

SERFF Tracking Number: STAR-125995651 State: Arkansas
Filing Company: Starmount Life Insurance Company State Tracking Number: 41424
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: group enrollment and application forms
Project Name/Number: VI/DN-2007 ENROLL and VI/DN-2007 GRP APP

Filing at a Glance

Company: Starmount Life Insurance Company

Product Name: group enrollment and application forms SERFF Tr Num: STAR-125995651 State: ArkansasLH

TOI: H21 Health - Other

SERFF Status: Closed

State Tr Num: 41424

Sub-TOI: H21.000 Health - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: Belle Lucas

Disposition Date: 02/03/2009

Date Submitted: 02/02/2009

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: VI/DN-2007 ENROLL and VI/DN-2007 GRP APP

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer, Association

Filing Status Changed: 02/03/2009

State Status Changed: 02/03/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Re: STARMOUNT LIFE INSURANCE COMPANY, NAIC#68985

Form Nos. VI/DN-2007 Enroll, VI/DN-2007 GRPAPP

Dear Sir:

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We are pleased to file the above referenced generic group vision and dental enrollment and application forms in Arkansas. These generic forms are to replace previously approved dental and vision enrollment and application forms submitted with the original approved policies. These forms will replace DN-2007 Enroll AR, DN-2007 GRPAPP AR for the dental product originally approved in Arkansas on January 19, 2007 and VI-2007 Enroll, VI-2007 GRPAPP approved on September 6, 2007. This is a new filing and is being filed without an illustration.

Please call or email me at 926-2888, extension 282 or at bellel@starmountlife.com if you have any questions.

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

State of Domicile: Louisiana
 Company Type:
 State ID Number:

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	02/02/2009	25414874

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/03/2009	02/03/2009

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Disposition

Disposition Date: 02/03/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	group enrollment form	Approved-Closed	Yes
Form	application form	Approved-Closed	Yes

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Form Schedule

Lead Form Number: VI/DN-2007 ENROLL & VI/DN-2007 GRP APP

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	VI/DN-2007 ENROLL	Application/	group enrollment Enrollment form Form	Initial		35	VIDN-2007 Enroll-master enrollment form.pdf
Approved-Closed	VI/DN-2007 GRP APP	Application/	application form Enrollment Form	Initial		38	VIDN-2007 GRP APP Master application.pdf



Enrollment/Change Form

[DENTAL & VISION INSURANCE]

Underwritten by Starmount Life Insurance Company
 [Administered by: AlwaysCare Benefits, Inc. (A Starmount Life Insurance Company)]
 7800 Office Park Boulevard Baton Rouge, LA 70809-9100
 1-888-729-5433, Ext 2013 (in Baton Rouge, call 926-2888)
 Please print and complete all sections.

GROUP/[EMPLOYEE/MEMBER] INFORMATION		A: Add (enroll)		T: Terminate	C: Change (change of name or coverage)		
[Group/Policyholder] Name		Group Number	Location		Effective Date		
Date of Hire							
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name		First Name		M.I.	Date of Birth
Home Street Address		City/State/Zip		Home Phone ()		Work Phone ()	
Email Address						Cell Phone ()	

FAMILY INFORMATION (Only those eligible may be enrolled.)							A: Add (enroll)		T: Terminate	C: Change (change of name or coverage)	
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (spouse)		First Name		M.I.	Date of Birth				
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)		First Name		M.I.	Date of Birth		Child unmarried and full-time student or handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)		First Name		M.I.	Date of Birth		<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)		First Name		M.I.	Date of Birth		<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)		First Name		M.I.	Date of Birth		<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)		First Name		M.I.	Date of Birth		<input type="checkbox"/> Yes <input type="checkbox"/> No		

[NOTE for Dental: Members that waive coverage at initial enrollment (within 31 days of effective date) or in the new eligibility period and/or terminate coverage will have a twelve (12) month waiting period applied to basic and major services and orthodontia upon re-applying.

NOTE for Vision: Members that waive coverage at initial enrollment (within 31 days of effective date) or in the new eligibility period and/or terminate coverage are restricted to vision exams for 12 months.]

[Employee/Member] Signature: _____ Date: _____

[I elect the following coverage(s):

- | | |
|--|--|
| <input type="checkbox"/> Dental
<input type="checkbox"/> Employee Only \$ _____
<input type="checkbox"/> Employee + Spouse \$ _____
<input type="checkbox"/> Employee + Child(ren) \$ _____
<input type="checkbox"/> Employee Family \$ _____
<input type="checkbox"/> Waived due to other coverage
<input type="checkbox"/> Waive | <input type="checkbox"/> Vision
<input type="checkbox"/> Employee Only \$ _____
<input type="checkbox"/> Employee + Spouse \$ _____
<input type="checkbox"/> Employee + Child(ren) \$ _____
<input type="checkbox"/> Employee Family \$ _____
<input type="checkbox"/> Waived due to other coverage
<input type="checkbox"/> Waive |
|--|--|

Do you or any of your dependents have other [dental or vision] insurance? Yes No

If yes, please give: Policyholder _____ and Insurance Company _____.

