Filing at a Glance

Company: 5 Star Life Insurance Company

Product Name: Individual Lfe - Whole
SERFF Tr Num: FIVE-126287864
State: Arkansas

TOI: L07I Individual Life - Whole
SERFF Status: Closed-Approved-Closed
State Tr Num: 43377

Sub-TOI: L07I.111 Single Premium - Single Life
Co Tr Num: 909
State Status: Approved-Closed

Filing Type: Form
Reviewer(s): Linda Bird

Author: Mildred Hunt
Disposition Date: 09/02/2009

Date Submitted: 08/31/2009
Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
Implementation Date:

State Filing Description:

General Information

Project Name:
Status of Filing in Domicile: Pending

Project Number:
Date Approved in Domicile:

Requested Filing Mode:
Domicile Status Comments:

Explanation for Combination/Other:
Market Type: Individual

Submission Type: New Submission
Group Market Size:

Overall Rate Impact:
Group Market Type:

Filing Status Changed: 09/02/2009
Explanation for Other Group Market Type:

State Status Changed: 09/02/2009

Deemer Date:
Created By: Mildred Hunt

Submitted By: Mildred Hunt
Corresponding Filing Tracking Number:

Filing Description:

ISP WL App R909: Individual Silver Premier Whole Life Application

Company and Contact

Filing Contact Information

Mildred Hunt, Compliance Manager
mhunt@afba.com

909 North Washington Street
703-706-5975 [Phone]

Alexandria, VA 22314
703-224-0214 [FAX]

Filing Company Information

5 Star Life Insurance Company
909 North Washington Street

Alexandria, VA 22314
(703) 706-5975 ext. [Phone]

CoCode: 77879
Group Code: 77879

Group Name: NAIC
FEIN Number: 54-1829709

State of Domicile: Louisiana
Company Type: Life Iinsurance Company

State ID Number:

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
5 Star Life Insurance Company	$20.00	08/31/2009	30227921

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/02/2009	09/02/2009

Disposition

Disposition Date: 09/02/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FIVE-126287864*	*State:*	*Arkansas*
Filing Company:	*5 Star Life Insurance Company*	*State Tracking Number:*	*43377*
Company Tracking Number:	*909*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.111 Single Premium - Single Life*
Product Name:	*Individual Lfe - Whole*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Cover Letter		Yes
Form	Individual Silver Premier Whole Life		Yes

Form Schedule

Lead Form Number: ISP WL App R909

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	ISP WL App R909	Application/ Enrollment Form	Individual Silver Premier Whole Life	Initial			ISP WL App R909.pdf

Underwritten by 5Star Life Insurance Company (a Baton Rouge, Louisiana Company)
Admin Office: 909 North Washington Street, Alexandria, VA 22314
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:

Individual Silver Premier Whole Life
Application

IP 909 1

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

Applicant's Information

First Name M.I

Last Name Male Female

SSN – – D.O.B. / / (Month Day Year)

Height ft in Weight lbs Non-Tobacco Tobacco User*

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

Address Line 1

Address Line 2

City State Zip –

E-Mail

Daytime Phone – –

In the last 2 years, has the Applicant applied for life insurance with any other life insurance company(ies)? Yes No

Owner (If other than Applicant)

SSN – –

Name: _____

Address: _____

City, State, Zip _____

Relationship to Applicant _____ Phone No. _____

Payor

Applicant Policy Owner Other (Complete all info below)

SSN – –

Name: _____

Address: _____

City, State, Zip _____

Phone No. _____

Coverage and Premium Amounts

Payment Mode:
(Please choose only one.)

- Monthly Credit Card
- Monthly Checkmatic
- Monthly Bill**
- Quarterly Bill
- Semi-Annual Bill
- Annual Bill

**Requires home office approval

Applicant's Coverage $,

Applicant's Modal Premium		Modal Policy Fee		Amount payable to 5Star Life.
$.	+	$.	=	$.

Automatic Premium Loan

Automatic Loan Provision
Loan from your cash value if premium missed.

IP 2 909

Beneficiary(ies)

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

Primary _____
Name | Relationship | DOB | %

Secondary _____
Name | Relationship | DOB | %

Other Insurance

Do you have any existing life insurance or annuity contracts? ◯ Yes ◯ No

If yes, and you live in AK, AL, AR, AZ, CO, HI, IA, KY, LA, MD, ME, MS, MT, NE, 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 TO THE BEST OF YOUR KNOWLEDGE AND BELIEF.

