
State: Arkansas **Filing Company:** 5 Star Life Insurance Company
TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
Product Name: Group Level Term
Project Name/Number: /

Filing at a Glance

Company: 5 Star Life Insurance Company
Product Name: Group Level Term
State: Arkansas
TOI: L04G Group Life - Term
Sub-TOI: L04G.500 Other
Filing Type: Form
Date Submitted: 09/20/2012
SERFF Tr Num: FIVE-128695047
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: 912

Implementation: On Approval
Date Requested:
Author(s): Mildred Hunt, Lourdes Hilbers
Reviewer(s): Linda Bird (primary)
Disposition Date: 09/26/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas
TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
Product Name: Group Level Term
Project Name/Number: /

Filing Company: 5 Star Life Insurance Company

General Information

Project Name: Status of Filing in Domicile: Not Filed
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Domicile Status Comments: Not yet filed, but will be filed.
 Explanation for Combination/Other: Market Type: Group
 Submission Type: New Submission Group Market Size: Large
 Group Market Type: Association Overall Rate Impact:
 Filing Status Changed: 09/26/2012
 State Status Changed: 09/26/2012 Deemer Date:
 Created By: Mildred Hunt Submitted By: Mildred Hunt
 Corresponding Filing Tracking Number:

Filing Description:

G-Term App R912: Group Level Term Programs Enrollment Form
 Form ALCMF-100 (R912): Part B - Statements to Company's Medical Examiner

Company and Contact

Filing Contact Information

Mildred Hunt, Compliance Manager mhunt@afba.com
 909 North Washington Street 703-706-5975 [Phone]
 Alexandria, VA 22314 703-224-0214 [FAX]

Filing Company Information

5 Star Life Insurance Company CoCode: 77879 State of Domicile: Louisiana
 909 North Washington Street Group Code: 77879 Company Type: Life
 Alexandria, VA 22314 Group Name: NAIC Insurance Company
 (703) 706-5975 ext. [Phone] FEIN Number: 54-1829709 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: Retaliatory state, Louisiana, does not require a fee to file an application. Reverted to the state fee assessed for an application filing.
 Per Company: No

Company	Amount	Date Processed	Transaction #
5 Star Life Insurance Company	\$50.00	09/20/2012	62899184

State: Arkansas Filing Company: 5 Star Life Insurance Company
TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
Product Name: Group Level Term
Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/26/2012	09/26/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Group Level Term Programs Enrollment Form	Mildred Hunt	09/24/2012	09/24/2012

SERFF Tracking #:

FIVE-128695047

State Tracking #:

Company Tracking #:

912

State:

Arkansas

Filing Company:

5 Star Life Insurance Company

TOI/Sub-TOI:

L04G Group Life - Term/L04G.500 Other

Product Name:

Group Level Term

Project Name/Number:

/

Disposition

Disposition Date: 09/26/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Cover Letter		Yes
Form (revised)	Group Level Term Programs Enrollment Form		Yes
Form	Group Level Term Programs Enrollment Form	Replaced	Yes
Form	Part B - Statements to Company's Medical Examiner		Yes

SERFF Tracking #:

FIVE-128695047

State Tracking #:

Company Tracking #:

912

State:

Arkansas

Filing Company:

5 Star Life Insurance Company

TOI/Sub-TOI:

L04G Group Life - Term/L04G.500 Other

Product Name:

Group Level Term

Project Name/Number:

/

Amendment Letter

Submitted Date: 09/24/2012

Comments:

The application was revised in the "Other Insurance" section to include additional states. The states added were AR, KS, SC, and WI. All other information remains the same.

If you need additional information, please feel free to contact me.

