National Guard Association of Mississippi Group Life Insurance Program

No-cost $1,000 Death Benefit
For active Guard members only

Basic Coverage
From $10,000 - $35,000 of coverage from $3.80 per month

Enhanced Coverage
Starting at $4 per month for $50,000 of coverage for you and your spouse

Life Insurance product underwritten by 5Star Life Insurance Company (a Baton Rouge, Louisiana company)
AFBA/5Star 2015-MS
5/15

Your family makes great sacrifices every day that allow you to serve. If you were to make the ultimate sacrifice for your country, your family's grief would be painful enough without added financial worries. Think of the hardship and expenses your family would face alone – without you and the security you provide.

No Cost $1,000 Death Benefit for Active Guard Members

This benefit is free to you. All Mississippi active guard members are covered 24/7 whether drilling or not. There's no enrollment necessary - you are automatically eligible for this benefit should something happen to you. Death benefit is paid to named beneficiary, spouse, or next of kin.

Basic Coverage

The Basic program provides financial protection in the event of death. It also provides coverage for your spouse and/or children, all at an affordable monthly cost.

Member Coverage

Basic coverage gives you 4 options. After 12 consecutive months, you are eligible for increased insurance which becomes effective on the next June 1 following completion of the 12 month period. **The additional coverage is at no-cost to you.**

Dependent Coverage

If you and your spouse are both members of the MS National Guard you must have your own individual coverage. Either you or your spouse can apply for coverage on children but not both.

Member Coverage		
Amount	Monthly cost	After 12 months
$10,000	$3.80	$12,500
$16,000	$6.00	$21,000
$25,000	$8.95	$32,500
$35,000	$12.25	$45,000

Dependent Coverage		
Spouse	Each child	Monthly cost
$10,000	$2,500	$3.00
$15,000	$5,000	$4.00
$30,000	$10,000	$8.00
$50,000	$15,000	$13.00

Separation: If you have been insured for 12 consecutive months, you can retain your basic coverage until age 60. You may keep the same amount in force except for the extra increased insurance. You can pay the monthly contribution on a direct bill basis.

Retirement: At retirement, if you have 20 years of service and have been insured for 12 consecutive months, coverage continues in force until age 60 at the same premium. Between 60 - 70 death benefit reduces to $10,000, spouse benefit to $10,000, and dependent children to $2,500. At age 70, death benefit reduces to $5,000, spouse benefit to $5,000, and dependent children remains at $2,500.

Spouse retention: A surviving spouse age 59 or less of an insured member who dies before age 60 can retain the coverage he/she carried as a dependent of the deceased Guard member and may include related coverage on the already insured dependent children at a slightly higher cost.

Both the Basic and Enhanced coverage offer these two great benefits:

- Family survivor college scholarship. Surviving spouse and children are eligible for $10,000 per year, per family, up to a total maximum benefit of $40,000 toward a college degree when member dies in a combat zone as a result of combat action or acts of foreign or domestic terrorism.
- No combat or terrorism exclusions. No geographical area exclusions.

Enhanced Coverage

When you have the maximum coverage in the Basic program, you can purchase additional coverage. The Enhanced program provides affordable term life insurance with a level death benefit and only 3 age bands for contributions.

Affordable life insurance

You can purchase $50,000 of protection for as little as $4 a month if you're under 50 years of age and don't use tobacco products. Contributions increase at each age band as shown below.

No medical exam for Guard members under age 50 applying for up to $250,000 of coverage and ages 50-59 up to $100,000. For spouses, no medical exam under age 40 up to $250,000 and under age 50 up to $150,000. Just complete the enrollment form and answer a few health questions.

Coverage from $50,000 to $400,000

Based on your individual situation, you decide how much coverage is right for you and your family.

Emergency death benefit payment

Emergency death benefit payment of up to $15,000 within one business day of notification to help your loved ones with immediate costs.

Full coverage after retirement or separation

As long as contributions are paid, coverage continues to age 70*. There are no occupation restrictions, so regardless of what you do after the military, you're covered. Regardless of any health issues that may develop in the future, you're still covered. Upon retirement or separation, policy contributions will be paid directly to AFBA rather than through allotment.

Spouse coverage

You can easily purchase coverage for your spouse on the same application.

Monthly Contributions (Male/Female) Non-Tobacco**

Age	$50,000	$100,000	$150,000	$200,000	$250,000	$300,000	$350,000	$400,000
18-49	$4.00	$8.00	$12.00	$16.00	$20.00	$24.00	$28.00	$32.00
50-59	$18.00	$36.00	$54.00	$72.00	$90.00	$108.00	$126.00	$144.00
60-69	$44.00	$88.00	$132.00	$176.00	$220.00	$264.00	$308.00	$352.00

**Tobacco user contributions are two (2) times non-tobacco user contributions. Tobacco user is one who has used any tobacco product in the past 12 months.

