Filing at a Glance

Company: 5 Star Life Insurance Company
Product Name: Group Select Term with 10 Year Contribution Guarantee
SERFF Tr Num: FIVE-126467384
State: Arkansas
TOI: L04G Group Life - Term
SERFF Status: Closed-Approved-Closed
State Tr Num: 44653
Sub-TOI: L04G.500 Other
Co Tr Num: GST10-1209
State Status: Approved-Closed
Filing Type: Form
Reviewer(s): Linda Bird
Author: Carol Devine
Disposition Date: 03/29/2010
Date Submitted: 01/22/2010
Disposition Status: Approved-Closed
Implementation Date Requested: On Approval
Implementation Date:
State Filing Description:

General Information

Project Name: Arkansas GST10
Status of Filing in Domicile: Pending
Project Number: GST10-1209
Date Approved in Domicile:
Requested Filing Mode: Review & Approval
Domicile Status Comments:
Explanation for Combination/Other:
Market Type: Group
Submission Type: New Submission
Group Market Size: Large
Overall Rate Impact:
Group Market Type: Association
Filing Status Changed: 03/29/2010
Explanation for Other Group Market Type:
State Status Changed: 01/27/2010
Deemer Date:
Created By: Carol Devine
Submitted By: Carol Devine
Corresponding Filing Tracking Number:
Filing Description:
GST10-1209-25-LA - Member and Associate Member Certificate
GST10-1209-30-LA - Member and Associate Member Certificate

On behalf of 5 Star Life Insurance Company which is domiciled in Louisiana, I am submitting the above-referenced forms for your information, review and approval for issuance to Arkansas residents who are members of the Armed Forces Benefit Association (“AFBA”), our policyholder. The master group policy (sitused in DC) under which these group certificates are intended to be issued is restated Group Policy form LT 050197(Rev) that was FILED with the District of Columbia Department of Insurance and Securities Regulation on July 10, 2001.

These forms are new and are not intended to replace any previously approved forms

These forms are submitted as a new program of benefits to be made available for AFBA members. This new program is called Group Select Term with 10 Year Contribution Guarantee and has two options available – the 25 year option and the 30 year option. The program provides contributions that are guaranteed level for 10 years, projected to remain level for the entire initial term period of 25 or 30 years. Thereafter, contributions increase annually. After the initial level premium period, it may be renewed annually until the final expiry date.

This program is an illustrated product so I have enclosed an Illustration Actuary Certification with supporting documentation signed by an officer of 5 Star Life.

The group certificates include a sample of un-numbered page CCS-1 entitled “Coverage and Contribution Schedule” in John Doe format. These samples show the insurance coverage information and contribution information and the coverage amount of $100,000 for a male, non-smoker, age 35 in the Standard class and is included in this submission for illustrative purposes only. A personalized version will be provided to each person to whom a certificate is issued. This Coverage and Contribution Schedule contains individualized information/data enclosed in brackets ([ ]) that is the only part of the certificate that we wish to have considered variable. Please be assured that no change will be made in variable text which contravenes any legal requirement.

The group enrollment form that these certificates will be used with is form G-Term App R509 (approved 6/30/09 SERFF Tracking No. FIVE-126208270, AR Tracking No. 42778).

Coverage will be marketed via licensed agents and brokers.

I have enclosed the required certifications for readability and Arkansas Rule and Regulation 19.

I trust this submission is found to be in order and look forward to receiving your favorable reply. Should you have any questions or if I may provide any additional information, please do not hesitate to contact me. Thank you for your help and consideration.

Sincerely,

Carol K. Devine, FLMI, AIRC, CCP
Contract Manager
5 Star Life Insurance Company
909 North Washington Street
Alexandria, VA 22314
Tel: 703-299-5788

800-776-2322 ext.2202
Email: cdevine@afba.com

Company and Contact

Filing Contact Information

Carol Devine, Contract Manager
909 North Washington Street
Alexandria, VA 22314

cdevine@afba.com
703-299-5788 [Phone]
703-244-0214 [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?	Yes
Fee Amount:	$200.00
Retaliatory?	Yes
Fee Explanation:	2 products (25 and 30 year options) @ $100 per product = $200
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
5 Star Life Insurance Company	$200.00	01/22/2010	33709841

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/29/2010	03/29/2010
Approved-Closed	Linda Bird	01/27/2010	01/27/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Coverage and Contribution Schedules	Carol Devine	03/25/2010	03/25/2010

Disposition

Disposition Date: 03/29/2010

Implementation Date:

Status: Approved-Closed

Comment: The initial Filing Descriptin indicated that the new program being submitted was an illustrated product. Since that time their marketing approach for this product has changed to being a non-illustrated product. Revised Coverage and Contribution Schedules have been submitted to support this change.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FIVE-126467384*	*State:*	*Arkansas*
Filing Company:	*5 Star Life Insurance Company*	*State Tracking Number:*	*44653*
Company Tracking Number:	*GST10-1209*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Group Select Term with 10 Year Contribution Guarantee*		
Project Name/Number:	*Arkansas GST10/GST10-1209*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Actuarial Memorandum		No
Supporting Document	Illustration Actuary Certifications		No
Supporting Document *(revised)*	Coverage and Contribution Schedules		Yes
Supporting Document	Coverage and Contribution Schedules	Replaced	Yes
Supporting Document	Policy Amendment form		Yes
Form	Member and Associate Member Certificate		Yes
Form	Member and Associate Member Certificate		Yes

Disposition

Disposition Date: 01/27/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FIVE-126467384*	*State:*	*Arkansas*
Filing Company:	*5 Star Life Insurance Company*	*State Tracking Number:*	*44653*
Company Tracking Number:	*GST10-1209*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Actuarial Memorandum		No
Supporting Document	Illustration Actuary Certifications		No
Supporting Document *(revised)*	Coverage and Contribution Schedules		Yes
Supporting Document	Coverage and Contribution Schedules	Replaced	Yes
Supporting Document	Policy Amendment form		Yes
Form	Member and Associate Member Certificate		Yes
Form	Member and Associate Member Certificate		Yes

Amendment Letter

Submitted Date: 03/25/2010

Comments:

The initial Filing Description indicated that the new program being submitted was an illustrated product and was worded as follows: "This program is an illustrated product so I have enclosed an Illustration Actuary Certification with supporting documentation signed by an officer of 5 Star Life." Since this program is no longer an illustrated product please disregard the Illustration Actuary Certification with supporting documentation signed by an officer of 5 Star Life that was previously provided.

Since that time our marketing approach for this product has changed from being an illustrated product to being a non-illustrated product. We have not marketed or issued any documents based on this approval. We are now seeking your Approval of this very same product but on the basis as a non-illustrated product. The text of the Certificate is not affected by this change but the "Coverage and Contribution Schedule" personalized for each covered person and included with the Certificate has been revised to alter slightly the explanatory paragraph immediately preceding the table of Guaranteed Maximum Contributions. Also, the Table now omits all references to "current contributions."

I have accordingly attached in Supporting Documentation revised Coverage and Contribution Schedules as described above.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Coverage and Contribution Schedules

Comment: These revised sample Coverage and Contribution Schedules for the 25 year option plan and the 30 year option plan will include the individualized data and information (shown in brackets) applicable to each insured. They are distinguished from the previous versions by the edition date of Ed.3-10 in the lower right corner. The only changes are in the explanatory paragraph immediately preceding the table of Guaranteed Maximum Contributions and the deletion of all references to current contributions.