Respectfully submitted,

Mildred E. Hunt

Compliance Manager

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
G-Term App R912	Application/Enrollment Form	Group Level Term Programs Enrollment Form	Initial					G-Term App R912 (Generic).pdf

State: Arkansas
 TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
 Product Name: Group Level Term
 Project Name/Number: /

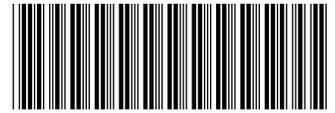
Filing Company: 5 Star Life Insurance Company

Form Schedule

Lead Form Number: G-Term App R912							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		G-Term App R912	AEF	Group Level Term Programs Enrollment Form	Initial:		G-Term App R912 (Generic).pdf
2		Form ALCMF-100 (R912)	OTH	Part B - Statements to Company's Medical Examiner	Initial:		Form ALCMF-100 (R912) (Generic).pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



GT 2 912

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)

Payor

SSN - -

Name: _____
First | Last

Address: _____

City, State, Zip _____

Relationship to Applicant _____ Phone No. _____

Owner Applicant Other (Complete all info below)

SSN - -

Name: _____
First | Last

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 - -

First Name | Last Name | SSN | Relationship | DOB

Secondary - -

First Name | Last Name | SSN | Relationship | DOB

Coverage and Contributions

Price class applying for:*

Ultra Preferred (GS Only)

Preferred (GS Only)

Standard Non-Tobacco

Tobacco User

Payment Method
 (Please choose only one.)

<input type="radio"/> Monthly Credit Card	0	<input type="radio"/> Semi-Annual Bill	6
<input type="radio"/> Monthly Checkmatic	0	<input type="radio"/> Annual Bill	12
<input type="radio"/> Monthly Military Allotment	2	<input type="radio"/> Non-Military Allotment	2
<input type="radio"/> Quarterly Bill	3	<input type="radio"/> Monthly List Bill	1

* 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: Yes No Children's Units # of Children

(BA & LT Only) (may not exceed 5)

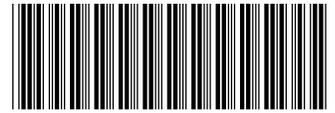
Applicant's Monthly Contribution

Children's Monthly Contribution-BA/LT Only

Total Monthly Contribution \$ x **Recurring Contribution Value** = \$

Amount payable to AFBA.

If available for this product, I elect to receive my certificate and any associated correspondence and disclosures via electronic means. Yes No



GT 912 3

Other Coverage

Answer only if this is an agent or broker initiated sale:

Do you or your children have an existing individual life insurance or annuity contract with another company? ... If yes, and you live in AK, AL, AR, AZ, CO, IA, KS, KY, LA, MD, ME, MS, MT, NC, NE, NH, NJ, NM, OH, OR, RI, SC, TX, UT, VA, VT, WI or WV please complete and sign the Notice: Replacement of Life Insurance and Annuity. ...

Statement of Health

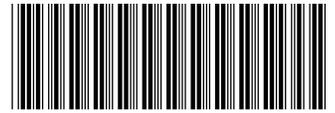
Answer each question and initial in box to acknowledge you've read and, TO THE BEST OF YOUR KNOWLEDGE AND BELIEF, understood each question. Circle the specific condition and give full details to any "yes" answers in the section below.

Height [] Ft [] [] In Weight [] [] [] Lbs

Initial Here [] []

- 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? ... 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? ... III. Has the Applicant or Child ever had or currently have any cancer, tumors, cysts, masses, polyps, or growths of any type? ... IV. 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)? ... V. List each prescribed medication the Applicant or Child takes regularly or frequently: ... VI. In the past 12 months, has any Applicant or Child used any tobacco or nicotine products (including nicotine patch, gum, or spray)? ... VII. Did the Applicant's or Child's parent(s) or sibling(s) die before age 60 of cardiovascular or cerebrovascular disease or cancer? ... VIII. Does the Applicant or Child receive disability benefits from any source? ... IX. 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 4 912

Conditions Relating to this Enrollment Form

Group Eligibility: I am eligible to apply for this group insurance coverage as a 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. Authorization: I hereby authorize any licensed physician; medical practitioner; hospital; clinic; insurance company; employer; Medical Information Bureau (MIB); or Motor Vehicle Administration that may have records of my physical or mental health condition to give 5Star Life Insurance Company, its authorized representative, and its reinsurers any such information. I authorize 5Star Life Insurance Company, or its reinsurers, to make a brief report of health information to MIB. 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.

