National Guard Association of Kentucky

ADMINISTERED BY:

National Guard Association of Kentucky
1117 Louisville Road
Frankfort, KY 40601
www.ngaky.org | (502) 564-7500

UNDERWRITTEN BY:

5Star Life Insurance Company
909 N. Washington Street
Alexandria, VA 22314
www.afba.com | (800) 462-7441

NOW AVAILABLE UP TO $50,000

BASIC LIFE INSURANCE BENEFIT: $1,000 NON-CONTRIBUTORY

OPTIONAL LIFE INSURANCE BENEFITS: $5,000-$50,000

INDIVIDUAL CERTIFICATES

Each member enrolled will receive a certificate giving a complete statement of the benefits as outlined.

MONTHLY PREMIUMS (Guard Member)

COVERAGE	PREMIUM
$5,000	$2.00
$10,000	$3.66
$15,000	$5.33
$20,000	$7.00
$25,000	$8.67
$30,000	$10.34
$35,000	$12.00
$40,000	$13.67
$45,000	$15.34
$50,000	$17.00

LIFE INSURANCE FOR DEPENDENTS

Spouse $2,000 ..... $5,000 ..... $10,000

Children

Birth to 6 months $400 ..... $1,000 ..... $2,000

6 months to 2 years $800 ..... $2,000 ..... $4,000

2 years to 3 years $1,600 ..... $4,000 ..... $8,000

3 years to 21 years* $2,000 ..... $5,000 ..... $10,000

*Remains in effect to age 25 if Dependent is Full-Time Student

DEPENDENT INSURANCE (Includes Spouse)

Cannot exceed 50% of Member's coverage

COVERAGE	PREMIUM
$ 2,000	$1.33
$5,000	$3.33
$10,000	$6.66

SPOUSE INSURANCE

Cannot exceed Member's coverage

COVERAGE	PREMIUM
$ 5,000	$2.00
$10,000	$3.66
$15,000	$5.33
$20,000	$7.00
$25,000	$8.67

LIFE INSURANCE BENEFITS

- $1,000, $5,000, $10,000, $15,000, $20,000, $25,000, $30,000, $35,000, $40,000, $45,000 or $50,000
- Life insurance payable in event of death from any cause
- Coverage is twenty-four hours a day, 365 days a year
- No War Clause
- No Aviation Exclusion
- No Hazardous Duty or Civilian Occupation Restriction
- Full Conversion privilege upon termination regardless of health

BENEFICIARY

Benefits will be paid to the member's named beneficiary in a lump-sum payment. If no beneficiary is living at the time of death of the insured member, the amount shall be paid to the duly qualified executors or administrators of the member's estate.

EXTENSION OF DEATH BENEFITS

We will pay life insurance benefits if an insured meets all of the following conditions:

1. becomes totally disabled before age 60;
2. remains totally disabled until death;
3. dies before reaching age 60; and
4. dies within one year after Life Insurance premiums were last paid

INDIVIDUAL TERMINATION

Insurance Coverage will terminate the date the policy or section of the policy under which coverage is offered ends, or the last day of the month for which premiums have been paid (subject to the Grace Period).

This Coverage may be continued after leaving the National Guard until age 65.

The Insurance Coverage elected will remain level until age 60. When the Insured attains age 60 (Guard Member, Spouse or Dependent), the benefits will be reduced by 50% and the premium will remain the same. All optional coverages expire on the last day of the month in which the member attains age 65.

CONVERSION PRIVILEGE

If life insurance ceases because of termination of membership in the classes eligible for insurance under this program or separation from the National Guard, coverage may be converted to an individual policy. See your certificate for details and requirements.

AFBA | 5STAR LIFE INSURANCE COMPANY

State Sponsored Life Insurance (SSLI) Survivor Benefit

Enrollment Form

Offered through AFBA Multi-Association Group Insurance Alliance Trust

Office Use Only:
Cert Number _____
Coverage Effective Date _____

Association Information

Association Name National Guard Association of Kentucky

Guard Member Information

Name (last, first, middle) _____ Rank _____ SSN _____

DOB _____ (Mo/Day/Year) Height _____ ft _____ in Weight _____ lbs

❒ Male ❒ Female ❒ Married ❒ Not-Married

Mailing Address _____
Street City State Zip

Home Phone Number _____ Cell Phone Number _____

Civilian Email Address _____

NG Unit _____ Date of Enlistment _____ (Mo/Day/Year)

As applicant, I designate beneficiary(ies) to receive benefits as indicated below.

