



STARMOUNT LIFE INSURANCE

GROUP TERM LIFE INSURANCE

Enrollment/Change Form

Please print and complete all sections. See instructions below.

EMPLOYER INFORMATION

Employer Name	Group Number	Date of Hire	Effective Date
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EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

<input type="checkbox"/> A	<input type="checkbox"/> T	<input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth	Social Security Number
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Home Street Address	City/State/Zip	Home Phone () ()	Work Phone () ()
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FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

<input type="checkbox"/> A	<input type="checkbox"/> T	<input type="checkbox"/> C	Student <input type="checkbox"/> Y <input type="checkbox"/> N	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (spouse)	First Name	M.I.	Date of Birth	Social Security Number
<input type="checkbox"/> A	<input type="checkbox"/> T	<input type="checkbox"/> C	Student <input type="checkbox"/> Y <input type="checkbox"/> N	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
<input type="checkbox"/> A	<input type="checkbox"/> T	<input type="checkbox"/> C	Student <input type="checkbox"/> Y <input type="checkbox"/> N	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
<input type="checkbox"/> A	<input type="checkbox"/> T	<input type="checkbox"/> C	Student <input type="checkbox"/> Y <input type="checkbox"/> N	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
<input type="checkbox"/> A	<input type="checkbox"/> T	<input type="checkbox"/> C	Student <input type="checkbox"/> Y <input type="checkbox"/> N	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
<input type="checkbox"/> A	<input type="checkbox"/> T	<input type="checkbox"/> C	Student <input type="checkbox"/> Y <input type="checkbox"/> N	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number

Amount of Insurance

	Life Coverage	Cost/\$1000
Employee	\$ _____	\$ _____
Spouse	\$ _____	\$ _____
Children	\$ _____	\$ _____

Designated Beneficiary:

Name _____	Rel. _____	_____ %
Last First MI		
Name _____	Rel. _____	_____ %
Last First MI		
Name _____	Rel. _____	_____ %
Last First MI		

Contingent Beneficiary: ESTATE or

Name _____ Rel. _____

Employee Signature: _____ **Date** _____

Instructions

Employer name: Legal name of the employer.
Group Number: Provided by Starmount Life Insurance Co.
Location code: Optional field for employers to track multiple locations.
Effective date: Date set by employer in accordance with Starmount Life Insurance Co. Employer also sets effective date for new adds during contract period.
Student: Refers to those dependents as defined in the Policy who are Full Time students.

Family Information: List only eligible family members who are enrolling. Dependent eligibility is the same as employer's health plan.
(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of name, employee address or employee phone.
Supplemental Coverage: Must fill out attached questionnaire for amounts in excess of the group's guaranteed-issue maximum.