Medical Requirements for Current or Former Military Member

	18-39	40-49	50-59
$50,000	●	●	●
$51,000 - $100,000	●	●	●
$101,000 - $150,000	●	●	●
$151,000 - $200,000	●	●	●
$201,000 - $250,000	●	●	●
$251,000 - $300,000	●	●	●
$301,000 - $400,000	●	●	●

Medical Requirements for Non-Military Spouse

	18-39	40-49	50-59
$50,000	●	●	●
$51,000 - $100,000	●	●	●
$101,000 - $150,000	●	●	●
$151,000 - $200,000	●	●	●
$201,000 - $250,000	●	●	●
$251,000 - $300,000	●	●	●
$301,000 - $400,000	●	●	●

● Statement of Health ● Paramed Exam, Blood Profile and Urinalysis ● Paramed Exam, Blood Profile and Urinalysis and Resting EKG

You can provide the protection and peace of mind your loved ones need at affordable rates with AFBA. All active Mississippi National Guard members are eligible to apply. In addition to peace of mind, an AFBA membership gives you access to a wealth of benefits and products designed with your needs in mind.

Visit www.afba.com for complete details on other member benefits.

* After 70th birthday, Enhanced coverage terminates on coverage anniversary date.

Term Insurance Information

Date coverage applied for: ____ / ____ / ____

Total amount of Guard Member coverage applied for: $ _____

Amount of Dependent coverage applied for: $ _____

Amount of Spouse coverage applied for: $ _____

Beneficiary designation: _____

Underwritten by 5Star Life Insurance Company (a Baton Rouge, Louisiana Company)
Offered through Armed Forces Benefit Association (AFBA)
1-800-776-2322 (AFBA)
1-601-354-7555 (NGAMS)

State Unit Code: _____

NGMS515 1

AGENT USE ONLY:
Agent No: NGA01

AFBA USE ONLY:
Source Code: NGAMS
Attachments: ☐☐ Initials: ☐☐

Mississippi
National Guard State Sponsored Life Insurance (SSLI)
Enrollment Form

USE BLACK INK AND PRINT USING ALL UPPER CASE LETTERS.

Guard Member Information

Rank _____ Last Name _____

First Name _____ M.I. ___ D.O.B. _____ ◯ Married ◯ Single

SSN _____ Height ____ FT _____ IN Weight _____ LBS ◯ Male ◯ Female

Branch of Service: ◯ Army ◯ Air Force ◯ AGR Unit/Location _____ Enlistment Date _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ E–Mail _____

Spouse Information

Last Name _____

First Name _____ M.I. ___ D.O.B. _____

SSN _____ Height____ FT _____ IN Weight _____ LBS ◯ Male ◯ Female

Please check coverage desired:

◯ New ◯ Increase ◯ Spouse/Child ◯ Spouse Only ◯ Child ◯ Enhanced only

Basic SSLI Coverage

Guard Member Coverage

◯ $10,000 ◯ $25,000
◯ $16,000 ◯ $35,000

Monthly Deduction

Family Coverage (Spouse/Each Child Over Age 1*/Each Child Under Age 1)

◯ $10,000/$2,500/$1,250 ◯ $30,000/$10,000/$5,000
◯ $15,000/$5,000/$2,500 ◯ $50,000/$15,000/$7,500

Monthly Deduction

*Age one year to 19 years old or 23 if full-time student.

◯ Declined Enhanced SSLI Coverage (Each Applicant must have max Basic coverage before applying for Enhanced)

Guard Member Coverage: The coverage amount shown below will include any existing coverage you have in the Enhanced SSLI program.

◯ $50,000 ◯ $150,000 ◯ $250,000 ◯ $350,000 ◯ Non-Tobacco User**
◯ $100,000 ◯ $200,000 ◯ $300,000 ◯ $400,000 ◯ Tobacco User**

Monthly Deduction

Spouse Coverage: The coverage amount shown below will include any existing coverage you have in the Enhanced SSLI program.

◯ $50,000 ◯ $150,000 ◯ $250,000 ◯ $350,000 ◯ Non-Tobacco User**
◯ $100,000 ◯ $200,000 ◯ $300,000 ◯ $400,000 ◯ Tobacco User**

Monthly Deduction

◯ Declined

**Tobacco user is one who has used any tobacco product in the past 12 months.

Total Monthly SSLI Deduction: $ 0.00

Beneficiary(ies)

Complete Enhanced section if beneficiary(ies) differ from the Basic. Spouse's beneficiary is the Guard Member unless otherwise designated.
If you have additional beneficiaries, please attach a separate 8 1/2 x 11 piece of paper.

Beneficiary(ies) of Guard Member:

	Last Name	First Name	Relationship	DOB (MM/DD/YYYY)	%
Basic					
Enhanced					

Other Insurance

Do you or your spouse have an existing individual life insurance or annuity contract with another company? ◯ Yes ◯ No

If yes, and required in your state, please complete and sign the Notice: Replacement of Life Insurance and Annuity. The Notice must be ***presented*** and ***read*** to you by your insurance representative at the time he/she takes your application.

