

National Guard Association of Arkansas



ADMINISTERED BY:

National Guard Association of Arkansas
PO Box 663
North Little Rock, AR 72115
(501) 758-6422
www.ngaa.org



UNDERWRITTEN BY:

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

NOW AVAILABLE UP TO \$50,000

BASIC MEMBER DEATH BENEFIT:

\$1,000 NON-CONTRIBUTORY provided to you by the National Guard Association of Arkansas.

OPTIONAL COVERAGE funded through life insurance underwritten by 5Star Life Insurance Company: \$10,000-\$50,000

INDIVIDUAL CERTIFICATES

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

MONTHLY CONTRIBUTIONS (Guard Member)

COVERAGE	CONTRIBUTION
\$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

COVERAGE FOR DEPENDENTS

Spouse \$5,000..... \$10,000

Children

Birth to 6 months \$1,000..... \$2,000
6 months to 2 years \$2,000..... \$4,000
2 years to 3 years \$4,000..... \$8,000
3 years to 21 years* \$5,000..... \$10,000

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

DEPENDENT COVERAGE (Includes Spouse)

Cannot exceed 50% of Member's coverage

COVERAGE	CONTRIBUTION
\$5,000	\$3.33
\$10,000	\$6.66

SPOUSE COVERAGE

Cannot exceed Member's coverage

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

BENEFITS

- \$1,000, \$10,000, \$15,000, \$20,000, \$25,000, \$30,000, \$35,000, \$40,000, \$45,000 or \$50,000
- Benefit payable in event of death from any cause (subject to contestability)
- 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 (see Conversion Privilege section below)

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.

TERMINATION

Optional 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 contributions have been paid (subject to the Grace Period).

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

The benefit(s) 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 contribution 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 elected benefit ceases because of termination of membership in the classes eligible for coverage under this program or separation from the National Guard, coverage may be converted to an individual policy within 31 days. See your certificate for details and requirements.



Member death benefits provided by AFBA are underwritten by 5Star Life Insurance Company (a Lincoln, Nebraska company), with an administrative office at: 909 N. Washington Street, Alexandria, VA 22314.

State Sponsored Life Insurance (SSLI) Survivor Benefit

Enrollment Form

**Offered through AFBA Multi-Association
Group Insurance Alliance Trust
Underwritten by 5Star Life Insurance Company**

Office Use Only:	
Cert Number _____	
Coverage Effective Date _____	
Enroller ID _____	

Association Information

Association Name National Guard Association of Arkansas (NGAA)

National Guard Member Information

Name (last, first, middle) _____ Rank _____ Social Security Number (SSN) _____

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

Male Female Married Not-Married Duty Status AGR (Active Guard Reserve) Traditional

Street Address _____ Cell Phone Number _____
Street

City, State, Zip _____ Home Phone Number _____
City State Zip

Civilian Email Address _____

National Guard Unit _____ Date of Enlistment _____ DoD ID # _____
Mo/Day/Year (Department of Defense)

As applicant, I designate beneficiary(ies) to receive benefits as indicated below. If designating multiple beneficiaries, total percentages designated must equal 100%.

Beneficiary _____	<small>First Name</small>	<small>Last Name</small>	<small>SSN</small>	<small>Relationship</small>	<small>DOB</small>	<small>%</small>
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Beneficiary _____	<small>First Name</small>	<small>Last Name</small>	<small>SSN</small>	<small>Relationship</small>	<small>DOB</small>	<small>%</small>
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Dependent Information – Complete if applying for Spouse or Dependent Coverage

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

DOB _____ Height _____ ft _____ in Weight _____ lbs Phone Number _____
Mo/Day/Year

Email Address _____

Number of Children _____ (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

National Guard Member Coverage (monthly contributions)				Spouse		Dependent(s)	
<input type="checkbox"/> \$10,000	(\$3.66)	<input type="checkbox"/> \$35,000	(\$12.00)	<input type="checkbox"/> \$5,000	(\$2.00)	<input type="checkbox"/> \$5,000	(\$3.33)
<input type="checkbox"/> \$15,000	(\$5.33)	<input type="checkbox"/> \$40,000	(\$13.67)	<input type="checkbox"/> \$10,000	(\$3.66)	<input type="checkbox"/> \$10,000	(\$6.66)
<input type="checkbox"/> \$20,000	(\$7.00)	<input type="checkbox"/> \$45,000	(\$15.34)	<input type="checkbox"/> \$15,000	(\$5.33)		
<input type="checkbox"/> \$25,000	(\$8.67)	<input type="checkbox"/> \$50,000	(\$17.00)	<input type="checkbox"/> \$20,000	(\$7.00)		
<input type="checkbox"/> \$30,000	(\$10.34)			<input type="checkbox"/> \$25,000	(\$8.67)		

Continued on back.

