

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 A COST OF ONLY 10¢ 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 a cost of only 10¢ 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. Do you have or are you applying for another accidental death or accidental death and dismemberment product with Starmount? Yes No

4. 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 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. 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.

For Pennsylvania residents only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subjects such person to criminal and civil penalties. **Exclusions are shown in your policy. No one to be covered by this policy is recovering from a life threatening accident.**

Signature (Main Insured) _____

Date ____/____/____

Spouse Signature (If Applying) _____

Date ____/____/____

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

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