If approved, will this coverage replace your existing life insurance or annuity contract? ◯ Yes ◯ No If yes, what is the company name for your existing coverage? _____. If yes, and if required, please complete and sign the applicable state-specific Notice: Replacement of Life Insurance and Annuity.

Statement of Health

Answer each question and initial below to acknowledge you've read and, TO THE BEST OF YOUR KNOWLEDGE AND BELIEF, understood each question. 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).

	Applicant Yes	Applicant No	Spouse Yes	Spouse No
I. In the last 10 years, has any Applicant under this application for coverage:				
A. Had a life or health insurance application declined or rated?	◯	◯	◯	◯
B. Been diagnosed or treated by a physician for any of the following: High blood pressure, high cholesterol, cardiac chest pain, heart attack, vascular disease (plaque in arteries), or any heart or blood vessel disorder; cancer or blood disorder; stroke, seizures, progressive neuropathy, or any nervous system disease; shortness of breath, asthma, chronic obstructive pulmonary disease (COPD), or any respiratory tract disorder; ulcers, hepatitis, colitis, disorder of the pancreas, liver, esophagus, stomach, or intestines; depression, schizophrenia, or any mental condition; diabetes, thyroid, pituitary, adrenal, or hormone disorder; disorder of the kidney, bladder, urinary tract, genital tract, or reproductive system; or any significant medical disorders?	◯	◯	◯	◯
II. In the past 5 years, has any Applicant:				
A. Been treated by a physician or medical facility or received professional counseling for alcohol or drug dependency or been advised to reduce or discontinue the use of alcohol?	◯	◯	◯	◯
B. Been convicted for driving under the influence of alcohol or drugs or while intoxicated?	◯	◯	◯	◯
C. Used amphetamines, cocaine, heroin, hallucinogens, barbiturates, marijuana, narcotics or any drug except as medication prescribed by a physician?	◯	◯	◯	◯
III. Has any Applicant 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. List each prescribed medication taken regularly or frequently by any Applicant: _____

Initial Here _____

Conditions Relating to this Enrollment Form

Eligibility: I am eligible to apply for this group life insurance as a Guard Member as defined in the Master Group Policy. **Agreement: I, as Guard Member, have the appropriate knowledge to answer the health questions for my spouse and children.** 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 me 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 hereby authorize any licensed physician; medical practitioner; hospital; clinic; insurance company; employer; Medical Information Bureau (MIB, Inc.); or Motor Vehicle Administration that may have records of my health condition to give 5Star Life Insurance Company, its authorized representative, and its reinsurers any such information. I authorize 5Star Life Insurance Company, or its reinsurers, to make a brief report of health information to MIB, Inc. I understand that this information will be used to determine my eligibility for coverage and that I may revoke this authorization and enrollment form at any time by providing written notice. A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for 24 months from the date below. I (or my authorized representative) am entitled to receive a copy of this authorization. **Signature must be personal.**

Sign Here

Guard Member's Signature _____ Date MM/DD/YYYY

Signed at (City, State) _____

Insurance Rep Certification: I certify that I asked all the questions and had the Applicant sign in my presence.
Is Applicant replacing existing coverage? ◯ Yes ◯ No

Ins Rep Name Allen McDaniel II

Ins Rep Signature _____ Date

NOTE: 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 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)*
☐ 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
$ 0.00

9. NAME OF ALLOTTEE *(First, Middle Initial, Last)*
National Guard Association of Mississippi

10. ALLOTMENT ACTION *(X one)*
☐ START ☐ STOP ☐ CHANGE

11. TERM IN MONTHS

12. CREDIT LINE *(If applicable)*

13. ALLOTMENT CLASS AUTHORIZED *(X one)*
☐ **C** CHARITY CFC
☐ **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 US DELINQUENT STATE OR LOCAL INCOME EMPLOYMENT TAXES
☐ OTHER *(Specify)*

14. ALLOTTEE'S MAILING ADDRESS *(Street or Box Number, City, State, ZIP Code)*
P.O. Box 627
Jackson, MS 39205-0627

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

16. REMARKS

17. COMPANY CODE/FINANCIAL INSTITUTION ROUTING TRANSIT NUMBER

18. ACCOUNT NUMBER POLICY NUMBER
GNG-MS-040113
☐ 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 *(YYYY/MM/DD)*

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.

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The National Guard Association of Mississippi
601-354-7555 ▪ www.ngams.org

AFBA Understands the Military Family

The Armed Forces Benefit Association was established in 1947 with the support of the General of the Army, Dwight D. Eisenhower, to ease the strain on military members and their families during wartime. At that time, service members could not purchase life insurance that would pay a death benefit if the member was killed in a war zone.

From its first offices in the basement of the Pentagon, and for nearly 70 years, AFBA has stood by our country's armed forces. We provide life insurance in both war and peace to those who serve this great nation. Today, we have over 420,000 members with $40 billion of insurance in force and, since 1947, have paid out more than $1.7 billion in claims. With a reputation for unparalleled member service and claims processing, we look forward with pride to serving you and your family.

AFBA and 5Star Life Insurance
1-800-776-2322 ▪ www.afba.com