

SERFF Tracking Number: STAR-125907660 State: Arkansas  
Filing Company: Starmount Life Insurance Company State Tracking Number: 40984  
Company Tracking Number:  
TOI: H03I Individual Health - Accidental Death & Dismemberment Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment  
Product Name: AD&D application  
Project Name/Number: /02-005 AD&D APP (Rev 10-08)

## Filing at a Glance

Company: Starmount Life Insurance Company

Product Name: AD&D application SERFF Tr Num: STAR-125907660 State: ArkansasLH

TOI: H03I Individual Health - Accidental Death & Dismemberment SERFF Status: Closed State Tr Num: 40984

Sub-TOI: H03I.000 Health - Accidental Death & Co Tr Num: State Status: Approved-Closed  
Dismemberment

Filing Type: Form Co Status: Reviewer(s): Rosalind Minor  
Authors: Belle Lucas, Natka Varisco Disposition Date: 12/03/2008  
Date Submitted: 12/01/2008 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

## General Information

Project Name: Status of Filing in Domicile: Pending  
Project Number: 02-005 AD&D APP (Rev 10-08) Date Approved in Domicile:  
Requested Filing Mode: Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Individual  
Submission Type: New Submission Group Market Size:  
Overall Rate Impact: Group Market Type:  
Filing Status Changed: 12/03/2008  
State Status Changed: 12/03/2008 Deemer Date:  
Corresponding Filing Tracking Number:  
Filing Description:  
RE: STARMOUNT LIFE INSURANCE COMPANY, NAIC#68985  
FORM NO. 02-005 AD&D APP (Rev 10-08)

Dear Sirs:

<i>SERFF Tracking Number:</i>	<i>STAR-125907660</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Starmount Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>40984</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H03I Individual Health - Accidental Death &amp; Dismemberment</i>	<i>Sub-TOI:</i>	<i>H03I.000 Health - Accidental Death &amp; Dismemberment</i>
<i>Product Name:</i>	<i>AD&amp;D application</i>		
<i>Project Name/Number:</i>	<i>/02-005 AD&amp;D APP (Rev 10-08)</i>		

The enclosed application 02-005AD&D APP (Rev 10-08) is being re-filed to replace form number 02-005AD&D APP R6 originally approved on April 30, 2008. This form will be used with policy numbers 02-005AR which was revised with 02-005AR R-1/04 and 02-003AR which was revised with 02-003AR R-1/04. The changes made to the application are as follows:

1. Removal of the statement requesting the last four digits of the applicants Social Security number. This is listed twice for the Main Insured and the Spouse.
2. Requesting the cell phone number of the applicant as an alternative to their work number. (Work or Cell).
3. Changing the way the possible exclusions are listed on the second page of the application. Instead of listing what all of the states specifically allow, we are simply listing any possible exclusions that may be on the policy. We then state "Please see your policy for exclusions specific to your state."
4. Adding question-"Are you employed?" for Main Insured and Spouse to complete.
5. Adding state specific language required from other states.

In addition to marketing by direct mail, this form will be placed on our website for applicants to complete. We look forward to receiving our approved form. If you need any further information, you may call me at 1-225-926-2888, x-282 or bellel@starmountlife.com.

## Company and Contact

### Filing Contact Information

Belle Lucas, Compliance Specialist  
P.O. Box 98100  
Baton Rouge, LA 70898

bellel@starmountlife.com  
(225) 926-2888 [Phone]

### Filing Company Information

Starmount Life Insurance Company  
7800 Office Park Boulevard  
Baton Rouge, LA 70809  
(225) 926-2888 ext. [Phone]

CoCode: 68985  
Group Code: 68985  
Group Name:  
FEIN Number: 72-0977315  
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State of Domicile: Louisiana  
Company Type:  
State ID Number:

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$100.00  
Retaliatory? Yes  
Fee Explanation:  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Starmount Life Insurance Company	\$100.00	12/01/2008	24218246

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/03/2008	12/03/2008

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*Product Name:* AD&D application  
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## **Disposition**

Disposition Date: 12/03/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	No
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Form</b>	AD&D application	Approved-Closed	Yes

