

**State:** Arkansas **Filing Company:** Starmount Life Insurance Company  
**TOI/Sub-TOI:** H10I Individual Health - Dental/H10I.000 Health - Dental  
**Product Name:** One Plus  
**Project Name/Number:** /

## Filing at a Glance

Company: Starmount Life Insurance Company  
Product Name: One Plus  
State: Arkansas  
TOI: H10I Individual Health - Dental  
Sub-TOI: H10I.000 Health - Dental  
Filing Type: Form  
Date Submitted: 12/14/2012  
SERFF Tr Num: STAR-128796723  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num:  
  
Implementation: On Approval  
Date Requested:  
Author(s): Belle Lucas, Natka Varisco, Ruston Woolley, Jennifer LeGlue  
Reviewer(s): Rosalind Minor (primary)  
Disposition Date: 12/17/2012  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

**State:** Arkansas **Filing Company:** Starmount Life Insurance Company  
**TOI/Sub-TOI:** H101 Individual Health - Dental/H101.000 Health - Dental  
**Product Name:** One Plus  
**Project Name/Number:** /

## General Information

Project Name: Status of Filing in Domicile: Not Filed  
Project Number: Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Individual  
Submission Type: New Submission Individual Market Type:  
Overall Rate Impact: Filing Status Changed: 12/17/2012  
State Status Changed: 12/17/2012  
Deemer Date: Created By: Jennifer LeGlue  
Submitted By: Belle Lucas Corresponding Filing Tracking Number:

### Filing Description:

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

December 10, 2012

RE: Starmount Life Insurance Company  
NAIC# 68985

Form: One Plus Website Application-IDN-2009

Dear Sirs:

We are pleased to file the above referenced website application in Arkansas. This filing is a new filing and is being filed without an illustration. The Individual Dental Policy, IDN-2009, et al was first approved on 11/19/2009 under STAR-126385934 and some forms were resubmitted and reapproved on 2/08/2010 under STAR-126483059. We are now requesting approval of website application form no. IDN-2009 ap (W12A). This website has been designed to offer Policy IDN-2009 Individual Dental Insurance online as a standalone site or in conjunction with other marketing/distribution partners or for agent use. This application is new and will not replace any prior approved applications.

We have included webshots of the application pages, including any drop-down boxes. Also attached is a webshot of each payment option. Payment options may differ depending upon the use of the web application.

The Standalone website will give the consumer the option to select Credit Card or Checking Account. When the website is used by an employer or group opportunities to offer dental coverage, the website will ask for the employee's authorization to deduct payments through payroll deduction.

Website Applications set up for agent use will gather the agent's license and producer information.

Upon completion of the application and payment approval the website will generate the state specific policy, provided the applicant has agreed to Electronic Acceptance of the policy.

We request approval of the website application only. Webshots are attached under the form schedule for your review. Please contact me if you have any questions at 225-400-9282, or by email at bellel@starmountlife.com.

Sincerely,  
Belle Lucas  
Compliance Specialist

## Company and Contact

**State:** Arkansas **Filing Company:** Starmount Life Insurance Company  
**TOI/Sub-TOI:** H101 Individual Health - Dental/H101.000 Health - Dental  
**Product Name:** One Plus  
**Project Name/Number:** /

**Filing Contact Information**

Jennifer LeGlue, Compliance Specialist jenniferl@starmountlife.com  
 8485 Goodwood Blvd. 225-400-9194 [Phone]  
 Baton Rouge, LA 70806-7878 225-610-1394 [FAX]

**Filing Company Information**

Starmount Life Insurance Company CoCode: 68985 State of Domicile: Louisiana  
 7800 Office Park Boulevard Group Code: 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: \$100 per product.  
 Per Company: No

Company	Amount	Date Processed	Transaction #
Starmount Life Insurance Company	\$100.00	12/14/2012	65771715

SERFF Tracking #:

STAR-128796723

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company: Starmount Life Insurance Company

TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental

Product Name: One Plus

Project Name/Number: /

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/17/2012	12/17/2012

SERFF Tracking #:

STAR-128796723

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

Starmount Life Insurance Company

TOI/Sub-TOI: H101 Individual Health - Dental/H101.000 Health - Dental

Product Name: One Plus

Project Name/Number: /

## Disposition

Disposition Date: 12/17/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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	One Plus Web	Approved-Closed	Yes

**SERFF Tracking #:**

STAR-128796723

**State Tracking #:**

**Company Tracking #:**

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**State:**

Arkansas

**Filing Company:**

Starmount Life Insurance Company

**TOI/Sub-TOI:**

H10I Individual Health - Dental/H10I.000 Health - Dental

**Product Name:**

One Plus

**Project Name/Number:**

/

## Form Schedule

State: Arkansas

Filing Company:

Starmount Life Insurance Company

TOI/Sub-TOI: H101 Individual Health - Dental/H101.000 Health - Dental

Product Name: One Plus

Project Name/Number: /

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 12/17/2012	One Plus Web	IDN-2009 ap (W12)	AEF	Initial			AR-1PLUS-3payrolldeduction.pdf AR-1PLUS-AuthorizationAL&AR.pdf AR-1PLUS-2familydropdown.pdf AR-1PLUS-2payrolldeduction.pdf AR-1PLUS-2spouse.pdf AR-1PLUS-3.pdf AR-1PLUS-3agent.pdf AR-1PLUS-1.pdf AR-1PLUS-2checking.pdf AR-1PLUS-2childrendropdown.pdf AR-1PLUS-2childrenfamily.pdf AR-1PLUS-2creditcard.pdf

**SERFF Tracking #:**

STAR-128796723

**State Tracking #:****Company Tracking #:****State:**

Arkansas

**Filing Company:**

Starmount Life Insurance Company

**TOI/Sub-TOI:**

H101 Individual Health - Dental/H101.000 Health - Dental

**Product Name:**

One Plus

**Project Name/Number:**

/

**Form Type Legend:**

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

## APPLY NOW FOR YOUR DENTAL COVERAGE



### Don't Forget

- Regular dental care is integral to maintaining your overall health and detecting or preventing major medical issues
- AlwaysCare provides coverage for over 300+ dental procedures
- Enroll online in three easy steps

### Just 3 Simple Steps

1 2 **3**

#### Review Your Application

#### Your Coverage

EDIT

Plan Name: **Value**  
 Covering: **Individual Only**  
 Existing Coverage: **N**  
 Replacing Coverage: **N**

#### Applicant Information

EDIT

First Name: **John**  
 Middle Initial: **F**  
 Last Name: **Doe**  
 Address/Apt: **1231 Any Street**  
 City: **Anytown**  
 State: **AR**  
 Zip Code: **71601**  
 Primary Phone: **(555) 555-2424**  
 Secondary Phone: **(555) 555-2424**  
 Email Address: **johndoe@email.com**  
 Gender: **M**  
 Date of Birth: **7/14/1970**  
 Last 4 digits of your SSN: **1234**

#### Payment Information

EDIT

The following total sum for the Insured listed above will be charged:  
 Total Monthly Premium: **\$19.24**  
 Payment Method: **List Bill**

#### Electronic Acceptance

By checking the "Yes" box below, I agree that the receipt of my Policy and all notices required to be delivered with the Policy, shall be conducted electronically via the Internet. In order to access the documents, I understand that I must have access to the Internet and must have or install Adobe Reader. I understand that at any time and for any reason I may withdraw my consent and receive a paper copy of all the Policy and/or notices, free of charge, by calling Customer Service at 888-729-5433, Ext. 2013, or by writing to 8485 Goodwood Blvd, Baton Rouge, LA 70806.

- YES, I agree to receive the Policy electronically via the Internet.  
 NO, I prefer to receive paper copies of the Policy and Notices.

