5STAR LIFE INSURANCE COMPANY

For claim questions call:
1-866-863-9753

5Star Family Protection Plan
Accelerated Payment of Benefits

Claim Instructions

This claim kit has been designed for you to provide 5Star Life with all the necessary information to process your claim as quickly and efficiently as possible. Please follow the instructions below as carefully as possible to insure proper completion of all forms.

1. Complete the front side of the Application for Accelerated Payment of Benefits.

2. Please read the back page carefully and sign in the *two* spaces indicated.

3. Complete the top section of the Physician Statement for Accelerated Payment of Benefits; read and sign the attached authorization statement.

4. Submit the Physician Statement to the physician whose care you are under. The physician should complete the form, attach pertinent medical records, and return them to you.

5. You should verify that the information on the Physician Statement is complete and that the appropriate medical records are attached.

6. Please return the Application, Physician Statement and copies of medical records to the 5Star Life Claims Department at 421 South 9th Street, Suite 222, Lincoln, NE 68508.

While your claim is being reviewed, we will disclose the specific impact that the payment of this benefit will have on your remaining death benefit. You will receive a letter displaying this information and indicating the period of time during which you have the right to change your mind and decline this benefit, if you so desire. We must withhold payment during this waiting period (most statutory regulations require 14 days). If we do not hear from you, your benefit will be paid immediately following this period, assuming your claim has been approved.

Retain these instructions and if you have any questions about your claim, please call 1-866-863-9753 and ask for the Claims Department.

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Application for Accelerated Payment of Benefits

Please fill in all the information requested on this form to the best of your knowledge.

Policy #: _____

Name of Insured:_____ Social Security #: _____

Name of Owner: _____ (if other than insured)

Date of Birth: _____ Sex: _____ Male_____ Female

Marital Status:_____ Single _____Married _____Divorced _____ Widowed

Please provide the address that is the best location for correspondence.

Address: _____ Phone #: _____

If the insured person is not able to correspond, please provide below the name, address, telephone number and relationship of the power of attorney/ guardian dealing with this claim inquiry.

Name: _____ Relationship to Insured: _____

Address: _____ Phone #: _____

Attending Physician Information—Please list the physician(s) involved in your care.

Name: _____ Phone #: _____

Address: _____

Name: _____ Phone #: _____

Address: _____

Name: _____ Phone #: _____

Address: _____

Please be sure to sign the reverse side of this form to authorize the release of medical information to us for claims review.

Authorization to Release Medical Information:

I hereby authorize any physician or other practitioner, or any other hospital or other institution to furnish **5Star Life Insurance Company, or its representatives,** with all information concerning me with respect to treatment, diagnosis, and past medical history, and to furnish copies of any records requested. I understand that this information will be used to determine my eligibility for the accelerated benefit. This signed authorization or a photographic copy shall be sufficient authority for such purpose. This authorization shall be valid for the duration of this claim. I acknowledge that I or my authorized representative is entitled to receive a copy of this authorization.

Insured's Signature: _____ Date: _____

Power of Attorney/Guardian's Signature*: _____ Date: _____
* Attach copy of appointment.

Disclosure Statement for Accelerated Payment of Benefits

5Star Life's Accelerated Payment of Benefits is an accelerated benefit provision that is part of the 5Star Family Protection Plan.

You may apply for Accelerated Payment of Benefits if you have been diagnosed as having: 1) a heart attack; 2) a stroke; 3) cardiac surgery; 4) life threatening cancer; or 5) a terminal condition and you meet the criteria and conditions as described in your insurance policy. You are only eligible for one benefit payment of up to 30% (25% in MI) of the death benefit amount during the life of the policy. Upon approval by 5Star Life Insurance Company, the benefit will be paid in the following manner:

The amount of the life insurance on the insured, under the above specified program(s), will be reduced by the amount of the accelerated benefit paid and will take effect on the date that the accelerated benefit is approved by 5Star Life. The accelerated benefit will be paid in one lump sum. Premium payments will be waived for the first 12 months after the accelerated benefit is paid, thereafter premiums will continue and will be based on the amount of life insurance inforce prior to the reduction.

