Underwritten by 5Star Life Insurance Company (a Lincoln, Nebraska Company)
Admin Office: 777 Research Dr., Lincoln, NE 68521
1-866-863-9753 • www.5StarLifeInsurance.com

Agent use only—Agent# C C 0 2 6 B Z D

INTERNAL USE ONLY:

Attachments: ☐☐ Initials: ☐☐

Group Life Insurance Enrollment Form

Use black or blue ink and print using all upper case letters.

NTG 1208 1

○ New Enrollee ○ Late Enrollee (Statement of Health must be completed.) ○ Name Change ○ Coverage Change ○ Beneficiary Change

Employer Information

Employer Name H O P K I N S ☐ C O . ☐ B O E

Employee/Applicant Information

Last Name

First Name M.I. D.O.B. ☐☐/☐☐/☐☐☐☐ (Month/Day/Year)

SSN ☐☐☐-☐☐-☐☐☐☐ ○ Male ○ Female Height ☐ ft ☐☐ in Weight ☐☐☐ lbs

Home Address:

Street Line 1

Street Line 2

City State Zip ☐☐☐☐☐-☐☐☐☐

Email

Daytime Phone Number ☐☐☐-☐☐☐-☐☐☐☐

Full-Time Employment Date ☐☐/☐☐/☐☐☐☐ (Month/Day/Year) Coverage Effective Date ☐☐/☐☐/☐☐☐☐ (Month/Day/Year)

Employee Insurance Coverage

Basic Group Life Amount $ ☐☐☐,☐☐☐ Basic Group AD&D Amount $ ☐☐☐,☐☐☐

Amounts requiring Evidence of Insurability are subject to Statement of Health.

Optional/Voluntary Group Life Amount $ ☐☐☐,☐☐☐ Optional/Voluntary AD&D Amount $ ☐☐☐,☐☐☐

Amounts requiring Evidence of Insurability are subject to Statement of Health.

Annual Earnings $ ☐☐☐,☐☐☐ (If coverage is earnings based) Voluntary Premium Amount $ ☐☐☐.☐☐

Voluntary/Optional Dependent Insurance Coverage

○ Life Only ○ Life and AD&D

	Name	SSN	DOB	Sex	Height	Weight	Coverage Amount	Premium Amount
Spouse								
Child 1								
Child 2								
Child 3								
Child 4								

Beneficiary Information

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I designate my beneficiary(ies) to receive benefits as indicated below. The employee is the beneficiary for all dependent coverages. If more than one beneficiary is named, the beneficiaries shall share equally unless otherwise stated below.

Primary _____

Name | Address | Relationship | SSN | DOB | %

Secondary _____

Name | Address | Relationship | SSN | DOB | %

Statement of Health (To be completed only for amounts of coverage requiring evidence of insurability)

~~**Answer each question TO THE BEST OF YOUR KNOWLEDGE AND BELIEF. Circle the specific condition and give full details to any "yes" answers in the chart below.**~~

Do not have to fill out

~~Yes~~ ~~No~~

~~I. In the past 10 years, has any Applicant:~~

~~A. Had a life or health insurance application declined, postponed, modified or rated?~~ ○ ○

~~B. Been diagnosed, advised, or treated by a physician or health advisor for the listed conditions: Heart attack, coronary artery disease, or any heart disorder, stroke, high blood pressure, blood or circulatory disorder, diabetes, cancer, tumor, chronic obstructive pulmonary disease (COPD) or any lung or respiratory disorder, liver disorder, alcohol or drug abuse, kidney disorder, disorder of the pancreas, paralysis, epilepsy, or mental, nervous or emotional disorder?~~ ○ ○

~~II. In the past 5 years, has any Applicant been admitted or confined to any hospital or medical treatment facility or consulted a physician or health advisor for any disease not listed above, or been advised to have any surgical operation or diagnostic tests (excluding genetic tests and screenings)?~~ ○ ○

~~III. Has any Applicant 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. For each Applicant list any prescribed medication taken regularly or frequently:~~

_____

_____

~~For any "Yes" answers above, please complete the following. Attach additional details on an 8.5 x 11 piece of paper and submit with this enrollment form.~~

~~Ques No.~~	~~Name~~	~~Condition, injury, findings of examination or prescription~~	~~Date (Mo/Yr)~~	~~Date of Recovery~~	~~Name & Address of Hospital or Attending Physician~~

Conditions Relating to This Enrollment Form

Group Eligibility: I am eligible to apply for this group insurance as a full-time employee under the Group Policy issued to the Employer by 5Star Life Insurance Company. **Agreement:** I, as employee, have the appropriate knowledge to answer the statement of health questions for my dependents. 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 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 the health relating to each person to be covered being as described in this enrollment form, and upon receipt of the full first premium, in which case the coverage shall take effect as of the effective date as shown in the Certificate of Insurance;** 3) if within 60 days of receipt of all required documentation this enrollment form is not approved, it will become void and any premiums paid will be refunded and I will be so notified. **Authorization:** I hereby authorize payroll deduction from my earnings of the required amount, if any, toward the cost of such insurance for myself and my family members. Authorization may be revoked by me at any time by written notice to my employer. I understand that if my employment is terminated, upon re-employment, insurance will not become effective until I apply again for insurance in accordance with the terms of the Group Policy. I hereby authorize any licensed physician; medical practitioner; hospital; clinic; insurance company; employer; Medical Information Bureau, Inc. (MIB, Inc.); 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, Inc. 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 am entitled to receive a copy of this authorization upon request. This request may be made by me or my authorized representative.

Signature must be personal.

Sign Here

Employee's Signature _____ Date _____

Signed at (City, State) _____

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.