Benefits Underwritten by 5Star Life Insurance Company (a Lincoln, Nebraska company)
Admin. Office: PO Box 663, North Little Rock, AR 72115 • 1-501-758-6422 • www.ngaa.org



Member Benefit

\$1,000 member benefit with no contribution required. Benefit paid by state Guard Association.

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		Spouse	
	Yes	No	Yes	No
I. In the past 10 years, has any Applicant:				
A. Had a life or health insurance application declined, postponed, modified or rated?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 National Guard Member per the Master Group Policy.

Agreement: I, as National 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 (5Star Life), 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 any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager, or other health care provider that has provided payment, treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to 5Star Life Insurance Company, (5Star Life), and its employees, reinsurers and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.

I also authorize any medical practitioner, insurance company, Department of Motor Vehicles, employer or MIB, Inc. to give all medical or nonmedical information about me including alcohol or drug abuse, driving violations, association with criminal activity, possible over-insurance, foreign residency or travel, aviation activity, hazardous occupational or sports activity, to 5Star Life and its reinsurers. I authorize all said sources, except MIB, Inc. to give such information to any agency employed by 5Star Life to collect and transmit such information. I authorize 5Star Life, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. This information is to be disclosed under this Authorization so 5Star Life may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; and 4) administer coverage I have or have applied for with 5Star Life.

I understand in determining eligibility for insurance or benefits, this information may be made available to underwriting, claims, medical and support staff of 5Star Life. If I do not revoke this authorization, to determine my insurability it will be valid for 24 months from the date I sign it. For claims purposes, this authorization is valid for the duration of a claim. A copy of this Authorization is as valid as the original. I understand my authorized representative or I am entitled to receive a copy of this Authorization. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to 5Star Life. I understand that a revocation does not apply to any action that was taken in reliance on this Authorization or to 5Star Life's legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand that if I refuse to sign this Authorization to release my complete medical record, 5Star Life may not be able to process my application or issue coverage.

 Member's Signature _____ Date _____

Sign Here Signed at (City, State) _____

NOTE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement to prison.



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)		2. NAME OF ALLOTTER (Last, First, Middle Initial) <i>(Print or Type)</i>		3. SSN		4. PAY GRADE	
<input type="checkbox"/> AIR FORCE	<input type="checkbox"/> MARINE CORPS						
<input type="checkbox"/> ARMY	<input type="checkbox"/> NAVY						
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) NGAA			10. ALLOTMENT ACTION (X One)			11. TERMS IN MONTHS	
			<input checked="" type="checkbox"/> START <input type="checkbox"/> STOP <input type="checkbox"/> CHANGE				
12. CREDIT LINE (If Applicable)			13. ALLOTMENT OF CLASS AUTHORIZED (X One)				
			<input type="checkbox"/> C - CHARITY/CFC				
14. ALLOTTEE'S MAILING ADDRESS (Street or Box Number, City, State, Zip Code) PO BOX 663 NORTH LITTLE ROCK, AR 72115			<input checked="" type="checkbox"/> D - DISCRETIONARY ALLOTMENTS (Includes dependent support, payment to financial institution, insurance, repayment of home loan, rent, etc. (Notes 1 and 2))				
15. IF FOREIGN ADDRESS COMPLETE AS FOLLOWS (Province, Country)			<input type="checkbox"/> F - CHARITY - EMERGENCY/ASSISTANCE FUND CONTRIBUTION				
			<input type="checkbox"/> L - REPAYMENT OF LOAN TO SERVICE ORGANIZATION (Red Cross, Relief Society, etc. - Navy and Marine Corps only)				
			<input type="checkbox"/> N - NSLI OR USGLI INSURANCE PREMIUM				
			<input type="checkbox"/> T - PAYMENT OF DEBTS TO U.S., DELINQUENT STATE OR LOCAL INCOME/EMPLOYMENT TAXES				
16. REMARKS			<input type="checkbox"/> - OTHER (Specify)				
17. COMPANY CODE/FINANCIAL INSTITUTION/ROUTING TRANSIT NUMBER			18. ACCOUNT NUMBER/POLICY NUMBER			<input type="checkbox"/> CHECKING	<input type="checkbox"/> 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)
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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.