To exercise this Accelerated Payment of Benefits provision, a $150 processing fee may be charged to the insured, depending on state law.

Unlike conventional life insurance proceeds, accelerated benefits payable under the Accelerated Payment of Benefits provision **MAY BE TAXABLE**. You should consult a personal tax advisor about the tax consequences of receiving this benefit.

Receipt of accelerated benefits under this Accelerated Payment of Benefits provision **MAY AFFECT MEDICAID AND SUPPLEMENTAL SECURITY INCOME** eligibility. Without exercising your option to accelerate benefits, the mere fact that you own an accelerated benefit product will not in and of itself affect your eligibility for these government programs. However, exercising the option to accelerate benefits and receiving those benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. You may wish to contact the Medicaid Unit of your local Department of Public Welfare and Social Security Administration Office for more complete information.

If the policy is assigned, or if there is an irrevocable beneficiary, then we must obtain concurrence from assignee for payment.

I have read the above statement and understand the Accelerated Payment of Benefits for which I am applying. Furthermore, all of the information completed on this form is to the best of my knowledge and belief, true and correctly recorded.

Insured's Signature: _____ Date: _____

Owner (if other than insured): _____ Date: _____

Power of Attorney/Guardian's Signature*: _____ Date: _____
* Attach copy of appointment.

Warning: 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 in prison.

Please Note: Failure to complete all sections of this form will result in a delay of processing and possible denial of the insured's claim. We appreciate your attention to this matter.

Physician Statement for Accelerated Payment of Benefits

To be completed by Insured:

Dear Doctor:

_____ (insured's name) has filed a claim for Accelerated Payment of Benefits under a life insurance policy he/she holds with 5Star Life Insurance Company. In order to process this claim, our office needs the following information from you. Please fill out this form to the best of your knowledge, paying attention to accuracy, and return it to the insured **WITH COPIES OF MEDICAL RECORDS** as soon as possible. Be advised that after receipt of this completed form by our Home Office, we may ask for further documentation from you.

Physician's Name:_____ Speciality: _____

Address: _____ Phone #:_____

To be completed by Physician:

Primary Diagnosis: _____ ICD9: _____

Date of Onset: _____ Care Plan: _____

Please enclose copies of medical records/progress notes related to the diagnosis. We cannot process this claim without this information.

I certify that the above insured has been diagnosed with: (circle the condition) 1) heart attack, 2) stroke, 3) cardiac surgery, 4) life threatening cancer, or 5) a terminal medical condition from which upon reasonable medical judgement, it is probable that the insured will die of this condition, or complications thereof, within _____ (please complete) months from the date of this statement.

Physician's Signature _____ Date: _____

Physician's Name (please print): _____

License #: _____ State of Licensure: _____

To be signed by Insured:

Physician: Please detach this stub for your records and return the following to the Insured:

1) The above form, completed; and
2) A complete copy of all medical records that pertain to the insured named below.

Your prompt attention to this matter will be greatly appreciated by our staff and the claimant.

I hereby authorize any physician, other practitioner, hospital or other institution to furnish the **5Star Life Insurance Company, or its representatives**, with all information concerning me with respect to treatment, diagnosis and past medical and mental health history and to furnish copies of any records requested. I understand that this information will be used to determine my eligibility for the accelerated benefit. This signed authorization or a photographic copy shall be sufficient authority for such purpose. This authorization shall be valid for the duration of this claim. I acknowledge that I or my authorized representative is entitled to receive a copy of this authorization.

Insured's Name: _____ Signature:_____ Date:_____

Power of Attorney/Guardian's Signature*:_____ Date:_____

* Attach copy of appointment.