

ACCIDENT INSURANCE APPLICATION FORM

YES! Please enroll me for the Expanded Accidental Death & Dismemberment Protection and include the \$1,000.00 Accidental Death Insurance at **NO COST TO ME!**

Choose one: Main Insured Only **Choose one:** \$50,000.00 for \$5.50 per month \$100,000.00 for \$11.00 per month
 Family Plan \$150,000.00 for \$16.50 per month \$250,000.00 for \$27.50 per month

YES (For Main Insured only.) Please only sign me up for \$1,000.00 of Basic Accidental Death Insurance Protection at no cost to me. Lasts one full year.

PLEASE COMPLETE THE FOLLOWING:

Main Insured: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: Home (_____) _____ (required)

Work or Cell (_____) _____

Are you employed? Yes No

Occupation: _____
(if self employed, explain)

Sex: M F Date of Birth ____/____/____

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

Relationship: _____

PLEASE ANSWER ALL QUESTIONS:

1. Will this replace any accident or sickness insurance you currently own? Yes No

2. Have you, or anyone to be insured, ever been convicted of a felony? Yes No

3. If you have had a life threatening accident in the last 2 years, are you still affected by it? Yes No

4. Do you have or are you applying for another accidental death or accidental death and dismemberment product with Starmount? Yes No

5. Do you now or have you ever had an insurance policy with Starmount Life? Yes No

COMPLETE IF APPLYING FOR THE FAMILY PLAN:

Name of Spouse to whom you are legally married: (if to be insured)

Sex: M F Date of Birth ____/____/____

Are you employed? Yes No

Occupation: _____
(if self employed, explain)

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

Relationship: _____

Name(s), Age(s), Date(s) of Birth of your natural or legally (in CT, prospective) adopted unmarried Children, or Stepchildren, under age 25 if to be insured:

| | Age | Date of Birth |
|----------|-------|----------------|
| 1. _____ | _____ | ____/____/____ |
| 2. _____ | _____ | ____/____/____ |
| 3. _____ | _____ | ____/____/____ |
| 4. _____ | _____ | ____/____/____ |

COMPLETE ALL BILLING INFORMATION:

I WILL PAY: Every 12 Months
 Every 6 months
 Every 3 months

I authorize Starmount Life to deduct future premium payments from my personal checking account. My voided check is enclosed.

Charge payments to: Visa MasterCard
Card #: _____ - _____ - _____ - _____
Expiration Date: ____/____/____

Bill me direct. My first payment is enclosed.

I agree the answers will form part of the policy and they are complete and accurate (in MD and CT, to the best of my knowledge and belief). I understand no person can be protected by more than one of these or a like policy from Starmount Life, 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. I understand benefits are reduced by half for anyone age 75 or older. (See back of this page for exclusions.) 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. (See back of application for state specific fraud statements.)

Notice: In Florida, pursuant to Section 627.4555, Florida Statutes, you may name a secondary addressee to receive notice of past due premiums and possible lapse in coverage. The agent has no personal knowledge regarding policy replacement other than that provided by applicant's response above.

In Florida, Agent's Signature: _____ Agent: Hans J. Sternberg Lic. No.: A254068

Signature (Main Insured) _____

Date ____/____/____

Spouse Signature (If Applying) _____

Date ____/____/____

Send _____ more applications for friends/relatives. Send information about low cost life insurance.

In Florida, I am aware that the Company may terminate this insurance at the end of any period for which the premium has been paid.

For information or answers to any questions, please call our
Toll-Free help hotline 1-888-SAY LIFE
(that's 1-888-729-5433, ext 2014)
Monday-Friday 8:00 a.m. to 8:30 p.m.
Saturday 9 a.m. to 1 p.m. CST
Starmount Life Insurance Co.
The Starmount Building
7800 Office Park Blvd
Baton Rouge, LA 70809-7603

Here's what is not covered:

Accidental Death Benefits are not paid if death results directly or indirectly from: **PLEASE SEE YOUR POLICY FOR EXCLUSIONS SPECIFIC TO YOUR STATE.**

Possible exclusions are : Suicide; Illness or disease; Medical or surgical treatment; Inhalation of poisonous gas; Riding in or descent from any kind of aircraft except as a fare-paying passenger in a regularly scheduled commercial aircraft operated by a licensed pilot; War; Committing an assault, felony, participation in a riot or being engaged in an illegal occupation; Participation in sky or skin diving, auto or motorcycle racing, or hang gliding; Participation in full-time active duty or reserve duty for more than 30 days in any Armed Forces; injuries received while intoxicated or while under the influence of a controlled substance; Homicide, except for law enforcement officers receiving injuries while on duty; Bodily injury due to the act of another provoked by the insured; Injuries received from an accident that happened before this rider was in force.

FOR OHIO RESIDENTS ONLY: 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 insurance fraud.

FOR KANSAS AND OREGON RESIDENTS ONLY: 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 may be guilty of a crime as determined by a court of law.

FOR GEORGIA AND TEXAS RESIDENTS ONLY: 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 may be guilty of a felony.

FOR ARKANSAS AND LOUISIANA RESIDENTS ONLY: 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 crime and may be subject to fines and confinement in prison.

FOR NEW MEXICO RESIDENTS ONLY: 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 life insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

FOR TENNESSEE RESIDENTS ONLY: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

FOR NORTH CAROLINA RESIDENTS ONLY: 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 may be guilty of a class H felony.

FOR RESIDENTS OF KENTUCKY ONLY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

FOR RESIDENTS OF MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits

FOR RESIDENTS OF WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

FOR RESIDENTS OF MINNESOTA: 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 may be guilty of a gross misdemeanor and subject to denial of coverage if applicant's false statements materially affect the acceptance of risk or hazard assumed by the insurer.