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: Initials:

5Star Multiple Employer Trust
Group Life Insurance Enrollment Form

MET 106 1

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

☑ 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 A R D O F E D .

Employer Tax ID #: 6 1 – 6 0 0 1 3 1 9

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 –

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.

Voluntary Group Life Amount $,

Voluntary AD&D Amount $,

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

Earnings $, (If coverage is earnings based)

Voluntary Premium Amount $.

Voluntary/Optional Dependent Insurance Coverage

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

Beneficiary Information

MET 2 106

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 and initial in the box to acknowledge you've read and understood each question.**~~
~~**Circle the specific condition and give full details to any "yes" answers in the chart below.**~~

Initial Here ____

Do not have to fill out

~~Yes~~ ~~No~~

I. ~~In the last 10 years, has the Applicant under this application for coverage:~~

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

B. ~~Had any known indication of or been treated by a physician or consulted with a health advisor for any of the following:~~
~~High blood pressure, high cholesterol, chest pain, heart attack, vascular disease (plaque in arteries), or other heart or blood vessel disorder; cancer or blood disorder; stroke, seizures, progressive neuropathy, or other nervous system disease; shortness of breath, asthma, chronic obstructive pulmonary disease (COPD), or other respiratory tract disorder; hepatitis, pancreatitis, colitis, or other disorder of the stomach, liver, pancreas, intestines, or digestive system; depression, schizophrenia, or other mental condition; alcoholism or alcohol abuse; diabetes, thyroid disease, pituitary disorder, or other gland disorder; disorder of the kidney, bladder, urinary tract, genital tract, or reproductive system; or any other significant medical disorders?~~ ..... ○ ○

C. ~~Used marijuana, cocaine, heroin, barbiturates, hallucinogens, amphetamines, or any illicit drug except by physician prescription?~~ ..... ○ ○

II. ~~Has the Applicant been diagnosed by a physician or tested positive for Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), or any AIDS-related condition?~~ ..... ○ ○

III. ~~List each prescribed medication taken regularly or frequently by Applicant:~~ _____

IV. ~~In the past 5 years, has the Applicant for this coverage been admitted or confined to any hospital or medical treatment facility?~~ ..... ○ ○

~~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 of an employer under the Group Policy issued to the Trustee, America's 5Star Multiple Employer Trust by 5Star Life Insurance Company. **Agreement:** I, as employee, have the appropriate knowledge to answer the statement of health questions for my spouse. 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 Coverage 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 contribution, in which case the coverage shall take effect as of the effective date as shown in the Certificate of Insurance Coverage; 3) if within 60 days of receipt of all required documentation this enrollment form is not approved, I will be notified that it will become void and any contributions paid will be refunded. **Note:** Within the time limits prescribed by the law of the state where you live, no benefits will be paid and contributions will be refunded if the covered person commits suicide while sane or insane. Refer to your Certificate of Insurance Coverage for details. **Authorization:** I hereby authorize payroll deduction from my earnings of the required contribution, 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 or other medical facility; insurance company; employer; Medical Information Bureau; Motor Vehicle Administration or 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 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, or my authorized representative is entitled to receive a copy of this authorization.

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.