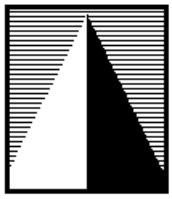
Starmount Life Insurance Co.
7800 Office Park Boulevard
Baton Rouge, LA 70809-7603
1-888-SAY-LIFE
(that's 1-888-729-5433; in Baton Rouge, call 926-2888)

STARMOUNT DENTAL

Underwritten by Starmount Life Insurance Company

Enrollment Form

Please print and complete <u>all</u> sections. See instructions below.



EMPLOYER/EMPLOYEE INFORMATION **A: Add (enroll) T: Terminate C: Change (change of name or coverage)**

Employer Name	Group Number	Location	Effective Date *	Date of Hire

☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth	Social Security Number

Home Street Address	City/State/Zip	Home Phone	Work Phone
		( )	( )

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name or coverage)

☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name	First Name	M.I.	Date of Birth	
☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth	
☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Child unmarried and full-time student? Yes No
☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Yes No
☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Yes No
☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Yes No
☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Yes No

NOTE: Coverage for a Late Entrant or Re-enrollee will be limited to those procedures listed under **Coverage A** in the Schedule of Covered Procedures during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date. This limited coverage also applies to the Late Entrant's or Re-enrollee's Dependents, if enrolled.

*For existing personnel, the "effective date" is shown on your group's monthly statement. New hires must join within the applicable waiting period.

Do you or any of your dependents have other dental insurance? ☐ Yes ☐ No

If yes, please give: Policyholder_____ and Insurance Company _____.

Employee Signature: _____ Date: _____

I elect the following coverage(s):

☐ **Dental**

- ☐ Employee Only _____
- ☐ Employee & Spouse _____
- ☐ Employee & Child(ren) _____
- ☐ Employee & Family _____
- ☐ Waived

Declination of coverage must be accompanied by the employee's signature above.

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.