

Children's Protect



Protecting their future just got easier

Your young children or grandchildren mean the world to you. And you want nothing more than their happiness, safety, and wellbeing. There is an important thing you can do today to protect them for years to come. You can provide life insurance protection and guarantee their insurability regardless of future health changes.

\$50,000 of level term life insurance coverage for \$8.50 per month

Children's Protect level term insurance offered through the Armed Forces Benefit Association (AFBA), makes it easy and affordable to secure a peace of mind.

Monthly contributions for \$50,000 of coverage

Age	Contributions
1-44	\$8.50
45-59	\$17.00
60-69	\$68.00

Plan features:



Available for children
between 1 and 17
years of age



\$50,000 of coverage -
amount is guaranteed
to not decrease



Coverage continues
to age 70 and
cannot be cancelled*



Simplified issue - no medical
exam, simply answer a
few health questions



Rates remain level
until age 45 and after
that, increase per
age band**

About AFBA

For nearly 70 years, AFBA has offered life insurance in both war and peace to those who serve this great nation and their families, including our military, emergency first responders, government employees, and government contractors.

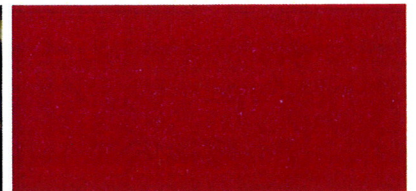
*As long as contributions are paid.

**Contribution rates increase on the anniversary of the coverage effective date after entry into a new age group.

Product is underwritten by F-Star Life Insurance Company (a Baton Rouge, Louisiana company). Product is not available in all states.
LT15 ChildProtect R06/2016

787-273-9160

787-562-1294




 Ins Prod Number:

 2nd Ins Prod Split:

Insurance Producer Market Code:

Insurance Prod Level: Source Code:

INTERNAL USE ONLY:

TPA Code

Pymt Enclosed: ☐ Yes ☐ No ☐ SplitAmt: \$ CC/Checkmatic Auth Rec'd: ☐ Yes ☐ NoAttachments: Initials: 

CT 314 1

Children's Group Level Term Life Insurance Application

USE BLACK OR BLUE INK AND PRINT USING ALL UPPER CASE LETTERS.

Insured Child's Information

Last Name:
☐ Male
☐ Female
First Name: M.I. D.O.B. / /

Month Day Year

Address Line 1: Address Line 2: City: State: Zip: - SSN: - - Is the child a United States citizen? ☐ Yes ☐ No

Coverage and Payment Method

<input type="radio"/> Monthly Credit Card	0	<input type="radio"/> Semi-Annual Bill	6
<input type="radio"/> Monthly Checkmatic	0	<input type="radio"/> Annual Bill	12
<input type="radio"/> Monthly Allotment	2	<input type="radio"/> Payroll	0
<input type="radio"/> Quarterly Bill	3	<input type="radio"/> List Bill*	0

\$50,000 for \$8.50 a month

Monthly Contribution	\$8.50	x	Recurring Contribution Value**	=	Amount payable to AFBA.
					\$ <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>

* If List Bill selected, complete Employer Tax ID #:

 -

** See value after payment method.

Sponsor/Owner/Payor

SSN: - - Name: Address: City, State, Zip: Phone No.:

Relationship to child: (Choose only one)

- ☐ Parent
☐ Step-parent
☐ Grandparent
☐ Legal Guardian
☐ Other

Email: If Contingent Owner is desired, check here ☐ and a form will be sent to the Owner. If not, the Contingent Owner will be the Sponsor.



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BeneficiaryCheck here ☐ if you would like an additional beneficiary form sent to you.

First Name

Last Name

SSN

Relationship to Child

DOB

Other Insurance**Answer only if this is an agent or broker initiated sale:**Does the child have any existing life insurance or annuity contracts with another company? ☐ Yes ☐ NoIf yes, and the child lives in AK, AL, AR, AZ, CO, IA, KS, KY, LA, MD, ME, MS, MT, NC, NE, NH, NJ, NM, OH, OR, RI, SC, TX, UT, VA, VT, WI or WV please complete and sign the Notice: Replacement of Life Insurance and Annuity. The Notice must be **presented** and **read** to you by your agent at the time he/she takes your application.If approved, will this coverage replace any existing life insurance or annuity contracts? ☐ Yes ☐ No

If yes, what is the company name, address, and policy number of the child's existing coverage? _____

If yes, and the child does not live in the above listed states, please complete and sign the applicable state-specific Notice: Replacement of Life Insurance and Annuity.

Statement of Health**Answer each question and initial in box 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 in the section below.**Child's Height Ft In Child's Weight LbsSponsor/Owner/Payor's
Initials Here _____I. Has the child been diagnosed, treated, or prescribed medication by a member of the medical profession for specified symptoms such as: heart trouble, elevated blood pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotherapeutic treatment, epilepsy, respiratory disorder, kidney or liver disorder (including hepatitis), enlarged lymph nodes or immune deficiency disorder, thyroid disorder, blood disorder, albumin, blood or sugar in urine, back trouble/disorder, arthritis, or unexplained weight loss? ☐ Yes ☐ No

II. List each prescribed medication the child takes regularly or frequently: _____

III. Has the child been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ NoIV. Has the child proposed for insurance received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs? ☐ Yes ☐ No

Details: _____

Conditions Relating to this Application**Agreement:** I represent that all statements and answers in this application are complete, true and correctly recorded **TO THE BEST OF MY KNOWLEDGE AND BELIEF**. I agree that: 1) upon approval of this application by 5Star Life Insurance Company, it, and the certificate will constitute the entire insurance contract; 2) except as provided, **insurance applied for will not become effective until approved by 5Star Life Insurance Company and is subject to the child's health being as described in this application, and upon receipt of the full contribution in which case the coverage shall take effect as of the effective date as shown in the certificate;** 3) if within 60 days of receipt of all required documentation this application is not approved, it will become void and all contributions paid will be refunded; I will be so notified. **Signatures must be personal:**Sign Sponsor/Owner/ _____ Date MM/DD/YYYY
Here Payor (Parent, step-parent, grandparent, legal guardian, other)Signed at (City) _____ (State)

Insurance Producer Name _____

Insurance Producer Signature _____

Date MM/DD/YYYY _____

Note: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony, and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (\$5,000) dollars and not more than ten thousand (\$10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.Not available in all states • Administrative Office: 909 N. Washington St, Alexandria, VA 22314 • 1-800-776-2322 • www.afba.com
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8/16