Beneficiary _____
Last Name First Name SSN Relationship DOB

Optional Dependent Information

Spouse Name (last, first, middle) _____ ❒ Male ❒ Female

DOB _____ (Mo/Day/Year) Height ____ ft ____ in Weight _____ lbs

Number of Children _____ (List all children under age 21, or 25 if a full-time student.)

Child 1 Name (last, first, middle) _____ DOB _____ ❒ Male ❒ Female

Child 2 Name (last, first, middle) _____ DOB _____ ❒ Male ❒ Female

Child 3 Name (last, first, middle) _____ DOB _____ ❒ Male ❒ Female

Child 4 Name (last, first, middle) _____ DOB _____ ❒ Male ❒ Female

Coverage

This application is requested for: ❒ New Enrollment ❒ Change

Guard Member - Coverage (monthly contributions)				Spouse		Dependent(s)	
❒ $5,000	($2.00)	❒ $30,000	($10.34)	❒ $5,000	($2.00)	❒ $2,000	($1.33)
❒ $10,000	($3.66)	❒ $35,000	($12.00)	❒ $10,000	($3.66)	❒ $5,000	($3.33)
❒ $15,000	($5.33)	❒ $40,000	($13.67)	❒ $15,000	($5.33)	❒ $10,000	($6.66)
❒ $20,000	($7.00)	❒ $45,000	($15.34)	❒ $20,000	($7.00)		
❒ $25,000	($8.67)	❒ $50,000	($17.00)	❒ $25,000	($8.67)		

Benefits Underwritten by 5Star Life Insurance Company (a Lincoln, Nebraska company)
Admin. Office: 1117 Louisville Road, Frankfort, KY 40601
1-502-564-7500 • www.ngaky.org

Statement of Health

Answer each question TO THE BEST OF YOUR KNOWLEDGE AND BELIEF. Circle the specific condition and give full details to any "yes" answers on a separate 8 1/2 x 11 piece of paper (include name, DOB, and question # the answer refers to).

	Member Yes	Member No	Spouse Yes	Spouse No
I. In the past 10 years, has any Applicant:				
A. Had a life or health insurance application declined, postponed, modified or rated?	❒	❒	❒	❒
B. Been diagnosed, advised, or treated by a physician or health advisor for the listed conditions: Heart attack, coronary artery disease, or any heart disorder, stroke, high blood pressure, blood or circulatory disorder, diabetes, cancer, tumor, chronic obstructive pulmonary disease (COPD) or any lung or respiratory disorder, liver disorder, alcohol or drug abuse, kidney disorder, disorder of the pancreas, paralysis, epilepsy, or mental, nervous or emotional disorder?	❒	❒	❒	❒
II. In the past 5 years, has any Applicant been admitted or confined to any hospital or medical treatment facility or consulted a physician or health advisor for any disease not listed above, or been advised to have any surgical operation or diagnostic tests (excluding genetic tests and screenings)?	❒	❒	❒	❒
III. Has any Applicant ever been diagnosed or treated by a physician or tested positive for Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)?	❒	❒	❒	❒

IV. For each Applicant list any prescribed medication taken regularly or frequently: _____

_____

_____

Conditions Relating to This Enrollment Form

Eligibility: I am eligible to apply for this benefit as a Guard Member per the Master Group Policy.

Agreement: I, as Guard Member, have the appropriate knowledge to answer the 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 fund my benefit will describe the benefits and terms of coverage provided under the Master Group policy; and 2) if within 180 days of receipt of all required documentation this enrollment form is not approved, it will become void and any contributions paid will be refunded; I will be so notified.

Authorization: I authorize 5 Star Life Insurance Company to collect medical information or investigation reports about proposed insureds named in this application. I authorize those with such information or reports to release them to 5 Star Life. I give 5Star Life permission to send such information or reports to its reinsurers, any Insurance Representative who solicited the application, and any third parties who administer the policies issued by 5Star Life. I authorize MIB, Inc. ("MIB") and any MIB member insurer, to provide any medical or personal information that it has about me to 5Star Life, its reinsurer or any MIB-authorized third party administrator performing underwriting services on 5Star Life's behalf. I also authorize 5Star Life, its reinsurer or authorized third-party administrator, to make a brief report of my personal health information to MIB. This authorization shall remain in effect for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, but in no event more than 24 months from the date I sign below.

Acknowledgement: I acknowledge that I am, or my authorized representative is, entitled to receive a copy of this authorization upon request. Signature must be personal.

Sign Here

Member's Signature _____ Date _____

Signed at (City, State) _____

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

KY

AUTHORIZATION TO START, STOP OR CHANGE AN ALLOTMENT

PRIVACY ACT STATEMENT

AUTHORITY: 37 U.S.C. Section 701, E.O. 9397.

