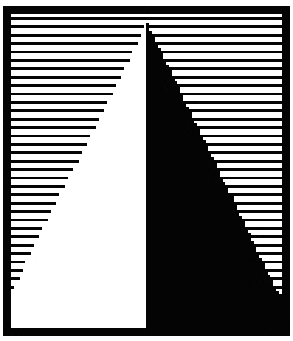

AlwaysCare
Flexible Dental & Vision Benefits
(a Starmount Life Insurance company)

P.O. Box 98100
Baton Rouge, LA 70898
PH: (225) 926-2888 x 2013
Local Fax: 225-929-7288
Toll Free Fax: 888-843-5872

FAX:

To:		From:	
Fax:		Phone:	
Pages:		Date:	
Re:	Enrollment Forms		

Please review your information, make sure all is complete, and fax the signed copy to fax number (225) 610-1403.

If we receive an eligible application by the 15th of the month, it will have a coverage effective date of the first day of the following month.

Please keep a copy of your paperwork for your records.

Thank You.

AlwaysCare
Flexible Dental & Vision Benefits

Dental & Vision Insurance Application

1. Complete all areas in the application form below. Please be sure to read all information fully and sign where indicated on the back.
2. Indicate Dental and/or Vision coverage desired.

Starmount Life Insurance Company

The Starmount Building • 7800 Office Park Boulevard • Baton Rouge, LA 70898-7603 • 1-888-729-5433

To Be Completed by Applicant:

Applicant's Name: _____
(Last, First, Middle Initial)

Applicant's Address: _____ _____
(Street or Post Office Box) (Apartment Number)

City:_____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ MM/DD/YYYY ☐ Male ☐ Female Last 4 Digits of Applicant's Social Security Number: _____

Name of Spouse (if to be insured): _____
(Last, First, Middle Initial)

Spouse Date of Birth: _____/_____/_____ MM/DD/ YYYY ☐ Male ☐ Female Home Telephone Number: (_____) _____

Email Address: _____ Is it OK to email your policy? ☐ Yes ☐ No

Check Coverage Desired:

DENTAL
- ☐ Employee $_____
- ☐ Employee + Spouse $_____
- ☐ Employee + Children $_____
- ☐ Employee Family $_____

VISION BASIC
- ☐ Employee $_____
- ☐ Employee + One $_____
- ☐ Employee Family $_____

VISION ENHANCED
- ☐ Employee $_____
- ☐ Employee + One $_____
- ☐ Employee Family $_____

To Be Completed for Each Dependent Child (if to be insured):

CHILD'S NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH (MM/DD/YYYY)	GENDER	CHECK IF:
		☐ Male ☐ Female	☐ Handicapped Child ☐ Full-Time Student
		☐ Male ☐ Female	☐ Handicapped Child ☐ Full-Time Student
		☐ Male ☐ Female	☐ Handicapped Child ☐ Full-Time Student
		☐ Male ☐ Female	☐ Handicapped Child ☐ Full-Time Student
		☐ Male ☐ Female	☐ Handicapped Child ☐ Full-Time Student
		☐ Male ☐ Female	☐ Handicapped Child ☐ Full-Time Student

Do You have any other dental insurance in force with another company? ☐ Yes ☐ No
If yes, please give the Policyholder and the Insurance Company: _____
Is this insurance intended to replace any other insurance now in force? ☐ Yes ☐ No **(Over, please)**

APPLICATION CONTINUED ON OTHER SIDE. PLEASE READ, SIGN AND DATE WHERE INDICATED.

For questions call 1-888-729-5433 ext. 2013

Applicant's Statements and Agreements:

1. I understand the effective date of the policy will be the date recorded in the Policy Schedule of Benefits by Us.
2. I understand the Dental policy I am applying for contains 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 dependent children, if any, will be covered until the end of the month following their 21st birthday (24th if full-timestudents).
4. I acknowledge receipt of, if applicable: ☐ Outline of Coverage.
5. 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.

