

Ohio National Guard Association



ADMINISTERED BY:

Ohio National Guard Association
1299 Virginia Avenue
Columbus, OH 43212
www.ngaoh.org | (614) 486-4186



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:

\$10,000-\$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 |
|----------|---------|
| \$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 \$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 INSURANCE (Includes Spouse)

Cannot exceed 50% of Member's coverage

| COVERAGE | PREMIUM |
|----------|---------|
| \$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, \$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.



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 Ohio National Guard Association

Guard Member Information

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

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

Male Female Married Not-Married

Mailing Address _____

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 _____ Height _____ ft _____ in Weight _____ lbs
Mo/Day/Year

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) | |
|---|-----------|-----------------------------------|----------|-----------------------------------|----------|
| <input type="checkbox"/> \$10,000 | (\$3.66) | <input type="checkbox"/> \$5,000 | (\$2.00) | <input type="checkbox"/> \$5,000 | (\$3.33) |
| <input type="checkbox"/> \$15,000 | (\$5.33) | <input type="checkbox"/> \$10,000 | (\$3.66) | <input type="checkbox"/> \$10,000 | (\$6.66) |
| <input type="checkbox"/> \$20,000 | (\$7.00) | <input type="checkbox"/> \$15,000 | (\$5.33) | | |
| <input type="checkbox"/> \$25,000 | (\$8.67) | <input type="checkbox"/> \$20,000 | (\$7.00) | | |
| <input type="checkbox"/> \$30,000 | (\$10.34) | <input type="checkbox"/> \$25,000 | (\$8.67) | | |
| <input type="checkbox"/> \$35,000 | (\$12.00) | | | | |
| <input type="checkbox"/> \$40,000 | (\$13.67) | | | | |
| <input type="checkbox"/> \$45,000 | (\$15.34) | | | | |
| <input type="checkbox"/> \$50,000 | (\$17.00) | | | | |

Benefits Underwritten by 5Star Life Insurance Company (a Baton Rouge, Louisiana company)

Admin. Office: 1299 Virginia Avenue, Columbus, OH 43212

1-614-486-4186 • www.ngaoh.org

OH

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 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 understand that I may request to be interviewed in connection with the preparation of the investigative consumer report and, if so requested, I am entitled to receive a copy of the investigative consumer report. 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 30 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.

 Member's
Signature _____ Date _____

Sign
Here Signed at (City, State) _____

NOTE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the law.

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) ONGA | | 10. ALLOTMENT ACTION (X One) | | | 11. TERMS IN MONTHS |
| | | <input 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) 1299 VIRGINIA AVE COLUMBUS, OH 43212 | | <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)) | | | |
| | | <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) | | | |
| 15. IF FOREIGN ADDRESS COMPLETE AS FOLLOWS (Province, Country) | | <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) |
|----------------------------------|----------------------------|

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.