

SERFF Tracking Number: STAR-127160664 State: Arkansas  
Filing Company: Starmount Life Insurance Company State Tracking Number: 48782  
Company Tracking Number:  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: GRPAPP 03/11 & Enroll 03/11 Combined APP & Enrollment form  
Project Name/Number: /GRPAPP 03/11 & Enroll 03/11

## Filing at a Glance

Company: Starmount Life Insurance Company

Product Name: GRPAPP 03/11 & Enroll 03/11 SERFF Tr Num: STAR-127160664 State: Arkansas

Combined APP & Enrollment form

TOI: H21 Health - Other

SERFF Status: Closed-Approved-  
Closed

State Tr Num: 48782

Sub-TOI: H21.000 Health - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Author: Belle Lucas

Disposition Date: 06/01/2011

Date Submitted: 05/16/2011

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: GRPAPP 03/11 & Enroll 03/11

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer, Association

Overall Rate Impact:

Filing Status Changed: 06/01/2011

State Status Changed: 06/01/2011

Deemer Date:

Created By: Belle Lucas

Submitted By: Belle Lucas

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

The attached application and enrollment form (GRPAPP 03/11 and Enroll 03/11) are enclosed for your approval. The forms are new and are not intended to replace any previously approved forms. We are hereby requesting that you file the enclosed forms on a Reference or Me Too basis. The enclosed forms are identical to the forms approved for National Guardian Life, (NAIC #66583) which was filed under SERFF #NGLI-127137777 and was approved on 4/27/11.

The forms will be used with group products previously approved in your state for Starmount Life Insurance Company,

SERFF Tracking Number: STAR-127160664 State: Arkansas  
Filing Company: Starmount Life Insurance Company State Tracking Number: 48782  
Company Tracking Number:  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: GRPAPP 03/11 & Enroll 03/11 Combined APP & Enrollment form  
Project Name/Number: /GRPAPP 03/11 & Enroll 03/11

National Guardian Life Insurance(NGL), or a combination of both. The previously approved Starmount products are:

Dental: DN-2007-AR approved 1/19/07

Vision:VI-2007-AR- approved 9/6/07

Safety Glasses Rider:VI-SAFE-2010- approved 11/19/10

Hearing Services Rider:DVGRP-HSR-07- approved 6/12/07

These forms are designed to be used when the Administrator (AlwaysCare Benefits, Inc.) is enrolling groups into products that are offered by both Starmount Life Insurance Company and/or our partner company, National Guardian Life Insurance. Instead of a group filling out separate forms for each company, the attached combined forms allow them to fill out one application and enrollment form.

These forms may be used within a web-based enrollment and electronic signatures may be collected.

This filing is only on behalf of Starmount Life Insurance, and is being done in coordination with the above mentioned NGL approved filing.

Your approval of these forms would be greatly appreciated.

Please call or email me at 225-400-9282, or at bellel@starmountlife.com if you have any questions or concerns.

Sincerely,  
Belle Lucas  
Compliance Specialist

## 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

SERFF Tracking Number: STAR-127160664 State: Arkansas  
Filing Company: Starmount Life Insurance Company State Tracking Number: 48782  
Company Tracking Number:  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: GRPAPP 03/11 & Enroll 03/11 Combined APP & Enrollment form  
Project Name/Number: /GRPAPP 03/11 & Enroll 03/11

Fee Required? Yes  
Fee Amount: \$100.00  
Retaliatory? No  
Fee Explanation: 2 forms x \$50.00=\$100.00  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Starmount Life Insurance Company	\$100.00	05/16/2011	47642558

SERFF Tracking Number: STAR-127160664 State: Arkansas  
Filing Company: Starmount Life Insurance Company State Tracking Number: 48782  
Company Tracking Number:  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: GRPAPP 03/11 & Enroll 03/11 Combined APP & Enrollment form  
Project Name/Number: /GRPAPP 03/11 & Enroll 03/11

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/01/2011	06/01/2011

SERFF Tracking Number: STAR-127160664 State: Arkansas  
Filing Company: Starmount Life Insurance Company State Tracking Number: 48782  
Company Tracking Number:  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: GRPAPP 03/11 & Enroll 03/11 Combined APP & Enrollment form  
Project Name/Number: /GRPAPP 03/11 & Enroll 03/11