Declination of coverage must be accompanied by the [Employee's/Member's] signature above.]

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.

Starmount Life Insurance Company
[Dental and Vision]
Group Application Instructions

[Thank you for choosing Starmount Life [Dental and Vision.] Please answer all the questions in the instruction sheet and Group Application below and return completed group applications, enrollment forms, and premium check to:
[TPA NAME AND ADDRESS]

We prefer member ID numbers to be: social security numbers randomly selected numbers

IMPORTANT NOTE:

Unless agreed otherwise, membership cards, welcome letters and coverage summaries are printed and provided in a single package following group approval. The certificate of coverage, group policy, administration manuals and other information will be provided on a customized, group-specific CD-ROM to enable the Employer to distribute as needed via email or printouts to all enrolled employees.

For groups with 50 or more enrolled employees, Starmount Life waives the monthly administration fee due to the Employer accepting the CD-ROM and distribution of the certificates of coverage.

Thank you, we look forward to surpassing your expectations.]

STARMOUNT LIFE INSURANCE COMPANY GROUP [DENTAL / VISION] APPLICATION [7800 Office Park Blvd., Baton Rouge, LA 70809 PH: 1-888-729-5433 FAX: 1-888-729-7827]	
Group No. _____	SIC No. _____
Legal Name of Group _____	Phone (_____) _____
Physical Address _____	Fax (_____) _____
City\State\Zip _____	EMAIL ADDRESS _____
Billing Address (If different) _____	Phone (_____) _____
City\State\Zip _____	Fax (_____) _____
Contact for Administration & Eligibility _____	Contact for Billing _____
# [Employees]: _____ # Eligible _____ # of [Employees] with Dependents _____ Group Effective Date: ____ / ____ / ____	
[Policyholder Contribution: (for voluntary coverage please enter \$0)]	
[Dental: \$ _____ per month _____ % of premium] [Payroll Frequency: _____]	
[Vision: \$ _____ per month _____ % of premium]	
A check for the first month's premium and other applicable fees must be attached to begin processing. Eligibility data will be submitted using:	
<input type="checkbox"/> Starmount Life enrollment forms	
<input type="checkbox"/> Email or electronic media (Employer must keep signed enrollment forms on file for future reference.)	
[Plan Selection: We elect to offer the following coverages to our [Employees] [Members]:	
<input type="checkbox"/> Dental Insurance:	<input type="checkbox"/> Vision Insurance:
<input type="checkbox"/> Policy Year <input type="checkbox"/> Calendar Year	<input type="checkbox"/> Wal-Mart <input type="checkbox"/> Elite Series <input type="checkbox"/> Other _____
Deductible: _____ Annual Maximum: _____	Frequency: <input type="checkbox"/> 12/12/12/12 <input type="checkbox"/> 12/12/24/12 <input type="checkbox"/> Other _____]
Co-Pay: Class 1 ___ Class 2 ___ Class 3 ___	
Orthodontia: <input type="checkbox"/> Yes <input type="checkbox"/> No Maximum _____]	
Eligibility:	
[Permanent, full-time employees working _____ hours per week are eligible for coverage (Standard: 30 hours).	
An eligible employee must have been actively at work on a full-time basis for _____ months in order to be eligible for coverage.	
An eligible dependent must be less than _____ yrs. Old or less than _____ yrs. Old if a full-time student.	
(same as employer health plan)]	
Participation: Depending on group size and coverage elected, specific participation requirements may apply. Participation must be met before the insurance can be effective and must be maintained continuously while insurance is in force to prevent cancellation of coverage.	
I understand and agree that audits will be made by Starmount Life Insurance Company now and in the future to verify the number and names of [full-time employees] [members] of this group. I will furnish with application, and upon any future request, [a current census and State Quarterly Unemployment Tax Report, and] any other information requested.	
[Monthly Administration Fee: I understand there is a [\$15.00] monthly administrative billing charge.]	

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Rate Information

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Supporting Document Schedules

Satisfied -Name:	Flesch Certification	Review Status:	Approved-Closed	02/03/2009
Comments:				
Attachment:				
Flesch.pdf				
Bypassed -Name:	Application	Review Status:	Approved-Closed	02/03/2009
Bypass Reason:	N/A- this is a revised application and enrollment form.			
Comments:				
Bypassed -Name:	Outline of Coverage	Review Status:	Approved-Closed	02/03/2009
Bypass Reason:	N/A-revised application and enrollment form only.			
Comments:				

STARMOUNT LIFE INSURANCE COMPANY

FLESCH ANALYSIS

<u>FORM NO.</u>	<u>WORDS</u>	<u>PARAGRAPHS</u>	<u>SENTENCES</u>	<u>SCORE</u>
VI/DN-2007 ENROLL	393	114	9	35.0
VI/DN-2007 GRP APP	787	77	24	37.7

This is to certify that these forms meet 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 by excepted under the act: the a name and address of the insurer; the name, number or title of the policy; the table of contents or index; captions and sub-captions; specifications pages, schedules or tables; language required by law or regulation; medical terminology; and words which are defined in the policy.

Jeffrey Wild
Secretary/Treasurer
Starmount Life Insurance Company

Date: 01-19-2009