GST10-1209-25 (CCS) (Ed.3-10).pdf

GST10-1209-30 (CCS) (Ed.3-10).pdf

Form Schedule

Lead Form Number: GST10-1209-25

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	GST10-1209-25	Certificate	Member and Associate Member Certificate	Initial			GST10-1209-25 (Ed.12-09).pdf
	GST10-1209-30	Certificate	Member and Associate Member Certificate	Initial			GST10-1209-30 (Ed.12-09).pdf

Administrative Office: 909 North Washington Street, Alexandria, VA 22314 • 800-776-2322 • www.afba.com

(hereinafter called the Insurance Company or 5 Star Life)

Certifies that under and subject to the terms and conditions of the Group Level Term Life Insurance Policy (the Group Policy) Number shown on the attached Coverage and Contribution Schedule issued to:

ARMED FORCES BENEFIT ASSOCIATION

(hereinafter called the Association)

the Member or Associate Member named in the Coverage and Contribution Schedule provided by the Association is covered for the Group Level Term Life Insurance Coverage described herein and for the Coverage Amount indicated on such Coverage and Contribution Schedule. The effective date is shown on the Coverage and Contribution Schedule. On receipt of Due Proof at the Administrative Office of 5 Star Life of the death of the Covered Person occurring while covered under said Group Policy, 5 Star Life shall pay to the Beneficiary the amount of Coverage in force on the Covered Person at the date of death. Payment is subject to the conditions and provisions set forth in this Certificate of Insurance Coverage.

READ YOUR CERTIFICATE CAREFULLY

Right of Examination - This Certificate may be returned by delivering or mailing it to the Association within 30 days of the date the Covered Person receives it. If the law of the state where the certificate is delivered provides a different period, the law of the state governs. Immediately on such delivery or mailing, the Coverage shall be deemed void from the beginning. Any contribution made on the Coverage will then be refunded.

Secretary ***President***

GROUP SELECT LEVEL TERM
WITH 10 YEAR CONTRIBUTION GUARANTEE (25 YEAR OPTION)
LIFE INSURANCE COVERAGE

MEMBER AND ASSOCIATE MEMBER CERTIFICATE

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DEFINITIONS

AGE means on any given date, the Age of the Covered Person on his or her last birthday.

ASSOCIATE MEMBER means a current or former dependent of a "Member" as defined below.

"Current or former dependent" means a person who is now or at one time was a "dependent" as defined below of a Member or Associate Member covered under the policy:

(a) the spouse of the Member or Associate Member;

(b) each child of a Member or Associate Member while:

- (i) unmarried;
- (ii) not employed on a regular full-time basis;
- (iii) dependent on the Member or Associate Member for support; and
- (iv) 15 days of age but less than 21 years of age (less than 23 years of age if a full-time student.)

The term "child" includes natural children, stepchildren, and adopted children.

(c) However, if on attaining the maximum Age to be considered a dependent, the child is incapable of self-sustaining employment by reason of mental or physical incapacity, the child shall continue to be deemed a dependent during the uninterrupted continuation of said incapacity and while the child is otherwise included as a "dependent" under the above definition.

BENEFICIARY means the party(ies) so named in the Enrollment Form, unless later changed as provided in the policy.

COVERAGE means a one-year period of time starting on successive Coverage anniversaries, with the first Coverage year starting on the Effective Date of Issue.

COVERAGE AND CONTRIBUTION SCHEDULE means the pages of this certificate so titled which show Your benefits, contributions, and other information.

COVERAGE AMOUNT means the death benefit amount shown in the Coverage and Contribution Schedule.

COVERED PERSON means the person whose life is covered under the policy as shown in the Coverage and Contribution Schedule.

DUE PROOF means reasonable information as to the existence of fact or condition.

EFFECTIVE DATE OF ISSUE means the date shown in the Coverage and Contribution Schedule. The Suicide and Contestability provisions use this date.

ENROLLMENT FORM means the Enrollment Form for this certificate.

EXPIRY DATE means the date the Covered Person reaches Age 95.

IN FULL FORCE means that the policy has not lapsed in accordance with the Grace Period provision.

DEFINITIONS - Continued

MEMBER means members of the Uniformed Services of the United States serving on active duty; members of the Ready Reserve Forces of the United States, including the Army and Air National Guard; Retirees and Separatees of the aforementioned categories; cadets and midshipmen in the Service Academies of the United States and other officer candidates as may be qualified by the Department of Defense. "Member" also means members or Contractors of any Organized Governmental Entity and Federal Civilian employees who are employed by the United States Government or retired with pay from such employment.

"Active Duty Forces" means those military personnel:

(a) serving on Active Duty or Extended Active Duty for a period of more than 90 days in the: United States Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service or the National Oceanic and Atmospheric Administration; or

(b) serving as a Midshipman or Cadet in one of the Service Academies of the United States; or

(c) serving as an officer candidate in a program leading to commissioning in one of the Uniformed Services of the United States.

"Reserve Forces" means those military personnel of the Ready Reserve, including the Army and Air National Guard:

(a) who are assigned to a Reserve or National Guard unit drilling for pay or points; or

(b) who are designated as Individual Mobilization Augmentees (IMA's) by official orders requiring periodic drilling or training for pay or points.

"Retired Member/Retiree" means a Member who has been placed on an appropriate Retired List of the respective service, with or without pay; and who is not serving with the Active Duty Forces or the Reserve Forces as defined above.

"Separated Member/Separatee" means a Member who is separated from the Active Duty Forces or the Reserve Forces as defined above.

"Organized Governmental Entity" means any fire department; state or local law enforcement group; or any state, county, municipal or other local governmental body.

"Federal Civilian Employee" means civilian employees of the U.S. Government who, on the date of application, are actively employed on a full or part-time basis or who are retired with pay from such employment.

"Contractor" means a person whose occupation is in support of the Uniformed Services of the United States, the Department of Defense, any federal agency or any Organized Governmental Entity.

OPTION DATE means the date shown in the Coverage and Contribution Schedule when You may apply to Exchange this certificate for another 5 Star Life term insurance certificate under certain conditions.

OWNER is the Covered Person, unless a different Owner is named by You.

RATING CLASS means the mortality classification (gender/tobacco use) assigned under the certificate, and shown in the Coverage and Contribution Schedule.

REQUEST means a request in writing on a form acceptable to Us, signed by You and received by Us.

WE, OUR, OURS, US means 5 Star Life Insurance Company.

WRITTEN NOTICE means unless otherwise stated, a written notice filed at Our Administrative Office in Alexandria, Virginia.

YOU, YOUR, YOURS means the party(ies) named as Owner in the Enrollment Form unless later changed as provided in this certificate.

ELIGIBILITY
The eligible Class of Covered Persons includes all Members and Associate Members as defined in the section entitled "Definitions."

DATES OF ELIGIBILITY OF MEMBERS OR ASSOCIATE MEMBERS
Each Member or Associate Member in the Eligible Class shall become eligible for insurance upon submission of an Enrollment Form.