	Yes	No
1. Do you need assistance with the normal activities of daily living (for example: eating, bathing, dressing, taking medications, etc.), or are you currently hospitalized, disabled due to illness, confined to a bed or nursing facility, using oxygen equipment to assist in breathing, been medically diagnosed as having a terminal illness or life expectancy of 12 months or less, or receiving hospice care?	◯	◯
2. In the past 48 months have you been convicted of a felony or are you currently incarcerated, on parole or probation, been treated for or been advised to have treatment for alcohol or any drugs of abuse, attempted suicide, or been convicted or operating a vehicle while intoxicated or impaired?	◯	◯
3. Have you ever been medically diagnosed, treated for, medically advised to have treatment for, or taken medication for: congestive heart failure (CHF), cardiomyopathy, organ transplant, renal (kidney) failure, chronic kidney disease (with or without dialysis), renal insufficiency, liver failure, Alzheimer's, dementia, schizophrenia, manic depression, bipolar disorder, mental incapacity, Lou Gehrig's disease (ALS), Huntington's disease, amputation of a body part caused by disease, diabetic insulin shock, diabetic coma, or taken insulin injections prior to age 40?	◯	◯
4. Have you ever been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)?	◯	◯
5. In the past 24 months have you:		
a. Been confined three (3) times or more to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility or hospice care?	◯	◯
b. Been diagnosed with internal cancer, leukemia, lymphoma, or melanoma or had more than one occurrence of any cancer in your lifetime (excluding basal or squamous cell skin cancer), had a recurrence of any cancer, or currently being treated for cancer?	◯	◯
c. Been declined for life or health insurance?	◯	◯
6. In the past 36 months, have you:		
a. Been medically diagnosed, treated or taken medication for: cirrhosis, liver disease, chronic hepatitis, angina, chronic bronchitis, emphysema, chronic obstructive lung or pulmonary disease (COLD/COPD), Hodgkin's disease, neuromuscular or brain disease (including cerebral palsy, muscular dystrophy, multiple sclerosis, grand mal epilepsy, cystic fibrosis or Parkinson's disease), systemic lupus (SLE) or have paralysis of two or more extremities?	◯	◯
b. Been diagnosed as having, been treated for, or hospitalized for: heart disease, heart attack, stroke, or transient ischemic attack (TIA/mini-stroke),uncontrolled high blood pressure, or heart or circulatory vascular surgery (including coronary artery bypass, pacemaker or replacement pacemaker, heart valve replacement, abdominal aortic aneurysm, angioplasty, or stent placement), or any procedure to improve circulation to the heart or brain?	◯	◯

IP 909 3

Conditions Relating to this Application

Agreement: I have read the completed application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. I agree that this application will be the basis for, and will become part of, the policy that is issued. The above representations are true to the best of my knowledge and belief. I agree the policy shall not be in effect until it has been issued by 5 Star Life Insurance Company and all premiums have been paid. I understand that the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the policy's incontestability provision. I understand that the agent has no authority to approve the application, change the policy, or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met. I understand that the USA Patriot Act requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and taxpayer identification number allows us to verify your identity. Our verification process may include the use of third-party sources to verify the information provided. I am not being paid cash and have not been promised services as an inducement to enter into this application for life insurance. The purpose of this insurance application is not to sell or assign it to any type of viatical settlement, senior settlement, or life-settlement company. I acknowledge receipt of a copy of the Information Practices Notice, MIB Pre-Notice, and Fair Credit Reporting Act Notice. **Authorization.** I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, MIB, Inc., pharmacy manager, pharmacy, insurance laboratory, a consumer reporting agency, my employer, or any other person or organization that has any record of information about me to give 5 Star Life Insurance Company, its reinsurers or its authorized representatives information about my health, other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition including information about drugs, alcoholism, or other information 5 Star Life Insurance Company requires to determine insurability or eligibility of benefits. I further authorize the sources listed above except for MIB, Inc. to give such information to a consumer reporting agency acting on behalf of 5 Star Life Insurance Company. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent 5 Star Life Insurance Company has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to 5 Star Life Insurance Company at its administrative address. I agree that a copy of this authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for 30 months from the date signed.