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## Form Schedule

**Lead Form Number:** 02-005 AD&D (Rev 10-08)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	02-005	Application/	AD&D application	Initial		49	02-005 AD&D APP (rev 10-08).pdf
		AD&D APP Enrollment					
		(Rev 10-08)Form					

# ACCIDENT INSURANCE APPLICATION FORM

**YES!**  Please enroll me for the Expanded Accidental Death & Dismemberment Protection and include the \$1,000.00 Accidental Death Insurance at **NO COST TO ME!**

**Choose one:**  Main Insured Only **Choose one:**  \$50,000.00 for \$5.50 per month  \$100,000.00 for \$11.00 per month  
 Family Plan  \$150,000.00 for \$16.50 per month  \$250,000.00 for \$27.50 per month

**YES**  (For Main Insured only.) Please only sign me up for \$1,000.00 of Basic Accidental Death Insurance Protection at no cost to me. Lasts one full year.

**PLEASE COMPLETE THE FOLLOWING:**

Main Insured: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home (\_\_\_\_\_) \_\_\_\_\_ (required)

Work or Cell (\_\_\_\_\_) \_\_\_\_\_

Are you employed?  Yes  No

Occupation: \_\_\_\_\_  
(if self employed, explain)

Sex:  M  F Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Beneficiary: \_\_\_\_\_  
(if none listed, benefits will go to your estate)

Relationship: \_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS:**

1. Will this replace any accident or sickness insurance you currently own?  Yes  No

2. Have you, or anyone to be insured, ever been convicted of a felony?  Yes  No

3. If you have had a life threatening accident in the last 2 years, are you still affected by it?  Yes  No

4. Do you have or are you applying for another accidental death or accidental death and dismemberment product with Starmount?  Yes  No

5. Do you now or have you ever had an insurance policy with Starmount Life?  Yes  No

**COMPLETE IF APPLYING FOR THE FAMILY PLAN:**

Name of Spouse to whom you are legally married: (if to be insured) \_\_\_\_\_

Sex:  M  F Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you employed?  Yes  No

Occupation: \_\_\_\_\_  
(if self employed, explain)

Beneficiary: \_\_\_\_\_  
(if none listed, benefits will go to your estate)

Relationship: \_\_\_\_\_

Name(s), Age(s), Date(s) of Birth of your natural or legally (in CT, prospective) adopted unmarried Children, or Stepchildren, under age 25 if to be insured:

	Age	Date of Birth
1. _____	_____	____/____/____
2. _____	_____	____/____/____
3. _____	_____	____/____/____
4. _____	_____	____/____/____

**COMPLETE ALL BILLING INFORMATION:**

I WILL PAY:  Every 12 Months  
 Every 6 months  
 Every 3 months

I authorize Starmount Life to deduct future premium payments from my personal checking account. My voided check is enclosed.

Charge payments to:  Visa  MasterCard  
Card #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Bill me direct. My first payment is enclosed.

I agree the answers will form part of the policy and they are complete and accurate (in MD and CT, to the best of my knowledge and belief). I understand no person can be protected by more than one of these or a like policy from Starmount Life, and that my accidental death protection will become effective when my approved policy is received by me and my payment is received by Starmount Life. I understand benefits are reduced by half for anyone age 75 or older. (See back of this page for exclusions.) 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 of a felony in the third degree. (See back of application for state specific fraud statements.)

**Notice:** In Florida, pursuant to Section 627.4555, Florida Statutes, you may name a secondary addressee to receive notice of past due premiums and possible lapse in coverage. The agent has no personal knowledge regarding policy replacement other than that provided by applicant's response above.

In Florida, Agent's Signature: \_\_\_\_\_ Agent: Hans J. Sternberg Lic. No.: A254068

Signature (Main Insured) \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse Signature (If Applying) \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Send \_\_\_\_\_ more applications for friends/relatives.  Send information about low cost life insurance.

In Florida, I am aware that the Company may terminate this insurance at the end of any period for which the premium has been paid.