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

Insurance Producer 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 _____

Insurance Producer Name _____ Insurance Producer 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. Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. 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. Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Not available in all states • Admin Office: 909 N. Washington St, Alexandria, VA 22314 • 1-800-776-2322 • www.afba.com

The questions and answers in 1-11 and Details of "Yes" answers apply to the following person proposed for insurance:

1. Person proposed for insurance: (PRINT)

a. _____
 First Name M.I. Last Name

b. Birth Date (mm/dd/yy) ____/____/____
 SSN ____-____-____

2. In the last 10 years, have you been medically treated for or had any known indication of: **Yes No**

a. Disorder of eyes, ears, nose, or throat?

b. Dizziness, fainting, convulsions, headaches; speech defect, paralysis or stroke; mental or nervous disorder?

c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?

d. High blood pressure, coronary artery disease, heart attack, heart failure, heart murmur, or any disorder of the heart or blood vessels?

e. Jaundice, intestinal bleeding, ulcer, colitis, diverticulitis, recurrent indigestion, or any disorder of the stomach, intestines, liver or gallbladder?

f. Sugar, albumin, blood or pus in urine, venereal disease; stone or any disorder of kidney, bladder, prostate, reproductive organs or breasts?

g. Diabetes; thyroid, pituitary, adrenal, or hormone disorder?

h. Neuritis, rheumatoid disease, amputation, or disorder of the muscles or bones, including the spine, back and joints?

i. Anemia or any disorder of the blood?

3. In the past 5 years have you:

a. Been treated by a physician or medical facility for alcohol or drug dependency?

b. Used amphetamines, cocaine, heroin, hallucinogens, barbiturates, marijuana, narcotics, or any drugs, except as medication prescribed by a physician?

4. Are you now under treatment or taking any prescribed medication?

5. Have you had any change in weight in the past year?
 Gain ____ lbs. Loss ____ lbs.

6. Within the past 5 years have you:

a. Had any mental or physical disorder not listed above?

b. Had a checkup, consultation, illness, injury, surgery?

6. c. Been a patient in a hospital, clinic, sanatorium, or any medical facility? **Yes No**

d. Had electrocardiogram, X-ray, or other diagnostic test?

e. Been medically advised to have any diagnostic test, hospitalization, or surgery which was not completed?

7. Have you ever:

a. Had military service deferment, rejection or discharge because of a physical or mental condition?

b. Requested or received a pension, benefits, or payment because of an injury, sickness or disability?

8. Have you had or do you currently have any cancer, tumors, cysts, masses, polyps, or growths of any type?

9. Have you ever been diagnosed or treated by a physician or tested positive for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency (AIDS) or any AIDS-Related Complex (ARC)?

10. Other Information:

a. Name and address of your personal physician: (If none, so state) _____
 Name _____
 Address _____

b. In the past 5 years have you consulted your personal physician for any matter not recorded in answers to questions 2-9? If "Yes", furnish reason, details and date in "Details" space below.

11. Do you have any family history of diabetes, cancer, high blood pressure or cholesterol, heart or kidney disease, or mental illness?

	Age if Living	Cause of Death	Age at Death
Father			
Mother			
Brothers and Sisters			
# Living _____			
# Dead _____			

DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER. CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

The foregoing statements and answers are **TO THE BEST OF MY KNOWLEDGE AND BELIEF**, complete, true, and correctly recorded and are representations and not warranties.