HIPAA Authorization for Release of Health Related Information. This Authorization complies with the HIPAA Privacy Rule. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, benefit manager, medical facility, insurance company, insurance support organization (such as MIB, Inc., or any of its members or affiliates), or other health care provider that has provided payment, treatment or services to me (collectively, "My Providers") to disclose the entire medical record and any other protected health information concerning me to the company referenced on this authorization ("the Company") and their 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 the entire medial record without restriction for use in underwriting risk selection purposes. This protected health information is to be disclosed under the Authorization at my request, as permitted by § 164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule"). This authorization shall remain in force for 36 months following the date of my signature below, regardless of my condition and whether living or deceased, 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 request for revocation to the Company addressed, Attention: 5 Star Life Insurance Company, Policyholder Service Department, 909 North Washington Street, Alexandria, VA 22314. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies. I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

I acknowledge that I have read and, TO THE BEST OF MY KNOWLEDGE AND BELIEF, understand the provisions of the fraud statements on page 4 of 4 of this application.

Signatures must be personal:

Sign Here

Proposed Insured _____ Date _____

Policy Owner _____ Date _____

Signed at (City, State) _____

Agent Certification: I certify that I asked all the questions and had the Applicant sign in my presence. To my knowledge, the applicant is ◯ / is not ◯ replacing any existing life insurance or annuities.

Agent Name _____

Agent Signature _____ Date _____

Temporary Insurance Acknowledgment: Complete this section if full first premium is submitted with application:

Agent: I provided the client with the Temporary Insurance Agreement ◯ Yes ◯ No

Fraud Statements

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.

Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

Puerto Rico Residents: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years or both penalties. If aggravating circumstances are present, the penalty thus established may be in creased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Tennessee Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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: Attached under Forms tab

Comments:

Item Status: **Status Date:**

Satisfied - Item: Cover Letter

Comments:

Attachment:

ARKANSAS Cover Letter.pdf

5STAR
LIFE INSURANCE
COMPANY

ARKANSAS DEPARTMENT OF INSURANCE

READABILITY CERTIFICATION

Re: *ISP WL App R909: Individual Silver Premier Whole Life Application*

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 the above policy meets the Flesch minimum reading ease score of 40.

Glenn R. Jones, Esq.
Vice President, Compliance

Date: August 31, 2009

909 North Washington Street, Alexandria, VA 22314

5STAR
LIFE INSURANCE
COMPANY

Mildred E. Hunt
Compliance Manager

August 31, 2009

VIA SERFF

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

Re: *5 Star Life Insurance Company*
Product: Individual Silver Premier Whole Life Application
Form Number: ISP WL App R909
NAIC No.: 77879

Dear Mr. Honey:

Enclosed for your review and approval is the Individual Silver Premier Whole Life insurance application. The prior application, ISP WL App R1208, was approved on December 10, 2008, SERFF Tracking Number: FIVE-125935823.

This application is not to replace any other forms approved by the Department of Insurance. The application will be used in conjunction with the Individual Silver Premier Whole Life Policy (ISP WL Policy R409-AR) was approved by the Department on March 19, 2009, SERFF Tracking Number: FIVE-126078482.

The following redline dictates the changes made to the previous approved version of ISP WL App R1208: (Note: ~~Strikethroughs~~ indicate deletions; **bold, underscore**, and ***italic*** indicate new inserts.)

Form Number	*Description*
ISP WL App R~~1208~~ ***909***	Page 1 of 4, Applicant's Information • Inserted the following statement: ***"In the past 2 years, have you***

909 North Washington Street, Alexandria, VA 22314

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

mhunt@afba.com

applied for life insurance with any other insurance company(ies)?"

