

SERFF Tracking Number: STAR-126376182 State: Arkansas
Filing Company: Starmount Life Insurance Company State Tracking Number: 44092
Company Tracking Number:
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
Product Name: HIP Application 11-09
Project Name/Number: /

Filing at a Glance

Company: Starmount Life Insurance Company

Product Name: HIP Application 11-09 SERFF Tr Num: STAR-126376182 State: Arkansas
TOI: H14I Individual Health - Hospital Indemnity SERFF Status: Closed-Approved- State Tr Num: 44092
Closed

Sub-TOI: H14I.000 Health - Hospital Indemnity Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor
Author: Natka Varisco Disposition Date: 11/17/2009
Date Submitted: 11/16/2009 Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Pending
Project Number: 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: 11/17/2009 Explanation for Other Group Market Type:
State Status Changed: 11/17/2009
Deemer Date: Created By: Natka Varisco
Submitted By: Natka Varisco Corresponding Filing Tracking Number:
Filing Description:
I have enclosed 06-002-APP, application to our Hospital Indemnity Policy. The policy and application were approved in Arkansas on January 18, 2008.

We wish to replace the previously approved application with the attached amended application. The policy remains unchanged. Please accept this as an informational filing.

The application revisions are listed below:

Dependent's Section:

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The following statement was added:

“If Dependent is not your natural child, attach documentation of legal custody or adoption. If coverage is court ordered attach a copy of the order.”

A Relationship Section has been added so the applicant may indicate the relationship of the dependents listed.

Question Section:

No. 1. Have you or any other proposed insured been admitted or treated at a hospital or at an emergency room during the last 12 months or do you or any other proposed insured expected to be admitted to the hospital in the next 12 months? If so, why?

“Or treated at a hospital or at an emergency room” has been added to the question.

There are no additional changes to the application. If you have any questions, you may contact me by phone at 225-926-2888, Extension 219 or my email address of natkav@starmountlife.com.

Company and Contact

Filing Contact Information

Natka Varisco, compliance specialist natkav@starmountlife.com
7800 Office Park Blvd. 225-926-2888 [Phone] 219 [Ext]
Baton Rouge, LA 70809 225-610-1419 [FAX]

Filing Company Information

Starmount Life Insurance Company CoCode: 68985 State of Domicile: Louisiana
7800 Office Park Boulevard Group Code: 68985 Company Type:
Baton Rouge, LA 70809 Group Name: State ID Number:
(225) 926-2888 ext. [Phone] FEIN Number: 72-0977315

Filing Fees

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

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Starmount Life Insurance Company	\$100.00	11/16/2009	32065969

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/17/2009	11/17/2009

SERFF Tracking Number: *STAR-126376182* *State:* *Arkansas*
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Disposition

Disposition Date: 11/17/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *STAR-126376182* *State:* *Arkansas*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	HIP Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 11/17/2009	06-002APP (Rev 11/09)	Application/ Enrollment Form	HIP Application	Initial		40.900	HIP APP Region 4 comp.pdf



Starmount Life Insurance Company
The Starmount Building
P.O. Box 98100
Baton Rouge, LA 70898-9100

PLEASE NOTE: YOUR FIRST MONTH'S
PREMIUM IS JUST \$1! (See enclosed rate chart)

PERSONAL APPLICATION

Form No. UB-002
Accidental Death Rider A

MEDPLUS
Hospital CashSM

Name of Main Insured _____ Sex: M F
 Address _____ City _____
 State _____ ZIP _____ Date of Birth (month/day/year) _____ Height (Ft. In) _____ Weight (Lbs.) _____
 Occupation _____ Email Address: _____
 Home Phone (_____) _____ Work or Cell Phone (_____) _____
 Name of Doctor (Full Name) _____ Doctor's Location (City, State) _____

I want a Daily Benefit (includes the Daily Basic Benefit + 50% Home Recovery¹) of the plan that pays:

\$300.00 a day \$150.00 a day \$75.00 a day

Daily Cash Benefits double the Basic Benefit for up to 30 days when you are in the ICU. Home Recovery Benefit only applies to other than ICU stays.

¹ Home Recovery not offered in every state.

