

Additional Children's Information



Child 3:

Name (First, MI, Last)	DOB	SSN	Sex	Coverage Amount	Weekly Premium
------------------------	-----	-----	-----	-----------------	----------------

Child 4:

Name (First, MI, Last)	DOB	SSN	Sex	Coverage Amount	Weekly Premium
------------------------	-----	-----	-----	-----------------	----------------

Other Insurance

Do you, your spouse or children have any existing individual life insurance or annuity contracts? Yes No
 If yes, and you live in CO, HI, IA, LA, MD, MS, MT, NH, OR or VT, please complete the Replacement Notice.
 If yes, do you, your spouse or children intend to replace them? Yes No If yes, complete the applicable state Replacement Notice.

Beneficiary(ies)

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

Beneficiary Of Employee Coverage	_____	_____	_____	_____	_____	_____
	Last Name	First Name	MI	Relationship	DOB	SSN
Beneficiary Of Spouse Coverage	_____	_____	_____	_____	_____	_____
	Last Name	First Name	MI	Relationship	DOB	SSN
Beneficiary Of Child 1 Coverage	_____	_____	_____	_____	_____	_____
	Last Name	First Name	MI	Relationship	DOB	SSN
Beneficiary Of Child 2 Coverage	_____	_____	_____	_____	_____	_____
	Last Name	First Name	MI	Relationship	DOB	SSN
Beneficiary Of Child 3 Coverage	_____	_____	_____	_____	_____	_____
	Last Name	First Name	MI	Relationship	DOB	SSN
Beneficiary Of Child 4 Coverage	_____	_____	_____	_____	_____	_____
	Last Name	First Name	MI	Relationship	DOB	SSN

Statement of Health

Please answer each question and circle the specific condition.

I. In the last 5 years, have you had or been treated by a member of the medical profession for any of the following:	Employee	Spouse	Child 1	Child 2	Child 3	Child 4
	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
A. Heart attack, stroke or coronary artery disease?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Any form of cancer to include leukemia and Hodgkin's Disease?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Chronic hepatitis, cirrhosis or other disease of the liver?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Lung disease?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) or AIDS related conditions? .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
II. Have you ever applied for and been rejected for life insurance?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Conditions Relating to this Application

Agreement: I, as employee, have the appropriate knowledge to answer the questions for my spouse and children. I represent that all statements and answers in this application are complete, true and correctly recorded to the best of my knowledge and belief. I agree that: 1) if this application is approved by 5Star Life Insurance Company, it, the policy and any riders or endorsements will constitute the entire insurance contract; 2) insurance applied for will not become effective until approved by 5Star Life Insurance Company and subject to the health relating to each person to be insured being as described in this application, in which case the coverage shall take effect as of the effective date as shown in the policy; 3) if within 60 days of receipt of all required documentation this application is not approved, I will be notified that it will become void and all premiums paid will be refunded.

Authorization: I hereby authorize any licensed physician; medical practitioner; hospital; clinic or other medical facility; insurance company; employer; other organization or persons that have any records or knowledge of me or my physical or mental health condition to give 5Star Life Insurance Company, its authorized representative, and its reinsurers any such information. I understand that this information will be used to determine my eligibility for insurance and that I may revoke this authorization 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 30 months (24 months in KS, KY, NM, OK & VT and 26 months in MN) from the date below. I acknowledge that I, or my authorized representative is entitled to receive a copy of this authorization. As employee, my signature authorizes payroll deduction of premium from my employer for myself and my family members. **I acknowledge that I have received and read the Accelerated Benefit Disclosure form.**

Signatures must be personal:

Sign Here Employee _____ Date _____
 Owner _____ SSN _____
(If different than Employee.)
 Signed At (City, State) _____

Agent Certification:
 Is applicant replacing existing insurance coverage? Yes No
 Agent Name _____
Witness (Licensed Resident Agent, if required)
 Agent Signature _____ Date _____

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.