National Guard State Sponsored Life Insurance (SSLI) Enrollment Form

Provided through Armed Forces Benefit Association (AFBA)
Multi-Association Group Insurance Alliance Trust (MAT)

AFBA

Tell us about yourself

Guard Member Name (Last, First, Middle) | Guard Member Social Security Number (SSN) | Guard Member Date of Birth

Mailing Address (Street, City, State, Zip) | City | State | Zip

Preferred Phone Number | Email Address | Membership Status with the Wisconsin National Guard ❒ Active ❒ Separated/Retired

Height _____ ft _____ ins Weight _____ lbs ❒ Male ❒ Female ❒ Army ❒ Air-Milwaukee ❒ Air-Madison/Volk

Spouse Name (Last, First, Middle) | Spouse Social Security Number (SSN) | Spouse Date of Birth

Height _____ ft _____ ins Weight _____ lbs ❒ Male ❒ Female Number of Dependent Children _____

Child 1 Name (Last, First, Middle) | Date of Birth (MM/DD/YYYY)

Child 2 Name (Last, First, Middle) | Date of Birth (MM/DD/YYYY)

Child 3 Name (Last, First, Middle) | Date of Birth (MM/DD/YYYY)

Child 4 Name (Last, First, Middle) | Date of Birth (MM/DD/YYYY)

Member Benefit

Coverage ❒ **$1,000 (Non-contributory), coverage paid for by WINGA.** ❒ New Enrollment ❒ Change

Guard Member		Spouse			Dependent(s)	
❒ $10,000	❒ $30,000	❒ $5,000	❒ $20,000	❒ $35,000	❒ $5,000	❒ $15,000
❒ $15,000	❒ $35,000	❒ $10,000	❒ $25,000	❒ $40,000	❒ $10,000	❒ $20,000
❒ $20,000	❒ $40,000	❒ $15,000	❒ $30,000	❒ $45,000		
❒ $25,000	❒ $45,000	**Spouse and/or Dependent total coverage amount cannot exceed Member's coverage amount.*				

In no event may the total coverage applied for exceed the maximum plan benefit of $45,000. If a husband and wife are both members of the Wisconsin National Guard, both may apply for member coverage. If both apply for member coverage, neither may apply for spouse (stand alone) coverage.

Beneficiary Information A Beneficiary is the person who is designated to receive the benefit, typically a spouse, child, or parent.

Name (last, first) | Relationship | Date of Birth

Statement of Health

	Member: Yes	Member: No	Spouse: Yes	Spouse: No
I. In the last 5 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?	❒	❒	❒	❒

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Benefits underwritten by 5Star Life Insurance Company (a Lincoln, Nebraska company). Not available in all states.

Statement of Health (cont'd)

	Member: Yes	No	Spouse: Yes	No
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 ever been diagnosed or treated by a physician Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)? (The Applicant need not reveal HIV test results received from an anonymous counseling and testing site or the results of a home test kit).	❒	❒	❒	❒

IV. List each prescribed medication taken regularly or frequently by any Applicant: _____

If you answered "yes" to any of the Statement of Health questions, please give details below and on an additional sheet if needed.

Nature of Illness, Injury or Operation	Date(s) of Treatment	Remaining Effects	Name and Address of Doctors and Hospitals

Read This Information Carefully, Then Sign and Date Below

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 (5Star Life), 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); or Motor Vehicle Administration that has information relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, history of DUI/DWI, alcohol misuse or drug use, medical impairments, yearly driving violations or habitual offender, to provide this information to 5Star Life to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I authorize 5Star Life, or its reinsurers, to make a brief report of health information to MIB. 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 30 months from the date below or the duration of the claim. I (or my authorized representative) am entitled to receive a copy of this authorization.

Acknowledgment: I acknowledge that 5Star Life, any of its administrators, or the group policyholder has the right to cancel coverage if the member account is in arrears longer than six (6) months.

Signature must be personal.

Guard Member's Signature_____ Date_____

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.

For more information visit: www.winga.org/insurance.html
Admin.office: WINGA Insurance Plan (SSLI)
2400 Wright St., Room 162, Madison, WI 53704-2572
P (608) 242-3100 | F (608) 242-3106
email: insinfo@winga.org

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