EFFECTIVE DATES OF INSURANCE COVERAGE OF MEMBERS OR ASSOCIATE MEMBERS
Each Member or Associate Member shall be covered for Group Level Term insurance Coverage described in this certificate effective on the date each person's requested Coverage is approved by the Association, provided that:
(a) Application for such Coverage is made on the prescribed Enrollment Form;
(b) The required initial contribution has been paid;
(c) The guidelines established by 5 Star Life have been satisfied; and
(d) Any required evidence of insurability has been provided and approved.

An Enrollment Form shall be deemed declined if it has not been approved within 60 days of receipt of all information required by 5 Star Life. The amount paid shall be refunded to the applicant.

RIGHT TO REQUIRE EVIDENCE OF INSURABILITY
5 Star Life may require evidence of insurability prior to the date insurance Coverage becomes effective in addition to the statements required to be declared on the Enrollment Form.

CONTINUATION OF COVERAGE UPON RETIREMENT OR SEPARATION
Each Active Member or Associate Member of the Association may continue to be covered under the Group Policy following such Member's retirement or separation from Active Duty or the Reserve Forces. This is subject to the provision herein entitled Termination of Coverage. This continuation of Coverage is available; if such Member or Associate Member is in good standing with the Association at the end of the calendar month in which the Member is retired or separated.

OWNER, CHANGE OF OWNERSHIP
The rights and privileges of the insurance Coverage belong to the Owner during the Covered Person's lifetime. The Covered Person is the Owner unless a different Owner is named by You. If the Owner dies before the Covered Person, the rights and privileges of ownership will vest in the executors, administrators or assignees of the Owner, unless a contingent Owner has been named.

You may assign ownership by required Written Notice to the Association. When Written Notice is received, the change will take effect on the date the notice was signed. The change will take effect whether or not You or the Covered Person is then alive. A change shall be subject to the rights of any assignee of record with the Association, and subject to any payment made or other action taken by the Association or 5 Star Life before the Request is received.

BENEFICIARY PROVISIONS
The Beneficiary shall be the person designated on the Covered Person's Enrollment Form, or on any valid change of beneficiary form subject to the terms and conditions specified in such enrollment or change form. The Covered Person may from time to time change the Beneficiary by filing Written Notice thereof with the Association. After such Written Notice has been received, the change shall relate back to take effect as of the date the Covered Person signed said Written Notice. This change is valid whether or not the Covered Person is living at the time of the receipt of such Written Notice, but without prejudice to 5 Star Life on account of any payment made by them before receipt of such Written Notice.

BENEFICIARY PROVISIONS – Continued

Facility of Payment
If, with respect to any amount of insurance Coverage payable at the Covered Person's death,
(1) no beneficiary designation is in effect, or
(2) no designated Beneficiary is then living,

5 Star Life may, at its option:

(a) pay a part of such amount not to exceed $250 or the amount established by state law to any person appearing to the insurer to be entitled equitably thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person covered; or

(b) pay such amount to the Covered Person's estate or to any one or more of the following relatives who survive the Covered Person:

(A) wife or husband;
(B) children, including adopted or stepchildren;
(C) mother or father;
(D) brothers or sisters.

The liability of 5 Star Life shall be fully discharged to the extent of payment made under this provision.

If the Beneficiary is a minor or is otherwise incapable of giving a valid release for any payment due, 5 Star Life may, at its option and until claim is made by a court appointed guardian or committee of such Beneficiary, make payment of the amount payable to such Beneficiary at a rate not exceeding $50 a month to any relative connected by blood or by marriage to such Beneficiary, or to any other person or institutions appearing to them to have assumed custody and principal support of such Beneficiary. Such payments shall constitute a full discharge of the liability of 5 Star Life to the extent thereof.

MISSTATEMENT OF AGE OR SEX
If the Age or Sex of the Covered Person has been misstated on the Enrollment Form for insurance Coverage, 5 Star Life will determine the adjustments to be made to reflect the benefits that would have been provided at the true Age or Sex.

CLAIMS OF CREDITORS
The death benefit proceeds and any income payments from this Coverage will be exempt from the claims of creditors to the extent permitted by law. Before becoming payable the proceeds and payments may not be assigned or withdrawn without 5 Star Life's agreement.

MAKING CONTRIBUTIONS
Contributions for Coverage are due on the first day of the Coverage month. Coverage for which the contributions are not paid will be in default and the Grace Period provisions apply.

CHANGE OF CONTRIBUTIONS
This section advises You that contributions are subject to change after a certain period of time as shown in the Coverage and Contribution Schedule.

GRACE PERIOD
Any contribution not paid on or before the first day of the Coverage month shall be in default; but a grace period of thirty-one days, without interest, shall be allowed. Payment of all overdue contribution(s) made during the grace period shall continue the Coverage in force.

PAYMENT OF CLAIMS
5 Star Life will pay a benefit to the Member's or Associate Member's Beneficiary upon receipt at its Administrative Office of Due Proof of the death of the Member or Associate Member while covered under this Coverage. This benefit is equal to the amount of Coverage in force under this Coverage at the Member's or Associate Member's death, as determined from the most recent Coverage and Contribution Schedule issued to the Covered Person.

The Member's or Associate Member's Beneficiary will be determined from the Beneficiary provisions.

The death benefit will be paid in one sum under this program.

ASSIGNMENT
The Owner may assign the interest and ownership in this Coverage, without the consent of any revocable Beneficiary, by filing Written Notice with the Association. Such notice shall be on a form furnished by 5 Star Life for that purpose. When received, whether or not the Assignee or the Covered Person is then alive, the change will take effect on the date the notice was signed.

A change shall be subject to the rights of any Assignee of record with the Association, and subject to any payment made or other action taken by the Association or 5 Star Life before the notice is received.

5 Star Life and the Association shall not be bound by an assignment unless it is in writing and a duplicate copy of the original assignment has been filed with 5 Star Life. Nor shall they be responsible for determining the validity or sufficiency of an assignment.

The interest of the Assignee, any interest of the Covered Person, and any revocable Beneficiary shall be subject to the terms of the assignment.

INCONTESTABILITY
No statement or representation by an individual under the Group Policy which relates to the insurability of the person on whose behalf Coverage is applied for shall be used in contesting the validity of:
(a) such person's Coverage; or
(b) that Coverage or portion of such person's Coverage with respect to which the statement or representation was made;

after such insurance Coverage, or portion, as the case may be, has been in force before the contest for 2 years during such person's life, except when contributions are insufficient to keep the Coverage in force.

Nor shall such statement or representation be used at all unless:
(1) contained in a written instrument signed by the person making such statement or representation; and
(2) a copy of that instrument is or was provided to such person or such person's Beneficiary or personal representative.

SUICIDE
If the Covered Person commits suicide, while sane or insane, within two years from the Effective Date of Coverage; or from the Effective Date of any approved increase in Coverage, no benefits will be paid. If the law of the state where the certificate is delivered provides a different period, the law of the state governs. However, in each such instance, all contributions received will be remitted to the Beneficiary.

THE CONTRACT
The Group Policy is the contract of insurance Coverage between the Association and 5 Star Life. The Group Policy contains all the terms and conditions of the Covered Person's Coverage all of which are also contained in this individual Certificate of Insurance Coverage.