## Authorization

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.

By checking this box, I authorize that I have read the terms and conditions noted and agree.



**SUBMIT**

IDN-2009 ap (W12A)

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Administered by: AlwaysCare Benefits, Inc. (a Starmount Life Insurance company)  
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### **Applicant Statements and Agreements**

1. I understand that the effective date of the policy will be the date recorded in the Policy Schedule of Benefits by Us.
2. I understand the 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 Policy Anniversary Date following the end of the month of the child's 26th birthday.
4. 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.

### **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 (24 months in AK, KS, KY, NM, OK, WV and WY) months from the date signed. 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 re-disclosure, and may no longer be protected by federal privacy laws. I agree that a copy of this authorization is as valid as the original. I know that I have a right to receive a copy of this authorization upon request.

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I understand that the premium amount listed on the rate chart represents the modal (monthly, quarterly, semi-annual or annual) premium for my coverage. If I am purchasing coverage directly from Starmount, my modal premium will be deducted from my bank account or my credit card account designated by me. If my bank or credit card account changes, I will notify Starmount and provide new account information needed keep my coverage in force. If I am purchasing coverage through my employer, my employer will remit my premium to Starmount. I understand that the amount deducted from my paycheck for my premium may differ from the premium amount quoted to me by my associate/agent because of my employer's billing/payroll practices.

I also understand that if I am receiving any 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.

**IDN-2009 ap (W12A)**

**AL-AR**

## APPLY NOW FOR YOUR DENTAL COVERAGE



### Don't Forget

- Regular dental care is integral to maintaining your overall health and detecting or preventing major medical issues
- AlwaysCare provides coverage for over 300+ dental procedures
- Enroll online in three easy steps

### Just 3 Simple Steps

1 **2** 3

#### Additional Coverage & Payment Info

#### Family Members to Be covered

First Name:   
 Middle Initial:   
 Last Name:   
 Date of Birth:     
 Gender:   
 Relationship to insured:   
 Check any that apply:  **Select --**  
                                    Spouse  
                                    Daughter  
                                    Son  
                                    Stepdaughter  
                                    Stepson  
 First Name:   
 Middle Initial:   
 Last Name:   
 Date of Birth:     
 Gender:   
 Relationship to insured:   
 Check any that apply:  Handicapped Child  
                                    Full-Time Student

**Add Dependent**

#### Coverage Information

Does the proposed insured have any existing dental insurance in force with another company?  Yes  No

If yes, please enter the policy information as requested.

Company Name:

Policy/Application Number:

Is this insurance intended to replace any other insurance currently in force?  Yes  No

#### Billing Information

I would like Starmount to charge my payments directly to my:

Checking Account  Credit Card

Account Holder Name:

Routing Number:

Account Number:

John Q. Public  
123 Main Street  
Your Town, USA 12345-6789

Date: \_\_\_\_\_

Pay to the order of \_\_\_\_\_

\_\_\_\_\_ DOLLARS

Memo \_\_\_\_\_

Routing/Transit Number: 123456789 Account Number: 101

## Billing Address

Is your billing address the same as the applicant address:

Yes  No, my billing address is different

Address:

Address2:

City:

State: -- Select --

Zip Code:

**CONTINUE**

IDN-2009 ap (W12A)

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## APPLY NOW FOR YOUR DENTAL COVERAGE



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### Just 3 Simple Steps

1 2 3

#### Additional Coverage & Payment Info

#### Coverage Information

Does the proposed insured have any existing dental insurance in force with another company?  Yes  No

If yes, please enter the policy information as requested.

Company Name:

Policy/Application Number:

Is this insurance intended to replace any other insurance currently in force?  Yes  No

#### Billing Information

I authorize my employer to deduct future premiums through payroll deduction.