PRINCIPAL PURPOSE: To permit starts, changes, or stops to allotments. To maintain a record of allotments and ensure starts, changes, and stops are in keeping with member's desires.

ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. Section 552a(b) of the Privacy Act, these records of information contained therein may specifically be disclosed outside the DoD as a routine use to the Federal Reserve banks to distribute payments made through the direct deposit system to financial organizations or their processing agents authorized by individuals to receive and deposit payments in their accounts. It may also be disclosed to the Treasury Department, Internal Revenue Service, Social Security Administration, Department of Veterans Affairs, Federal, state and local agencies for civil or criminal law enforcement. In addition it can be released for any of the blanket routine uses published at the beginning of the DFAS compilation of system of record notices.

DISCLOSURE: Voluntary; however, failure to provide the requested information as well as the Social Security number may result in the member not being able to start, change, or stop allotments.

TO BE COMPLETED BY ALLOTTER

1. BRANCH OF SERVICE *(X One)*

	AIR FORCE		MARINE CORPS
	ARMY		NAVY

2. NAME OF ALLOTTER *(Last, First, Middle Initial) (Print or Type)*

3. SSN

4. PAY GRADE

5. ADDRESS OF ALLOTTER *(Street or Box Number, City, State, Zip Code)*

6. DAYTIME TELEPHONE NUMBER *(Include Area Code)*

7. EFFECTIVE DATE *(YYYYMM)*

8. MONTHLY AMOUNT OF ALLOTMENT

$

9. NAME OF ALLOTTEE *(First, Middle Initial, Last)*

NGAKY

10. ALLOTMENT ACTION *(X One)*

	START		STOP		CHANGE

11. TERMS IN MONTHS

12. CREDIT LINE *(If Applicable)*

13. ALLOTMENT OF CLASS AUTHORIZED *(X One)*

	C - CHARITY/CFC
X	D - DISCRETIONARY ALLOTMENTS *(Includes dependent support, payment to financial institution, insurance, repayment of home loan, rent, etc. (Notes 1 and 2))*
	F - CHARITY - EMERGENCY/ASSISTANCE FUND CONTRIBUTION
	L - REPAYMENT OF LOAN TO SERVICE ORGANIZATION *(Red Cross, Relief Society, etc. - Navy and Marine Corps only)*
	N - NSLI OR USGLI INSURANCE PREMIUM
	T - PAYMENT OF DEBTS TO U.S., DELINQUENT STATE OR LOCAL INCOME/EMPLOYMENT TAXES
	- OTHER *(Specify)*

14. ALLOTTEE'S MAILING ADDRESS *(Street or Box Number, City, State, Zip Code)*

1117 LOUISVILLE ROAD
FRANKFORT, KY 40601

15. IF FOREIGN ADDRESS COMPLETE AS FOLLOWS *(Province, Country)*

16. REMARKS

17. COMPANY CODE/FINANCIAL INSTITUTION/ROUTING TRANSIT NUMBER

18. ACCOUNT NUMBER/POLICY NUMBER

	CHECKING
	SAVINGS

19. TOTAL CLASS L AMOUNT

20. TOTAL CLASS T AMOUNT

STATEMENT OF UNDERSTANDING

I understand that this allotment is legal and that by voluntarily completing this form, I am responsible for:

- **Ensuring** that the information is correct;
- **Reviewing** my Leave and Earnings Statement to ensure the allotment stops, starts, or changes as directed including amount and payee;
- **Collecting** overpayments from the receiver (payee) of the allotment, if I do not change or stop the allotment after a loan is repaid;
- **Contacting** the receiver (payee) of the allotment, at my expense, to obtain monthly statements for my personal records.

I also understand that any problems once the allotment is delivered to the receiver (payee) are beyond the control of the Defense Finance and Accounting Service (DFAS) and that DFAS is only responsible for ensuring proper delivery of any voluntary allotment for the period directed. I further understand that pursuant to conditions listed in the DoD 7000.14-R, Volume 7A, changes can be made by DFAS to an allottee's name, address, or account number.

Under penalty of the Uniform Code of Military Justice, I certify that this allotment is NOT for the purchase, lease, or rental of personal property or payment toward personal property.

21. SIGNATURE OF ALLOTTER

22. DATE *(YYYYMMDD)*

NOTE 1. Must be different address than allotter. Each dependent allotment must have a different credit line. Only one support allotment per dependent is allowed.
NOTE 2. This is a voluntary allotment and can be to any payee you desire.