Notice of Information Practices:

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. This notice applies only in Arizona, California, Georgia, Illinois, Maine, Minnesota, Montana, Nevada, North Carolina, Oregon and Virginia.

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, government agency, consumer reporting agency or employer. "Information" means facts of a medical nature in regard to my physical or mental 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. I know that I have a right to receive a copy of this authorization upon request. I agree that a copy of this authorization is as valid as the original.

I understand that the premium amount listed on this application represents the premium amount that either my employer will remit to Starmount Life Insurance Company on my behalf, or I will remit directly to them. I further understand that this amount, because of my employer's billing/payroll practices, may differ from that amount being deducted from my paycheck or the premium amount quoted to me by my associate/agent.

I also understand that if I am receiving 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 and agree that 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. I understand that 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 at _____ **on** ____/____/____
(City and State) (Date)

Applicant's Signature: ☒ _____

Starmount Authorized Signature: _____ Agent Number: _____

SED-4 (R 01/10)

Starmount Life

State of Louisiana Employee Payroll Deduction Authorization

Employee Name	Soc. Sec. No.	Employee No. (for agency use)

Agency No.	Department/Agency/Section Name

I hereby authorize my employer to deduct a total of $_____, monthly rate, from my salary until further notice and remit same to **Starmount Life**. A TOTAL Semi-Monthly Deduction in the amount of $ _____ represents one half of the total monthly premium required for the coverage(s) detailed below.

The Office of State Uniform Payroll and the employing agency are **not** representatives or agents of the employee or the vendor. It is the responsibility of the **employee** to notify each vendor he/she has a payroll deduction with of address and/or name changes. It is solely the responsibility between the **employee and the vendor** to ensure that the amount of any payroll deduction is correct and is properly credited to the appropriate policy. Cancellation of a policy must be submitted by the employee in a written request to **both** the vendor **and** his/her agency's payroll office. An employee signed SED-4 stopping the deduction may be required before the deduction can be stopped in the ISIS HR payroll system. Statewide vendor deductions that are not taken due to an employee being on LWOP, not being due any wages, or not being paid enough wages to take the deduction **are the employee's responsibility** to pay directly to the vendor. Payments made outside of the payroll system are not pre-taxed. By signing this form, both the employee **and** the vendor representative acknowledge that the statements in this section have been read, are understood and are agreed upon.

DEDUCTION DETAIL (Product Names & Codes, 125 Eligible, Premium Amts.) MENU ELECTIONS

PRODUCT NAME	PLAN PART CD	PLAN PART YES	PLAN PART NO	125 ELIG	MO PREM.	PAYROLL CODE	INELIGIBLE & NON-PART Semi-Mo.	ELIGIBLE PART Semi-Mo.
Dental	17		N	Y	$	**NA**	$	
Dental	17	P		Y	$	**PA**		$
Vision	40		N	Y	$	**NB**	$	
Vision	40	P		Y	$	**PB**		$

	Total Mo. Prem.	$	
PP Begin Date	Total Semi-Mo. **Ineligible**		
	Total Semi-Mo. **Non-Part**.	$	
Date Authorized	Total Semi-Mo. **Part.**		$

By:

Employee Signature

TOTAL SEMI-MONTHLY $

*Applications must be received by the 15th of the month in order to have an effective date for the 1st of the following month. If applications are received after the 15th of the month, your effective date will be delayed until the 1st of the 2nd following month. (Example: Receive application between 5/16-6/15, effective date is 7/1; receive application between 6/16-7/15, effective date is 8/1.)

(THIS FORM SUPERSEDES AND REPLACES ALL OTHER AUTHORITY FOR DEDUCTIONS FOR THIS VENDOR)

Presentation and deduction authorization processed by:

Starmount Life Representative Phone Date

PO Box 98100 Baton Rouge, LA 70898

Address

PLEASE REMEMBER TO SIGN AT THE ⌦ ON EACH SIDE OF THIS SHEET!!