

The questions and answers in 1-10 and Details of "Yes" answers apply to the following person proposed for insurance:

1. Person proposed for insurance: (PRINT)

a. _____
 First Name M.I. Last Name

b. Birth Date (mm/dd/yy) ____/____/____
 SSN ____-____-____

2. In the last 10 years, have you been medically treated for or had any known indication of: **Yes No**

a. Disorder of eyes, ears, nose, or throat?

b. Dizziness, fainting, convulsions, headaches; speech defect, paralysis or stroke; mental or nervous disorder?

c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?

d. High blood pressure, coronary artery disease, heart attack, heart failure, heart murmur, or any disorder of the heart or blood vessels?

e. Jaundice, intestinal bleeding, ulcer, colitis, diverticulitis, recurrent indigestion, or any disorder of the stomach, intestines, liver or gallbladder?

f. Sugar, albumin, blood or pus in urine, venereal disease; stone or any disorder of kidney, bladder, prostate, reproductive organs or breasts?

g. Diabetes; thyroid, pituitary, adrenal, or hormone disorder?

h. Neuritis, rheumatoid disease, amputation, or disorder of the muscles or bones, including the spine, back and joints?

i. Disorder of skin, lymph glands, cyst, tumor, or cancer?

j. Anemia or any disorder of the blood?

3. In the past 5 years have you:

a. Been treated by a physician or medical facility for alcohol or drug dependency?

b. Used amphetamines, cocaine, heroin, hallucinogens, barbiturates, marijuana, narcotics, or any drugs, except as medication prescribed by a physician?

4. Now under treatment or taking any prescribed medication?

5. Any change in weight in the past year?
 Gain ____ lbs. Loss ____ lbs.

6. Within the past 5 years:

a. Had any mental or physical disorder not listed above?

b. Had a checkup, consultation, illness, injury, surgery?

c. Been a patient in a hospital, clinic, sanatorium, **Yes No** or any medical facility?

6. d. Had electrocardiogram, X-ray, or other diagnostic test?

e. Been medically advised to have any diagnostic test, hospitalization, or surgery which was not completed?

7. Ever:

a. Had military service deferment, rejection or discharge because of a physical or mental condition?

b. Requested or received a pension, benefits, or payment because of an injury, sickness or disability?

8. Have you ever been diagnosed or treated by a physician or tested positive for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency (AIDS) or any AIDS-Related Complex (ARC)?

9. Other Information:

a. Name and address of your personal physician: (If none, so state) _____
 Name _____
 Address _____

b. In the past 5 years have you consulted your personal physician for any matter not recorded in answers to questions 2-8? If "Yes", furnish reason, details and date in "Details" space below.

10. Any family history of diabetes, cancer, high blood pressure or cholesterol, heart or kidney disease, or mental illness?

| | Age if Living | Cause of Death | Age at Death |
|----------------------|---------------|----------------|--------------|
| Father | | | |
| Mother | | | |
| Brothers and Sisters | | | |
| # Living _____ | | | |
| # Dead _____ | | | |

DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER. CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

The foregoing statements and answers are **TO THE BEST OF MY KNOWLEDGE AND BELIEF**, complete, true, and correctly recorded and are representations and not warranties.

Dated at (City, State) _____ on the month, day and year of _____

Medical Examiner _____
 Signature of person proposed for insurance, if age 15 or over, or Applicant, if person proposed is under age 15.

TO BE COMPLETED IN EVERY CASE. DO NOT DETACH. Date _____
Authorization and Acknowledgment

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 and any children of the undersigned to give 5Star Life Insurance Company, its authorized representatives, or its reinsurer(s) any such information, including information concerning every condition for which each has been under observation or treatment, including if the information specified contains information related to treatment for drug and/or alcohol abuse or for psychiatric and/or mental conditions, the history obtained, physical and laboratory findings, diagnosis, and treatment. I understand that this information will be used to determine my eligibility for insurance and that I may revoke this authorization and application at any time by providing written notice. I acknowledge that I am, or my authorized representative is, entitled to receive a copy of this authorization. The authorization shall be valid for 30 months from the date above. A photocopy of this authorization shall be as valid as the original.

 Name of proposed insured if under age 15 (PRINT) Signature of proposed insured, if age 15 or over, or Applicant, if proposed insured is under age 15.

Note: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.