## Disposition

Disposition Date: 06/01/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: STAR-127160664 State: Arkansas  
 Filing Company: Starmount Life Insurance Company State Tracking Number: 48782  
 Company Tracking Number:  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: GRPAPP 03/11 & Enroll 03/11 Combined APP & Enrollment form  
 Project Name/Number: /GRPAPP 03/11 & Enroll 03/11

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
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	group application	Approved-Closed	Yes
Form	grou enrollment form	Approved-Closed	Yes

SERFF Tracking Number: STAR-127160664 State: Arkansas  
 Filing Company: Starmount Life Insurance Company State Tracking Number: 48782  
 Company Tracking Number:  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: GRPAPP 03/11 & Enroll 03/11 Combined APP & Enrollment form  
 Project Name/Number: /GRPAPP 03/11 & Enroll 03/11

## Form Schedule

### Lead Form Number: GRPAPP 03/11 \* Enroll 03/11

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/01/2011	GRPAPP 03/11	Application/group application Enrollment Form		Initial		42.000	Combined Master App- FINAL_03_28 _ 11.pdf
Approved-Closed 06/01/2011	Enroll 03/11	Application/grou Enrollment Form	enrollment form	Initial		40.100	Combined Enrollment Form FINAL 03 28 11.pdf

**GROUP INSURANCE APPLICATION**

[Underwritten by: National Guardian Life Insurance Company and/or Starmount Life Insurance Company]

Application is hereby made to the Company ([Starmount Life Insurance Company and/or National Guardian Life Insurance Company]) on the basis of the information contained in this application, the group risk specifications, the enrollment data, and available experience data. The application in its entirety, and any required additional information, is subject to Home Office approval before insurance can become effective.

Once approved, the application will be attached to and made part of the Group Policy(ies). Insurance will become effective on the requested effective date shown below, unless written notice of a different effective date is sent.

If this application is not approved, no insurance is in effect at any time, and any deposit premium AlwaysCare has received will be returned.

This application is made with the following deposit premium. The premium amount is estimated, as the amount due for the first month, and will be applied toward the first premium on the proposed Group Policy(ies): \$ \_\_\_\_\_

If any insurance requires member contributions, any underwriting requirements for enrollment must be met before insurance can become effective.

**Legal Name of Group** \_\_\_\_\_

Physical Address \_\_\_\_\_

City\State\Zip \_\_\_\_\_

**Billing Address (If different)** \_\_\_\_\_

City\State\Zip \_\_\_\_\_

Federal Tax ID \_\_\_\_\_

# Members: \_\_\_\_\_ # Eligible: \_\_\_\_\_ # of Members with Dependents: \_\_\_\_\_

**Group Effective Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_**Contact for Administration & Eligibility:**

\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Contact for Billing** \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Plan Selection:**  Policy Year  Calendar Year **Dental Insurance** <sup>[1][+]</sup>  **Vision Insurance** <sup>[1][+]</sup> **Hearing Rider** <sup>[1][+]</sup> (where applicable)  
Attached to:  Dental  Vision **Safety Glass Rider** <sup>[1][+]</sup> (where applicable)  
Attached to:  Vision **Basic Life (Policyholder Funded)** <sup>[1][+]</sup>  
 AD&D  Dependent Life **Supplemental / Voluntary Life** <sup>[1][+]</sup>  
 AD&D  Dependent Life **Short Term Disability** <sup>[1][+]</sup> **Long Term Disability** <sup>[1][+]</sup> **Critical Illness** <sup>[1][+]</sup> [\* Underwritten by National  
Guardian Life Insurance Co.] **Accident** <sup>[1][+]</sup> [+Underwritten by Starmount Life  
Insurance Co.]**Policyholder contributions:**

[Dental \$\_\_\_\_\_ per month or \_\_\_\_ % of premium ]

[Vision \$\_\_\_\_\_ per month or \_\_\_\_ % of premium]

[Basic Life –Employee \$\_\_\_\_\_ per month or \_\_\_\_ % of premium]

[Basic Life-Dependent \$\_\_\_\_\_ per month or \_\_\_\_ % of premium]

[Supplemental /  
Voluntary Life –Employee \$\_\_\_\_\_ per month or \_\_\_\_ % of premium ][Supplemental/  
Voluntary Life –Dependent \$\_\_\_\_\_ per month or \_\_\_\_ % of premium]

[Short Term Disability \$\_\_\_\_\_ per month or \_\_\_\_ % of premium]

[Long Term Disability \$\_\_\_\_\_ per month or \_\_\_\_ % of premium]

[Critical Illness \$\_\_\_\_\_ per month or \_\_\_\_ % of premium]

[Accident \$\_\_\_\_\_ per month or \_\_\_\_ % of premium]

**Eligibility:** [ Permanent, full-time employees working 30 hours (Standard) or \_\_\_\_\_ (other) per week are eligible for coverage.

