5Star Family Protection Plan
Individual Term Life Insurance to Age 100 Application

Agent use only—Agent# ☐☐☐☐☐☐☐☐
Select only one product per app: FPP-CI ☐ FPP-TI ☐

Insurance Representative Assisted: ☒ Self Completed: ☐

Section 1 - Employer Information

Employer/Group Name: WTXEBC - ______ Group Number: 01928

Section 2 - Employee

Coverage Amount	Premium
$ ______	$ ______

Employee/Owner: ______ SSN: ___ - ___ - ____ Gender: ☐M ☐F

Birth Date: ___/___/___ Are you actively at work?* ☐Y ☐N Date of Hire: ___/___/___

Mailing Address: ______

City: ______ State: ____ Zip Code: ______

Email Address: ______ @ ______

☐ Weekly
☐ Bi-Weekly
☐ Semi Monthly
☒ Monthly

Riders to be added
☐ Disability Waiver of Premium (WP)
☐ Auto Increase Rider (AIR)
x☐ Chronic Illness Rider (CHR) (FPP-TI only)
☐ Other: ______

* "Actively at Work" means that you are an eligible employee/member of the employer/affiliation through which you are applying for this individual insurance; you are able to work and to perform the normal activities of a person of like age and gender; and you are not confined in a hospital, at home or elsewhere due to injury or sickness on the date you signed this application.

Beneficiary

Primary: ______ Relationship: ______ Age: ___ Birth Date: ___/___/___ SSN: ___ - ___ - ____

Contingent: ______ Relationship: ______ Age: ___ Birth Date: ___/___/___ SSN: ___ - ___ - ____

Section 3 - Spouse

Coverage Amount	Premium
$ ______	$ ______

The employee will be the owner unless otherwise stated.

Spouse's Name: ______ SSN: ___ - ___ - ____

Gender: ☐M ☐F Birth Date: ___/___/___

During the prior 6 months, other than for routine medical care, has your spouse been diagnosed or treated by a member of the medical profession in a hospital or any other medical facility? ☐Y ☐N
(If yes, complete the questions in Section 6)

Has your spouse been disabled** in the prior 6 months or received disability payments? ☐Y ☐N

Mailing Address: ______

City: ______ State: ____ Zip Code: ______

Email Address: ______ @ ______

Riders to be added
☐ Disability Waiver of Premium (WP)
☐ Auto Increase Rider (AIR)
☒ Chronic Illness Rider (CHR) (FPP-TI only)
☐ Other: ______

** "Disabled" means that a person is unable to work, to attend school, or to perform the normal activities of a person of like age and gender or that a person is confined in a hospital, at home or elsewhere due to injury or sickness.

Beneficiary

Primary: ______ Relationship: ______ Age: ___ Birth Date: ___/___/___ SSN: ___ - ___ - ____

Contingent: ______ Relationship: ______ Age: ___ Birth Date: ___/___/___ SSN: ___ - ___ - ____

Section 4 - Children's Information (ages 14 days - 23 years)

Coverage Amount	Premium
$ ______	$ ______

The employee will be the owner and the beneficiary unless otherwise stated.

Child 1

Name (First, MI, Last): ______

SSN: ___ - ___ - ____ Gender: ☐M ☐F Birth Date: ___/___/___

Child 2 (Additional Children can be shown on a separate sheet of 8.5" x 11" paper.)

Name (First, MI, Last): ______ $ ______ $ ______

SSN: ___ - ___ - ____ Gender: ☐M ☐F Birth Date: ___/___/___

		Total Premium
Total Employee Premium	$ ______	
Total Spouse Premium	$ ______	
Total Children Premium	$ ______	$ ______

Underwritten by 5Star Life Insurance Company (a Baton Rouge, Louisiana Company)
Not available in all states ▪ Admin Office: 777 Research Dr., Lincoln, NE 68521 ▪ 1-866-863-9753

Section 5 - Other Insurance

Do you, your spouse, or children have any existing life insurance or annuity contracts? ☐ Y ☐ N
Will the coverage applied for replace any existing life insurance or annuities? ☐ Y ☐ N

If you answered "yes" to either question please complete and sign the Notice of Replacement.

