STARMOUNT

Underwritten and Administered by: **Starmount Life Insurance Company**
8485 Goodwood Boulevard • PO Box 98100 • Baton Rouge, LA 70898-9100 • 1-888-729-5433

Individual Insurance Application

❑ **Dental** ❑ **Dental with Vision Rider**

Plan Selected: _____

Coverage Tier: ❑ Individual ❑ Individual & Children ❑ Individual & Spouse ❑ Individual & Family

Applicant Information:

Applicant's Name: _____ Gender: ❑ M ❑ F Date of Birth ___/___/_____

Address/Apt: _____ Last Four Digits of SSN: _____

City: _____ Phone:Primary (Required) (____) _____-_____ Secondary (____) _____-_____

State: _____ Zip Code: _____-_____ Email Address: _____

I agree to receive my policy and all communications regarding my policy and benefits electronically. If my email address changes I will notify Starmount. This authorization may be revoked by calling 888-400-9304 or writing to 8485 Goodwood Blvd, Baton Rouge, LA 70806. ❑**Yes** ❑**No**

Do you have any other dental insurance in force with another company? ❑**Yes** ❑**No**
If Yes, Company Name_____ Policy Number_____

Do you intend to replace any other insurance now in force? ❑**Yes** ❑**No**

Spouse or Lawful Domestic Partner Information (If insured):

Name: Last First MI DOB: MM/DD/YYYY ❑ M ❑ F

Dependent Information (If insured):

Child's Name – Last, First, MI	**DOB** (MM/DD/YYYY)	**Gender**	**Relationship**	**Check if:**
		❑ M ❑ F	❑ Son ❑ Stepson ❑ Daughter ❑ Stepdaughter ❑ Other _____	❑ Handicapped Child
		❑ M ❑ F	❑ Son ❑ Stepson ❑ Daughter ❑ Stepdaughter ❑ Other _____	❑ Handicapped Child
		❑ M ❑ F	❑ Son ❑ Stepson ❑ Daughter ❑ Stepdaughter ❑ Other _____	❑ Handicapped Child
		❑ M ❑ F	❑ Son ❑ Stepson ❑ Daughter ❑ Stepdaughter ❑ Other _____	❑ Handicapped Child

* If dependent is not your natural child, attach documentation of legal custody or adoption. If coverage is court ordered, attach a copy of the order.

Payment Information:

❑ Deduct premium payments from my account automatically. (Please attach a voided check to this application) ❑ Checking ❑ Savings

Bank Name:_____ Account #:_____ Routing #: __ __ __ __ __ __ __ __ __ Name on Account:_____

❑ Charge future payments to: ❑ VISA ❑ MasterCard Credit Card # |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| Expiration Date: MM/YY

Payment Frequency: ❑ Every month ❑ Every 12 months

Applicant Statements and Agreements:

1. I understand that the effective date of the policy will be the date recorded in the Policy Schedule of Benefits by Us.
2. I understand the policy I am applying for may contain different Waiting Periods for certain benefits listed in the Policy Schedule of Benefits. This means that no benefits are payable during the listed Waiting Period. The Waiting Period begins on the effective date of coverage.
3. I understand that: (a) Starmount Life Insurance Company is not bound by any statement made by me, the applicant, or any associate/agent of Starmount Life Insurance Company unless written herein. (b) The associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (c) The policy together with this application, endorsements, benefit agreements and riders, if any, is the entire contract of insurance. (d) No change to the policy will be valid until approved by Our president and secretary, and noted in or attached to the policy.

Application continued on other side. Please read, sign and date where indicated.

Individual Insurance Application

Notice of Information Practices:

This notice applies only in Georgia, Illinois, Maine, Minnesota, Montana, Nevada, and Oregon. To issue an insurance policy, We may need to obtain additional information about You and any other persons proposed for insurance. Some information will come from You and some may come from other sources. That information and any other subsequent information collected by Us may in some circumstances be disclosed to third parties without Your specific consent. You have the right to access and correct the information collected about You except information that relates to a claim or to a civil or criminal proceeding. If You wish to have a more detailed explanation of Our information practices, please submit a written request to Us.

Authorization to Obtain Information:

I authorize the following to give information (defined below) to Starmount Life Insurance Company or any person or group acting on their part: any medical professional, any medical care institution, insurer, reinsurer, consumer reporting agency or employer. "Information" means facts of a medical nature in regard to my physical condition, employment, or other insurance coverage, or any other nonmedical facts. I understand that this information will be used by Starmount Life Insurance Company to determine eligibility for insurance and may be used to evaluate a claim for benefits during the time it is valid. I agree that this authorization is valid for 30 months from the date signed. In MN, this authorization is valid as long as the applicant is continually insured with the insurer. I understand that I may revoke this authorization at any time by sending a written revocation to Starmount Life Insurance Company, 8485 Goodwood Blvd., Baton Rouge, LA 70806-7878. Such revocation will not affect any action taken or information released prior to the revocation, and will not affect any legal right the Company has to contest an insurance policy, or to contest a claim under an insurance policy. I understand that if I revoke this authorization, the Company may not be able to process my application, and may not be able to make any benefit payments due under the policy, or other binding agreement. I understand that once this information is received by the authorized person/organization, then this information may be subject to re-disclosure, and may no longer be protected by federal privacy laws. I agree that a copy of this authorization is as valid as the original. I know that I (or my designated representative) have a right to receive a copy of this authorization upon request.

I understand that the premium amount listed on the rate chart represents the modal (monthly, quarterly, semi-annual or annual) premium for my coverage. If I am purchasing coverage directly from Starmount, my modal premium will be deducted from my bank account or my credit card account designated by me. If my bank or credit card account changes, I will notify Starmount and provide new account information needed to keep my coverage in force.

I also understand that if I am receiving any Medicaid benefits, the purchase of this coverage may not be necessary.

If I am applying to replace existing coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand that by replacing existing coverage I am terminating my current policy and its benefits for the benefits provided in the Starmount Life Insurance Company Policy. I have read, or had read to me, the completed application, and I realize policy issuance is based upon statements and answers provided herein, and they are complete and true to the best of my knowledge and belief.

Fraud Statement: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed and Dated (City, State)_____ on (Date) _____

Applicant's Signature_____

Associate/Agent's Name Lani Corriveau Agent Code: N1994

General Agent/Managing General Agent (if applicable): _____