An eligible employee must have been actively at work on a full-time basis for \_\_\_\_\_ months in order to be eligible for coverage.]

[A member in good standing with the Policyholder.]

[An eligible dependent must be less than \_\_\_\_ yrs. old.] Coverage becomes effective the first of the month following eligibility.

**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 the 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.

**IMPORTANT NOTES:**

Unless agreed to 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 Policyholder to distribute via email or printouts to all enrolled Members. Members may also print ID Cards and certificates by visiting our website at [www.AlwaysCareBenefits.com](http://www.AlwaysCareBenefits.com).

[Monthly Administration Fee: I understand there is a **\$5.00** monthly administrative billing charge for groups with less than 10 employees enrolled.]

Please send Membership Materials and Enrollment Materials to (CHECK ONE):

Group Attn: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Broker or Agent

[Under ERISA (Employee Retirement Income Security Act of 1974), it is required that there be a named fiduciary for each employee benefit plan. It is understood that the undersigned Employer is the named fiduciary for each employee benefit plan. I understand and agree that if, on the effective date, an employee is not in permanent full-time active work or unable to perform usual and customary duties, coverage will not be effective until the employee returns to an active eligible status. I hereby certify that the information provided herein is true and complete to the best of my knowledge and that I have read and understand this form.]

The information contained herein describes the essential provisions of the elected coverage(s) discussed between the above client and the Company representative. By signing this form, both parties agree that these are the essential provisions the client is purchasing. The details of this form may be changed by either party with mutual agreement.

The applicant understands that the requested group insurance will:

- a. be issued only if the requested insurance is acceptable to the Company and is legally permissible;
- b. be issued under a group Policy or Policies in the language customarily used by the Company;
- c. be subject to the Company's usual underwriting requirements (including Evidence of Insurability, if applicable);
- d. be subject to all exclusions and limitations of the policy; and take effect on the date determined by the Company.

The Applicant understands that no agent or broker has the authority to guarantee the acceptability of the requested insurance. The effective date of insurance for which an employee is required to submit satisfactory Evidence of Insurability will be determined in accord with the Policy's terms. [The Actively at Work requirement will apply.] The applicant agrees not to:

- a. collect or pay premiums (other than the Binder Premium) for such insurance, before receiving the Company's notice of approval; or
- b. distribute material describing Policy coverage to persons to be insured, without the Company's prior written consent.

**WARNING:** 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.

Applicant Signature: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Name Title Date

Starmount Life or National Guardian Representative: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

Agent (if applicable)	Tax I.D. Number
-----------------------	-----------------

Firm Name (if applicable)	[Starmount Life Insurance Company and/or National Guardian Life Insurance Company] appointment is on file  <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>(Please attach Appointment Paperwork if not appointed)</b>
---------------------------	--

Address	Phone
City/State/Zip	Fax
	Email Address

**TO BE COMPLETED BY ALWAYS CARE BENEFITS**

Group Set Up Information	Account Management Approval
Group Code: _____	Account Manager: _____
SIC Code: _____	Signature _____ Date ____/____/____

Notes:
--------



[Accident][*][+]	[Member:] <input type="checkbox"/> Elect <input type="checkbox"/> Waive	[Spouse: <input type="checkbox"/> Elect <input type="checkbox"/> Waive]	[Child(ren) <input type="checkbox"/> Elect <input type="checkbox"/> Waive]	[Mode Premium] \$
[Short Term Disability][*][+]	<input type="checkbox"/> Elect <input type="checkbox"/> Waive	If Buy-up available: <input type="checkbox"/> Elect <input type="checkbox"/> Waive	Total Mode Premium \$	
[Long Term Disability][*][+]	<input type="checkbox"/> Elect <input type="checkbox"/> Waive	If Buy-up available: <input type="checkbox"/> Elect <input type="checkbox"/> Waive	Total Mode Premium \$	

[\*Underwritten by National Guardian Life]

[+Underwritten by Starmount Life Insurance Co.]