Section 6 - Statement of Health

Please answer the following Statement of Health for all coverage:	**Employee**	**Spouse**	**Child 1**	**Child 2**
I. Has any Applicant been diagnosed or treated by a member of the medical profession, or tested positive for: Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Complete ONLY if applying for Simplified Issue amounts:				
II. Has any Applicant ever applied for and been rejected for life insurance?..........	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
III. Has any Applicant been hospitalized in the past 90 days?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
IV. In the past 5 years, has any Applicant been hospitalized for, been diagnosed or treated by a member of the medical profession or taken prescription medication for:				
A. Angina, heart attack, stroke, heart bypass surgery, angioplasty, coronary artery stenting, or coronary artery disease?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
B. Any form of cancer to include leukemia or Hodgkin's Disease (excluding non-invasive, non-melanoma skin cancer)?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
C. Chronic obstructive pulmonary disease (COPD), emphysema, or any other chronic respiratory disorder, excluding asthma?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
D. Alcoholism or drug or alcohol abuse, cirrhosis, hepatitis, or any other disease of the liver?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Section 7 - Conditions Relating to this Application

Representations

I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the applied for insurance . I understand that 5Star Life Insurance Company (5Star Life) will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured(s). 5Star Life may rescind the policy in accordance with the Contestability provision of the Policy due to any material misrepresentation of fact made in this application. Insurance is effective under the policy only when it is delivered to the owner, and then only if the full first premium is paid and all of the statements in this application remain correct and complete.

Authorization

I authorize 5Star Life to collect medical information or investigation reports about proposed insureds named in this application. I authorize those with such information or reports to release them to 5Star Life. I give 5Star Life permission to send such information or reports to MIB, Inc. ("MIB"), reinsurers, the Insurance Representative who solicited the application, and any third parties who administer the policies issued by 5Star Life. I authorize 5Star Life, or its reinsurers, to make a brief report of health information to MIB. This authorization shall remain in effect for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, but in no event more than 30 months from the date I sign below.

Acknowledgments

I acknowledge that I have received or will receive (in the case of solicitation by direct response methods) the Accelerated Benefit Disclosure form(s).

Note: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Sign Here

Employee (Policy Owner): ____ Date: ___/___/___

Signed at City: ______________________________ State: _____

I certify I have authorized my employer to make payroll deduction of premiums for myself and my family members. Signed: ______________________________

Insurance Representative Certification (when Insurance Representative assisted in completion of the application): I certify that I reviewed all questions on this application, and that the answers have been recorded accurately. I know of nothing affecting the insurability of the proposed insured(s) which is not fully recorded on this application.

To my knowledge, the Applicant has existing life insurance or annuity coverage. ☐Yes ☐No If yes, are they replacing existing coverage? ☐Yes ☐No

Insurance Representative Name: ____

Insurance Representative Signature: ____ Date: ___/___/___

Exhibit A
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? __Yes __No

Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? __Yes __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.				
2.				
3.				

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 ____
____.

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

Date: ______________, 20__

____
Applicant's Signature

____
Applicant's Printed Name

Date: ____________, 20__

____
Producer's Signature

____
Producer's Printed Name

I do not want this notice read aloud to me. ____ *(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 contract. 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 there 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 the existing company?

5Star Family Protection Plan
Individual Term Life Insurance to Age 100 Application

Agent use only—Agent# ☐☐☐☐☐☐☐☐
Select only one product per app:
FPP-CI ☐ FPP-TI ☐

Additional Children's Information (ages 14 days - 23 years)	Coverage Amount	Premium
The employee will be the owner and the beneficiary unless otherwise stated. **Child 3** Name (First, MI, Last): ______ SSN: ____ - ____ - _____ Gender: ☐ M ☐ F Birth Date: ___/___/___	$ ________	$ ________
Child 4 Name (First, MI, Last): ______ SSN: ____ - ____ - _____ Gender: ☐ M ☐ F Birth Date: ___/___/___	$ ________	$ ________
Child 5 Name (First, MI, Last): ______ SSN: ____ - ____ - _____ Gender: ☐ M ☐ F Birth Date: ___/___/___	$ ________	$ ________
Child 6 Name (First, MI, Last): ______ SSN: ____ - ____ - _____ Gender: ☐ M ☐ F Birth Date: ___/___/___	$ ________	$ ________