LIST OTHER MEMBERS OF YOUR FAMILY TO BE INSURED:

Please note: List any child to be enrolled below. The child(ren) must be unmarried and under age 21 (in ME, age 19) - unmarried under age 24, if full-time student.⁴ If you want to insure more than 3 children, please list them on a separate sheet of paper and attach it to this form. If Dependent is not your natural child, attach documentation of legal custody or adoption. If coverage is court ordered attach a copy of the order.

Dependent's Full Name	Relationship	Date of Birth	Age	Height	Weight
Spouse: _____	<input type="checkbox"/> Husband <input type="checkbox"/> Wife				
Child: _____	<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other				
Child: _____	<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other				
Child: _____	<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other				

⁴ Please check your policy for state specific dependent age requirements.

HEALTH QUESTIONS:

1. Have you or any other proposed insured been admitted or treated at a hospital or at an emergency room during the last 12 months or do you or any other proposed insured expect to be admitted to the hospital in the next 12 months? If so, why? Please list the complete details for each proposed insured. Use a separate sheet of paper, if necessary. Yes No
2. Have you or any other proposed insured ever (in TX, been diagnosed by a health care provider as having) tested positive for exposure to the HIV infection or been diagnosed by a health care provider as having ARC or AIDS caused by the HIV infection? Yes No
3. For residents of Missouri only: Have you or any other proposed insured within the last 10 years had: high blood pressure, cancer, polyps, a tumor, diabetes, asthma, an ulcer, or a stroke; any disease or disorder of the kidneys, heart, blood, lungs, liver; tested positive, positively diagnosed or treated for ARC or AIDS caused by the HIV infection? If Yes, please explain: _____ Yes No

PAYMENT METHOD: (Please Choose One)

- My check for \$1 is enclosed, payable to Starmount Life Insurance Company. I authorize Starmount to automatically deduct future premium payments from my checking account. (Starmount prefers this method.)
- Charge \$1 and future payments to:
 Credit card #: _____ - _____ - _____ - _____ Expiration Date: ____/____
- My check for \$1 is enclosed. Bill me directly for future payments. I prefer to pay:
 Annually (5% discount) Every 3 months Monthly (\$1 fee per month for monthly billing.) We recommend annual or every 3 months.

PLEASE READ CAREFULLY AND SIGN BELOW: To the best of my knowledge, I and the others to be covered by this policy are in good health. Please enroll me and everyone listed on this application in the MedPlus Hospital Indemnity Health Protection Plan from Starmount Life Insurance Company. I declare the answers to the questions are complete and true to the best of my knowledge and belief. I agree the answers will form a part of the policy and the insurance will not be in force until this application has been approved by the Company and the Policy is issued and delivered to me subject to all conditions set forth in the Policy, and the first premium paid. I have read and understand the terms. I understand that conditions which pre-existed for 12 months prior to the policy issuance date of this plan will qualify for no benefits for 12 months after coverage begins. I understand I can have only one policy providing the same or similar coverage with Starmount Life.

AUTHORIZATION: I authorize any licensed physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, the Medical Information Bureau or other organizations, institutions or person that has records of me, my health, or anyone proposed for coverage to give STAR MOUNT LIFE INSURANCE, my legal representative for medical records receipt, its assignees or its reinsurers any such information. This includes knowledge about drug abuse, alcoholism or mental illness, and HIV and/or AIDS status. Although information about drug or alcohol abuse, or mental illness, and HIV and/or AIDS status may be protected by government regulation, I allow Starmount to collect it to determine insurability. I understand I am entitled to a copy of the information obtained; that this authorization will expire in 30 months (in KS and OK, 24 months), but can be revoked at any time with my written notification. A copy is as valid as the original. I am also aware that the records may be subject to re-disclosure by the recipient. 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. (Please see back page for fraud statements and policy exclusions & limitations for specific states.)

