**Dental and Vision Enrollment Form**
Underwritten by: Starmount Life Insurance Company
8485 Goodwood Blvd., Baton Rouge, LA 70806-7878
Fax Number: (207) 771-4019

Please print legibly and complete this form in its entirety. Blank fields will cause delays in processing.
☐ Initial Enrollment: To make initial elections; or
☐ Annual Enrollment or Change in Status: To make changes to existing elections and/or information. The elections/information you indicate will replace your prior elections/information on file. Note: If you do not wish to make any changes, do not complete this form. Please contact your employer with any questions.
☐ Terminate Coverage: To terminate coverage for yourself and all dependents.
☐ Waive coverage. ☐ Covered under Spouse's or Domestic Partner's group plan ☐ I have other coverage
☐ Other:_____

| Employer Name | | | Policy No. | Division No. | Effective Date |
|---|---|---|---|---|---|
| Employee Social-Security Number | Gender ☐ M ☐ F | | Date of Birth (mm/dd/yyyy) | Hours Worked Per Week | |
| Employee First Name | | M.I. | Last Name | | |
| Employee Street Address | | | City | State | Zip Code |
| Original Date of Hire | Actively Employed: ☐ Yes ☐ No | ☐ Date entered into an eligible class (ex: part time to full time or promotion date) ☐ Rehire date _____ | | | |

**SPOUSE or DOMESTIC PARTNER/DEPENDENT ELECTIONS: (For additional dependents, complete and attach an additional form.)**

| Name (First, MI, Last) | Gender | Date of Birth | Relationship | Election (A=Add; T=Terminate) | Effective Date (if different) |
|---|---|---|---|---|---|
| | ☐ M ☐ F | | | ☐ A ☐ T | |
| | ☐ M ☐ F | | | ☐ A ☐ T | |
| | ☐ M ☐ F | | | ☐ A ☐ T | |
| | ☐ M ☐ F | | | ☐ A ☐ T | |
| | ☐ M ☐ F | | | ☐ A ☐ T | |

**If dependent children listed are disabled or full-time students age 19 or over, please contact your group administrator.**
**COVERAGE ELECTIONS:**

| Type of Coverage | Employee Only | Employee/Spouse or Domestic Partner | Employee/Child(ren) | Employee/Family |
|---|---|---|---|---|
| Dental ☐ High ☐ Low ☐ Other ☐ Waive | ☐ | ☐ | ☐ | ☐ |
| Vision ☐ High ☐ Low ☐ Other ☐ Waive | ☐ | ☐ | ☐ | ☐ |

**REPLACEMENT:**

| In the past 12 months, have you had continuous coverage providing like or similar benefits with a prior carrier? | | ☐ Yes ☐ No |
|---|---|---|
| If Yes, please provide: | Policyholder: | Insurance Company: |

**The certificate provides limited benefits. Review your certificate carefully.**

**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.

**Request for Signature and Certification:** I understand that my coverage may be subject to waiting periods, limitations, exclusions and termination as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer and will not be effective until approved. All statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I understand that any untrue statement or material misrepresentation may result in claim denial or cancellation of coverage. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

I understand that if I waive coverage and later decide to enroll, late entrant penalties may apply.

_____ _____
Employee Signature Date (mm/dd/yyyy)

**RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER**

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