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UNUM

Enrollment Form for Group Insurance

Underwritten by: Starmount Life Insurance Company

P.O. Box 98100 Baton Rouge, LA 70898-9100, (225)926-2888 or 1-888-729-5433

1. MEMBER INFORMATION ☐ A: Add (Enroll) ☐ T: Terminate ☐ C: Change (change of name or coverage)

Group/Policyholder Name	Group Number	Location	Effective Date
Pearl River Community College	443957		

Gender	Last Name (Member or subscriber)	First Name	M.I.	Birth Date mm / dd / yyyy	Social Security Number
☐ M ☐ F				Birth City: Birth State: U.S. Citizen: ☐ Yes ☐ No	

Home Street Address	City/State/Zip	Home Phone	Work Phone	Cell Phone
			Email:	

Please include me in future communications regarding product offerings. ☐ Yes ☐ No
You may opt out at any time by contacting Customer Service.

COMPLETED BY EMPLOYER

Date of Hire	☐ Full time ☐ Part-time ☐ Retiree If part time: Hrs worked per week: ________	Occupation	Class

Salary $: ______________ ☐ Yearly ☐ monthly ☐ semi-monthly ☐ weekly ☐ bi-weekly ☐ hourly

2. FAMILY INFORMATION (Only those eligible may be enrolled. Use additional paper if needed) (Relationship – If Dependent is not your natural child, attach documentation of legal custody or adoption. If coverage is court ordered, attach a copy of the order.)

Please include an email address for each dependent over Age 18.

	Gender	Relationship	Last Name, First Name, MI, Email Address	Social Security #, Child Handicap Status	Date of Birth (mm/dd/yyyy)	Place of Birth (City and State)
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐ Husband ☐ Wife Legally recognized ☐ Civil Union Partner ☐ Domestic Partner	(Spouse) Email Address:	SS#	U.S. Citizen: ☐ Yes ☐ No	
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter ☐ Other__________	(Dependent) Email Address:	SS# Handicapped: ☐ Yes ☐ No Age when Handicap began: ____	Date of Birth (mm/dd/yyyy) U.S. Citizen: ☐ Yes ☐ No Married: ☐ Yes ☐ No	Place of Birth (City and State)
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter ☐ Other__________	(Dependent) Email Address:	SS# Handicapped: ☐ Yes ☐ No Age when Handicap began: ____	Date of Birth (mm/dd/yyyy) U.S. Citizen: ☐ Yes ☐ No Married: ☐ Yes ☐ No	Place of Birth (City and State)
☐ Add ☐ Terminate ☐ Change	☐ M ☐ F	☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter ☐ Other________	(Dependent) Email Address:	SS# Handicapped: ☐ Yes ☐ No Age when Handicap began: ____	Date of Birth (mm/dd/yyyy) U.S. Citizen: ☐ Yes ☐ No Married: ☐ Yes ☐ No	Place of Birth (City and State)

3. BENEFIT ELECTIONS (Employer determines benefits available for election):

☐ **Dental** ☐ High ☐ Low ☐ Other	☐ **Member Only** Monthly Premium $27.31-Low $38.92-High	☐ **Member/ Spouse** Monthly Premium $54.64-Low $77.81-High	☐ **Member/Child(ren)** Monthly Premium $60.12-Low $85.61-High	☐ **Member/Family** Monthly Premium $88.80-Low $124.37-High	☐ Waive
☐ **Vision** ☐ High Plan ☐ Other____________	☐ **Member Only** Monthly Premium $7.84	☐ **Member/Spouse** Monthly Premium $16.02	☐ **Member/Child(ren)** Monthly Premium $14.12	☐ **Member/Family** Monthly Premium $21.96	☐ Waive

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STATEMENTS AND AGREEMENTS:

- My dependents are not eligible for coverages I don't have. If I refuse dental or vision coverage, I and/or my dependents may enroll later but this will affect the level of benefits. If I refuse life, disability, or critical illness coverage, I may apply later but I must show proof of good health. If I refuse coverage, I cannot enroll after retirement. If the group policy does not require my contribution, I cannot decline any coverage unless the policy indicates otherwise.
- If the group policy requires my contribution: (1) I authorize my employer to deduct from my pay; and (2) I understand that no insurance is in force until the first premium is paid.
- I represent all information on this form and attachments are complete and true to the best of my knowledge. They are part of this request for coverage.
- I agree Starmount Life Insurance Company (the Company) is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, false statements, omissions and/or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- I authorize the Company to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date of signature. I may revoke authorization for information not yet obtained. I understand data obtained will be used by the Company for claims administration and determining eligibility for life and disability insurance. Information will not be used for any purpose prohibited by law.
- Explanation of Benefits reflecting claim payments for myself and/or my dependents will be sent to my home address. I also understand collection of social security numbers from myself and/or my dependents will be used by the Company only as allowed by law.
- NOTE for Dental: Coverage for a Late Entrant or Re-enrollee will be limited to those procedures listed under Class A Services in the Schedule of Covered Procedures during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date. (For EHB Plan, applies only to ages 19+)
- NOTE for Vision: Coverage for a Late Entrant or Re-enrollee will be limited to the Vision Examination benefit in the Benefits Summary during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date. These limited coverages also apply to the Late Entrant's or Re-enrollee's Dependents, if enrolled.

AUTHORIZATION AND AGREEMENT: I hereby declare that all the statements made in this application are, to the best of my knowledge and belief, true and complete, and that they are the basis on which insurance requested by me may be issued. I understand that coverage will not become effective until the Company grants its underwriting approval if required. I understand that there is no coverage for a Pre-existing Condition except as described in the Certificate of Insurance.

I hereby authorize any licensed physician, psychologist, medical practitioner, hospital, clinic, pharmacy benefit manager or other medically related facility, insurance company or its reinsurer, MIB, Inc., formerly known as Medical Information Bureau, or other organization, institution, or person that has any records or knowledge of me or my physical or mental health, drug or alcohol use history, other insurance coverage or employment status, or that of any member of my family whose name appears in the application to which this is attached, to give the Company and its affiliates or authorized representative any such information. I authorize Starmount Life Insurance Company, or its reinsurers, to make a brief report of my protected health information to MIB. This information will be used to determine eligibility for insurance. I understand that I may revoke this authorization at any time by sending a written revocation to the Company at the address above. Such revocation will not affect any action taken or information released prior to the revocation, and will not affect any legal right the Company has to contest an insurance policy / certificate, or to contest a claim under an insurance policy / certificate. I understand that if I revoke this authorization, the Company may not be able to process my application, and may not be able to make any benefit payments due under any existing policy, certificate, or other binding agreement. I understand that once this information is received by the authorized person/organization, then this information may be subject to re-disclosure, and may no longer be protected by federal privacy laws. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 12 months from the date signed. I also understand that I or a person authorized to act on my behalf is entitled to receive a copy of this authorization form and that I may cancel this Authorization at any time by notifying the company in writing, subject to the rights of any individual who acted in reliance on this Authorization prior to my notice of revocation. I also certify that the producer and I, if applicable, also certify that I have read, or have had read to me, this completed application and that I realize any false statements or misrepresentation in it may result in loss of coverage under the policy. I certify that I have received the Notice of Disclosure of Information that is provided at the end of this Enrollment Form. A copy of this form will be as valid as the original. After this form is completed and signed, make one copy for the Policyholder and a copy of page one only for the Member.

In the past 12 months, have you had continuous group coverage providing like or similar benefits (for yourself and/or your dependents) with a prior carrier?
☐ Yes ☐ No If yes, please provide: Policyholder _____ and Insurance Company _____

Important! If declining any coverage for yourself or any dependent, give reason. Covered under: ☐ Spouse's group coverage
☐ Individual insurance ☐ other coverage offered by my employer ☐ other_____

I declare that the information I have completed on this enrollment form is complete and true. I have read and understand the statements and understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from the Company.

Your Signature: x_____ Date signed _____

Spouse's Signature: x_____ Date signed _____

Notice of Disclosure of Information

Information regarding your insurability will be treated as confidential. Starmount Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Starmount Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumer about MIB may be obtained on its Website at www.mib.com.

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