- Inserted: *"Height ft in Weight lbs"*

Page 2 of 4, Statement of Health

- Line 1 revised to read: "Answer each question ~~and initial in the box to acknowledge you've read and,~~ **TO THE BEST OF YOUR KNOWLEDGE AND BELIEF**~~, understood each question. Circle the specific condition and give full details to any "yes" answers on a separate 8 ½ x 11 piece of paper.~~"
- Questions 1. deleted "1. ~~Is the Applicant currently confined to a wheelchair or powered chair due to chronic illness or disease, now bedridden at home, or staying in a hospital, psychiatric, nursing, or assisted long-term care facility?~~. Inserted: *"1. Do you need assistance with the normal activities of daily living (for example, eating, bathing, dressing, taking medications, etc.), or are you currently hospitalized, disabled due to illness, confined to a bed or nursing facility, using oxygen equipment to assist in breathing, been medically diagnosed as having a terminal illness or life expectance of 12 months or less, or receiving hospice care?"*
- Question 2. deleted "~~2. In the past 12 months, has the Applicant been hospitalized two or more times or required assistance with two or more of the following activities: bathing, dressing, eating, toileting, taking medications, or moving about.?~~. Inserted: *"2. In the past 48 months have you been convicted of a felony or are you currently incarcerated, on parole or probation, been treated for or been advised to have treatment for alcohol or any drugs or abuse, attempted suicide, or been convicted or operating a vehicle while intoxicated or impaired?"*
- Question 3. deleted ~~"In the past 10 years, has the Applicant had or been hospitalized for, been medically diagnosed, advised, treated, or taken prescription drugs for: (a) chronic renal failure (CRF) or any kidney disease requiring dialysis? (b) Any disease requiring use of home oxygen? (c) Alzheimer's disease, any form of dementia, psychosis, schizophrenia, clinical depression, Parkinson's disease, multiple sclerosis, paralysis, any other mental health or neurological disorder? (d) Liver failure or cirrhosis, chronic hepatitis, acute or chronic pancreatitis? (e) Any organ transplant (except cornea)? (f) Alcoholism or drug or alcohol abuse?~~ Inserted: *"3. Have you ever been medically diagnosed, treated for, medically advised to have treatment for or taken medication for: congestive heart failure (CHF), cardiomyopathy, organ transplant, renal (kidney) failure, chronic kidney failure, chronic kidney disease (with or without dialysis), renal insufficiency, liver failure, Alzheimer's, dementia, schizophrenia, manic depression, bipolar disorder, mental incapacity, Lou Gehrig's disease (ALS), Huntington's disease, amputation of a body part caused by disease, diabetic insulin shock, diabetic coma, or taken insulin injections prior to*

	age 40." • Question 4. deleted ~~"4. In the past 5 years, has the Applicant had or been hospitalized for, been medically diagnosed, advised, treated, or taken prescription drugs for congestive heart failure?~~ Inserted: *"Have you ever been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)?"* • Question 5. deleted ~~"5. In the past 5 years, has the Applicant had or been hospitalized for, been medically diagnosed, treated, or taken prescription drugs for cancer (other than non-melanoma skin cancer)?~~ Inserted: *"5. In the past 24 months have you: (a) been confined three (3) times or more to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility or hospice care? (b) been diagnosed with internal cancer, leukemia, lymphoma, or melanoma or had more than one occurrence of any cancer in your lifetime (excluding basal or squamous cell skin cancer), had a recurrence of any cancer, or currently being treated for cancer? (c) been declined for life or health insurance?"* • Question 6. deleted ~~"6. In the past 3 years, has the Applicant had or been hospitalized for, been medically diagnosed, advised, treated, or taken prescription drugs for chronic obstructive pulmonary disease (COPD), emphysema, or any other chronic respiratory disorder, excluding asthma?"~~ Inserted: *"6. In the past 36 months, have you: a. been medically diagnosed, treated or taken medication for: cirrhosis, liver disease, chronic hepatitis, angina, chronic bronchitis, emphysema, chronic obstructive lung or pulmonary disease (COLD/COPD), neuromuscular or brain disease (including cerebral palsy, muscular dystrophy, multiple sclerosis, grand mal epilepsy, cystic fibrosis or Parkinson's disease), systemic lupus (SLE) or have paralysis of two or more extremities? b. been diagnosed as having, been treated for, or hospitalized for: heart disease, heart attack, stroke, or transient ischemic attack (TIA/mini-stroke), Hodgkin's disease, uncontrolled high blood pressure, or heart or circulatory vascular surgery (including coronary artery bypass, pacemaker or replacement pacemaker, heart valve replacement, abdominal aortic aneurysm, angioplasty, or stent placement), or any procedure to improve circulation to the heart or brain?"* • Question 7.deleted: ~~"In the past 2 years, has the Applicant had or been hospitalized for, been medically diagnosed, treated, or taken prescription drugs for: a. Stroke or transient ischemic attack (TIA)? b. Angina, heart attack, pacemaker insertion or malfunction, coronary artery stenting, or heart surgery? c. surgery to improve circulation or amputation caused by disease? d. any disease expected to cause death within 24 months?~~ • Question 8. deleted: ~~"In the past 2 years, has the Applicant~~

