

SERFF Tracking Number: STAR-128331656 State: Arkansas  
Filing Company: Starmount Life Insurance Company State Tracking Number:  
Company Tracking Number:  
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only  
Product Name: JAD website application  
Project Name/Number: /

## Filing at a Glance

Company: Starmount Life Insurance Company

Product Name: JAD website application

TOI: H02I Individual Health - Accident Only

Sub-TOI: H02I.000 Health - Accident Only

Filing Type: Form

SERFF Tr Num: STAR-128331656 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num:

Co Tr Num:

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 05/07/2012

Authors: Belle Lucas, Natka

Varisco, Ruston Woolley, Ronetta

Andrus

Date Submitted: 05/04/2012

Disposition Status: Approved-  
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 05/07/2012

State Status Changed: 05/07/2012

Deemer Date:

Created By: Belle Lucas

Submitted By: Belle Lucas

Corresponding Filing Tracking Number:

Filing Description:

Re: STARMOUNT LIFE INSURANCE COMPANY, NAIC#68985

Website Application- New JAD accidental death -01-002-APP-web (Website Approval)

Dear Sir/Madam:

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. This product provides coverage for losses due to accidents only.

The original paper application filing was approved on 10/6/11-STAR-127630397 and we are now requesting approval of

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 the website application for the new JAD product.

Please contact me if you have any questions at 225-400-9282 or by email bellel@starmountlife.com.

Sincerely,  
 Belle Lucas  
 Compliance Specialist  
 State Narrative:

## 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:  
 Group Name:  
 FEIN Number: 72-0977315

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: \$100 per filing  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Starmount Life Insurance Company	\$100.00	05/04/2012	58951015

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/07/2012	05/07/2012

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	05/04/2012	05/04/2012	Belle Lucas	05/07/2012	05/07/2012

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## Disposition

Disposition Date: 05/07/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Form (revised)</b>	JAD website application	Approved-Closed	Yes
<b>Form</b>	JAD website application	Replaced	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 05/04/2012  
Submitted Date 05/04/2012  
Respond By Date  
Dear Belle Lucas,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Application (Supporting Document)
- JAD website application, 01-002-APP-web (Form)

### Comment:

The fraud statement for Arkansas should read: "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". Refer to ACA 23-66-503.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,  
Rosalind Minor

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## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 05/07/2012  
 Submitted Date 05/07/2012

Dear Rosalind Minor,

### Comments:

Please see response below:

### Response 1

Comments: Amended fraud statement as requested.

### Related Objection 1

Applies To:

- Application (Supporting Document)
- JAD website application, 01-002-APP-web (Form)

Comment:

The fraud statement for Arkansas should read: "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". Refer to ACA 23-66-503.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
JAD website application	01-002-APP-web		Application/Enrollment Form	Initial			AR-JAD revised 5-12.pdf AR-JAD FM

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revised 5-  
12.pdf

**Previous Version**

JAD website application01-002- Application/Enrollment Initial  
APP-web Form

AR-  
JAD.pdf  
AR-JAD-  
FM.pdf

No Rate/Rule Schedule items changed.

Thanks,  
Belle Lucas  
225-400-9282

Sincerely,  
Belle Lucas, Natka Varisco, Ronetta Andrus, Ruston Woolley

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## Form Schedule

### Lead Form Number: 01-002-APP-web

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 05/07/2012	01-002- APP-web	Application/ Enrollment Form	JAD website application	Initial			AR-JAD revised 5- 12.pdf AR-JAD FM revised 5- 12.pdf



- Home
- Product Info
- Apply
- Register
- About Us
- Contact Us

To apply, complete the information below and click submit or [download an application](#).

Individual Accident Insurance Application Form - For Policy Form No. 01-002

- Choose One:\*
- \$9.99/month Plan: \$1,000,000 - \$200,000 - \$100,000 Cash Benefit Accident Protection
  - \$19.59/month Plan: \$1,000,000 - \$400,000 - \$200,000 Cash Benefit Accident Protection

Please Complete The Following Information:

Primary Insured:\*

Sex:\*  Male  Female

Date of Birth:\*

Address:\*

City:\*

Zip:\*

Home Phone:\*

Work or Cell: \*

Email Address:\*

Are you employed?\*

- Yes
- No

Occupation (if self employed, explain):

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

Relationship: (If Beneficiary is a minor, please include their date of birth)\*

Please include me in future communications regarding product offerings. You may opt out at any time by contacting customer service.\*  Yes  No

Indicate Method Of Payment:

I will pay:\*

- Every 12 months (Receives 5% discount)
- Every 6 months
- Every 3 months
- Monthly

Billing Method:\*

- Deduct my first and future payments from my checking account automatically. (Complete bank information below)
- Charge premium payments to my credit card. (Complete credit card information below)

Bank Route #:

Bank Account #:

Bank Name:

Bank Location:

Charge payments to:

- Visa
- MasterCard

Credit Card #

Exp. Date : (mm/yy)

Please Answer These Questions

Do you now or have you ever had an insurance policy with Starmount Life?\*

- Yes
- No

Do you now have or are you applying for another accidental death product with Starmount?\*

- Yes
- No

Will this replace any accident or sickness insurance you currently own?\*

- Yes
- No

Have you, or anyone to be insured, ever been convicted of a felony?\*

- Yes
- No

If you had a life threatening accident in the last 2 years, are you still affected by it?\*

- Yes
- No
- N/A

All the information given is correct and true to the best of my knowledge and belief. I agree the answers will form part of the policy. I understand that no person can be protected by more than one of these or a like policy from Starmount Life Insurance Company, 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 Insurance Company. I understand that benefits are reduced by half for anyone age 75 or older. **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.**

Primary Insured's Signature\*

Send me more applications for friends and relatives. Number needed?

**ACCIDENTAL DEATH:** Death due to Accidental Bodily Injury caused by Accident occurring while the insurance is in force; the death must occur within 90 days after the date of the Accident, directly and independently of all other causes.

**EXCLUSIONS:** Exclusions may apply. Please see your policy for limitations and exclusions specific to your state.

01-002-APP-web AR-web

How did you find us?

- Submit Application
- Cancel

\* Required information



- Home
- Product Info
- Apply
- Register
- About Us
- Contact Us

To apply, complete the information below and click submit or [download an application](#).

Family Accident Insurance Application Form - For Policy Form No. 01-002

- Choose One:\*
- \$11.99/month Plan: \$1,000,000 - \$200,000 - \$100,000 Cash Benefit Accident Protection
  - \$21.59/month Plan: \$1,000,000 - \$400,000 - \$200,000 Cash Benefit Accident Protection

Please Complete The Following Information:

Primary Insured:\*

Sex:\*

- Male
- Female

Date of Birth:\*

Address:\*

City:\*

Zip:\*

Home Phone:\*

Work or Cell: \*

Email Address:\*

Are you employed?\*

- Yes
- No

Occupation (if self employed, explain):

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

Relationship: (If Beneficiary is a minor, please include their date of birth)\*

Please include me in future communications regarding product offerings. You may opt out at any time by contacting customer service.\*

- Yes
- No

Complete If Applying For The Family Plan:

Name of Spouse or lawful domestic partner:

Spouse's Sex:

- Male
- Female

Spouse's Date of Birth:

Spouse's Beneficiary: (if none listed, benefits will go to your estate)

Spouse Beneficiary Relationship: (If Beneficiary is a minor, please include their date of birth)

Name(s) of child(ren) to be included:

First Child's Name:

First Child's Age:

First Child's Date of Birth:

Second Child's Name:

Second Child's Age:

Second Child's Date of Birth:

Third Child's Name:

Third Child's Age:

Third Child's Date of Birth:

Fourth Child's Name:

Fourth Child's Age:

Fourth Child's Date of Birth:

Fifth Child's Name:

Fifth Child's Age:

Fifth Child's Date of Birth:

Indicate Method Of Payment:

I will pay:\*

- Every 12 months (Receives 5% discount)
- Every 6 months
- Every 3 months
- Monthly

Billing Method:\*

- Deduct my first and future payments from my checking account automatically. (Complete bank information below)
- Charge premium payments to my credit card. (Complete credit card information below)

Bank Route #:

Bank Account #:

Bank Name:

Bank Location:

Charge payments to:

- Visa
- MasterCard

Credit Card #

Exp. Date : (mm/yy)

Please Answer These Questions

Do you now or have you ever had an insurance policy with Starmount Life?\*

- Yes
- No

Do you now have or are you applying for another accidental death product with Starmount?\*

- Yes
- No

Will this replace any accident or sickness insurance you currently own?\*

- Yes
- No

Have you, or anyone to be insured, ever been convicted of a felony?\*

- Yes
- No

If you had a life threatening accident in the last 2 years, are you still affected by it?\*

- Yes
- No
- N/A

All the information given is correct and true to the best of my knowledge and belief. I agree the answers will form part of the policy. I understand that no person can be protected by more than one of these or a like policy from Starmount Life Insurance Company, 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 Insurance Company. I understand that benefits are reduced by half for anyone age 75 or older. **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.**

Primary Insured's Signature including spouse if  to be insured\*

Send me more applications for friends and relatives. Number needed?

