Starmount Life Insurance Company

7800 Office Park Blvd., Baton Rouge, LA 70809 (225) 926-2888

Evidence of Insurability Form for Group Insurance

(Over Maximum Issue Amount and Late Entrants)

(For home office use only)
Group Policy Number:_____ Certificate Number:_____

1. Your full name:_____ ☐ Male ☐ Female

2. Physician:_____ Physician's Phone:_____

   Physician Address:_____

3. Employed by:_____ Date Employed:_____

4. Are you now working at least 30 hours per week with your present employer? ☐ Yes ☐ No

PERSONAL DATA

5. Give the following details about: Spouse's full name:_____

a. yourself, if you are giving a statement of insurability:

Date of Birth	Place of Birth	Height	Weight
		Ft. In.	Lbs.

b. your spouse, if she or he is giving a statement of insurability:

Date of Birth	Place of Birth	Height	Weight
		Ft. In.	Lbs.

6. **<u>Anyone applying for Coverage Must Answer These Questions</u>**: Have you had, scheduled or been advised to have any medical or surgical examination or current treatment for any disorder, injury or sickness during the past 5 years, or do you now have any impairment, disorder or disease? Have any self-administered tests not been normal? Do you have any medical conditions for which you have not consulted a doctor? (If yes, please explain.) **Main Insured** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No

_____

_____

INSURABILITY QUESTIONS

7. HAVE YOU EVER HAD OR BEEN TREATED FOR: (Circle specific disorders experienced.)

	Main Insured		Spouse	
	Yes	**No**	**Yes**	**No**
a. Heart trouble or murmur, chest pain, rheumatic fever, high blood pressure, stroke?	☐	☐	☐	☐
b. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury?	☐	☐	☐	☐
c. Arthritis, gout, bursitis or rheumatism?	☐	☐	☐	☐
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears?	☐	☐	☐	☐
e. Disease or disorder of rectum or anus? Varicose veins or other vascular disorder?	☐	☐	☐	☐
f. Diabetes? Sugar, albumin or pus in urine? Thyroid or other glandular disorder? Any disease of the blood?	☐	☐	☐	☐
g. Duodenal or stomach ulcer, or other disorder of stomach, liver, gall bladder? Colitis, diverticulitis, or other disorder of small or large intestine?	☐	☐	☐	☐
h. Prostate disorder? Kidney stones or colic, nephritis, nephrosis or other kidney disorder? Urinary infection?	☐	☐	☐	☐
i. Menstrual, uterine or ovarian disorder? Disorder of the breast?	☐	☐	☐	☐
j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting or other disorder of lung or nose? Asthma?	☐	☐	☐	☐
k. Cancer or other tumor? Deformity or loss of limb? Congenital defect?	☐	☐	☐	☐
l. Mental or emotional problem or depression requiring help of a physician or psychologist?	☐	☐	☐	☐
m. A surgical operation? A surgical operation advised but not performed?	☐	☐	☐	☐
n. Tested positive for exposure to the HIV infection or been diagnosed as having AIDS or ARC caused by the HIV infection?	☐	☐	☐	☐
o. Alcoholism, a drug habit or taken illegal drugs, been ticketed for DWI or DUI, or had a felony conviction?	☐	☐	☐	☐

8. Have you had an application for life or health insurance rated, postponed, or modified? ☐ Yes ☐ No

I have read the above questions and declare the answers are complete and true. I agree the answers will form a part of my insurance certificate and the insurance will not be in force until this application has been approved by Starmount Life Insurance Company and the certificate issued and delivered to me when I am in the same health condition as described above, subject to all conditions set forth in the policy and the first premium paid. AUTHORIZATION: I authorize any physician, medical practioner, hospital, clinic or other medical related facility, insurance company, the Medical Information Bureau or other organization or person that has any records of me, my health, or any member of my family to give STARMOUNT LIFE or its reinsurers any such information. This includes knowledge about drug abuse, alcoholism, or mental illness. Although information about drug or alcohol abuse may be protected by government regulations, I allow Starmount to collect it to determine insurability. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty (in Ohio, is guilty of insurance fraud) (in Arkansas, is guilty of a crime and may be subject to fines and confinement in prison) of a felony of the third degree. This authorization is valid for 30 months. A copy is as valid as the original.

(Date Signed)	(Signature of Employee/Member)
(Date Signed)	(Signature of Spouse, if giving a statement of insurability)

Owner and persons proposed for insurance. Please read:
By submitting this application I acknowledge the following: I have read the questions on this form and declare the answers are complete and true. I agree the answers will form a part of the policy and the insurance shall not be in force until this application has been approved by Starmount Life Insurance Company, and the certificate is issued and delivered to me when I am in the same health condition as described above, subject to all conditions set forth in the policy, and the first premium paid.

AUTHORIZATION: I hereby authorize those care providers and medical treatment facilities having previously administered health care to me or any member of my family to be insured, to release to Starmount Life Insurance Company copies of all recorded medical data. I also authorize other insurers, reinsurers, consumer reporting firms and medical information bureaus to make similar reports for the purpose of evaluating insurability and that only one life insurance certificate will be issued by the insurer. I understand that either my authorized representative or I am entitled to a copy of the authorization and of the information obtained, that this authorization will expire 30 months from this date and a photostatic copy thereof will be as valid as the original.

Medical Information Bureau Disclosure Notice
Information regarding your insurability will be treated as confidential. Starmount Life, or its reinsurers, may, however, make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. Starmount Life or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Notice of Insurance Information Practices
Personal information about you or members of your family who are to be insured may be collected from other persons. This information as well as other personal or privileged information subsequently collected by the Company or its agent may in certain circumstances be disclosed to third parties without authorization. You have a right of access and correction with respect to all personal information requested. You may write the Company at the address shown to obtain additional information regarding information practices.

Starmount Life Insurance Company, The Starmount Building 7800 Office Park Blvd
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