

Starmount Life Insurance Co.
 7800 Office Park Boulevard
 Baton Rouge, LA 70809-7603
 1-888-SAY-LIFE
 (that's 1-888-729-5433; in
 Baton Rouge, call 926-2888)

AlwaysCare Employee Benefits Dental & Vision Insurance



Underwritten by Starmount Life Insurance Company

Enrollment/Change Form

Please print and complete all sections. See instructions below.

EMPLOYER/EMPLOYEE INFORMATION					
Employer Name East Baton Rouge Parish Schools		Group Number EBRPS	Location	Effective Date	Date of Hire
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (Employee or subscriber)		First Name	M.I.	Date of Birth
Home Street Address	City/State/Zip		Home Phone ()	Work Phone ()	

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name or coverage)					
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (spouse)		First Name	M.I.	Date of Birth
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)		First Name	M.I.	Date of Birth
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)		First Name	M.I.	Date of Birth
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)		First Name	M.I.	Date of Birth
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)		First Name	M.I.	Date of Birth
<input type="checkbox"/> A Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (dependent)		First Name	M.I.	Date of Birth

NOTE: Coverage for a Late Entrant or Re-enrollee will be limited to those procedures listed under **Coverage A** in the Schedule of Covered Procedures during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date. This limited coverage also applies to the Late Entrant's or Re-enrollee's Dependents, if enrolled.

Employee Signature: _____ Date: _____

I elect the following coverage(s):		
<input type="checkbox"/> Dental – “Gold Plan”* <input type="checkbox"/> EE \$ <u>22.30</u> <input type="checkbox"/> ES \$ <u>46.70</u> <input type="checkbox"/> EC \$ <u>51.06</u> <input type="checkbox"/> EF \$ <u>72.48</u> <input type="checkbox"/> Waived	<input type="checkbox"/> Dental – “Silver Plan”* <input type="checkbox"/> EE \$ <u>14.08</u> <input type="checkbox"/> ES \$ <u>28.18</u> <input type="checkbox"/> EC \$ <u>32.84</u> <input type="checkbox"/> EF \$ <u>46.92</u> <input type="checkbox"/> Waived	<input type="checkbox"/> Vision <input type="checkbox"/> EE \$ <u>8.74</u> <input type="checkbox"/> ES \$ <u>18.72</u> <input type="checkbox"/> EC \$ <u>14.11</u> <input type="checkbox"/> EF \$ <u>25.69</u> <input type="checkbox"/> Waived
*Dental Rates are not finalized. Rates are subject to change based on school board approval.		
Declination of coverage must be accompanied by the employee's signature above.		

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.