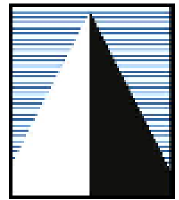
Enrollment/Change Form
DENTAL & VISION INSURANCE

Underwritten by Starmount Life Insurance Company
Administered by: AlwaysCare Benefits, Inc. (A Starmount Life Insurance Company)
8485 Goodwood Boulevard Baton Rouge, LA 70806-7878
1-888-729-5433, Ext 2013 (in Baton Rouge, call 926-2888)
Please print and complete all sections.



GROUP/EMPLOYEE/MEMBER INFORMATION A: Add (enroll) T: Terminate C: Change (change of name or coverage)

Group/Policyholder Name	Group Number	Location	Effective Date	Date of Hire

☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name	First Name	M.I.	Date of Birth	Social Security Number

Home Street Address	City/State/Zip	Home Phone ( )	Work Phone ( )

Email Address	Cell Phone ( )

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name or coverage)

Action	Sex	Last Name	First Name	M.I.	Date of Birth	Handicapped child?
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth	
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No

NOTE for Dental: Members that waive coverage at initial enrollment (within 31 days of effective date) or in the new eligibility period and/or terminate coverage will have a twelve (12) month waiting period applied to basic and major services and orthodontia upon re-applying.
NOTE for Vision: Members that waive coverage at initial enrollment (within 31 days of effective date) or in the new eligibility period and/or terminate coverage are restricted to vision exams for 12 months.

Employee/Member Signature: ______________________ Date: ____________

I elect the following coverage(s):

☐ Dental
- ☐ Employee Only $_____
- ☐ Employee + Spouse $_____
- ☐ Employee + Child(ren) $_____
- ☐ Employee Family $_____
- ☐ Waived due to other coverage
- ☐ Waive

☐ Vision
- ☐ Employee Only $_____
- ☐ Employee + Spouse $_____
- ☐ Employee + Child(ren) $_____
- ☐ Employee Family $_____
- ☐ Waived due to other coverage
- ☐ Waive

Do you or any of your dependents have other dental or vision insurance? ☐ Yes ☐ No

If yes, please give: Policyholder_______________ and Insurance Company ____________________.

Declination of coverage must be accompanied by the Employee's/Member'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.