INTERNAL USE ONLY:

Check Enclosed: Yes No

Amt: $ _____

Attachments: _____ Initials: _____

Request for Conversion Application
Individual Conversion Whole Life Insurance

Current Group Policy Information for Conversion

Group Association or Employer _____
if applicable

Certificate Number: _____ Group Policy Number: _____
if available if available

I hereby request that 5Star Life Insurance Company convert my current group coverage to an individual policy. The terms of this policy shall be in accordance with the conversion provision of the group insurance contract. It is agreed that the converted individual policy shall be deemed to be a continuation of the insurance under the Group Policy, but shall be a new, separate, and independent contract and that all its terms and conditions shall be operative at and from its date of issue. All rights and interests of every kind in the converted amount of insurance under said Group Policy are hereby released and discharged.

Insured Information

Insured's Full Name (First, Middle, Last) _____

Insured's SSN _____ DOB (MM/DD/YYYY) _____ Male Female

Home Address:

Street Line 1 _____

Street Line 2 _____

City _____ State _____ Zip _____

Daytime Contact Phone Number _____

Email address: _____

Owner (if other than applicant)

Social Security Number: _____

Name: _____

Address: _____

City, State, Zip: _____

Relationship to Applicant: _____

Phone No. _____

Payor

Owner Applicant Other (Complete all info below)

Social Security Number: _____

Name: _____

Address: _____

City, State, Zip _____

Phone No. _____

Policy Information

Payment Mode/ # of Months Payment:
(Please choose one.)

MonthlyBank Draft	1
Quarterly	3
Semi-Annually	6
Annually	12

Existing Coverage Amount: _____

Total Amount to Convert: _____

Effective Date of Existing Coverage: _____

Premium	# of Months Payment	Total Premium Due
$ _____	x _____	$ 0

Continued on back.

Beneficiary(ies)

I designate my beneficiary(ies) to receive benefits, in order of class, as indicated below. Check here ❒ if you would like an additional beneficiary form sent to you.

Primary _____
Name | Address | Relationship | SSN | DOB

Secondary _____
Name | Address | Relationship | SSN | DOB

Conditions Relating to this Conversion Form

1. The Conversion Privilege may be exercised prior to the date coverage is reduced or ends as described in the Group certificate as applicable.
2. The amount of insurance to be converted shall not be more than the amount of group insurance which ends.
3. The date of issue of any individual policy shall be the day following the last day of the period during which the Applicant has a right to convert the group insurance as described in the Group Certificate.
4. Any individual policy shall take effect as of its date of issue, but only if: (1) the Applicant has a right to convert his or her group insurance for the amount and plan of insurance applied for; and (2) this application has been made and the first premium, according to 5Star Life Insurance Company's published rates for the insurance applied for and the payment interval selected, is paid in full not later than the last day on which the Applicant has a right to convert his or her group coverage, as applicable.

Agreement: I agree that:

a. I have read the above questions and answers and declare that they are complete and true to the best of my knowledge and belief. I agree that this application shall form a part of the policy if attached thereto;

b. That the statements and answers in the application are the basis for any policy issued by 5 Star Life Insurance Company (5 Star Life), and that no information about me will be considered to have been given to 5 Star Life unless it is stated in the application, and that I will notify the company of any changes in the statements or answers given in the application between the time of application and delivery of the policy.

c. No agent or sales representative has the authority to accept risk, pass on insurability, or make, void, waive or change any conditions or provsions of the application, policy or receipt, as applicable;

d. 5 Star Life has no liability until: (i) A policy is issued on this application and delivered to and accepted by the owner; and (ii) The first premium due is paid in full while each proposed insured is alive.

e. I hereby authorize any licensed physician; medical practitioner; hospital; clinic; insurance company; employer; financial institution; Medical Information Bureau; or Motor Vehicle Administration that may have records of my financial, physical, or mental health condition to give 5Star Life, 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 or as permitted by applicalbe state law. I acknowledge that I, or my authorized representative is entitled to receive a copy of this authorization.

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

Applicant's Signature _____ Date_____

Payor Signature_____ Date_____
(If different than Applicant)

Owner Signature _____ Date_____
(If different than Applicant)

Signed at (City, State) _____