For information or answers to any questions, please call our  
**Toll-Free help hotline 1-888-SAY LIFE**  
(that's 1-888-729-5433, ext 2014)  
Monday-Friday 8:00 a.m. to 8:30 p.m.  
Saturday 9 a.m. to 1 p.m. CST  
**Starmount Life Insurance Co.**  
The Starmount Building  
7800 Office Park Blvd  
Baton Rouge, LA 70809-7603

Here's what is not covered:

Accidental Death Benefits are not paid if death results directly or indirectly from: **PLEASE SEE YOUR POLICY FOR EXCLUSIONS SPECIFIC TO YOUR STATE.**

Possible exclusions are : Suicide; Illness or disease; Medical or surgical treatment; Inhalation of poisonous gas; Riding in or descent from any kind of aircraft except as a fare-paying passenger in a regularly scheduled commercial aircraft operated by a licensed pilot; War; Committing an assault, felony, participation in a riot or being engaged in an illegal occupation; Participation in sky or skin diving, auto or motorcycle racing, or hang gliding; Participation in full-time active duty or reserve duty for more than 30 days in any Armed Forces; injuries received while intoxicated or while under the influence of a controlled substance; Homicide, except for law enforcement officers receiving injuries while on duty; Bodily injury due to the act of another provoked by the insured; Injuries received from an accident that happened before this rider was in force.

**FOR OHIO RESIDENTS ONLY:** 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 of insurance fraud.

**FOR KANSAS AND OREGON RESIDENTS ONLY:** 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 may be guilty of a crime as determined by a court of law.

**FOR GEORGIA AND TEXAS RESIDENTS ONLY:** 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 may be guilty of a felony.

**FOR ARKANSAS AND LOUISIANA RESIDENTS ONLY:** 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 of a crime and may be subject to fines and confinement in prison.

**FOR NEW MEXICO RESIDENTS ONLY:** 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 life insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**FOR TENNESSEE RESIDENTS ONLY:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

**FOR NORTH CAROLINA RESIDENTS ONLY:** 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 may be guilty of a class H felony.

**FOR RESIDENTS OF KENTUCKY ONLY:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**FOR RESIDENTS OF MAINE:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits

**FOR RESIDENTS OF WASHINGTON:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**FOR RESIDENTS OF MINNESOTA:** 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 may be guilty of a gross misdemeanor and subject to denial of coverage if applicant's false statements materially affect the acceptance of risk or hazard assumed by the insurer.



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## Supporting Document Schedules

<b>Satisfied -Name:</b>	Certification/Notice	<b>Review Status:</b>	Approved-Closed	12/03/2008
<b>Comments:</b>				
<b>Attachment:</b>				
	Readability certification.pdf			
<b>Bypassed -Name:</b>	Application	<b>Review Status:</b>	Approved-Closed	12/03/2008
<b>Bypass Reason:</b>	submitting revised application-application is attached under form schedule.			
<b>Comments:</b>				
<b>Bypassed -Name:</b>	Health - Actuarial Justification	<b>Review Status:</b>	Approved-Closed	12/03/2008
<b>Bypass Reason:</b>	N/A- submission of revised application.			
<b>Comments:</b>				
<b>Bypassed -Name:</b>	Outline of Coverage	<b>Review Status:</b>	Approved-Closed	12/03/2008
<b>Bypass Reason:</b>	N/A- submission of revised application			
<b>Comments:</b>				



**Department of Insurance**  
**State of Arizona**  
*Life and Health Division*  
 Telephone: (602) 364-2393  
 Facsimile: (602) 364-2175

**JANET NAPOLITANO**  
 Governor

2910 North 44<sup>th</sup> Street, Suite 210  
 Phoenix, Arizona 85018-7269  
[www.id.state.az.us](http://www.id.state.az.us)

**CHRISTINA URIAS**  
 Director of Insurance

## READABILITY CERTIFICATION

Arizona Administrative Code R20-6-213  
 Life and Disability Insurance Policy Language Simplification

COMPANY NAME \_\_\_\_\_, NAIC # \_\_\_\_\_,  
 hereby certifies that the following form(s) comply with the requirements of paragraph (C)(1)(a) of  
 the captioned Rule and achieve a Flesch reading ease test score of:

**FORM NUMBER**

**FLESCH SCORE**











\_\_\_\_\_  
 Signature of Insurance Company Officer  
**(rubber stamp, copy or facsimile NOT ACCEPTED)**

\_\_\_\_\_  
 Typed Name and Title

\_\_\_\_\_  
 Date

Certification is required for all policy forms. A photocopy of this specimen is acceptable.