TERMINATION OF COVERAGE
Coverage will terminate on the earliest of:
(1) the date the Covered Person terminates Membership or Associate Membership in the Association;
(2) the date the contribution is not paid in full for the period of Coverage; or
(3) the date the Covered Person attains Age 95.

CONVERSION PRIVILEGE
The conversion privilege described below is available only to those who convert to an individual policy of life insurance prior to the date they attain Age 95 plus (+) 31 days.

If all or any portion of Coverage under the Group Policy ends in accordance with the Termination of Coverage provision contained in this Certificate, the Covered Person may convert to an individual policy of life insurance issued by 5 Star Life. The amount of that policy shall not be more than the amount of Coverage which ends.

The following shall apply with respect to issue of the individual policy.

(1) Written application and the first premium must be submitted to 5 Star Life within the Conversion Period. The Conversion Period is the 31-day period following the date the Covered Person's insurance Coverage ends.

(2) The policy will be issued in any of the forms of individual life insurance then issued by 5 Star Life, except term insurance. The policy shall not have any disability or supplementary benefits.

(3) Premium for the policy will be determined from the rates used by 5 Star Life at the date of issue of such policy. The rates will be based upon:
   (A) the Covered Person's attained age on the effective date of the individual policy;
   (B) the class of risk to which the Covered Person belongs at such date; and
   (C) the form and amount of such policy.

(4) The individual policy will take effect at the end of the Conversion Period.

(5) 5 Star Life will not require evidence of insurability.

BENEFITS FOR DEATH DURING CONVERSION PERIOD
If the Covered Person dies during the Conversion Period, 5 Star Life will pay a death benefit to the Beneficiary:

(a) upon receipt at its Administrative Office of Due Proof of the Covered Person's death within such period; and
(b) equal to the largest amount for which a policy could have been issued to the Covered Person under the Conversion Privilege provision.

5 Star Life will pay this benefit whether or not the Covered Person applied for an individual policy under that provision.

Administrative Office: 909 North Washington Street, Alexandria, VA 22314 • 800-776-2322 • www.afba.com

(hereinafter called the Insurance Company or 5 Star Life)

Certifies that under and subject to the terms and conditions of the Group Level Term Life Insurance Policy (the Group Policy) Number shown on the attached Coverage and Contribution Schedule issued to:

ARMED FORCES BENEFIT ASSOCIATION

(hereinafter called the Association)

the Member or Associate Member named in the Coverage and Contribution Schedule provided by the Association is covered for the Group Level Term Life Insurance Coverage described herein and for the Coverage Amount indicated on such Coverage and Contribution Schedule. The effective date is shown on the Coverage and Contribution Schedule. On receipt of Due Proof at the Administrative Office of 5 Star Life of the death of the Covered Person occurring while covered under said Group Policy, 5 Star Life shall pay to the Beneficiary the amount of Coverage in force on the Covered Person at the date of death. Payment is subject to the conditions and provisions set forth in this Certificate of Insurance Coverage.

READ YOUR CERTIFICATE CAREFULLY

Right of Examination - This Certificate may be returned by delivering or mailing it to the Association within 30 days of the date the Covered Person receives it. If the law of the state where the certificate is delivered provides a different period, the law of the state governs. Immediately on such delivery or mailing, the Coverage shall be deemed void from the beginning. Any contribution made on the Coverage will then be refunded.

Secretary ***President***

GROUP SELECT LEVEL TERM
WITH 10 YEAR CONTRIBUTION GUARANTEE (30 YEAR OPTION)
LIFE INSURANCE COVERAGE

MEMBER AND ASSOCIATE MEMBER CERTIFICATE

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DEFINITIONS

AGE means on any given date, the Age of the Covered Person on his or her last birthday.

ASSOCIATE MEMBER means a current or former dependent of a "Member" as defined below.

"Current or former dependent" means a person who is now or at one time was a "dependent" as defined below of a Member or Associate Member covered under the policy:

(a) the spouse of the Member or Associate Member;

(b) each child of a Member or Associate Member while:

- (i) unmarried;
- (ii) not employed on a regular full-time basis;
- (iii) dependent on the Member or Associate Member for support; and
- (iv) 15 days of age but less than 21 years of age (less than 23 years of age if a full-time student.)

The term "child" includes natural children, stepchildren, and adopted children.

(c) However, if on attaining the maximum Age to be considered a dependent, the child is incapable of self-sustaining employment by reason of mental or physical incapacity, the child shall continue to be deemed a dependent during the uninterrupted continuation of said incapacity and while the child is otherwise included as a "dependent" under the above definition.

BENEFICIARY means the party(ies) so named in the Enrollment Form, unless later changed as provided in the policy.

COVERAGE means a one-year period of time starting on successive Coverage anniversaries, with the first Coverage year starting on the Effective Date of Issue.

COVERAGE AND CONTRIBUTION SCHEDULE means the pages of this certificate so titled which show Your benefits, contributions, and other information.

COVERAGE AMOUNT means the death benefit amount shown in the Coverage and Contribution Schedule.

COVERED PERSON means the person whose life is covered under the policy as shown in the Coverage and Contribution Schedule.

DUE PROOF means reasonable information as to the existence of fact or condition.

EFFECTIVE DATE OF ISSUE means the date shown in the Coverage and Contribution Schedule. The Suicide and Contestability provisions use this date.

ENROLLMENT FORM means the Enrollment Form for this certificate.

EXPIRY DATE means the date the Covered Person reaches Age 95.

IN FULL FORCE means that the policy has not lapsed in accordance with the Grace Period provision.

DEFINITIONS - Continued

MEMBER means members of the Uniformed Services of the United States serving on active duty; members of the Ready Reserve Forces of the United States, including the Army and Air National Guard; Retirees and Separatees of the aforementioned categories; cadets and midshipmen in the Service Academies of the United States and other officer candidates as may be qualified by the Department of Defense. "Member" also means members or Contractors of any Organized Governmental Entity and Federal Civilian employees who are employed by the United States Government or retired with pay from such employment.

"Active Duty Forces" means those military personnel:

(a) serving on Active Duty or Extended Active Duty for a period of more than 90 days in the: United States Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service or the National Oceanic and Atmospheric Administration; or

(b) serving as a Midshipman or Cadet in one of the Service Academies of the United States; or

(c) serving as an officer candidate in a program leading to commissioning in one of the Uniformed Services of the United States.

"Reserve Forces" means those military personnel of the Ready Reserve, including the Army and Air National Guard:

(a) who are assigned to a Reserve or National Guard unit drilling for pay or points; or

(b) who are designated as Individual Mobilization Augmentees (IMA's) by official orders requiring periodic drilling or training for pay or points.

"Retired Member/Retiree" means a Member who has been placed on an appropriate Retired List of the respective service, with or without pay; and who is not serving with the Active Duty Forces or the Reserve Forces as defined above.

"Separated Member/Separatee" means a Member who is separated from the Active Duty Forces or the Reserve Forces as defined above.

"Organized Governmental Entity" means any fire department; state or local law enforcement group; or any state, county, municipal or other local governmental body.

"Federal Civilian Employee" means civilian employees of the U.S. Government who, on the date of application, are actively employed on a full or part-time basis or who are retired with pay from such employment.

"Contractor" means a person whose occupation is in support of the Uniformed Services of the United States, the Department of Defense, any federal agency or any Organized Governmental Entity.

