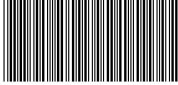
## **Underwritten by 5Star Life Insurance Company (a Baton Rouge, Louisiana Company)**

Admin Offices: 909 North Washington Street, Alexandria, VA 22314

1-800-776-2322 • www.afba.com

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

## **Multiple Employer Trust Group Life Insurance Enrollment Form**



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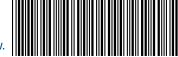
Use black or blue ink and print using all upper case letters. New Enrollee Late Enrollee Name Change **Coverage Change Beneficiary Change** (Statement of Health must be completed.) **Employer Information Employer** Name **Employer** Tax ID # **Employee/Applicant Information** Last Name First Name SSN Male Female Height Home Address: Street Line 1 Street Line 2 City **Daytime Phone Number** Full-Time Employment Date **Coverage Effective Date Employee Insurance Coverage Basic Group Basic Group** Life Amount **AD&D Amount** Amounts requiring Evidence of Insurability are subject to Statement of Health. Voluntary Group Voluntary AD&D Amount Life Amount Amounts requiring Evidence of Insurability are subject to Statement of Health. Voluntary (If coverage is earnings based) **Earnings Premium Amount** Voluntary/Optional Dependent Insurance Coverage

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

**GMT200ENR-R106** 10/07

## **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.



Primary						
	Name	Address	Relationship	SSN	DOB	%
Secondary						
	Name	Address	Relationship	SSN	DOB	%

Secon	dary							
	Name	Address		Relations	hip	SSN	DOB	%
	Statement of Hea	alth (To be completed only for an	nounts of c	overage re	quiring evi	idence of insu	ırability)	
Answer	each question and initial in	the box to acknowledge you've re	ad and und	erstood ead	<del>ch question</del>	h <del>.</del>		
		<del>e full details to any "yes" answers</del>				Initial He	rev	os Na
I. In the	last 10 years, has the Applica	nt under this application for coverage	Do r	not h	21/2	to fill	Out *	es <del>No</del>
A. Had	l a life or health insurance app	lication declined or rated?	ו טע		avc	<u>to iiii</u>	<u> </u>	$\circ$
B. Hac	<del>I any known indication of or be</del>	<del>een treated by a physician or consulte</del>	ed with a hea	<del>alth advisor f</del>	<del>or any of the</del>	e following:		
		terol, chest pain, heart attack, vascu						
		er; stroke, seizures, progressive neuro						
	· · · · · · · · · · · · · · · · · · ·	nonary disease (COPD), or other resp	•					
		nereas, intestines, or digestive syste petes, thyroid disease, pituitary disor						
		roductive system; or any other signi		-				
		barbiturates, hallucinogens, amphetai						
							•	
		y a physician or tested positive for He						
	*	en regularly or frequently by Applican						
		nt for this coverage been admitted or		ony boonital	er modical t	reatment facilit		
		•					•	
	Yes answers above, please c	omplete the following. Attach addition						ent form.
Ques	Name	Condition, injury, findings	<del>Date</del> <del>(Mo/Yr)</del>	Date of	4		ess of Hospital	
No.	Name Name	of examination or prescription	<del>(IVIO/YF)</del>	<del>Recovery</del>		<u>or Attendi</u>	<del>ng Physician</del>	
		Conditions Relating						
		y for this group insurance as a full tin			•		•	
		ust by 5Star Life Insurance Company						
		spouse. I represent that all statemen nd belief. I agree that 1) upon approv						
		me will describe the benefits and ter						
		roved by 5Star Life Insurance Compa						
describe	d in this enrollment form, and	upon receipt of the full first contribu	tion, in which	ch case the o	coverage sh	all take effect a	as of the effective	date as
		Coverage; 3) if within 60 days of rece						
		d any contributions paid will be refur						
		contributions will be refunded if the c horization: I hereby authorize payrol						
		my family members. Authorization n						
		nated, upon re-employment, insurance						
		ereby authorize any licensed physici						
company	; employer; Medical Informat	ion Bureau; Motor Vehicle Administr	ation or oth	er organizati	on; or perso	ons that have a	ny records or kno	wledge of
		ondition to give 5Star Life Insurance (						
		will be used to determine my eligib						
		<ul> <li>A photocopy of this authorization s nat I, or my authorized representative</li> </ul>					snall be valid for 2	:4 months
	re must be personal.	at i, or my authorized representative	; is cittitied t	to receive a	copy or tills	autiiviiZdtiVII.		
Sign	•							
Here	Employee's Signature			Date			-	
~								
	Signed at (City, State)	and with intent to injure, defraud			en :			
AILLIE: /	any nereon who knowingly	and with intent to initire detraid	or deceive	any incuror	tiloc a etat	rement of clair	m or an annlicati	on con-

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: 909 N. Washington St, Alexandria, VA 22314 • 1-800-776-2322 • www.afba.com