**ACCIDENTAL DEATH:** Death due to Accidental Bodily Injury caused by Accident occurring while the insurance is in force; the death must occur within 90 days after the date of the Accident, directly and independently of all other causes.

**EXCLUSIONS:** Exclusions may apply. Please see your policy for limitations and exclusions specific to your state.

01-002-APP-web AR-web

How did you find us?

FM

- Submit Application
- Cancel

\* Required information

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## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Flesch Certification	Approved-Closed	05/07/2012
<b>Bypass Reason:</b>	N/A- website application		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Application	Approved-Closed	05/07/2012
<b>Bypass Reason:</b>	N/A- website application for previously approved paper application.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Health - Actuarial Justification	Approved-Closed	05/07/2012
<b>Bypass Reason:</b>	N/A- website application only.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Outline of Coverage	Approved-Closed	05/07/2012
<b>Bypass Reason:</b>	N/A- website application only.		
<b>Comments:</b>			

SERFF Tracking Number: STAR-128331656 State: Arkansas  
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## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/04/2012	Form	JAD website application	05/07/2012	AR-JAD.pdf (Superceded) AR-JAD-FM.pdf (Superceded)



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To apply, complete the information below and click submit or [download an application](#).

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- Choose One:\*
- \$9.99/month Plan: \$1,000,000 - \$200,000 - \$100,000 Cash Benefit Accident Protection
  - \$19.59/month Plan: \$1,000,000 - \$400,000 - \$200,000 Cash Benefit Accident Protection

Please Complete The Following Information:

Primary Insured:\*

Sex:\*

- Male
- Female

Date of Birth:\*

Address:\*

City:\*

Zip:\*

Home Phone:\*

Work or Cell:\*

Email Address:\*

Are you employed?\*

- Yes
- No

Occupation (if self employed, explain):

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

Relationship: (If Beneficiary is a minor, please include their date of birth)\*

Please include me in future communications regarding product offerings. You may opt out at any time by contacting customer service.\*

- Yes
- No

Indicate Method Of Payment:

I will pay:\*

- Every 12 months (Receives 5% discount)
- Every 6 months
- Every 3 months
- Monthly

Billing Method:\*

- Deduct my first and future payments from my checking account automatically. (Complete bank information below)
- Charge premium payments to my credit card. (Complete credit card information below)

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Please Answer These Questions

Do you now or have you ever had an insurance policy with Starmount Life?\*

- Yes
- No

Do you now have or are you applying for another accidental death product with Starmount?\*

- Yes
- No

Will this replace any accident or sickness insurance you currently own?\*

- Yes
- No

Have you, or anyone to be insured, ever been convicted of a felony?\*

- Yes
- No

If you had a life threatening accident in the last 2 years, are you still affected by it?\*

- Yes
- No
- N/A

All the information given is correct and true to the best of my knowledge and belief. I agree the answers will form part of the policy. I understand that no person can be protected by more than one of these or a like policy from Starmount Life Insurance Company, 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 Insurance Company. I understand that benefits are reduced by half for anyone age 75 or older. **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.**

Primary Insured's Signature\*

Send me more applications for friends and relatives. Number needed?

**ACCIDENTAL DEATH:** Death due to Accidental Bodily Injury caused by Accident occurring while the insurance is in force; the death must occur within 90 days after the date of the Accident, directly and independently of all other causes.

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01-002-APP-web AR-web

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\* Required information



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Email Address:\*

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Name of Spouse or lawful domestic partner:

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Spouse's Date of Birth:

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Name(s) of child(ren) to be included:

First Child's Name:

First Child's Age:

First Child's Date of Birth:

Second Child's Name:

Second Child's Age:

Second Child's Date of Birth:

Third Child's Name:

Third Child's Age:

Third Child's Date of Birth:

Fourth Child's Name:

Fourth Child's Age:

Fourth Child's Date of Birth:

Fifth Child's Name:

Fifth Child's Age:

Fifth Child's Date of Birth:

Indicate Method Of Payment:

I will pay:\*

- Every 12 months (Receives 5% discount)
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Billing Method:\*

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Primary Insured's Signature including spouse if to be insured\*

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EXCLUSIONS: Exclusions may apply. Please see your policy for limitations and exclusions specific to your state.

01-002-APP-web

AR-web

How did you find us? Please select...

FM

- Submit Application
- Cancel

\* Required information