OPTION DATE means the date shown in the Coverage and Contribution Schedule when You may apply to Exchange this certificate for another 5 Star Life term insurance certificate under certain conditions.

OWNER is the Covered Person, unless a different Owner is named by You.

RATING CLASS means the mortality classification (gender/tobacco use) assigned under the certificate, and shown in the Coverage and Contribution Schedule.

REQUEST means a request in writing on a form acceptable to Us, signed by You and received by Us.

WE, OUR, OURS, US means 5 Star Life Insurance Company.

WRITTEN NOTICE means unless otherwise stated, a written notice filed at Our Administrative Office in Alexandria, Virginia.

YOU, YOUR, YOURS means the party(ies) named as Owner in the Enrollment Form unless later changed as provided in this certificate.

ELIGIBILITY
The eligible Class of Covered Persons includes all Members and Associate Members as defined in the section entitled "Definitions."

DATES OF ELIGIBILITY OF MEMBERS OR ASSOCIATE MEMBERS
Each Member or Associate Member in the Eligible Class shall become eligible for insurance upon submission of an Enrollment Form.

EFFECTIVE DATES OF INSURANCE COVERAGE OF MEMBERS OR ASSOCIATE MEMBERS
Each Member or Associate Member shall be covered for Group Level Term insurance Coverage described in this certificate effective on the date each person's requested Coverage is approved by the Association, provided that:
(a) Application for such Coverage is made on the prescribed Enrollment Form;
(b) The required initial contribution has been paid;
(c) The guidelines established by 5 Star Life have been satisfied; and
(d) Any required evidence of insurability has been provided and approved.

An Enrollment Form shall be deemed declined if it has not been approved within 60 days of receipt of all information required by 5 Star Life. The amount paid shall be refunded to the applicant.

RIGHT TO REQUIRE EVIDENCE OF INSURABILITY
5 Star Life may require evidence of insurability prior to the date insurance Coverage becomes effective in addition to the statements required to be declared on the Enrollment Form.

CONTINUATION OF COVERAGE UPON RETIREMENT OR SEPARATION
Each Active Member or Associate Member of the Association may continue to be covered under the Group Policy following such Member's retirement or separation from Active Duty or the Reserve Forces. This is subject to the provision herein entitled Termination of Coverage. This continuation of Coverage is available; if such Member or Associate Member is in good standing with the Association at the end of the calendar month in which the Member is retired or separated.

OWNER, CHANGE OF OWNERSHIP
The rights and privileges of the insurance Coverage belong to the Owner during the Covered Person's lifetime. The Covered Person is the Owner unless a different Owner is named by You. If the Owner dies before the Covered Person, the rights and privileges of ownership will vest in the executors, administrators or assignees of the Owner, unless a contingent Owner has been named.

You may assign ownership by required Written Notice to the Association. When Written Notice is received, the change will take effect on the date the notice was signed. The change will take effect whether or not You or the Covered Person is then alive. A change shall be subject to the rights of any assignee of record with the Association, and subject to any payment made or other action taken by the Association or 5 Star Life before the Request is received.

BENEFICIARY PROVISIONS
The Beneficiary shall be the person designated on the Covered Person's Enrollment Form, or on any valid change of beneficiary form subject to the terms and conditions specified in such enrollment or change form. The Covered Person may from time to time change the Beneficiary by filing Written Notice thereof with the Association. After such Written Notice has been received, the change shall relate back to take effect as of the date the Covered Person signed said Written Notice. This change is valid whether or not the Covered Person is living at the time of the receipt of such Written Notice, but without prejudice to 5 Star Life on account of any payment made by them before receipt of such Written Notice.

BENEFICIARY PROVISIONS – Continued

Facility of Payment
If, with respect to any amount of insurance Coverage payable at the Covered Person's death,
(1) no beneficiary designation is in effect, or
(2) no designated Beneficiary is then living,

5 Star Life may, at its option:

(a) pay a part of such amount not to exceed $250 or the amount established by state law to any person appearing to the insurer to be entitled equitably thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person covered; or

(b) pay such amount to the Covered Person's estate or to any one or more of the following relatives who survive the Covered Person:

(A) wife or husband;
(B) children, including adopted or stepchildren;
(C) mother or father;
(D) brothers or sisters.

The liability of 5 Star Life shall be fully discharged to the extent of payment made under this provision.

If the Beneficiary is a minor or is otherwise incapable of giving a valid release for any payment due, 5 Star Life may, at its option and until claim is made by a court appointed guardian or committee of such Beneficiary, make payment of the amount payable to such Beneficiary at a rate not exceeding $50 a month to any relative connected by blood or by marriage to such Beneficiary, or to any other person or institutions appearing to them to have assumed custody and principal support of such Beneficiary. Such payments shall constitute a full discharge of the liability of 5 Star Life to the extent thereof.

MISSTATEMENT OF AGE OR SEX
If the Age or Sex of the Covered Person has been misstated on the Enrollment Form for insurance Coverage, 5 Star Life will determine the adjustments to be made to reflect the benefits that would have been provided at the true Age or Sex.

CLAIMS OF CREDITORS
The death benefit proceeds and any income payments from this Coverage will be exempt from the claims of creditors to the extent permitted by law. Before becoming payable the proceeds and payments may not be assigned or withdrawn without 5 Star Life's agreement.

MAKING CONTRIBUTIONS
Contributions for Coverage are due on the first day of the Coverage month. Coverage for which the contributions are not paid will be in default and the Grace Period provisions apply.

CHANGE OF CONTRIBUTIONS
This section advises You that contributions are subject to change after a certain period of time as shown in the Coverage and Contribution Schedule.

GRACE PERIOD
Any contribution not paid on or before the first day of the Coverage month shall be in default; but a grace period of thirty-one days, without interest, shall be allowed. Payment of all overdue contribution(s) made during the grace period shall continue the Coverage in force.

PAYMENT OF CLAIMS
5 Star Life will pay a benefit to the Member's or Associate Member's Beneficiary upon receipt at its Administrative Office of Due Proof of the death of the Member or Associate Member while covered under this Coverage. This benefit is equal to the amount of Coverage in force under this Coverage at the Member's or Associate Member's death, as determined from the most recent Coverage and Contribution Schedule issued to the Covered Person.

The Member's or Associate Member's Beneficiary will be determined from the Beneficiary provisions.

The death benefit will be paid in one sum under this program.

ASSIGNMENT
The Owner may assign the interest and ownership in this Coverage, without the consent of any revocable Beneficiary, by filing Written Notice with the Association. Such notice shall be on a form furnished by 5 Star Life for that purpose. When received, whether or not the Assignee or the Covered Person is then alive, the change will take effect on the date the notice was signed.

A change shall be subject to the rights of any Assignee of record with the Association, and subject to any payment made or other action taken by the Association or 5 Star Life before the notice is received.

5 Star Life and the Association shall not be bound by an assignment unless it is in writing and a duplicate copy of the original assignment has been filed with 5 Star Life. Nor shall they be responsible for determining the validity or sufficiency of an assignment.

The interest of the Assignee, any interest of the Covered Person, and any revocable Beneficiary shall be subject to the terms of the assignment.