Dated at (City, State) _____ on the month, day and year of _____

Medical Examiner _____
 Signature of person proposed for insurance, if age 15 or over, or Applicant, if person proposed is under age 15.

TO BE COMPLETED IN EVERY CASE. DO NOT DETACH.

Authorization and Acknowledgment

Date _____

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, insurance company, employer, Medical Information Bureau (MIB), or Motor Vehicle Administration that may have records of my physical or mental health condition and any children of the undersigned to give 5Star Life Insurance Company, its authorized representatives, or its reinsurer(s) any such information, including information concerning every condition for which each has been under observation or treatment, including if the information specified contains information related to treatment for drug and/or alcohol abuse or for psychiatric and/or mental conditions, the history obtained, physical and laboratory findings, diagnosis, and treatment. I authorize 5Star Life Insurance Company, or its reinsures, to make a brief report of health information to MIB. The authorization shall be valid for 24 months from the date above. A photocopy of this authorization shall be as valid as the original.

Name of proposed insured if under age 15 (PRINT)

Signature of proposed insured, if age 15 or over, or Applicant, if proposed insured is under age 15.

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. **Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **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. **Washington Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

SERFF Tracking #:

FIVE-128695047

State Tracking #:

Company Tracking #:

912

State:

Arkansas

Filing Company:

5 Star Life Insurance Company

TOI/Sub-TOI:

L04G Group Life - Term/L04G.500 Other

Product Name:

Group Level Term

Project Name/Number:

/

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
ARKANSAS.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter		
Comments:			
Attachment(s):			
ARKANSAS.pdf			



ARKANSAS INSURANCE DEPARTMENT

READABILITY CERTIFICATION

Re: *G-Term App R912: Group Level Term Programs Enrollment Form
Form ALCMF-100 (R912): Part B – Statements to Company's Medical
Examiner*

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

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

Glenn R. Jones, Esq.
Vice President, Compliance

Dated: September 20, 2012



Mildred E. Hunt
Compliance Manager

September 20, 2012

VIA SERFF

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

<i>Form Number</i>	<i>Description</i>
G-Term App R912	Group Level Term Programs Enrollment Form
Form ALCMF-100 (R912)	Part B – Statements to Company’s Medical Examiner

Dear Mr. Honey:

Submitted for filing and approval are the above referenced forms. Form number G-Term App R509 was approved by the Insurance Department on June 30, 2009. The SERFF Tracking Number is FIVE-126208270. The Part B is a new form and will be used in conjunction with the application. The underwriters, through a telephonic interview, will use the form to confirm the information recorded on the application. The interview is recorded.

The application and form are submitted in conjunction with the Group Level Term Insurance Policy (LT 050197) stamped approved by the Insurance Department on November 13, 1997.

This is not an illustrated product.

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

	<i>Description</i>
G-Term App R608 <u>912</u>	Page 1 of 4, Civil Union <ul style="list-style-type: none"> • <u>CT, DE, HI, IL</u>, NJ, NH, <i>RI and VT</i> Residents: Married includes civil unions and civil union partners. Page 2 of 4, Coverage and Contributions section <ul style="list-style-type: none"> • O Monthly Credit Card + <u>0</u>

909 North Washington Street, Alexandria, VA 22314

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

mhunt@afba.com

- O Monthly Checkmatic + 0
- O Gov't 1199 Non-Military Allot
- ~~O Bi-weekly 2~~
- ~~O Weekly 4~~
- If available for this product, I elect to receive my certificate and any associated correspondence and disclosures via electronic means. O Yes O No

Page 3 of 4: Other Coverage section

- Modified the section to read as follows: "Do you, your spouse, or children have an existing individual life insurance or annuity contract with another company? O Yes O No If yes, and you live in AK, AL, AR, AZ, CO, HI, IA, KS, KY, LA, MD, ME, MS, MT, NC, NE, NH, NJ, NM, OH, OR, RI, SC, TX, UT, VA, VT, WI, 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. If approved, will this coverage applied for replace any your existing life insurance or annuity contract? O Yes O No If yes, what is the company name for your existing coverage?"