	~~experienced complications of diabetes (Type 1 or Type 2) such as Neuropathy (numbness in the hands or feet), amputation, or retinopathy (severe vision loss); diabetic coma, insulin shock or diabetic shock, or taken insulin shots prior to age 50?"~~ • Question 9. deleted: ~~"Has the Applicant been diagnosed or treated by a physician, or tested positive for: Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), or any AIDS-Related Complex (ARC)?~~ Page 3 of 4, Conditions Relating to this Application • Deleted **Agreement** paragraph, ~~"I represent that all statements and answers in this application are complete, true and correctly recorded~~ ~~**TO THE BEST OF MY KNOWLEDGE AND BELIEF**~~, ~~I agree that: 1) upon approval of this application by 5 Star Life Insurance Company, it, the policy and any riders or endorsements will constitute the entire insurance contract; 2) except as provided or as stated in the Temporary Insurance Agreement, insurance applied for will not become effective until approved by 5Star Life Insurance Company and is subject to the Applicant's health being as described in this application, and upon receipt of the full first premium, in which case the coverage shall take effect as of the effective date as shown in the policy; 3) if within 60 days of receipt of all required documentation this application is not approved, it will become void and all premiums paid will be refunded; I will be so notified."~~ Inserted: *"I have read the completed application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. I agree that this application will be the basis for, and will become part of, the policy that is issued. The above representations are true to the best of my knowledge and belief. I agree the policy shall not be in effect until it has been issued by 5Star Life Insurance Company and all premiums have been paid. I understand that the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the policy's incontestability provision. I understand that the agent has no authority to approve the application, change the policy, or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met. I understand that the USA Patriot Act requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and taxpayer identification number allows us to verify your identity. Our verification process may include the use of third-party sources to verify the information provided. I am not being paid cash and have not been promised services as an inducement to enter into this application for life insurance. The purpose of this insurance application is not to sell or assign it to*

	any type of viatical settlement, senior settlement, or life-settlement company. I acknowledge receipt of a copy of the Information Practices Notice, MIB Pre-Notice, and Fair Credit Reporting Act Notice." • Deleted **Authorization** paragraph: ~~"I hereby authorize any licensed physician; medical practitioner; hospital; clinic; insurance company; employer; financial institution; Medical Information Bureau; or Motor Vehicle Administration; that may have records of my financial; physical or mental health condition to give 5Star Life Insurance Company, its authorized representative, and its reinsurers any such information. I understand that this information will be used to determine my eligibility for insurance and that I may revoke this authorization and application at any time by providing written notice. A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for 23 months from the date below. I acknowledge receipt of 5Star Life's Temporary Insurance Agreement if the initial premium is submitted with this application. I acknowledge that I, or my authorized representative is entitled to receive a copy of this authorization."~~ Inserted: *"Authorization. I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, MIB, Inc., pharmacy manager, pharmacy, insurance laboratory, a consumer reporting agency, my employer, or any other person or organization that has any record of information about me to give 5 Star Life Insurance Company, its reinsurers or its authorized representatives information about my health, other insurance coverage, employment, age, general character, finances, participation I hazardous activities, medical care or advice about any physical or mental condition including information about drugs, alcoholism, or other information 5 Star Life Insurance Company requires to determine insurability or eligibility of benefits. I further authorize the sources listed above except for MIB, Inc. to give such information to a consumer reporting agency acting on behalf of 5 Star Life Insurance Company. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent 5 Star Life Insurance has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to 5 Star Life Insurance Company at its administrative address. I agree that a copy of this authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for 30 months from the date signed.* • Inserted the HIPAA Authorization as part of the application. • Inserted the following language: *"I acknowledge that I have read and, TO THE BEST OF MY KNOWLEDGE AND BELIEF, understand the provisions of the fraud statements on page 4 of 4 of this application."*

	Page 4 of 3, Fraud Statements • Inserted the following fraud statement: *"Puerto Rico Residents: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss of any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.* • Inserted the following fraud statement: *"Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."* • Inserted the following fraud statement: *"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 in surer may deny insurance benefits, if false information materially related to a claim was provided by the applicant."* • Inserted the following fraud statement: *"Tennessee Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits."*

Individual Silver Premier Whole Life insurance will be marketed on a direct mail basis, and via licensed agents and brokers. Once approved 5 Star Life Insurance Company reserves the right to use all forms associated with this policy and certificate 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.

If additional information is required, please do not hesitate to contact me.

Very truly yours,