INCONTESTABILITY
No statement or representation by an individual under the Group Policy which relates to the insurability of the person on whose behalf Coverage is applied for shall be used in contesting the validity of:
(a) such person's Coverage; or
(b) that Coverage or portion of such person's Coverage with respect to which the statement or representation was made;

after such insurance Coverage, or portion, as the case may be, has been in force before the contest for 2 years during such person's life, except when contributions are insufficient to keep the Coverage in force.

Nor shall such statement or representation be used at all unless:
(1) contained in a written instrument signed by the person making such statement or representation; and
(2) a copy of that instrument is or was provided to such person or such person's Beneficiary or personal representative.

SUICIDE
If the Covered Person commits suicide, while sane or insane, within two years from the Effective Date of Coverage; or from the Effective Date of any approved increase in Coverage, no benefits will be paid. If the law of the state where the certificate is delivered provides a different period, the law of the state governs. However, in each such instance, all contributions received will be remitted to the Beneficiary.

THE CONTRACT
The Group Policy is the contract of insurance Coverage between the Association and 5 Star Life. The Group Policy contains all the terms and conditions of the Covered Person's Coverage all of which are also contained in this individual Certificate of Insurance Coverage.

TERMINATION OF COVERAGE
Coverage will terminate on the earliest of:
(1) the date the Covered Person terminates Membership or Associate Membership in the Association;
(2) the date the contribution is not paid in full for the period of Coverage; or
(3) the date the Covered Person attains Age 95.

CONVERSION PRIVILEGE
The conversion privilege described below is available only to those who convert to an individual policy of life insurance prior to the date they attain Age 95 plus (+) 31 days.

If all or any portion of Coverage under the Group Policy ends in accordance with the Termination of Coverage provision contained in this Certificate, the Covered Person may convert to an individual policy of life insurance issued by 5 Star Life. The amount of that policy shall not be more than the amount of Coverage which ends.

The following shall apply with respect to issue of the individual policy.

(1) Written application and the first premium must be submitted to 5 Star Life within the Conversion Period. The Conversion Period is the 31-day period following the date the Covered Person's insurance Coverage ends.

(2) The policy will be issued in any of the forms of individual life insurance then issued by 5 Star Life, except term insurance. The policy shall not have any disability or supplementary benefits.

(3) Premium for the policy will be determined from the rates used by 5 Star Life at the date of issue of such policy. The rates will be based upon:
   (A) the Covered Person's attained age on the effective date of the individual policy;
   (B) the class of risk to which the Covered Person belongs at such date; and
   (C) the form and amount of such policy.

(4) The individual policy will take effect at the end of the Conversion Period.

(5) 5 Star Life will not require evidence of insurability.

BENEFITS FOR DEATH DURING CONVERSION PERIOD
If the Covered Person dies during the Conversion Period, 5 Star Life will pay a death benefit to the Beneficiary:

(a) upon receipt at its Administrative Office of Due Proof of the Covered Person's death within such period; and
(b) equal to the largest amount for which a policy could have been issued to the Covered Person under the Conversion Privilege provision.

5 Star Life will pay this benefit whether or not the Covered Person applied for an individual policy under that provision.

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Certifications attached pursuant to Rule & Regulation 19, 49 and Flesch requirements.

Consumer Information required by ACA 23-79-138 and Bulletin 15-2009 is contained in Form CMPLNT R110-AR.

Attachments:

AR Certification - Rule and Reg 19.pdf
AR Readability Certification.pdf
Form CMPLNT R110-AR.pdf
GAA-AR(REV.1-04).pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

The group enrollment forms with which these certificates will be used are: G-Term App R509 and G-Term App R509E approved by Arkansas on 6/30/09 (SERFF Tracking No. 126208270). They are attached here for your reference.

Attachments:

G-Term App R509 (Generic).pdf
G-TERM APP R509E (GENERIC).PDF

Item Status: **Status Date:**

Satisfied - Item: Illustration Actuary Certifications

Comments:

The new program for which the documents are being submitted is an illustrated product so I have enclosed an Illustration Actuary Certification with supporting documentation signed by an officer of 5 Star Life.

Attachments:

5Star Life - Illustration actuary cert - Dec 2009 - Select Term.pdf
Annual Illustration Certification (12-9-09).pdf
Resolution - (5-2-02).pdf

Item Status: **Status Date:**

Satisfied - Item: Coverage and Contribution Schedules

Comments:

These revised sample Coverage and Contribution Schedules for the 25 year option plan and the 30 year option plan will include the individualized data and information (shown in brackets) applicable to each insured. They are distinguished from the previous versions by the edition date of Ed.3-10 in the lower right corner. The only changes are in the explanatory paragraph immediately preceding the table of Guaranteed Maximum Contributions and the deletion of all references to current contributions.

Attachments:

GST10-1209-25 (CCS) (Ed.3-10).pdf
GST10-1209-30 (CCS) (Ed.3-10).pdf

Item Status: **Status Date:**

Satisfied - Item: Policy Amendment form

Comments:

Since the master group policy is sitused in another jurisdiction (DC), I have attached, for informational purposes, the policy amendment form that reflects the addition of the new program for which the two new certificates included in this filing are submitted.

Attachment:

LT 050197(Rev) A-GST10.pdf

5STAR
LIFE INSURANCE
COMPANY

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE WITH ARKANSAS RULE AND REGULATION 19
Unfair Sex Discrimination in the Sale of Insurance

Re: ***GST10-1209-25 and GST10-1209-30 et al***

I hereby certify that the above-referenced filing meets all applicable requirements including the requirements of Rule and Regulation 19.

Glenn R. Jones, JD, CLU, ChFC, FLMI, RHU
Vice President of Compliance

Dated: January 21, 2010

909 North Washington Street, Alexandria, VA 22314

5STAR
LIFE INSURANCE
COMPANY

STATE OF ARKANSAS

READABILITY CERTIFICATION

Re: ***GST10-1209-25 and GST10-1209-30 et al***

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

Glenn R. Jones, JD, CLU, ChFC, FLMI, RHU
Vice President of Compliance

Dated: January 21, 2010

909 North Washington Street, Alexandria, VA 22314

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

CONSUMER INFORMATION NOTICE

Questions regarding your policy or coverage should be directed to:

5 STAR LIFE INSURANCE COMPANY
Administrative Office:
909 North Washington Street
Alexandria, VA 22314
Toll-Free Number 1-800-776-2322

If we at 5 Star Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

ARKANSAS INSURANCE DEPARTMENT
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640 or (800) 852-5494

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Disability Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 -- no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values -- again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

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.

5 STAR LIFE INSURANCE COMPANY
Illustration Actuary Certification - (December 1, 2009 – July 31, 2010)

To: The Board of Directors of the 5 STAR Life Insurance Company and all Insurance Commissioners

I, John R. Miller, FSA, MAAA, am a Consulting Actuary with Miller & Newberg, Inc. and I serve as the Illustration Actuary for the 5 Star Life Insurance Company. I am a member of the American Academy of Actuaries in good standing. I was appointed by the Board of Directors of 5 Star Life to be the illustration actuary for all plans of insurance subject to the Life Insurance Illustration Regulation (Regulation) for all states that have adopted the Regulation and in which the company is licensed to sell life insurance. I meet the Academy of Actuaries requirements for making this certification and the requirements of the applicable state regulations.