Page 3 of 4: Statement of Health section

- ~~"4. Skin disorder, cyst, tumor, or cancer?"~~ Renumbered questions 5. through 10.
- III. Has the Applicant or Child ever had or do you currently have any cancer, tumors, cysts, masses, polyps or growths of any type?
- ~~"VII. Did the Applicant's or Child's parent(s) or sibling(s) die before age 60 of cardiovascular or cerebrovascular disease or cancer?"~~

Page 4 of 4: Conditions Relating to this Enrollment Form section

- Line 1, revise to read: "I am eligible to apply for this group insurance coverage as a Member ~~or Associate Member~~ as defined in the Master Group Policy....."
- Delete the following sentence in its entirety: "~~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.~~"
- Revise to read: "Authorization: I hereby authorize any licensed physician;; employer; ~~financial institution;~~ Medical Information Bureau (MIB); or Motor Vehicle Administration that may have records of my ~~financial,~~ physical, or mental health....."
- Inserted the following language: "I authorize 5Star Life Insurance Company, or its reinsurers, to make a brief report of health information to MIB."

	Page 4 of 4: Agent Certification section <ul style="list-style-type: none">Replaced the words "agent" with "<u>producer.</u>"
Form ALCMF-100 (R608) <u>(R912)</u>	Line 1, revised to read: "The question and answers in 1-1011 and Details of "Yes" answers apply to the following person proposed for insurance: <ul style="list-style-type: none">Question 2.i. deleted: "i. Disorder of skin, lymph glands, cyst, tumor, or cancer?"Inserted 8.: "<u>8. Have you had or do you currently have any cancer, tumors, cysts, masses, polyps, or growths of any type?</u>" The remaining numbers were renumbered. Authorization and Acknowledgment section <ul style="list-style-type: none">Revised to read as: "I hereby authorize any licensed physician, medical practitioner, hospital, clinic, insurance company, employer, financial institution, Medical Information Bureau (<u>MIB</u>), or Motor Vehicle Administration that may have records of my financial, physical, or mental health condition....."Inserted the following language: "<u>I authorize 5Star Life Insurance Company, or its reinsurers, to make a brief report of health information to MIB.</u>"Inserted the following language: "The authorization shall be valid for 24 months (<u>30 months in VA</u>) from the date above."

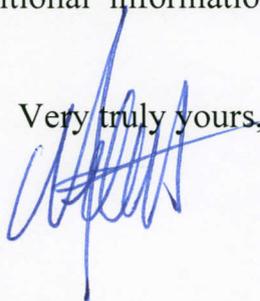
All other sections of the application remain the same.

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

An electronic version of the application will be filed in several months.

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

Very truly yours,



SERFF Tracking #:

FIVE-128695047

State Tracking #:**Company Tracking #:**

912

State:

Arkansas

Filing Company:

5 Star Life Insurance Company

TOI/Sub-TOI:

L04G Group Life - Term/L04G.500 Other

Product Name:

Group Level Term

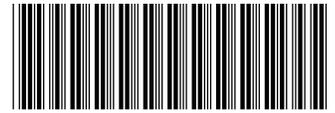
Project Name/Number:

/

Superceded 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)
09/20/2012	Form	Group Level Term Programs Enrollment Form	09/24/2012	G-Term App R912 (Generic).pdf (Superceded)



GT 2 912

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)

Payor

SSN - -

Name: _____ First _____ Last _____

Address: _____

City, State, Zip _____

Relationship to Applicant _____ Phone No. _____

Owner Applicant Other (Complete all info below)

SSN - -

Name: _____ First _____ Last _____

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 - - Relationship DOB

Secondary - - Relationship DOB

Coverage and Contributions

Price class applying for:*

- Ultra Preferred (GS Only)
- Preferred (GS Only)
- Standard Non-Tobacco
- Tobacco User

Payment Method

(Please choose only one.)

