Ohio
National Guard Association

ADMINISTERED BY:

Ohio National Guard Association
2825 W. Dublin Granville Road, Ste C119
Columbus, OH 43235-2789
www.ngaoh.org | (614) 486-4186

UNDERWRITTEN BY:

5Star Life Insurance Company
(an AFBA related enterprise)
909 N. Washington Street
Alexandria, VA 22314

NOW AVAILABLE UP TO $50,000

BASIC MEMBER DEATH BENEFIT:

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

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

DEPENDENT COVERAGE (Includes Spouse)

Cannot exceed 50% of Member's coverage

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

Dependent child coverage birth to 21 years or age, or 25 if a full-time student.

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.

AFBA | 5STAR LIFE INSURANCE COMPANY

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 Ohio National Guard Association (ONGA)

National Guard Member Information

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

Date of Birth (DOB) _____ (Mo/Day/Year) Height ____ft ____in Weight_____lbs

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

Street Address _____ (Street) Cell Phone Number _____

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

Civilian Email Address _____

National Guard Unit _____ Date of Enlistment _____ (Mo/Day/Year) DoD ID # _____ (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 _____
First Name Last Name SSN Relationship DOB %

Beneficiary _____
First Name Last Name SSN Relationship DOB %

Dependent Information – Complete if applying for Spouse or Dependent Coverage

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

DOB _____ (Mo/Day/Year) Height____ ft____ in Weight_____lbs Phone Number _____

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)**	
❒ $10,000	($3.66)	❒ $35,000	($12.00)	❒ $5,000	($2.00)	❒ $5,000	($3.33)
❒ $15,000	($5.33)	❒ $40,000	($13.67)	❒ $10,000	($3.66)	❒ $10,000	($6.66)
❒ $20,000	($7.00)	❒ $45,000	($15.34)	❒ $15,000	($5.33)		
❒ $25,000	($8.67)	❒ $50,000	($17.00)	❒ $20,000	($7.00)		
❒ $30,000	($10.34)			❒ $25,000	($8.67)		

Continued on back.

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 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 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.

Sign Here

Member's Signature _____ Date _____

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)*

[ ] 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)*

ONGA

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)*

2825 W. DUBLIN GRANVILLE RD, STE C119
COLUMBUS, OH 43235-2789

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.