Scales of non-guaranteed elements used in illustrating the plans and forms and any plan specific riders associated with those shown below meet the requirements of the Regulation. The specific forms considered and included in this certification are as follows:

ICC09-IST10-25	Individual Select Term with 10 Year Premium Guarantee - 25 year option
ICC09-IST10-30	Individual Select Term with 10 Year Premium Guarantee - 30 year option
GST10-1209-25	Group Select Term with 10 Year Contribution Guarantee - 25 year option
GST10-1209-30	Group Select Term with 10 Year Contribution Guarantee - 30 year option

The disciplined current scales for the plans are in conformity with the Actuarial Standard of Practice for Compliance with the NAIC Life Insurance Model Regulation (ASOP 24) promulgated by the Actuarial Standards Board except as noted below. Moreover:

No currently payable scale for business issued within the last five years and within the scope of this certification has been reduced for reasons other than changes in the experience factors underlying the disciplined current scale. Non-guaranteed elements illustrated for new policies are consistent with those illustrated for similar in- force policies. Illustrated non-guaranteed elements for new and in- force policies subject to this regulation are consistent with the non-guaranteed elements actually credited or charged to the same or similar forms.

The minimum expenses used in the calculation of the disciplined current scale for all policy forms subject to the regulation were based upon a full allocation of company expenses (a Fully Allocated Expense Table).. I have relied on, reviewed, and tested for accuracy and reasonableness the data supplied by Mr. Craig Piers, President, 5 Star Life Insurance Company, in making this certification. I have used procedures that are consistent with and not materially different than those set forth in ASOP 24 in forming my opinion.

Subsequent annual certifications will be made as of August 1st of each calendar year. The next certification will be as of August 1, 2010. Any new products introduced between certifications will require an additional certification in order to be illustrated and be in compliance with the Regulation.

Respectfully submitted:

John R. Miller, FSA, MAAA
Consulting Actuary

Miller & Newberg, Inc.
8717 West 110th Street, Suite 530
Overland Park, KS 66210

913-393-2522
Fax - 913-393-2922

12/09/2009

ANNUAL ILLUSTRATION CERTIFICATION

I, Craig S. Piers, am President and Chief Executive Officer of 5 Star Life Insurance Company. I was appointed by the Board of Directors as the responsible officer to certify as to the compliance of the company with the Life Insurance Illustration Regulation for the state. The appointment is documented by the attached Resolution dated May 2, 2002. I am familiar with the requirements of the regulation.

The illustration format meets the requirements of the state Regulation and the scales used in the company's authorized illustrations are those scales certified by the Illustration Actuary.

The company has provided its agents with information about the expense allocation method used by the company in its illustrations and disclosed in the Illustration Actuary's Certification which accompanies this Certification.

Date: December 9, 2009

Craig S. Piers
President, Chief Executive Officer

Attachment

5 STAR LIFE INSURANCE COMPANY

RESOLUTIONS
of
BOARD OF DIRECTORS

May 2, 2002

WHEREAS, 5 Star Life Insurance Company ("the Company") develops and markets to its military and federal civilian customer base a variety of life insurance products that require comprehensive consulting actuarial services; and

WHEREAS, the Company has entered into an Agreement with John R. Miller, FSA, MAAA, of the firm Miller & Newberg, Inc., to provide such independent contractor consulting services.

NOW, THEREFORE, BE IT RESOLVED, that John R. Miller of the firm Miller & Newberg, Inc. is hereby appointed to serve as the ***"Consulting Actuary (Valuation Actuary)"*** of the Company; and it is

FURTHER RESOLVED, that John R. Miller, in the capacity of the Company's consulting actuary, being familiar with the Company's insurance products, pricing, reserves, expenses, and other aspects necessary to perform self-support and lapse-support tests, is hereby also appointed as ***Illustration Actuary*** of the Company vested with full authorization and power to attest to, certify, or otherwise verify compliance of the illustrated products of the Company; and it is

FURTHER RESOLVED, that Craig S. Piers, President and Chief Executive Officer of the Company is hereby appointed to serve as the "Responsible Officer" who shall annually attest to, certify, or otherwise verify compliance of the Company with the Life Insurance Illustration laws and regulations of each and every state, territory, or other governmental jurisdiction where the Company conducts its business.

COVERAGE AND CONTRIBUTION SCHEDULE

Group Policy Number: [LT050197 (Rev)]
Group Policyholder: [AFBA]
Plan: [GST10-25]
Certificate ID: [00000000000]
Covered Person: [John Doe]
Coverage Amount: [$100,000]
Rating Class: [Male, Standard, Non-Tobacco User]

Effective Date: [12/01/2009]
Option Date: [12/01/2019]
Expiry Date: [12/01/2069]
Date of Birth: [07/01/1974] **Issue Age:** [35]
Payment Mode: [Monthly]

Owner and Beneficiary: As selected on the Enrollment Form subject to the sections entitled "Owner, Change of Ownership" and "Beneficiary Provisions" of this Certificate of Insurance Coverage.

Group level term life insurance coverage to Expiry Date with Contribution increases as shown below.

Monthly Contribution for the First Coverage Year: [$19.00]

The initial contribution is based on Your Age and Rating Class as shown above. The contribution is guaranteed to be level for 10 years. After the 10th coverage year, the contribution may increase each year for this coverage, but will never be more than the Guaranteed Maximum Contribution. Any change will be set by 5 Star Life and will be based on interest rates and mortality. After a term period of 25 years, the contribution will convert to an annual renewable term basis. Coverage will continue until the Expiry Date. See section entitled "Change of Contributions."

[Guaranteed Maximum Contributions

Coverage Year	Guaranteed Annual Contribution	Coverage Year	Guaranteed Annual Contribution
1	$228.00	31	$4,415.28
2	$228.00	32	$4,883.76
3	$228.00	33	$5,391.48
4	$228.00	34	$5,936.40
5	$228.00	35	$6,530.88
6	$228.00	36	$7,201.68
7	$228.00	37	$8,085.00
8	$228.00	38	$9,000.36
9	$228.00	39	$10,139.76
10	$228.00	40	$11,631.96
11	$739.20	41	$13,282.20
12	$795.00	42	$15,093.36
13	$854.88	43	$17,058.24
14	$918.84	44	$19,165.56
15	$991.08	45	$21,285.36
16	$1,067.40	46	$23,640.36
17	$1,158.24	47	$26,292.60
18	$1,263.48	48	$29,316.36
19	$1,381.20	49	$32,503.20
20	$1,517.40	50	$35,732.28
21	$1,668.00	51	$39,163.68
22	$1,835.28	52	$42,728.28
23	$2,012.76	53	$46,395.96
24	$2,204.64	54	$50,091.60
25	$2,421.36	55	$53,866.56
26	$2,662.92	56	$57,771.72
27	$2,931.24	57	$61,873.92
28	$3,236.64	58	$66,306.36
29	$3,585.48	59	$71,255.76
30	$3,979.68	60	$77,640.84]

COVERAGE AND CONTRIBUTION SCHEDULE

Group Policy Number: [LT050197 (Rev)]
Group Policyholder: [AFBA]
Plan: [GST10-30]
Certificate ID: [00000000000]
Covered Person: [John Doe]
Coverage Amount: [$100,000]
Rating Class: [Male, Standard, Non-Tobacco User]

Effective Date: [12/01/2009]
Option Date: [12/01/2019]
Expiry Date: [12/01/2069]
Date of Birth: [07/01/1974] **Issue Age:** [35]
Payment Mode: [Monthly]

Owner and Beneficiary: As selected on the Enrollment Form subject to the sections entitled "Owner, Change of Ownership" and "Beneficiary Provisions" of this Certificate of Insurance Coverage.

