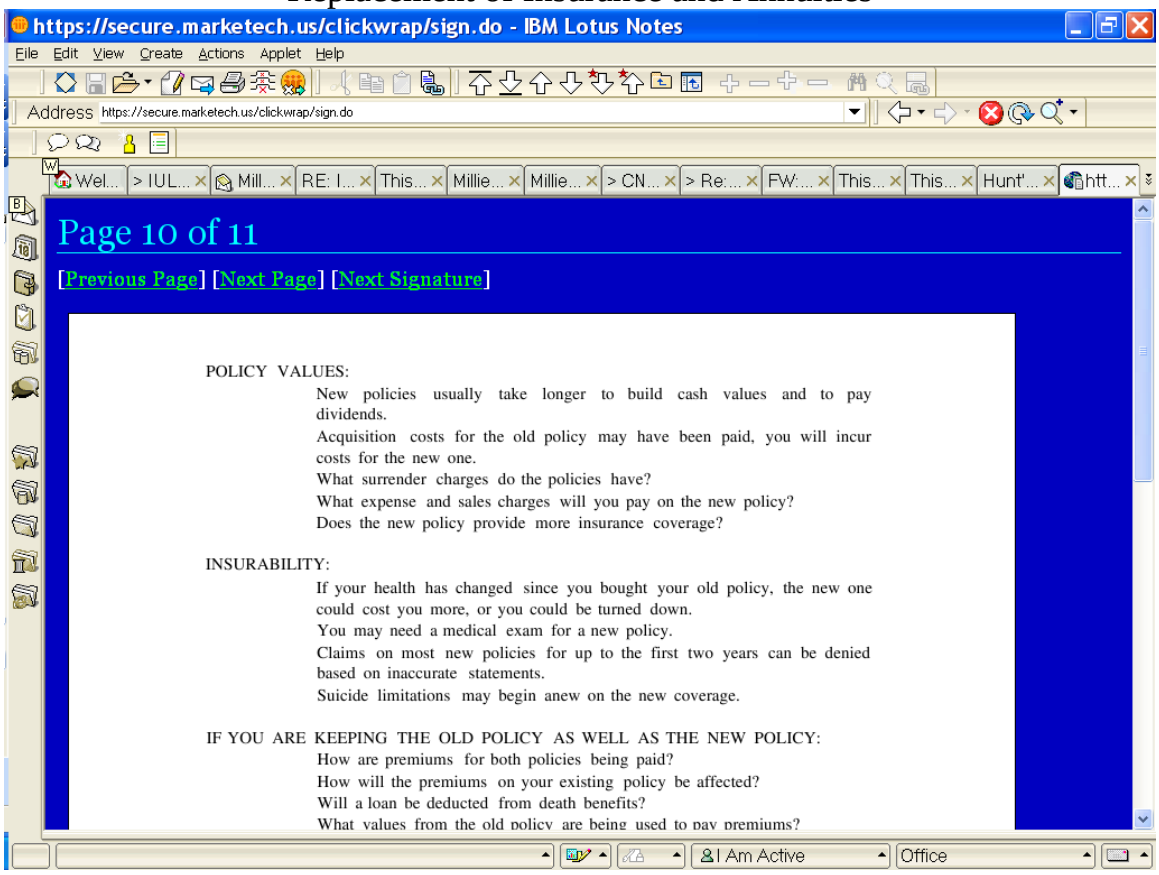
5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART IV – eSignature (Agent)

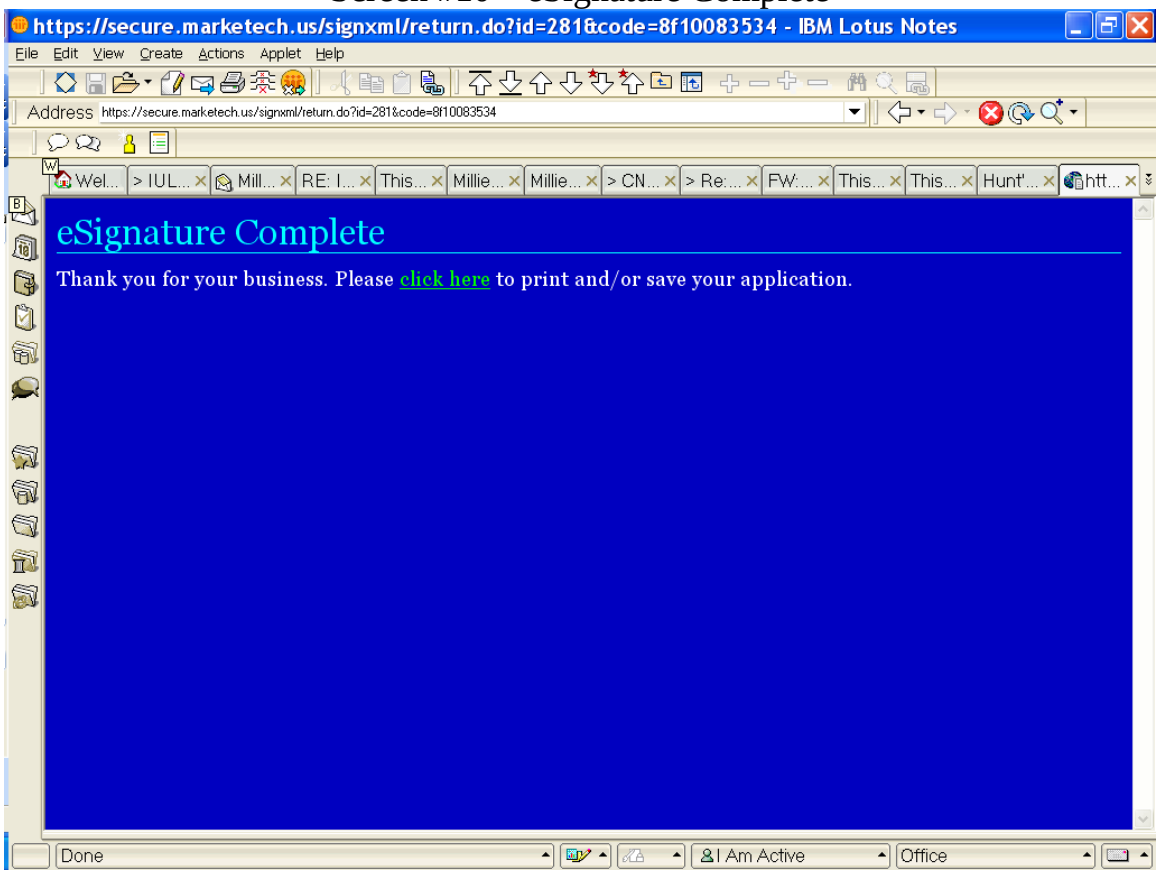
Screen #8 – Page 9 of 11 (Cont'd)
Replacement of Insurance and Annuities – ***Insert of Signature Code:***



5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART IV – eSignature (Agent)

Screen #9 – Page 10 of 11
Replacement of Insurance and Annuities



5 STAR LIFE INSURANCE COMPANY
Electronic Snap Shots
of
Group Level Term Programs Enrollment Form (G-Term App R509E)
PART IV – eSignature (Agent)

Screen #10 – eSignature Complete