**CONTINUE**

## APPLY NOW FOR YOUR DENTAL COVERAGE



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### Just 3 Simple Steps

1 **2** 3

#### Additional Coverage & Payment Info

#### Family Members to Be covered

First Name:

Middle Initial:

Last Name:

Date of Birth:

Gender:

Relationship to insured:

#### Coverage Information

Does the proposed insured have any existing dental insurance in force with another company?  Yes  No

If yes, please enter the policy information as requested.

Company Name:

Policy/Application Number:

Is this insurance intended to replace any other insurance currently in force?  Yes  No

#### Billing Information

I would like Starmount to charge my payments directly to my:

Checking Account  Credit Card

Account Holder Name:

Routing Number:

Account Number:

**EXAMPLE**

John Q. Public  
123 Main Street  
Your Town, USA 12345-6789

Date:

Pay to the order of \_\_\_\_\_

\_\_\_\_\_ DOLLARS

Memo

⑆000007894⑆ ⑆2345678⑆ 010⑆

Routing/Transit Number      Account Number

## Billing Address

Is your billing address the same as the applicant address:

Yes  No, my billing address is different

Address:

Address2:

City:

State: -- Select --

Zip Code:

**CONTINUE**

IDN-2009 ap (W12A)

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## APPLY NOW FOR YOUR DENTAL COVERAGE



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### Just 3 Simple Steps

1 2 **3**

#### Review Your Application

#### Your Coverage

EDIT

Plan Name: **Value**  
 Covering: **Individual Only**  
 Existing Coverage: **N**  
 Replacing Coverage: **N**

#### Applicant Information

EDIT

First Name: **John**  
 Middle Initial: **F**  
 Last Name: **Doe**  
 Address/Apt: **1231 Any Street**  
 City: **Anytown**  
 State: **AR**  
 Zip Code: **71601**  
 Primary Phone: **(555) 555-2424**  
 Secondary Phone: **(555) 555-2424**  
 Email Address: **johndoe@email.com**  
 Gender: **M**  
 Date of Birth: **7/14/1970**  
 Last 4 digits of your SSN: **1234**

#### Payment Information

EDIT

The following total sum for the Insured listed above will be charged:  
 Total Monthly Premium: **\$19.24**  
 Payment Method: **Checking Account**  
 Account Number: **\*\*\*\*\*4567**  
 Address: **Same**

#### Electronic Acceptance

By checking the "Yes" box below, I agree that the receipt of my Policy and all notices required to be delivered with the Policy, shall be conducted electronically via the Internet. In order to access the documents, I understand that I must have access to the Internet and must have or install Adobe Reader. I understand that at any time and for any reason I may withdraw my consent and receive a paper copy of all the Policy and/or notices, free of charge, by calling Customer Service at 888-729-5433, Ext. 2013, or by writing to 8485 Goodwood Blvd, Baton Rouge, LA 70806.

- YES, I agree to receive the Policy electronically via the Internet.  
 NO, I prefer to receive paper copies of the Policy and Notices.

## Authorization

If I am applying to replace existing coverage from 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.

By checking this box, I authorize that I have read the terms and conditions noted and agree.



**SUBMIT**

IDN-2009 ap (W12A)

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## APPLY NOW FOR YOUR DENTAL COVERAGE



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### Just 3 Simple Steps

1 2 **3**

#### Review Your Application

#### Your Coverage

EDIT

Plan Name: **Value**  
 Covering: **Individual Only**  
 Existing Coverage: **N**  
 Replacing Coverage: **N**

#### Applicant Information

EDIT

First Name: **John**  
 Middle Initial: **F**  
 Last Name: **Doe**  
 Address/Apt: **1231 Any Street**  
 City: **Anytown**  
 State: **AR**  
 Zip Code: **71601**  
 Primary Phone: **(555) 555-2424**  
 Secondary Phone: **(555) 555-2424**  
 Email Address: **johndoe@email.com**  
 Gender: **M**  
 Date of Birth: **7/14/1970**  
 Last 4 digits of your SSN: **1234**