X _____ X _____
 Your Signature _____ Date _____ Spouse's Signature (if to be insured) _____

EXCEPTIONS AND LIMITATIONS TO THE HIP POLICY:

We will not pay for loss caused by: Emergency Room care; an act or acts of war, declared or undeclared; pregnancy that occurs before this policy is in force; suicide or any attempt at suicide while sane or insane; intentionally self-inflicted injury; alcoholism or habitual substance abuse; mental or nervous disorders; hospitalization beginning before this policy was in force; treatment not considered medically necessary; any injury caused by commission or attempted commission of a crime or criminal act; cosmetic surgery, breast reduction or augmentation, weight modification or surgical treatment for obesity, sex change surgery; health examinations; sickness contracted or injury sustained while on full-time active duty (other than for one month or less training) in any military, naval or air force. When you give Us written notice, any unearned premium will be refunded pro-rata for any period not covered by the Policy because of this exclusion; dental care or treatment unless caused by injury; care provided in a hospice facility; care provided as an in-patient in a U.S. Government Hospital or a Charity Hospital; or hospital confinements of less than 24 hours.

Pre-existing conditions are not covered until after the policy has been in force continuously for a period of twelve months during a covered person's lifetime.

Pre-existing condition means a condition for which medical advice or treatment was recommended by a physician or received within a 12 month period preceding the Effective Date of the Covered Person's coverage or a condition which manifested symptoms which would cause an ordinary person to seek diagnosis or treatment.

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 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734; Telephone number and website are (781) 751-6000 and www.mib.com. 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 on the letter to obtain additional information regarding information practices.

FRAUD STATEMENTS:

FOR RESIDENTS OF KANSAS: 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 by a court of law.

FOR RESIDENTS OF TEXAS: 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 RESIDENTS OF ARKANSAS AND LOUISIANA: 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.



~ A 2008 Winner of BBB of South Central LA Award for Ethics in Business.

~ 2007 Recognized as One of the Country's Fastest Growing Private Companies by *Inc. 5000*.

~ 2006 Company of the Year (under 100 employees) by *Baton Rouge Business Report*.

Call toll Free 888-729-5433, ext. 2014; or visit our web site www.starmountlife.com

Starmount Life Insurance Company The Starmount Building • P.O. Box 98100 • Baton Rouge, LA 70898-9100

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachments: Flesch Readability.pdf Certification of Rule 49 .pdf Certification of Rule 19 .pdf	Approved-Closed	11/17/2009
Bypassed - Item: Application Bypass Reason: Application attached under forms Comments:	Approved-Closed	11/17/2009
Bypassed - Item: Health - Actuarial Justification Bypass Reason: n/a Comments:	Approved-Closed	11/17/2009
Bypassed - Item: Outline of Coverage Bypass Reason: n/a Comments:	Approved-Closed	11/17/2009

STARMOUNT LIFE INSURANCE COMPANY

FLESCH READABILITY ANALYSIS

<u>FORM</u>	<u>WORDS</u>	<u>PARAGRAPHS</u>	<u>SENTENCES</u>	<u>SCORE</u>
06-002-APP	1716	72	59	40.9

This is to certify that this form meets the minimum score on the Flesch reading ease test in the NAIC Life and Health Insurance Policy Language Simplification Model Act. The Flesch score has been measured by the method described in the act and reflects all text excluding only language or terminology in the following categories entitled to be excepted under the act: the name and address of the insurer; the name, number or title of the policy; the table of contents or index; captions and subcaptions; specifications pages, schedules or table; language required by law or regulation; medical terminology; and words which are defined in the policy.

Jeffrey G. Wild
Chief Financial Officer
Starmount Life Insurance Company

DATE: _November 12, 2009_____

Starmount Life Insurance Company

P.O. Box 98100
Baton Rouge, LA 70898

Certification

This is to certify that I have reviewed Rule and Regulation 49 – Life and Health Insurance Guaranty Association Notices. This submission meets the provisions of this rule as well as all applicable requirements of the Arkansas Department of Insurance.

Jeffrey G. Wild
Chief Financial Officer
Starmount Life Insurance Company

DATE: November 12, 2009

Starmount Life Insurance Company

P.O. Box 98100
Baton Rouge, LA 70898

Certification

This is to certify that I have reviewed Regulation 19 and this submission meets the provisions of this rule as well as all applicable requirements of the Arkansas Department of Insurance.

Jeffrey G. Wild
Chief Financial Officer
Starmount Life Insurance Company

DATE: November 12, 2009