Group level term life insurance coverage to Expiry Date with Contribution increases as shown below.

Monthly Contribution for the First Coverage Year: [$22.17]

The initial contribution is based on Your Age and Rating Class as shown above. The contribution is guaranteed to be level for 10 years. However, after the 10th coverage year, the contribution may increase each year for this coverage, but will never be more than the Guaranteed Maximum Contribution. Any change will be set by 5 Star Life and will be based on interest rates and mortality. After a term period of 30 years, the contribution will convert to an annual renewable term basis. Coverage will continue until the Expiry Date. See section entitled "Change of Contributions."

[Guaranteed Maximum Contributions

Coverage Year	Guaranteed Annual Contribution	Coverage Year	Guaranteed Annual Contribution
1	$266.00	31	$4,415.28
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27	$2,931.24	57	$61,873.92
28	$3,236.64	58	$66,306.36
29	$3,585.48	59	$71,255.76
30	$3,979.68	60	$77,640.84]

AMENDMENT
to be attached to and made a part of
Group Policy No. 050197 (Rev) (the Policy)
issued by

5 STAR LIFE INSURANCE COMPANY

to

ARMED FORCES BENEFIT ASSOCIATION

****

It is understood and agreed that effective as of [December 1, 2009], said Policy is hereby amended as follows:

ADDITION OF NEW PROGRAM ENTITLED "GROUP SELECT TERM WITH 10 YEAR CONTRIBUTION GUARANTEE"

The "Group Select Term with 10 Year Contribution Guarantee" program is hereby added.

Accordingly:

1. the section entitled "Coverage Schedule" on page 16 is amended to include the following:

"**Classification**	**Amount of Insurance Coverage That May Be Elected** **Group Select Term with 10 Year Contribution Guarantee**
All Members and Associate Members Who Elect the 25 Year Option under the Group Select Term with 10 Year Guarantee program	A minimum of $50,000 to a maximum of $500,000 in increments of $50,000
All Members and Associate Members Who Elect the 30 Year Option under the Group Select Term with 10 Year Guarantee program	A minimum of $50,000 to a maximum of $500,000 in increments of $50,000"

2. items (2) and (3) of the section entitled "Termination of Insurance of Member" on page 20 are amended to include "and Group Select Term with 10 Year Contribution Guarantee" after the phrase "Group Select Term";

3. items (2) and (3) of the section entitled "Termination of Insurance of Associate Member" on page 20 are amended to include "and Group Select Term with 10 Year Contribution Guarantee" after the phrase "Group Select Term"; and

4. the second sentence of the first paragraph of the section entitled "Conversion Privilege" on page 22 is amended to include "and Group Select Term with 10 Year Contribution Guarantee" after the phrase "Group Select Term."

Alexandria, Virginia
December 1, 2009
CKD

5 STAR LIFE INSURANCE COMPANY

By: _____

Title: **President**

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/22/2010	Supporting Document	Coverage and Contribution Schedules	03/25/2010	GST10-1209-25 (CCS) (Ed.12-09).pdf (Superceded) GST10-1209-30 (CCS) (Ed.12-09).pdf (Superceded)

COVERAGE AND CONTRIBUTION SCHEDULE

Group Policy Number: [LT050197 (Rev)]
Group Policyholder: [AFBA]
Plan: [GST10-25]
Certificate ID: [00000000000]
Covered Person: [John Doe]
Coverage Amount: [$100,000]
Rating Class: [Male, Standard, Non-Tobacco User]

Effective Date: [12/01/2009]
Option Date: [12/01/2019]
Expiry Date: [12/01/2069]
Date of Birth: [07/01/1974] **Issue Age:** [35]
Payment Mode: [Monthly]

Owner and Beneficiary: As selected on the Enrollment Form subject to the sections entitled "Owner, Change of Ownership" and "Beneficiary Provisions" of this Certificate of Insurance Coverage.

Group level term life insurance coverage to Expiry Date with Contribution increases as shown below.

Monthly Contribution for the First Coverage Year: [$19.00]

The initial contribution is based on Your Age and Rating Class as shown above. The contribution is guaranteed to be level for 10 years and projected to remain level for the entire initial term period of 25 years. However, after the 10th coverage year, the contribution is subject to change as set by 5 Star Life based on interest rates and mortality. After a term period of 25 years, the contribution will convert to an annual renewable term basis. Coverage will continue until the Expiry Date. See section entitled "Change of Contributions."

[Guaranteed and Current Maximum Contributions

Coverage Year	Guaranteed Annual Contribution	Current Annual Contribution	Coverage Year	Guaranteed Annual Contribution	Current Annual Contribution
1	$228.00	$228.00	31	$4,415.28	$4,415.28
2	$228.00	$228.00	32	$4,883.76	$4,883.76
3	$228.00	$228.00	33	$5,391.48	$5,391.48
4	$228.00	$228.00	34	$5,936.40	$5,936.40
5	$228.00	$228.00	35	$6,530.88	$6,530.88
6	$228.00	$228.00	36	$7,201.68	$7,201.68
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COVERAGE AND CONTRIBUTION SCHEDULE

Group Policy Number: [LT050197 (Rev)]
Group Policyholder: [AFBA]
Plan: [GST10-30]
Certificate ID: [00000000000]
Covered Person: [John Doe]
Coverage Amount: [$100,000]
Rating Class: [Male, Standard, Non-Tobacco User]

Effective Date: [12/01/2009]
Option Date: [12/01/2019]
Expiry Date: [12/01/2069]
Date of Birth: [07/01/1974] **Issue Age:** [35]
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5	$266.00	$266.00	35	$6,530.88	$6,530.88
6	$266.00	$266.00	36	$7,201.68	$7,201.68
7	$266.00	$266.00	37	$8,085.00	$8,085.00
8	$266.00	$266.00	38	$9,000.36	$9,000.36
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11	$739.20	$266.00	41	$13,282.20	$13,282.20
12	$795.00	$266.00	42	$15,093.36	$15,093.36
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19	$1,381.20	$266.00	49	$32,503.20	$32,503.20
20	$1,517.40	$266.00	50	$35,732.28	$35,732.28
21	$1,668.00	$266.00	51	$39,163.68	$39,163.68
22	$1,835.28	$266.00	52	$42,728.28	$42,728.28
23	$2,012.76	$266.00	53	$46,395.96	$46,395.96
24	$2,204.64	$266.00	54	$50,091.60	$50,091.60
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26	$2,662.92	$266.00	56	$57,771.72	$57,771.72
27	$2,931.24	$266.00	57	$61,873.92	$61,873.92
28	$3,236.64	$266.00	58	$66,306.36	$66,306.36
29	$3,585.48	$266.00	59	$71,255.76	$71,255.76
30	$3,979.68	$266.00	60	$77,640.84	$77,640.84]