#### Payment Information

EDIT

The following total sum for the Insured listed above will be charged:  
 Total Monthly Premium: **\$19.24**  
 Payment Method: **Checking Account**  
 Account Number: **\*\*\*\*\*4567**  
 Address: **Same**

#### Electronic Acceptance

By checking the "Yes" box below, I agree that the receipt of my Policy and all notices required to be delivered with the Policy, shall be conducted electronically via the Internet. In order to access the documents, I understand that I must have access to the Internet and must have or install Adobe Reader. I understand that at any time and for any reason I may withdraw my consent and receive a paper copy of all the Policy and/or notices, free of charge, by calling Customer Service at 888-729-5433, Ext. 2013, or by writing to 8485 Goodwood Blvd, Baton Rouge, LA 70806.

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 NO, I prefer to receive paper copies of the Policy and Notices.

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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.

By checking this box, I authorize that I have read the terms and conditions noted and agree.



Print

## Agent Information

Agent's (Producer) Signature:

Agent's License Number:

Agent's (Producer) Email Address:

**SUBMIT**

IDN-2009 ap (W12A)

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## APPLY NOW FOR YOUR DENTAL COVERAGE



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Just 3 Simple Steps

**1** 2 3

Start Your Application

### Applicant Information

First Name:

Middle Initial:

Last Name:

Address/Apt:

City:

State: **AR**

Zip Code: **71601**

Primary Phone:

Secondary Phone:

Email Address:

Gender:  ▼

Date of Birth: **7/14/1970**

Last 4 digits of your SSN:

**CONTINUE**

## APPLY NOW FOR YOUR DENTAL COVERAGE



### Don't Forget

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### Just 3 Simple Steps

1 **2** 3

#### Additional Coverage & Payment Info

#### Coverage Information

Does the proposed insured have any existing dental insurance in force with another company?  Yes  No

If yes, please enter the policy information as requested.

Company Name:

Policy/Application Number:

Is this insurance intended to replace any other insurance currently in force?  Yes  No

#### Billing Information

I would like Starmount to charge my payments directly to my:

Checking Account  Credit Card

Account Holder Name:

Routing Number:

Account Number:

John Q. Public 123 Main Street Your Town, USA 12345-6789	Date	101
Pay to the order of:	DOLLARS <input type="text"/>	
Memo		
*000067894* 23456789* 0404		
Routing/Transit Number	Account Number	

**EXAMPLE**

#### Billing Address

Is your billing address the same as the applicant address:

Yes  No, my billing address is different

Address:

Address2:

City:

State: -- Select --

Zip Code:

**CONTINUE**

**CONTINUE**

IDN-2009 ap (W12A)

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## APPLY NOW FOR YOUR DENTAL COVERAGE



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### Just 3 Simple Steps

1 **2** 3

#### Additional Coverage & Payment Info

#### Family Members to Be covered

First Name:

Middle Initial:

Last Name:

Date of Birth:

Gender:

Relationship to insured:

Check any that apply:

- Daughter
- Son
- Stepdaughter
- Stepson

#### Coverage Information

Does the proposed insured have any existing dental insurance in force with another company?  Yes  No

If yes, please enter the policy information as requested.

Company Name:

Policy/Application Number:

Is this insurance intended to replace any other insurance currently in force?  Yes  No

#### Billing Information

I would like Starmount to charge my payments directly to my:

Checking Account  Credit Card

Account Holder Name:

Routing Number:

Account Number:

John Q. Public  
123 Main Street  
Your Town, USA 12345-6789 Date: 101

Pay to the order of:

**EXAMPLE**

DOLLARS:

Memo  
⑆00006789⑆ ⑆2345678⑆ 0101  
Routing/Transit Number      Account Number

## Billing Address

Is your billing address the same as the applicant address:

Yes     No, my billing address is different

Address:

Address2:

City:

State: -- Select --

Zip Code:

**CONTINUE**

IDN-2009 ap (W12A)

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Underwritten by: Starmount Life Insurance Company  
Administered by: AlwaysCare Benefits, Inc. (a Starmount Life Insurance company)  
8485 Goodwood Blvd. • Baton Rouge, LA 70806 • PH: (888) 729-5433, Ext. 2013

## APPLY NOW FOR YOUR DENTAL COVERAGE



### Don't Forget

- Regular dental care is integral to maintaining your overall health and detecting or preventing major medical issues
- AlwaysCare provides coverage for over 300+ dental procedures
- Enroll online in three easy steps

### Just 3 Simple Steps

1 **2** 3

#### Additional Coverage & Payment Info

#### Family Members to Be covered

First Name:

Middle Initial:

Last Name:

Date of Birth:

Gender:

Relationship to insured:

Check any that apply:  Handicapped Child  
 Full-Time Student

First Name:

Middle Initial:

Last Name:

Date of Birth:

Gender:

Relationship to insured:

Check any that apply:  Handicapped Child  
 Full-Time Student

**Add Dependent**

#### Coverage Information

Does the proposed insured have any existing dental insurance in force with another company?  Yes  No

If yes, please enter the policy information as requested.

Company Name:

Policy/Application Number:

Is this insurance intended to replace any other insurance currently in force?  Yes  No

#### Billing Information

I would like Starmount to charge my payments directly to my:

Checking Account  Credit Card

Account Holder Name:

Routing Number:

Account Number:

John Q. Public  
123 Main Street  
Your Town, USA 12345-6789

Date: \_\_\_\_\_

Pay to the order of: \_\_\_\_\_

\_\_\_\_\_ DOLLARS

Memo \_\_\_\_\_

⑆00006789⑆ ⑆23156789⑆ 010⑆

Routing/Transit Number      Account Number

## Billing Address

Is your billing address the same as the applicant address:

Yes  No, my billing address is different

Address:

Address2:

City:

State: -- Select --

Zip Code:

**CONTINUE**

## APPLY NOW FOR YOUR DENTAL COVERAGE



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1 2 3

#### Additional Coverage & Payment Info

#### Coverage Information

Does the proposed insured have any existing dental insurance in force with another company?  Yes  No

If yes, please enter the policy information as requested.

Company Name:

Policy/Application Number:

Is this insurance intended to replace any other insurance currently in force?  Yes  No

#### Billing Information

I would like Starmount to charge my payments directly to my:

Checking Account  Credit Card

Card Type:

Cardholder Name:

Card Number:

Expiration Date: MM  YYY

Security Code:

#### Billing Address

Is your billing address the same as the applicant address:

Yes  No, my billing address is different

Address:

Address2:

City:

State:

Zip Code:

**CONTINUE**



**SERFF Tracking #:**

STAR-128796723

**State Tracking #:****Company Tracking #:****State:**

Arkansas

**Filing Company:**

Starmount Life Insurance Company

**TOI/Sub-TOI:**

H101 Individual Health - Dental/H101.000 Health - Dental

**Product Name:**

One Plus

**Project Name/Number:**

/

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
Bypassed - Item:	Flesch Certification	Approved-Closed	12/17/2012
Bypass Reason:	N/A- website application only.		
		<b>Item Status:</b>	<b>Status Date:</b>
Bypassed - Item:	Application	Approved-Closed	12/17/2012
Bypass Reason:	New website application to be submitted. paper application previously approved. Approval date of paper application is 2/8/2010 under IDN-2009-Application.		
		<b>Item Status:</b>	<b>Status Date:</b>
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	12/17/2012
Bypass Reason:	N/A- website application only.		
		<b>Item Status:</b>	<b>Status Date:</b>
Bypassed - Item:	Outline of Coverage	Approved-Closed	12/17/2012
Bypass Reason:	N/A- website application only.		