**[4. BENEFICIARY INFORMATION (Complete for Life/AD&D and Accident):]**

[Primary Beneficiary:]		[Relationship:]	[Date of Birth:]		
[Home Street Address]	[City/State/Zip]	[Home Phone]	[Work Phone]	[Cell Phone]	
[Email:]					
[Contingent Beneficiary:]		[Relationship:]	[Date of Birth:]		
[Home Street Address]	[City/State/Zip]	[Home Phone]	[Work Phone]	[Cell Phone]	
[Email:]					

**[5. The following questions should ONLY be completed if applying for Critical Illness coverage]**

	[Member]		[Spouse]		[Child]	
	Yes	No	Yes	No	Yes	No
[a. Has any person to be insured used tobacco products in any form during the previous 12 months?]	<input type="checkbox"/>					
[b. Has any person[ever][ in the past [2,5,7,10 years] ] tested positive for exposure to HIV infection or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex caused by the HIV infection or other sickness or condition derived from such infection?]	<input type="checkbox"/>					
[c. Has any person[ever had,][ in the past [2,5,7,10 years] ] been treated for, or been told by a member of the medical profession that he or she has: [diabetes;] [emphysema;] [asthma;] [epilepsy;] [hepatitis;] [mental] or [nervous illness;] [any disorder of the central nervous system;] [Parkinson's disease;] [lupus;] [any disorder of the kidneys;] [liver;] [lungs;] [pancreas] or [back] (including neck) or [paralysis] ?]	<input type="checkbox"/>					
[e. Is any person now being treated for, or [ever] [ in the past [2,5,7,10 years] been treated for: a stroke or transient ischemic attack (TIA); a heart attack; a heart condition; heart trouble; any abnormality of the heart; or any artery disease?]	<input type="checkbox"/>					
[f. Is any person currently undergoing any diagnostic test for, now being treated for, or [ever] [ in the past [2,5,7,10 years] been treated for cancer (except basal cell skin cancer) or any malignancy, which includes: carcinoma; Hodgkin's disease; leukemia; lymphoma; or any malignant tumor?]	<input type="checkbox"/>					
<b>[If includes coverage for Alzheimer's]</b> [g. Has any person [ever] [in the past [2,5,7,10 years], had, been treated for, or been told by a member of the medical profession that he or she has: Alzheimer's, Senility, Dementia or organic brain disease?]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>[If includes coverage for blindness]</b> [h. Has any person [ever] [ in the past [2,5,7,10 years] had, been treated for, or been told by a member of the medical profession that he or she has: Glaucoma; retinitis pigmentosa; Macular Degenerations; optic neuritis?]	<input type="checkbox"/>					
[If includes coverage for Children] [If Answer Yes for any child please indicate Child's name?]						

**STATEMENTS AND AGREEMENTS:**

- My dependents are not eligible for coverages I don't have. [If I refuse dental or vision coverage, I and/or my dependents may enroll later but this will affect the level of benefits. ] [If I refuse life, disability, or critical illness coverage, I may apply later but I must show proof of good health.] If I refuse coverage, I cannot enroll after retirement. If the group policy does not require my contribution, I cannot decline any coverage unless the policy indicates otherwise.
- If the group policy requires my contribution: [(1) I authorize my employer to deduct from my pay; and (2)] I understand that no insurance is in force until the first premium is paid.
- I represent all information on this form and attachments are complete and true to the best of my knowledge. They are part of this request for coverage.
- I agree [Starmount Life Insurance Company and/or National Guardian Life Insurance Company] (the Company) is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, false statements, omissions and/or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date. 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.
- I authorize the Company to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date of signature. I may revoke authorization for information not yet obtained. I understand data obtained will be used by the Company for claims administration and determining eligibility for life and disability insurance. Information will not be used for any purpose prohibited by law.
- Explanation of Benefits reflecting claim payments for myself and/or my dependents will be sent to my home address. I also understand collection of social security numbers from myself and/or my dependents will be used by the Company only as allowed by law.

- [NOTE for Dental: Coverage for a Late Entrant or Re-enrollee will be limited to those procedures listed under Coverage A in the Schedule of Covered Procedures during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date.]
- [NOTE for Vision: Coverage for a Late Entrant or Re-enrollee will be limited to the Vision Examination benefit in the Benefits Summary during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date. These limited coverages also apply to the Late Entrant's or Re-enrollee's Dependents, if enrolled.]

[AUTHORIZATION AND AGREEMENT: I hereby declare that all the statements made in this application are, to the best of my knowledge and belief, true and complete, and that they are the basis on which insurance requested by me may be issued. I understand that coverage will not become effective until the Company grants its underwriting approval if required. I understand that there is no coverage for a Pre-existing Condition except as described in the Certificate of Insurance.

