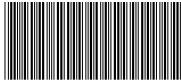
Underwritten by 5Star Life Insurance Company (a Lincoln, Nebraska Company)

Admin Office: 777 Research Dr., Lincoln, NE 68521 1-866-863-9753 • www.5StarLifeInsurance.com

Agent use only—Agent#									
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INTERNAL USE ONLY:									
Attachments:					lr	nitials	: [

Group Life Insurance Enrollment Form



Attachments:	initials:	Use black or bl	ue ink and print using all u	pper case letters.	NTG 12	08 1		
New Enrollee	Late Enrollee (Statement of Health must be completed)	ed.)	e Change	Coverage Change	Beneficiary Chan	ge		
Employer Information								
Employer H O P	K I N S	C O	BOE					
		Employee/	Applicant Informat	tion				
Last Name								
First Name			M.I. D.O.B.					
SSN			ale Female	Month Day Height ft	in Weight	lbs		
Home Address:			ale Pelliale	Height ft	in Weight	108		
Street Line 1								
Street Line 2								
City			State	Zip				
Email								
Daytime Phone Number								
Full-Time Employment Da	Month Day	Year	Coverage Effec	tive Date/	Day Yea	т		
		Employee	Insurance Covera	ge				
Basic Group Life Amount \$		Basic Group AD&D Amount						
Amounts requiring Eviden	nce of Insurability are subject to	Statement of Health.						
Optional/Voluntary Group Life Amount \$ Optional/Voluntary AD&D Amount \$ Optional/Voluntary								
Amounts requiring Eviden	nce of Insurability are subject to	Statement of Health.						
Annual Earnings \$	(If cover	age is earnings based)	Voluntary Premium A	Amount \$				
	Vo	untary/Optional	Dependent Insurar	nce Coverage				
Life Only	Life and AD&D							
Spouse	Name S	SN DOB	Sex	Height Weight	Coverage Amount Pr	remium Amount		
Child 1		SN DOB		Height Weight		remium Amount		
Child 2								
Child 3		SN DOB		Height Weight	Coverage Amount Pr	remium Amount		
Child 4		SN DOB		Height Weight	Coverage Amount Pr	remium Amount		
	Name S	SN DOB	Sex	Height Weight	Coverage Amount Pr	remium Amount		

GERENROLL R1208

Beneficiary Information

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.



NTG 2 1208

Primar	rv					1110 2 1200	
Secon	Name	Address		Relations	nip SSN	DOB	%
360011	Name	Address		Relations	nip SSN	DOB	%
	Statement of Hea	alth (To be completed only for an	nounts of c	overage re	quiring evidence of ins	urability)	
Answer	each question TO THE BES	T OF YOUR KNOWLEDGE AND BEL	IEF. Circle	the specific	condition and give full (details to any "yes	<u>"</u>
answers	s in the chart below.	_		•	4 6	- V-	- N-
	past 10 years, has any Applic	ant: Do r	10t	hav	e to fill	out *	es No
		lication declined, postponed, modified	l or rated?			 (
		ted by a physician or health advisor fo					
	, , ,	n blood pressure, blood or circulatory operatory disorder, liver disorder, alcoh	•	•	· · · · · · · · · · · · · · · · · · ·		
		rvous or emotional disorder?					
		nt been admitted or confined to any h					
	•	sted above, or been advised to have a	, ,		•	0 0	
							\mathcal{O}
		esed or treated by a physician or teste					
), or AIDS Related Complex (ARC)?				 (
IV. For ea	ach Applicant list any prescrib	ed medication taken regularly or frequ	entry:				
For any "	'Yes" answers above, please c	complete the following. Attach addition	_		<u> </u>	it with this enrollme	nt form.
Ques No.	Name	Condition, injury, findings of examination or prescription	Date (Mo/Yr)	Date of Recovery		ress of Hospital ling Physician	
110.	T T T T T T T T T T T T T T T T T T T	or oxamination or proscription	ŢIVIO/ II/	HCCCVCI	OI 7 MIONE	ing myololun	
		Conditions Relating t	to This Enr	ollment Fo	rm		
Group El	ligibility: I am eligible to appl	y for this group insurance as a full-tin	ne employed	e under the (Group Policy issued to the	Employer by 5Star	r Life
		s employee, have the appropriate kno					
		wers in this enrollment form are com I of this enrollment form by 5Star Life					
		rage provided under the Master Group					
		nd is subject to the health relating t					
		mium, in which case the coverage eipt of all required documentation this					
		elpt of all required documentation this ed. Authorization: I hereby authorize					
		and my family members. Authorization					
		minated, upon re-employment, insura					
		nereby authorize any licensed physicia					
		.); or Motor Vehicle Administration th d representative, and its reinsurers ar				•	
		formation to MIB, Inc. I understand the					
that I ma	ny revoke this authorization ar	nd enrollment form at any time by pro	viding writt	en notice. A	photocopy of this author	ization shall be as v	alid as
		e valid for 24 months from the date be		owledge tha	t I am entitled to receive	a copy of this auth	orization
	juest. This request may be ma r e must be personal .	ade by me or my authorized represen	tative.				
	•						
Sign	Lilipidy co a digilataro			Date		_	
Here							
	Signed at (Gity, 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.

Not available in all states • Admin Office: 777 Research Dr., Lincoln, NE 68521 • 1-866-863-9753 • www.5StarLifeInsurance.com