- Monthly Credit Card 0 Semi-Annual Bill 6
- Monthly Checkmatic 0 Annual Bill 12
- Monthly Military Allotment 2 Non-Military Allotment 2
- Quarterly Bill 3 Monthly List Bill 1

* 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: Yes No

Children's Units (may not exceed 5) # of Children

Applicant's Monthly Contribution

Children's Monthly Contribution-BA/LT Only

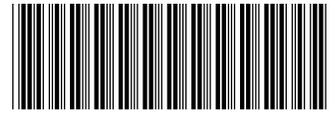
Total Monthly Contribution \$

Recurring Contribution Value

Amount payable to AFBA.

\$

If available for this product, I elect to receive my certificate and any associated correspondence and disclosures via electronic means. Yes No



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Other Coverage

Answer only if this is an agent or broker initiated sale:

Do you or your children have an existing individual life insurance or annuity contract with another company? ... If yes, and you live in AK, AL, AZ, CO, IA, KY, LA, MD, ME, MS, MT, NE, NH, NJ, NM, NC, OH, OR, RI, TX, UT, VA, VT or WV please complete and sign the Notice: Replacement of Life Insurance and Annuity. ...

Statement of Health

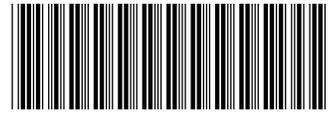
Answer each question and initial in box to acknowledge you've read and, TO THE BEST OF YOUR KNOWLEDGE AND BELIEF, understood each question. Circle the specific condition and give full details to any "yes" answers in the section below.

Height [] Ft [] [] In Weight [] [] [] Lbs

Initial Here [] []
Applicant Yes No Children Yes 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. Asthma, Chronic Obstructive Pulmonary Disease (COPD), tuberculosis, chronic cough or shortness of breath, or any disorder of the lungs or respiratory system?
5. Diabetes, thyroid, pituitary, adrenal, or hormone disorder?
6. Disorder of the kidney, bladder, urinary tract, genital tract, or reproductive system?
7. Ulcers, hepatitis, colitis, gastritis, disorder of the pancreas, liver, esophagus, stomach or intestines?
8. Rheumatoid disease, connective tissue disease, or disorder of the blood or lymph glands?
9. 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 had or currently have any cancer, tumors, cysts, masses, polyps, or growths of any type?
IV. 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)?
V. List each prescribed medication the Applicant or Child takes regularly or frequently:
VI. In the past 12 months, has any Applicant or Child used any tobacco or nicotine products (including nicotine patch, gum, or spray)?
VII. Did the Applicant's or Child's parent(s) or sibling(s) die before age 60 of cardiovascular or cerebrovascular disease or cancer?
VIII. Does the Applicant or Child receive disability benefits from any source?
IX. 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 4 912

Conditions Relating to this Enrollment Form

Group Eligibility: I am eligible to apply for this group insurance coverage as a 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. Authorization: I hereby authorize any licensed physician; medical practitioner; hospital; clinic; insurance company; employer; Medical Information Bureau (MIB); or Motor Vehicle Administration that may have records of my physical or mental health condition to give 5Star Life Insurance Company, its authorized representative, and its reinsurers any such information. I authorize 5Star Life Insurance Company, or its reinsurers, to make a brief report of health information to MIB. 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.

Applicant _____ Date [] [] / [] [] / [] [] [] []
(Or parent or legal guardian, if Applicant is a minor.)
Month Day Year

Sign Here



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

Insurance Producer 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 _____

Insurance Producer Name _____ Insurance Producer 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. Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. 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. Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Not available in all states • Admin Office: 909 N. Washington St, Alexandria, VA 22314 • 1-800-776-2322 • www.afba.com