I hereby authorize any licensed physician, psychologist, medical practitioner, hospital, clinic, or other medically related facility, insurance company or its reinsurer, the Medical Information Bureau (MIB), or other organization, institution, or person that has any records or knowledge of me or my physical or mental health, drug or alcohol use history, other insurance coverage or employment status, [or that of any member of my family whose name appears in the application to which this is attached,] to give the Company and its affiliates or authorized representative any such information. This information will be used to determine eligibility for insurance. I understand that I may revoke this authorization at any time by sending a written revocation to the Company at the address above. Such revocation will not affect any action taken or information released prior to the revocation, and will not affect any legal right the Company has to contest an insurance policy / certificate, or to contest a claim under an insurance policy / certificate. I understand that if I revoke this authorization, the Company may not be able to process my application, and may not be able to make any benefit payments due under any existing policy, certificate, or other binding agreement. I understand that once this information is received by the authorized person/organization, then this information may be subject to redisclosure, and may no longer be protected by federal privacy laws. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 12 months from the date signed. I also understand that I or a person authorized to act on my behalf is entitled to receive a copy of this authorization form and that I may cancel this Authorization at any time by notifying the company in writing, subject to the rights of any individual who acted in reliance on this Authorization prior to my notice of revocation. I also certify that the producer and I, if applicable, also certify that I have read, or have had read to me, this completed application and that I realize any false statements or misrepresentation in it may result in loss of coverage under the policy. I certify that I have received the Information Practices Notice.]

In the past 12 months, have you had continuous group coverage providing like or similar benefits (for yourself and/or your dependents) with a prior carrier?  
 Yes  No

If yes, please provide: Policyholder \_\_\_\_\_ and Insurance Company \_\_\_\_\_

**Important!** If declining any coverage for yourself or any dependent, give reason. Covered under:  Spouse's group coverage  
 Individual insurance  other coverage offered by my [employer][association]  other \_\_\_\_\_

I declare that the information I have completed on this enrollment form is complete and true. I have read and understand the statements and understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from the Company.

Your Signature: x \_\_\_\_\_ Date signed \_\_\_\_\_

[Spouse's Signature: x \_\_\_\_\_ Date signed \_\_\_\_\_]

A copy of this form will be as valid as the original. After this form is completed and signed, make one copy for the Policyholder and a copy of page one only for the Member.

SERFF Tracking Number: STAR-127160664 State: Arkansas  
 Filing Company: Starmount Life Insurance Company State Tracking Number: 48782  
 Company Tracking Number:  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: GRPAPP 03/11 & Enroll 03/11 Combined APP & Enrollment form  
 Project Name/Number: /GRPAPP 03/11 & Enroll 03/11

## Supporting Document Schedules

		Item Status:	Status Date:
<b>Satisfied - Item:</b>	Flesch Certification	Approved-Closed	06/01/2011
<b>Comments:</b>			
<b>Attachment:</b>			
Flesch.pdf			
		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Application	Approved-Closed	06/01/2011
<b>Bypass Reason:</b>	N/A- application filing		
<b>Comments:</b>			
		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Health - Actuarial Justification	Approved-Closed	06/01/2011
<b>Bypass Reason:</b>	N/A- application filing only.		
<b>Comments:</b>			
		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Outline of Coverage	Approved-Closed	06/01/2011
<b>Bypass Reason:</b>	N/A		
<b>Comments:</b>			
		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	PPACA Uniform Compliance Summary	Approved-Closed	06/01/2011
<b>Bypass Reason:</b>	N/A		
<b>Comments:</b>			

**STARMOUNT LIFE INSURANCE COMPANY**

**FLESCH ANALYSIS**

<u>FORM NO.</u>	<u>WORDS</u>	<u>PARAGRAPHS</u>	<u>SENTENCES</u>	<u>SCORE</u>
Enroll 03/11	1907	204	59	40.1
GRPAPP 03/11	671	93	89	42.0

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.

Digitally signed by Jeffrey G. Wild  
DN: cn=Jeffrey G. Wild, o=Starmount Life,  
ou=Financial, email=JeffW@Starmountlife.com, c=US  
Date: 2011.05.10 10:06:33 -05'00'

\_\_\_\_\_  
Jeffrey Wild  
Secretary/Treasurer  
Starmount Life Insurance Company

Date: 05-10-2011